The Transition Experiences of Overseas-trained Nurses from Kerala, India Working in Mental Health in Australia: A Phenomenological Study

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Abstract

Australia has had to recruit overseas trained nurses to meet ever-increasing workforce demands, especially in mental health. Over the past decade, there has been an influx of migrant nurses from Kerala, India. Background analysis and a literature review revealed that migrant professionals have specific transition needs and that there are particular challenges associated with working in mental health. The aim of this study was to explore the lived experiences of overseas trained nurses from Kerala and working in mental health in Australia. Hermeneutic phenomenology informed by van Manen was the methodological approach used in the study. The participants (n=16) were overseas trained nurses originally from Kerala, India who had been working in mental health in Australia for 2-10 years. The participants were recruited from different States and Territories of Australia. In-depth interview was the method of data collection. The findings resulted in the identification of three key themes: 'Transitioning from general to mental health nursing', 'Cultural transition experiences' and 'Transition experiences of overseas nurses working in Australian mental health services'. Lifeworld existentials associated with the lived experience of the participants were intertwined within each theme. Key findings from the research conducted in this study were challenges related to transition from general nursing to mental health, challenges and experiences related to living in the new culture and mixed experiences of working as an overseas trained nurse in mental health in Australia. The experiences of the overseas trained nurses highlight the specific unique challenges and hurdles that migrant nurses tackle with during the transition period and in their ongoing lives in Australia. Implications of this study indicate the need for ongoing educational and clinical support for overseas-trained nurses working in Australia. Based on the findings, this study also recommends further research in this topic.

Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

Signed…….. Date

Statement of Authorship

I hereby certify that the work embodied in this thesis contains published papers of which I am a joint author. I have included as part of the thesis a written statement, endorsed by my supervisor, attesting to my contribution to the joint publications.

Dedication

There are a number of people without whom this thesis might not have been written, and to whom I am greatly indebted.

My God, for giving me strength and guiding me through this path.

My parents Mr. Joseph and Mrs. Chinnakutty Joseph and my in-laws Mr. Jose and Mrs. Lucy Jose who supported me to learn, grow and develop and who have been a source of encouragement and inspiration to me throughout my life.

The love of my life, my husband Mr. Kishore Jose and the treasures of my life, my children Abel and Ashin, who remained supportive throughout my doctoral journey.

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List of Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian institute of Health and Welfare
INC	Indian Nursing Council
KNMC	Kerala Nurses and Midwifery Council
OECD	Organization for Economic Cooperation and Development
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

Preface

My academic journey began with my Bachelor's degree of Nursing from the Christian Medical College, Vellore, India. My passion at that time was Neurosurgery. I completed my postgraduate certificate in Neuro Nursing and worked in a Neurosurgery ICU and theatre for 1 year. Then I moved on from there to psychiatry, and took a job as a clinical teacher in psychiatry and worked there for 1 year. In 2005, I migrated to Australia and commenced my job as an RN in mental health. After completing my Master of Nursing in Mental Health in 2010, I started working as an Educator in Mental Health. I commenced my PhD in 2013. My motivations for the choice of the research topic are described in Chapter One.

Chapter 1

Introduction

1.1 Australia, a multicultural nation with a multicultural health work force

Australia is a democratic, economically stable nation with a population of 23 million (Department of Foreign Affairs, 2015). The population is derived from approximately 200 different countries, speaking more than 300 different languages (Department of Foreign Affairs, 2015). This multiculturalism is represented across every sector, including health, religion, education, trades and fashion. A large percentage of the population was born overseas (6.7 million persons) (Australian Bureau of Statistics, 2014), with individuals born in the United Kingdom the largest group of migrants (5.1%), followed by settlers from New Zealand (2.6%), China (2.0%), India (1.8%), the Philippines (1.0%) and Vietnam (1.0%). The states with the highest concentration of Indian-born residents are New South Wales (57,156), Victoria (52,853) and Western Australia (15,157) (Australian Bureau of Statistics, 2015).

Australia currently relies on the migration of health professionals from other countries to meet the workforce demands of the health care sector (Health Workforce Australia, 2012; Jeon & Chenoweth, 2007; Konno, 2008; Omeri, 2006 & Zhou, 2010). This explains why today, overseas trained nurses (Australian Institute of Health and Welfare [AIHW], 2015 constitute 30% of the Australian health workforce. Importantly for the present study, up until 2001, the UK was the major supplier of overseas-trained nurses in Australia (Australian Bureau of Statistics [ABS], 2013). More significantly, the migration rate of nurses originally born and trained in India increased from 2% in 2001 to 8% in 2011, and this increase represents “one of the largest proportional increases over this period” (ABS, 2011, p. 9). Many overseas-trained nurses provide care in mental health services, due to variety of reasons including increased job opportunities, visa related reasons and a passion for mental health.

1.2 The mental health care system in Australia

Mental illness is a principal burden on the Australian health care system (Department of Health, 2014). Approximately 7.3 million people aged 16–85 years will experience a common mental health-related condition such as depression, anxiety or substance use disorder in their lifetime (National Survey of Mental Health and Wellbeing, 2013).

The established social history of the Australian mental health care system from an institutional viewpoint began in the 18th century with the opening of the Australian Lunatic Asylum in Castle Hill, NSW (Happell, 2008). Several factors contributed to the attitudes towards mental illness and mentally unwell people including societal attitudes and values of colonial Australians during that time (Queensland Health, 2016). The establishment of therapeutic management of mentally unwell people by trained professionals commenced during the 1950s, and was concomitant with specialisation in mental health nursing as part of a curative process at around the same time (Happell, 2008; Queensland Health, 2016). During the 1980s, the amalgamation of mental health care into mainstream health provision was introduced, with an emphasis on community-based care.

Currently, mental health care in Australia is provided through residential care, outpatient clinics, community services, general practitioners, and mental health specialists, as well as mental health units within general hospitals (AIHW, 2015). Due to the recent introduction of Medicare-subsidised mental health treatment services, the number of people seeking mental health care has significantly increased (AIHW, 2015). This initiative aimed to improve outcomes for people with mental illness with different types of mental health issues. Under this program, Medicare rebates are available to patients from their general practitioners (GPs), psychiatrists, psychologists (clinical and registered) and eligible social workers and occupational therapists (AIHW, 2015). The Australian Institute of Health and Welfare (2016) reported that more than 10.6 million Medicare-subsidised mental health-related services were provided by psychiatrists, GPs, psychologists and other allied health professionals to nearly 2.3 million patients in 2015–16, an average of 4.7 services per patient. Importantly, the total number of Medicare-

subsidised mental health-related services increased by an annual average of 7.6% from 7.9 million in 2011–12 to 10.6 million in 2015–16 (AIHW, 2016).

The mental health workforce in Australia includes psychiatrists, psychologists, nurses, general practitioners and social workers. In 2014, there were an estimated 3,090 psychiatrists and 20,192 mental health nurses working in Australia, equating to 13 psychiatrists and 82 mental health nurses for every 100,000 people (AIHW, 2015).

Contemporary mental health care in Australia follows the recovery model of care (Department of Health, 2014). This strategy encourages patients to recognise and take responsibility for their own recovery and wellbeing, with an emphasis on identifying goals, wishes and aspirations (Victorian Department of Health, 2011). This model of care acknowledges the impact of unresolved trauma on patients' lives, and encourages trauma-informed care (Department of Health, 2014).

1.3 Mental health nursing in Australia

Mental health nursing is a specialised field of nursing. The scopes of practice of a mental health nurse range from working in patient units, community mental health, child and adolescent health, aged psychiatry, rehabilitation, and in drug and alcohol services (Australian College of Mental Health Nurses, 2013; New South Wales Health, 2013). However, the roles and responsibilities of a nurse working in mental health depend on educational qualifications and experience. The mandatory educational requirement for a registered nurse in Australia is a 3-year degree (Australian Health Practitioner Regulation Agency [AHPRA], 2014). In addition, mental health nurse specialisation requires further post-graduate qualifications (Australian College of Mental Health Nurses, 2015).

Nurses specialising in mental health represent 7% of all nurses employed in Australia (AIHW, 2015). Of these, 85% are registered nurses, and the remainder are enrolled nurses (Fig. 1.1). Interestingly, 60% of mental health nurses are aged 45 years and over, 31% are aged 55 and over and 4.4% are aged 65 and older (Department of Health, 2014) as depicted in Figure 1.2.

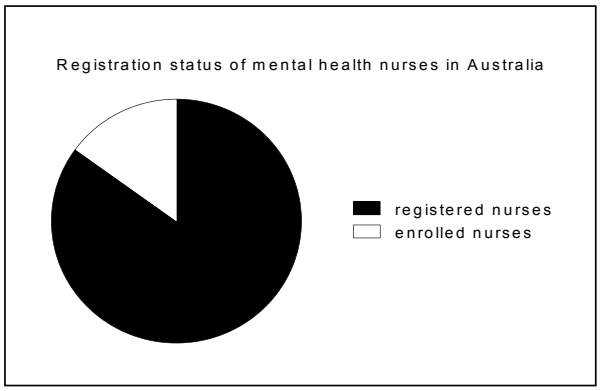

Figure 1.1 Registration status.

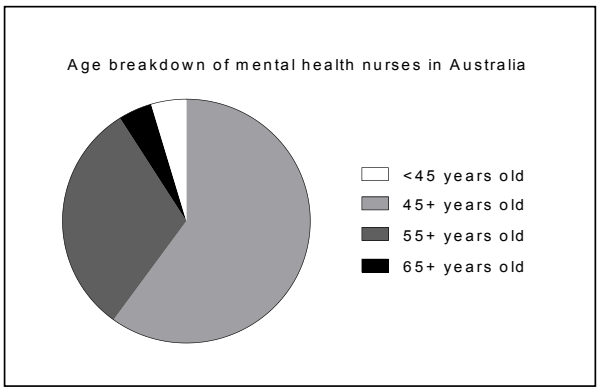

Figure 1.2 Age profile of mental health care nurses in Australia (Department of Health, 2014).

Mental health nursing has been described as challenging and poorly appreciated (Sabella & Fay – Hillier, 2014). It has been suggested that recruitment and retention of mental health nurses can be difficult, due to the complexities involved in the role, and Australia is one of the least self-sufficient nations in meeting their health care workforce needs (Stuart, 2013; Zhou, 2010). For this reason, Australia relies on the migration of health professionals from other countries to meet the workforce demand (Health Workforce Australia, 2012; Jeon & Chenoweth, 2007; Konno, 2008; Omeri, 2006; Zhou, 2010).

Over the past ten years, the number of overseas-qualified mental health care nurses migrating from non-English speaking background has increased, many coming from India (AIHW, 2013; Department of Health Victoria, 2011; Kodoth, 2013; Nurses and Midwifery Board of New South Wales, 2015; Walters, 2005). About 80% of migrating Indian nurses are from Kerala, a small south Indian state (Kodoth, 2013). Despite this increase, only a few studies have examined the migration, transition and working experiences of these nurses (Konno, 2009; Zhou, 2013).

1.3.1 The Recovery Model of Care

Anthony (1993, p.11), one of the pioneers of the recovery model defines recovery as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with

limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". Later, Deegan (2003, p.368) identified the recovery model as unique process, way of life or attitude, involving the growth of new meaning and purpose beyond the effects of mental illness' It is notable that available definitions on recovery highlight the notions of empowerment, uniqueness, personal values and personal goals.

Application of recovery models in mental health care is relatively recent. Recovery model became acknowledged and practised concept within mental health systems in a number of countries including the United States of America, England, Ireland, Australia and New Zealand (Schrank & Slade, 2007).

The recovery model of care can be traced to the United States of America from the 1970s and 1980s. The movement began when people with a mental illness started speaking and writing about their lived experiences of recovery (Deegan, 2003). The model was also researched by Canadian academics during the 1980s (Deegan, 2003). Later, the model of recovery was exported from America to other countries such as Australia and New Zealand (O'Hagan, 2004). In the United Kingdom, recovery was also a topic of discussion during 1970s and 1980s. The shift towards community based model in the UK during 1980s was based on this model. However, recovery was first acknowledged in a UK policy document in 2001 (O'Hagan, 2004). In Ireland, the Mental Health Commission (2008) released 'A Recovery Approach within the Irish Mental Health Services'.

New Zealand started adopting the concept of recovery during 1990s. New Zealand is currently considered as holding one of the most current and developing national recovery policies and practices internationally, with advanced concepts of recovery and recovery and recovery orientated services and practices (Schinkel & Dorrer, 2007). Australia is highly influenced by the New Zealand recovery model in mental health policies and practices.

Though many Western countries have shifted the paradigm and embraced recovery oriented mental health practice, developing countries still follow the medical model of care. There is limited literature available about recovery model of practice in the Indian

context. Furthermore, available literature identified that an under-resourced mental health care system, poor infrastructure, the poor ratio of health care professionals and stigma against mental illness are possible barriers, especially in adopting the recovery model (Addhlakha, 2008). In addition, the absence of a strong formal social care system including community mental health services and other reintegration, rehabilitation support services in India also are considered as challenges (Halliburton, 2009).

1.3.1a Recovery in Australia

Recovery oriented mental health practice is considered as the best available and contemporary model of practice in many Western countries including Australia. According to the Department of Health (2016), for an individual with mental illness, the personal meaning of recovery is mainly about gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. In other words, this concept claims that the personal recovery is determined and defined by the individual, based on his/her needs, hopes and aspirations, not by the treating team or policy makers. The National Mental Health Strategy (2012) asserts, that the recovery model is promoting and helping consumers to take control of their life and managing the symptoms of their mental illness. However, it is argued that the application of the recovery model during the acute phase of the illness is limited due to impaired mental status and thereby compromised judgement and decision-making (Department of Health, 2016). Involvement and input of carers and family is highly endorsed during that stage. However, during later stages, when capacity is improved, consumers are provided with opportunities to make decisions and choices about their treatment and future.

The concept of recovery was adopted in Australia from the late 1980s did recovery models of practice gain importance and influence in Australia. By the third National Mental Health Plan (2003) it was highlighted that recovery models should drive mental health service delivery. Recently, the Australian government introduced the 'National framework for recovery-oriented mental health services: Policy and theory' (Commonwealth of Australia, 2013).

The practice of recovery models of care in Australia has been adapted from the recovery literature from the USA, and also from Canada, the UK and New Zealand (Amering, & Oades, 2008).

It is evident that mental health nurses play a vital role in promoting and practising recovery models of care. The demanding role of a mental health nurse includes instilling hope in consumers and affirming positives, focusing on strengths and assisting consumers to view themselves as an individual rather than someone with a mental illness (Fisher, 2011). In addition, it has been voiced by consumers and nurses that therapeutic communication skills and counselling are central to the role of the mental health nurse in the recovery process (Fisher, 2011). Significantly, mental health nurses are in a unique position to assist individuals in assessing their mental health status and integrating their future goals and ambitions into recovery plans.

1.4 Kerala: A brief background

Kerala is one of the smallest states of India, and home to 2.8% of the population (Department of Tourism Kerala, 2013). The state has a strong cultural heritage, characterised by a rich history of customs and values. This culture is strongly influenced by religion, philosophy, language, art, education and social organization (Department of Tourism Kerala, 2013). Kerala is one of the most progressive states of India, and the state claims the highest literacy rate, the highest life expectancy and the highest 'Human Development Index' in India (Government of India, 2013).

According to Kurien and Rajan (2013), Kerala's migration history has had four main stages. The first stage during latter part of 19th century and early decades of 20th century; commenced when laborers and farmers migrated to other British colonies, such as Malaysia, Singapore, Burma, and Sri Lanka. The second stage occurred during early 1950s, when qualified Kerala residents, mostly teachers, migrated to African countries. During the 1960s (third stage), Kerala migrants, mainly professionals such as nurses, doctors, engineers and teachers started migrating to North America and Western Europe. The fourth stage occurred during the 1970s, where migration was mainly to the Persian Gulf. Over 10% of Kerala's population now, lives outside the state and remittances to Kerala from previous residents have had a positive impact on all facets of

Kerala, including the social structure, household expenditure, population growth and poverty levels (Samuel, 2011).

While previous studies have examined the migration of Indian nurses (Jose, 2008; Wells, 2013); little information is available on the migration of nurses from distinct provinces within the sub-continent. Specifically, there is an absence of information on the transition and working experiences of mental health care nurses from Kerala in south-west India.

1.5 Nursing in Kerala

Post-independence India adopted British infrastructure in various areas, including nursing education (Nursing and Midwifery Council Kerala, 2016). The history of formal nursing education in India began with the establishment of the School of Nursing, at the General Hospital in Madras in 1871 (Ministry of Health India, 2015).

In Kerala, there are both non-university and university programs of pre-registration nursing education. Non-university programs take the form of a 3.5-year Diploma of Nursing and Midwifery program, which is conducted in hospitals (Nursing and Midwifery Council Kerala, 2013). Universities offer a four-year degree and a Master of Nursing qualification. The Diploma of Nursing and Bachelor of Nursing qualifications can be used to gain a 'Registered Nurse' licence, which is provided by the Kerala and Indian Nursing Council. This licence enables eligibility to apply for registered nurse qualifications in most foreign nations (Nursing and Midwifery Council Kerala, 2013).

During the development of the nursing profession, nurses were expected to perform many non-nursing jobs (Mathew, 2012). For this reason, nursing was historically classified as a low status job, characterized by low salaries (Abraham, 2012). In Kerala at that time, there existed a distinct hierarchy in the health professions. While medicine was considered a profession of prestige, nurses were considered as no more than assistants to doctors. This attitude towards nursing started changing in Kerala during the 1960s, predominately due to the fact that many female nurses could support their entire households by migrating to foreign nations (Zachariah & Rajan, 2012). Subsequently, research conducted among Kerala nurses has identified that more than

half of Kerala's nursing graduates have intentions to migrate and practice overseas (Dicicco-Bloom, 2004; Thomas, 2006; Zachariah & Rajan, 2012).

1.6 Mental health nursing in Kerala

Mental health nursing was included in the Indian nursing curriculum during 1964 -1965 (Mandal, 2014). Currently, mental health nursing is considered as a speciality in India. Specialisations include the Post-Graduate Certificate in Mental Health Nursing, the Diploma in Mental Health Nursing and the Masters of Mental Health Nursing (Indian Nursing Council, 2013). Similar to other developing countries, the literature on mental health care in Kerala asserts that there is stigma attached to mental illness and mental health care (Mandal, 2014). There have been few studies on the mental health nursing profession and contemporary mental health practice in India. However, Poreddi, Chandra and BadaMath (2015) study, which according to the researchers, was the first Indian study to examine preparedness to work in mental health nursing and attitudes of undergraduate nursing students (n= 116) to mental illness and mental health nursing, highlighted the negative perceptions of students of mental illness and mental health nursing. This study also recommended important changes in the nursing curriculum. The authors completed a review of the Bachelor of Nursing and Master of Nursing course curricula (Indian Nursing Council, 2013). It was noted that Indian mental health nursing still places a significant focus on different diagnoses and their management. Further, the review identified the lack of emphasis on consumer/carer involvement and the recovery model of care.

1.7 Migration and migration of nurses from India

Migration of Indians to Australia commenced with a small number of labourers during the 18th century (The Government of India, 2013). While there were around 7000 Indians in Australia during the early 20th century, 'The White Australia' policy considerably restricted migration (Migration Heritage Centre, 2013; Walsh, 2001). After the end of this policy in 1973, migration slowly recommenced, and recent statistics have shown that Indians are the largest group seeking permanent residency in Australia (Australian Bureau of Statistics, 2013; The Government of India, 2013).

As stated, Australia currently relies on the migration of health professionals from other countries to meet the workforce demands of the health care sector. Prior to 2001, the UK was the major supplier of overseas-trained nurses in Australia; however, the pattern of inflow of overseas-trained nurses has changed more recently (Australian Bureau of Statistics, 2013). Currently, the highest numbers of overseas-trained nurses working in Australia have migrated from India. In addition, the statistics on the migration of foreign-educated nurses affirm that a significant number of Indian nurses have also relocated from Europe, the United Kingdom, India, and the Middle East (Kodoth, 2013), and some of these nurses have relocated to Australia.

The experiences and challenges faced by migrant professionals are different to those of domestic professionals. Research on the experiences of migrant nurses' highlights themes such as isolation, separation, communication, under-estimation by patients and colleagues, and issues related to enculturation and lack of orientation to the new health care system (Department of Health, 2015; Jeon & Chenoweth, 2007; Konno, 2008; Omeri, 2006; Walters, 2005). Studies have also suggested that working in mental health is more stressful than working in other nursing practices (Currid, 2008; Jenkins & Elliot, 2004). This is due to many factors, such as issues related to communication and the need for a beneficial therapeutic relationship. Another possible challenge may be the unfamiliar model of mental health care in Australia. The cumulative result of these factors can influence job satisfaction and sustainability. Therefore, an understanding of the issues arising from the transition of mental health nurses to a new country would provide insights to better support and supervise these nurses. However, there have been few published studies on these factors, resulting in a deficiency of this important information.

Other important aspects highlighted in the literature regarding migrants are acculturation and transition experiences. Again, a considerable number of studies focusing on overseas trained nurses have also emphasized acculturation and transition related challenges (Jeon & Chenoweth, 2007; Jose, 2008; Konno, 2008; Omeri, 2006; Walters, 2005). The following section outlines the theories and concepts about acculturation and transition.

1.8 Theories and concepts related to acculturation and transition

The International Organization for Migration (2014) estimates that 214 million individuals globally chose to be international migrants in 2013. This data, points to a considerable rise of more than 40% from 150 million just over a decade ago in 2000 (International Organization for Migration 2016). This indicates that 3.1% of the world's population or one in every 33 persons globally, is a migrant (International Organization for Migration, 2013). Various theories and concepts have been postulated to explain the acculturation process and the transition experiences of migrants. Research on acculturation has played a critical role in shaping and informing scientific research on migration and transition in the new country. Unlike other human sciences, sociology and psychology reported most of the literature around concepts of acculturation and transition.

1.8.1 Theories of stress and coping

The various stress management and coping mechanisms are used by migrants entering the new country and are underpinned by psychological theories of stress and coping. Berry (2006) argues that the process of cultural adaptation of a migrant in the new country and culture can be explained by two models: the cultural learning model and the stress, coping and adaptation model. Explaining Berry's theory, the process of cultural adaptation occurs when the migrant populations tend to learn various cultural specific skills that would help them survive and negotiate the ways through their new environment and culture. This theory also argues that the acculturative stress is mostly generated by the necessity to adapt with the demands of new culture and still following own culture (Berry, 1987). Berry's theory (1997), which is based on earlier works regarding stress and coping among migrants, identifies four acculturation strategies including assimilation, separation, marginalization and integration. It is noticeable that these four levels of acculturation strategies are often adopted of by migrants when trying to adapt the host culture. Again, this theory focuses on the role of personal factors such as values, believes and cultural norms prior to and during the process of acculturation (Berry, 1997). Additionally, these factors were found to be critical in

determining the extent to which the migrant population can adapt to their new environments.

Another scholar, Torres (2010) asserts that stress and coping are natural responses to the various challenges and conflicts arise from the intercultural contact with people in the new environment. Ward and Kennedy (2001) are also of the opinion that, the stress and coping model stand as the most widespread concept that has been used to explain the transition acculturation behaviors of migrants. It can be assumed that migrating to a new country is a major life event leading to stress due to unfamiliarity and challenges in the new country. Expectedly, strategies to deal with stress and coping are normal and natural for people migrating into new countries.

Berry's cultural adaptation model represents one of the most influential works about acculturation and transition. According to Barry (2006), adaptation in a new environment starts with a behavioral shift whereby the individual adopts the ways of the host culture as a means of reducing stress or intergroup conflicts. Paradoxically, this often leads to increased stress among the migrants. Another concept around the post migration experience is the acculturative stress model suggested Schwartz and his colleagues in 2010. This model describes about the stress experienced by the immigrants, refugee communities, and indigenous people when they interact with people from a dominant culture. Basically, Schwartz et al. (2010) postulate that a migrant's transition involves various levels of challenges thereby where the individual's personal identity and coping mechanism play a vital role. It includes the person's life goals and decisions (Schwartz et al., 2012). It also varies across the cultures and migrant generations (Schwartz et al., 2012).

1.8.2 Multivariate stress-mediation-outcome theory (Cervantes and Castro, 1985)

The stress-mediation-outcome (Cervantes & Castro, 1985) concept is one of the oldest theories of cultural adaptation. Furthermore, this theory specifically addresses the relationship between stress, its responses and mental repercussions among immigrants. Among the issues identified as causing stress among immigrants included the demand for cultural changes, loss of their individual statuses as immigrants and economic difficulties associated with migration. Additionally, various external factors were found

to be associated with the immigrant's stress appraisal interactions. This theory also proposed the identification of culture-specific stress appraisal and coping mechanisms used by migrants. It addresses the relationships among stress, stress responses, and mental health consequences for immigrants.

1.8.3 Resilience-based stress-appraisal-coping model (Castro and Murray, 2010)

More recently, Castro and Murray (2010) developed and refined the model based on resilience. According to this theory, resilience is an outcome of adaptation that results from the migrant's constant efforts to cope with multiple sources of stress in the new environment. Again, this model asserts that coping abilities are important in the psychosocial development of migrants. Furthermore, with such resilience and coping skills migrants survive in their new environments.

1.8.4 Stress and coping grounded theory for recent immigrants by Yakushko (2010)

The model by Yakushko (2010) was a direct derivative of an empirical qualitative study. Yakushko's (2010) findings pointed to broad categories of coping behaviors used by the immigrant participants are influenced by 'individual values', 'connections', 'giving', 'personal development', 'distractions', and 'help-seeking' by immigrants. Interestingly, this identifies acculturation related stresses as natural part of the cultural adaptation process (Yakushko, 2010).

1.8.5 Culture learning concept

In addition to the theories of stress and coping, cultural learning is another applicable theory that explains the acculturation transition from a culture learning perspective. According to Zhou et al. (2008) cross-cultural travelers and migrants need to learn social skills that are culturally relevant to their future stay in the new environments (Zhou et al., 2008). Culture learning theory focuses on the behavioral aspects related to intercultural interaction. This concept posits the ability to adapt to the new culture and environment is dependent on the individual's knowledge about the new culture, length of stay in the new environment, language competence, quantity and quality pf the migrant's contact with hosts and level of friendship networks (Masgoret & Ward, 2006).

1.8.6 Models of acculturation

The contemporary literature associates the phenomena of acculturation as a 'state' rather than a 'process' (Zhou, 2010). There are three models of acculturation, namely uni-dimensional, bi-dimensional and multidimensional. Explaining these concepts; the traditional uni-dimensional model involves the process of adjusting and adapting to the new country totally and gradually losing the ethnic originality as first introduced by Gordon (1964). The adjustments often involve losing of the ethnic identity and language by the third generation (Portes & Hao, 2002). In contrast, two-dimensional immigrant groups have been able to maintain their language and culture for multiple generations. Surprisingly, in this model immigrants are able to manage the demands of own culture and the host country's culture. This amalgamation maintenance of the ethnic culture and adoption of the mainstream culture is called integration or biculturalism (Van de Vijver, 2006). Whereas, in contemporary multidimensional acculturation, the individual is selective, however adapt a few new traits but retain what is important (Padilla, 1987). In other words, it is adapting the new culture and leading a multicultural life. Traditionally, theories of acculturation have developed from the unidirectional school of thought with an emphasis on assimilation, and eventually to bi-dimensional and interactive perspectives, which postulate various acculturative outcomes (Berry, 1980; Castro, 2003). In explaining these concepts further, it is argued that unidimensional acculturation can be identified as assimilation, were the person gets drawn up into the host culture (Ngo, 2008). Furthermore, it has been based on the assumption that adoption of the host culture facilitates equality in life style and identification with domestic people (Ngo, 2008). The bidimensional acculturation model in contrast, emphasises the preservation of the migrant's cultural heritage (Berry, 1980). Berry believes bidimensional acculturation is similar to integration, where the migrant is slowly integrating into the host culture, without completely adopting it (Berry, 1980). Berry asserts that the level of integration is subjective and varying (Berry, 1980). It is acknowledged that the bidimensional theory has conceptual limitations.

Later, Bourhis et al. (1997) introduced interactive acculturation from a psychosocial viewpoint. This theoretical framework argues that acculturation involves three steps, which are: acculturation adopted by the migrants, acculturation adopted by the

domestic population and finally, interaction and interpersonal reactions between migrants and the domestic population (Bourhis et al., 1997).

Importantly, all these theories have overlooked the process of transition and acculturation through psychology and sociological lenses. Most of these theories conclude that the transition process within the new country is contextual and influenced by multiple factors.

1.8.7 The social identity model of acculturation

This model of acculturation focusses on the process whereby the individuals develop a sense of identity in the new country. Social identity theory (Hogg & Terry, 2000) is based on the concept that individuals need strong sense of group identity for their psychological well-being. For this reason, migrants struggle to belong themselves for identity and self-esteem. Importantly migrants with distinct features compared to natives (skin color, accent) are usually under estimated and negatively seen by natives (Padilla & Perez, 2003). To enhance the identity migrants are generally motivated to join in groups (example church group).

Various theories have tried to conceptualize the notion of acculturation. Acculturation and transition are multifaceted phenomenon. Additionally, the above-mentioned concepts assert about the influence of various factors influencing acculturation.

1.9 Researcher's personal background

The researcher is a migrant from Kerala who has been working as a mental health nurse in Australia since 2005. The lived experiences in Australia differed from the researcher's expectations, which were built upon earlier experiences as a nursing student and registered nurse in mental health in India. The unfamiliarity with the Australian mental health system, including legal boundaries and practices, along with cultural aspects, such as social norms and language, created a challenging working environment, personal and social life. The author relied heavily on strong theoretical knowledge to boost her confidence in such challenging situations. Upon arriving in Australia to work, a three-month adaptation program was required before employment could commence. This

program was generic, and did not successfully prepare students for the Australian healthcare system, despite the level of clinical experience of the student nurses.

After gaining employment within the mental health sector, the realities of being alone in a new country, away from family and friends, and having to adapt to a new environment and context, along with the demands of having to 'fit in' to the new culture, added to an already stressful working environment. Through conversations with other nurses, the author discovered that her experiences as a mental health nurse in Australia were distinct from the experiences of other colleagues who had immigrated from Kerala and who were working in areas outside mental health. Therefore, the author sought to understand and describe these differences within a formal research context.

1.10 Area of interest

While there have been studies on overseas-trained nurses working in the US and Canada, (Jose, 2013; Kodoth, 2013; Wells, 2013), they have not covered the specific experiences of Kerala nurses, nor have they sought to examine specialty nursing areas such as mental health. Furthermore, the few available Australian studies (Konno, 2008; Zhou, 2010) investigated overseas-trained nurses from multiple ethic origins working as nurses in Australia. The present study therefore investigates the lived experiences of nurses who have migrated from Kerala to Australia and who are currently working in mental health.

1.11 Research question, aim and objectives

The **research question** is:

> What are the transition challenges of being an overseas trained nurse from Kerala, India, migrating to Australia, and currently working in mental health nursing?

The overall **research aim** of this study is:

> To contribute to the understanding of the lived experiences of Kerala trained nurses who currently work in mental health nursing in Australia, and the unique transition challenges they have faced.

The **research objectives** of this study are defined as follows:

To explore their reflections on the transition from becoming a general nurse to a mental health nurse.

To explore and interpret their reflections on the transition from Kerala to Australia.

1.12 Research methodology

According to van Manen (1990), phenomenological research provides an avenue for researchers to explore the lived worlds of individuals, and seeks to interpret the personal meanings that are embedded in their lived experiences. According to van Manen, phenomenological research motivates thoughtful sensitive reflection on experiences, by exploring the "heart of things" (p. 12). Therefore, the present study explores the lived experiences of overseas-trained nurses from Kerala, India who are working in Australian mental health nursing (the 'phenomenon'). The study was conducted with ethical approval from Monash University's Human Research Ethics Committee (Appendix. 1)

The study recruited sixteen registered nurses from three different states of Australia, who had originally trained in Kerala, and who at the time of interviews was working in mental health nursing in Australia. Data collections was achieved by in-depth face-to-face interviews and were analysed using van Manen's methods of thematic analysis to describe the subjective meaning of the participants lived experiences.

1.13 Significance of the research

Contemporary mental health practice in Australia focuses on primary care and client-led 'recovery models' of care with ongoing carer participation and collaborative planning. It also demands teamwork, assessing clients in their cultural context, engagement, communication and working within specific legal boundaries. As many developing countries still follow a 'medical model', rather than a 'recovery model' of mental health care, new migrant professionals may not have been exposed to this system previously. Further, it has been suggested that both the domestic work force and patients may show ambivalent feelings towards migrant professionals, which may lead to such

professionals feeling undervalued (Alexis & Vydelingum, 2004; Hawthorne 2000; Konno, 2008; Zhou, 2010).

Another factor that contributes to the importance of this research is the cultural background of Indian nurses. Like other Asian countries, India follows a strong collectivist culture (Wells, 2013). It is essential for healthcare providers and employers to understand the effects of cultural background in their employee's practices. It is known that Asian and Indian attitudes and practices are distinct from the Western model (Liou, 2007; Wells, 2013). This is also applicable to providing support and training and in terms of retention of the nursing workforce.

This current study will contribute to the existing body of knowledge by focusing on the lived experiences of overseas-trained nurses with the intention of exploring their migration and transition experience in the new country and new workplace, along with their hopes and aspirations for the future. The outcome of this research may assist future overseas-trained nurses from similar backgrounds undergoing a similar transition by enabling them to utilise support strategies for a positive transition experience. It is anticipated that this study will assist stakeholders and employers with the employment, training and support of overseas- trained nurses.

1.14 Synopsis of the thesis

The Introduction outlines the cultural and health systems context for the study as well as the research question, aim, objectives, significance and methodology. This is then followed by Chapter 2, the Literature Review, which provides an overview of the theory of transitions, culture theory, acculturation and an in-depth analysis of previous studies related to the research aim. Relevant aspects of the research topic are examined in relation to the existing body of knowledge. The Literature Review also uncovers the gap in the literature regarding the experiences of overseas-trained nurses, which facilitated the development of the research question. The focus here is on studies that address the experiences of overseas-trained nurses, transition experiences and experiences of working in mental health. Chapter 3 outlines the research design and the justification for the choice of hermeneutic phenomenology to answer the research question. The chapter also covers the developments in phenomenology over time as well as some

criticisms and limitations of phenomenology. A brief description regarding the use of phenomenology in the field of nursing is also presented. Chapter 4 presents an in-depth description of van Manen's method and a justification of its appropriateness for the present study. In addition, there is an explanation of how the research question fits with the method. There is detailed emphasis on the collection, analysis and interpretation of the data. Chapter 5 presents the general and descriptive findings about the participants' lives and their histories of having been trained overseas in Kerala and the cultural transition to living and working in Australia. Chapter 6 outlines general thematic codes identified in relation to the nurses' life transitions and work in mental health nursing in Australia. These thematic codes are supported by examples of data from the transcripts, in the form of quotations and paraphrased summaries. This chapter also presents the phenomenological findings of the research. The lifeworld themes derived from the analytic method of van Manen's four lifeworld existentials are also described. The final chapter, Chapter 7, provides a discussion of the findings in relation to the methodology used and the existing literature. The three main themes that emerge from this study are discussed in relation to the relevant research in this field. The implications of the study for practice, education and further research are discussed. It is anticipated that the findings of the study will be applicable in various contexts, including overseas-trained nurses from other countries working in mental health, Kerala nurses working in general health, and professionals from Kerala working in other disciplines. It is hoped that dissemination of these research findings will initiate further exploration and research in this field.

Chapter 2

Literature Review

This chapter provides an overview of the literature related to transitions theory, culture and acculturation and outlines the specific search of the literature and the findings of relevant studies on the experiences of migrant nurses, their transition experiences and their experiences working in mental health. The objective of this review is to identify, analyse and summarise the available literature on the lived experiences of overseas-trained nurses working in foreign nations. All relevant aspects of the research topic are analysed in relation to the existing body of knowledge. This chapter also presents the gap in the literature regarding the experiences of overseas-trained nurses, specifically in mental health, and the development of the research question. The main focus in the chapter is on studies that address the experiences of overseas-trained nurses, their transition experiences and their experiences of working in mental health. Importantly what was identified was limited understanding of the transition experiences of overseas-trained nurses working in mental health in Australia.

2.1 Literature search and selection strategy

This review was initially conducted in 2013. However, the literature review for this study was ongoing. Using the key words and phrases described in Table 2.1, the researcher conducted a search of the selected databases, focusing on empirical studies on the topic of interest. The researcher also set auto search alerts to receive alerts on relevant new articles on this topic. The second stage was implemented after the data analysis. A second stage literature review was undertaken in relation to terms and themes repeatedly used by the participants such as *acculturation, *culture shock, *transition, and *adaptation. Publications matching these search terms were selected. Primary parameters for the search were English language and full text (see Figure 2.1, Table 2.1). The included papers are identified in Table 2.1.

Table 2.1: Literature review parameters

Databases searched	Best Practice, Scopus, CINAHL Cochrane Systematic Review, EMBASE, FACTIVA, Joanna Briggs, Medline, OVID, Proquest, PsychINFO, and Wiley Online.
Search terms	*Australia, *Nurse, *overseas qualified, *migrant, *foreign (Australia*) AND (Nurse*) AND (migration*) (Australia*) AND (Nurse*) AND (overseas*) *Experiences AND challenges; *Overseas health professionals, *international nurses, *Kerala, *Kerala nurses *overseas, *Kerala nurses, *foreign nurses, *mental health, *mental health, *psychiatry, 'migrant'/exp OR migrant AND ('nurses'/exp OR nurses), overseas AND trained AND nurses AND experiences. Acculturation, *culture shock, *transition, and *adaptation.
Primary parameters	English language, full text, Published after 1995
Excluded articles	Articles dealing with illegal migrants, refugees, children

Initial literature search elicited a wide range of articles from various sources including peer reviewed journals, conference papers, reports and other electronic media. Several articles were on migration in general, refugees and other irrelevant topic to this research. Process of rejection of irrelevant articles was after careful analysis.

The search terms mentioned above include the terms researcher had used to identify articles from the beginning. During the second step of literature review, the researcher mainly focused on the themes identified during interviews such as cultural transition and other aspects of transition.

The below figure provided literature review parameters including database used, initial results, inclusion and exclusion criteria, and number of articles reviewed. A total of 30 main studies and a few other relevant studies were reviewed and included in this study. Within those 30 main studies, 25 are relevant peer reviewed journal articles and major research studies 5 are government documents and policies. A number other relevant articles have also been used for this study.

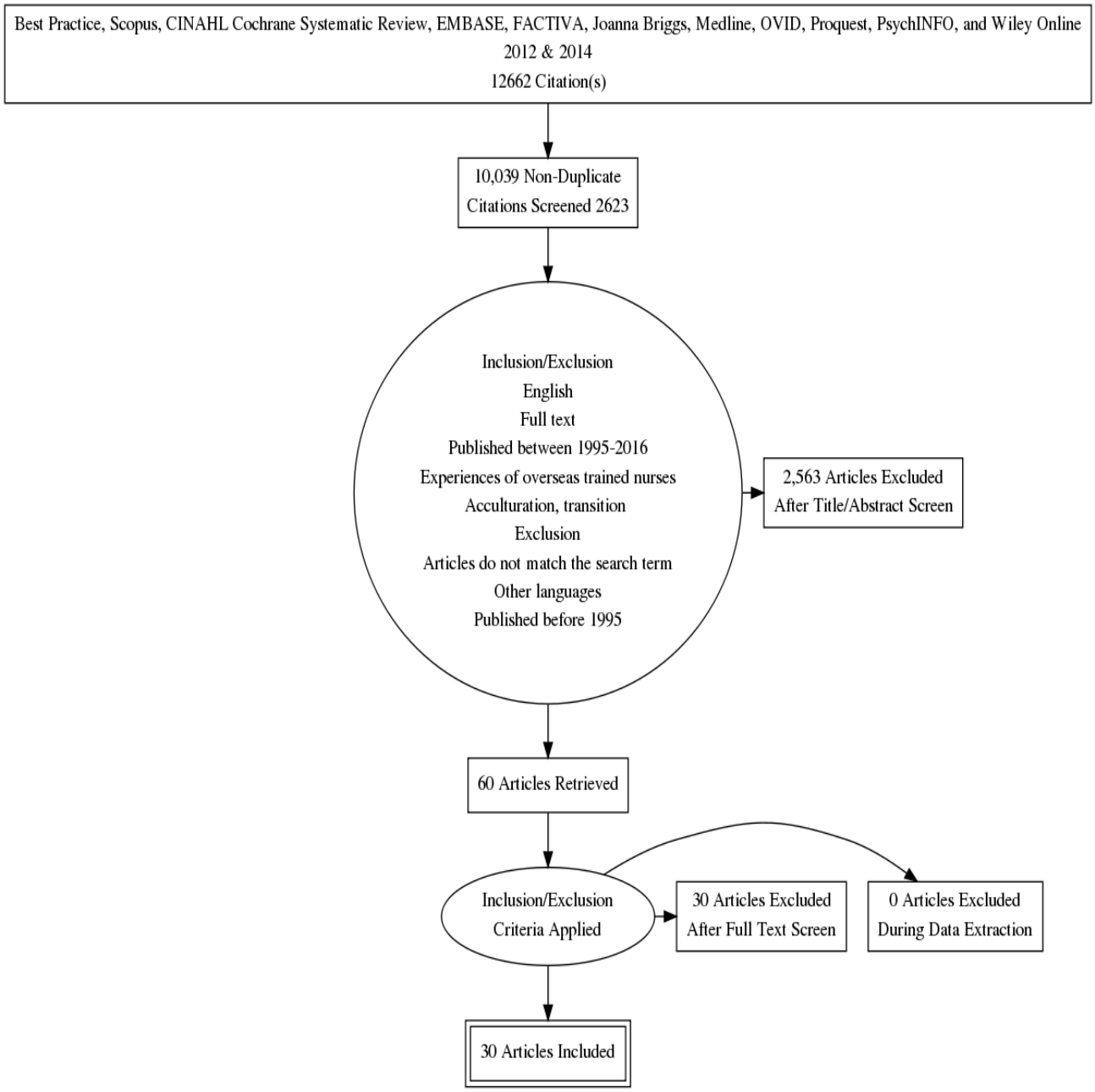

Figure 2.1: Literature review parameters

Table 2.2: Summary of main studies selected

Studies Selected	Study involved Kerala nurses working overseas	Study involved overseas-trained nurses	Study involved mental health nurses	Various aspects of transition	Overseas-trained nurses in mental health
Goh & Lopez (2015)		✓		✓	
Kishi, Inoue, Crookes and Shorten, (2014)		✓		✓	
Sabella and Fay-Hillier (2014)			✓		
Harrison, Hauck and Hoffman (2014)			✓		
Wells (2013)	✓			✓	
Heyman (2012)			✓		
Alexis (2012)				✓	
Zhou (2010)		✓		✓	
Smith, Fisher and Mercer, (2011)		✓		✓	
Wooldridge and Bland (2011)	✓			✓	
McTiernan and McDonald (2011)			✓		
Ea, Itzhaki, Ehrenfeld, and Fitzpatrick (2010)		✓		✓	
Dicicco-Bloom (2004)	✓			✓	
Jose (2008)	✓	✓		✓	
Xu (2008)					
Konno (2008)		✓		✓	
Brunero, Smith and Bates (2008)		✓		✓	
Omeri (2006)		✓		✓	
O'Brien & Jackson (2007)		✓		✓	
Jeon & Chenoweth (2007)		✓		✓	
Kingma (2007)		✓		✓	
Walters (2005)		✓		✓	
Jenkins & Elliot (2004)			✓		
Gerrish & Griffith 2004)		✓		✓	

The review highlighted the existence of a substantial gap in the literature regarding the experiences of overseas-trained nurses, especially in the context of Australia. In addition, although some aspects of the experiences of overseas-trained nurses have been investigated, there is a scarcity of literature regarding overseas-trained nurses from a specific cultural background and working in specialty areas such as mental health.

2.2 Migration history and current trends

Human migration is defined simply as the movement of people from one place to another (Glossary of Migration, 2013). The history of migration to Australia begins with the migration of Australian Aboriginal tribes some 40,000 years ago (Migration Heritage, 2015). Around 100 years ago, it is believed that Chinese, Indian, Arabian and Malay sailors began exploring the seas around Australia and trading with the original Aboriginal settlers. The first Europeans to arrive in Australia were the Dutch in the 16th century, and British colonization and settlement occurred during the 18th and 19th centuries. During this time, migration to Australia from other European countries was also heightened due to the discovery of gold, along with the global economic depression (Migration Heritage, 2011). Migration of non-Europeans was restricted during the 20th century due to the Australian Government's 'White Australia Policy' until the 1950s. During the 1970s and 1980s, more than 100,000 migrants from Asian countries arrived in Australia.

Australia has accepted 1.7 million migrants since World War II (Metcalf, 2010). Today, one in three Australians was born overseas, and nearly half of the Australian population (45%) has one parent born overseas (Australian Bureau of Statistics, 2014). Migration to Australia is through either the *skilled migration stream* or the *family stream* (Department of Immigration, 2015). The skilled migration stream is divided into four main categories: i) point-tested skilled migration (applicants must score a certain number of points on the different categories, such as age, language and occupation). ii) employer-sponsored migration (in which employers offers sponsorships for highly skilled foreign workers to fill vacancies), iii) business innovation and investment program (for investors and business owners who wish to establish businesses in Australia), and iv)

distinguished talent (visas for people who have internationally-recognised talents). The family stream enables family members of Australian citizens or permanent residents to reunite with their families by migrating to Australia. The state capitals Melbourne and Sydney are known as 'Global Hubs', with a significant number of residents originating from foreign countries (Migration Programme 2015-2016). It is believed that migration will provide a significant contribution to the growth of the Australian economy (Australian Bureau of Statistics, 2013).

2.3 Transition and acculturation experiences of migrants

This section explores and analyses the literature on transition and acculturation expereices of migrants' especially Indian migrants in Western world. It was evident that only a limited number of researches examined the post migration experiences of Indian migrants. Interestingly India has the largest diaspora population in the world (United Nations Department of Economic and Social Affairs, 2016).

An American study conducted in 2012, examined the acculturation outcomes of Asian Indian women (Kankipati, 2012) living in America. This study particularily considered the influence of demogaphic and socioeconomic factors in the process of acculturation. This study has employed quantitative survey method and Berry's Model (Berry, 1990) to explain the acculturation experience. A total of more than 150 Indians completed the survey. The results of this study Indicated Indian women adopted integration Model of acculturation where they accepted certain aspects of Western culture (Kankipati, 2012). The researcher of this study suggests that in comparison with Indian men, Indian women are considered as carriers of tradition and culture. Hence the model of acculturation of Indian women might influence the entire family (Kankipati, 2012). Again, this study has identified socioeconomic factors, personality traits and behaviour tendencies can influence acculturation (Kankipati, 2012 p.173). Additionally, employed Indians and who socialised more with Americans have shown more acceptances towards American culture and life style. The behaviour tendencies such as openness and socialisation with Americans also have influenced the process of acculturation. However, the main limitation of this study was lack of randomization of the sample (Kankipati, 2012). The

participants were from two main networking sites of Indians in America. The author of this study suggested future qualitative studies on acculturation experiences of Indians.

Another relevant study by Mathur (2000) has also examined the process of acculturation of migrant Indians in America. The aim of this study was to identify the preferred mode of adaptation of Indian migrants. The ethinic identity of participants (migrants living in America) were then compared with the ethinic identity of Indians living in India. The results of the study highlighted that children of Indian migrants have adopted bicultural identity however first-generation migrants have adopted bicultural identity only after an average of 20 years. The first-generation migrants valued their culture, identities and marriage system (Mathur, 2000). Indians who lived in India expressed negative bias towards Western culture. However, migrants and their children have demonstrated positivity towards Western Culture (Mathur, 2000). Eventhough the results are applicable to some extent to the current study; the above studies have examined experiences of migrants from Northern India. The culture and tradition of Nothern India is distinct compared to the south. Importantly, participants of this study are from Southern part of India, Kerala.

The literature suggests that many facors can affect the process of acculturation and transition. This include personal factors such as personality, behaviour traits values and own views towards one's culture.

2.4 Transition experiences of non-English speaking migrant nurses

There is ongoing concern over fluctuating shortages of health professionals throughout much of the industrialised world (OECD, 2014). There have been vigorous debates concerning the rights and responsibilities of healthcare personnel regarding migration, what factors affect these shortfalls, and what measures should be employed to minimise shortages (Aiken et al., 2004; AIHW, 2013; Konno, 2008; Omeri, 2006; Walters, 2005; White & Winstanley, 2010). Notably, the overall number of qualified health personnel is affected by generational patterns of career choice, the migration process, and educational opportunities. Previously, migrant nurses were mainly from countries such as the UK and Canada (AIHW, 2013). However, migration trends have changed recently, with an increasing number of migrants, especially nurses, originating in developing

countries such as India, Indonesia, The Philippines and the African Continent (Smith et al., 2011). Many of these migrants fill shortages in the health care sector and undergo significant difficulties transitioning into the Australian culture and workforce (Zhou, 2010). The available studies on migrant nurses in Australia offer valuable insights into some aspects that affect their transition into their adopted country.

Walters (2005) conducted a narrative analysis on a sample of 16 newly recruited nurses from Southeast Asia on their "migration experience and early settlement" in Australia (p. 61). The author identified five themes that significantly influenced the transition experiences of these overseas-trained nurses in Australia: i) trust and fear in the new environment, ii) English language requirements, iii) immigration processes, iv) integration with the local community, v) broken family ties. It is possible that while migrant nurses from English-speaking countries adjust to their new work place relatively easily, migrant nurses from non-English speaking backgrounds have to adapt not only to a new language, but also to a very dissimilar society, culture and workplace to their own. It is understandable that this may place considerable additional burdens on these nurses.

A Canadian study conducted on 12 international nurses identified three stages that they progressed through in their journey: i) Hope: their dream to become a registered nurse, ii) Disillusionment: identifying the reality that their qualifications from their home country do not meet the new host country's registered nursing entry requirements, and iii) Navigating disillusionment: redefining their dream and working towards fulfilment by returning to school (Sochan & Singh, 2007). As this study included nurses from non-English speaking backgrounds working in an English-speaking country, these results can to some extent be related to non-English speaking migrant nurses working in Australia. However, due to the high degree of cultural diversity in the study participants (with participants originating from the Philippines, mainland China, Korea, Ukraine and India), the study was unable to define the distinct aspects of migration that were difficult for nurses coming from individual countries.

Brunero at al. (2008) also investigated the experiences of a sample of 56 foreign nurses in Australia, originating from England, Canada, Scotland, Ireland, Zimbabwe, Italy, the

Philippines, Fiji, Singapore, New Zealand, Finland, Fiji and South Africa. The study reported that participants found entry into Australia difficult due to migration-related requirements, differences in cultures, feelings of loneliness and isolation, as well as difficulty in settling into the nursing working profession in Australia. It is interesting to note that nurses from other western and English-speaking countries reported difficulties in adapting to the new culture and challenges in the new work place. Remarkably, the additional impact of a stressful work environment, such as mental health care, has not been extensively addressed in the literature to date.

Zhou (2010) conducted a large study with the aim of understanding the experiences of 28 Chinese-educated nurses working in Australia using a 'symbolic interactionism' methodology (Symbolic interactionism, formulated by Blumer (1969) is the process of interaction and derivation of meanings through social interaction). The author highlights certain barriers and challenges for Chinese nurses working in various specialisations. These include recognising that the 'western way of nursing is different', that there is 'tension between the original and host cultures while adapting', and 'boundaries and marginalisation while embracing [the] new culture' (p. 163). A chief limitation of this study was that while symbolic interactionism was employed, observation of participants' behaviour was not included during data generation. Furthermore, the participants had arrived in Australia within the previous five years, which may have affected their expression of their experiences (Zhou, 2010). This might be an indication that they were still undergoing transition in the new country. However, some aspects of the experiences of these study participants could be related to Kerala nurses in Australia.

Investigators have examined the processes of acculturation and assimilation of migrant nurses (Ea et al., 2012; Sochan & Singh, 2007). Ea et al. (2012) compared the acculturation experiences of Filipino migrant nurses in the United States, and former Soviet Union nurses in Israel. The degree of acculturation was assessed using the Short Acculturation Scale (Ea et al., 2010). Interestingly, the study found that while the acculturation level of Filipino nurses was generally more inclined towards the adopted country's culture, the acculturation levels of the former Soviet Union nurses leaned towards their original culture. The authors concluded that the acculturation experiences

of these two groups were significantly different, and suggested that acculturation is a "complex and multi-dimensional" process (Ea et al., 2010, p. 22). These results imply that further studies of migrant nurses from distinct cultural backgrounds would contribute to an understanding of the factors impacting their transition experiences.

Smith et al. (2011) highlighted that the work environment itself can affect the transition of migrant nurses, and that lack of preparation to work in the new country, differences in clinical skills, the health service culture and the status of the nursing profession are considered major challenges. Participants commented they felt only 'partially prepared' although they had gained eligibility to work. This may be due to the absence of a comprehensive adaptation program, and the need for transition programs for overseas-trained nurses is a common theme of discussion in these studies.

In a study designed to assess prior training and other factors affecting the transition of Indian nurses to the New Zealand health care system, Wooldridge and Bland (2011) highlighted that discrimination, language barriers and a lack of understanding of the new culture were challenges during the period of transition. One of the recommendations of the study was that the well-organized incorporation of international nurses with support and respect was crucial to enable their transition.

Whilst a few studies have utilised surveys and questionnaires to investigate the transition experiences of overseas-trained nurses, the exploration of experiences using qualitative methodology is essential to understand how these experiences affect the transition of these nurses to work and life in the new country. This understanding can be utilised in supporting nurses while they are undergoing transition. In a study that explored the experiences of 12 internationally-trained nurses in the United Kingdom, Alexis (2012) identified six themes: 'leaving the familiar world', 'being thrown into an unfamiliar world', 'encountering marginalisation, experiencing inequalities', 'surviving in an everyday world' and 'making a new world'. The findings of this study are consistent with other studies on overseas-trained nurses.

Kishi, Inoue, Crookes and Shorten, (2014) conducted an Australian study investigating the experiences of a sample of 14 Japanese nurses. The study focused on the acculturation experience, and employed a qualitative research method using semi-

structured interviews. The interviews were conducted in Japanese, and the researchers concluded that the use of the mother tongue enabled openness and clearer expression of feelings among the participants. A thematic analysis of the data resulted in the discovery of three main themes: i) seeking, ii) acclimatising, and iii) settling (p. 25). These themes provided the background for the "SAS model for the adaptation process" of overseas-trained nurses in Australia (p. 25).

More recently, a cross-sectional correlational study conducted in Singapore by Goh and Lopez (2015) focused on the acculturation and quality of life and work of international nurses. The participants in this study were 814 international nurses working in Singapore. This study used 'World Health Organization Quality of Life, and Practice Environment Scale of the Nursing Work Index-Revised as outcome measures (Goh & Lopez, 2015). The authors concluded that the acculturation level of nurses varies among different cultural groups, and they also found a strong positive correlation between the acculturation level of migrant nurses and their quality of life.

It is apparent from the literature that adapting to a new culture and workplace is a complex process, and that the experiences of overseas-trained nurses incorporate numerous dynamic and context-specific features. The experiences of individual overseas-trained nurses are unique, and this may influence the quality of life and job satisfaction of these groups. It is therefore important to study the unique transition experiences of nurses coming from specific areas, such as Kerala.

2.5 Transition experiences of overseas-trained nurses from Kerala

Population statistics show that an influx of Kerala-trained nurses into Australia began in 2005 (Walters, 2005). Similarly, DiCicco-Bloom (2004) noted that a significant number of the Kerala population gain their nursing qualification and migrate to various foreign nations. Walton-Roberts (2010) designed a case study to assess the intention of nursing students to migrate to a foreign nation, and established that most people born and educated in Kerala eventually migrate to more developed countries for employment. Remarkably, focus groups and surveys among 1169 student nurses across the state of Kerala showed that 75% of students intend to travel overseas after graduation (Walton-Roberts, 2010).

Wells (2013) implemented a phenomenological study with Indian nurses, including nurses from Kerala, to identify and contextualise "the experience of Indian Nurses in America" (p. 47). Wells (2013) claimed that an in-depth understanding of this category of nurses was critically important for several reasons: to eliminate "stereotyping [a group of nurses as] Asian nurses", and to understand their unique culture, beliefs, and personal histories, as these have a significant impact in patient care (p. 48). Wells (2013) suggested that by migrating to a foreign country, these nurses sacrificed parts of their social and personal lives, and were forced to undergo changes in aspects of their lives, including differences in food, clothing, climate, currency, social system, and work. Akin to other studies, these findings also shed light on areas such as 'difficulties with communication', 'extended nursing roles, such as organizing investigations, referrals, accommodation, etc.', 'changes in doctor-nurse relationship' and 'challenges associated with leadership' (pp. 124-126).

Another descriptive correlational study conducted by Jose et al. (2008) also focused on the immigration experience of Indian nurses in America. The authors established that dealing with unaccustomed routines, the new environment, and 'feeling of loss' were the main challenges experienced by the participants. In addition, some participants felt that they were "treated differently" by local staff (p. 113). Three years later the main author conducted a qualitative study about the lived experiences of internationally-educated nurses from India (Jose, 2011) and found that participants dreamt for a better life, and the transition process was a significantly challenging journey. Perhaps helpfully, these internationally-educated nurses expressed that they were willing to support others with a similar background. This might make newly-arrived migrant nurses comfortable in seeking help. However, the exact coping strategies used by participants were not clearly identified.

Focusing on the Australian context, a phenomenological study conducted by Walters (2005) sampled 15 Kerala nurses working in Australia, and highlighted the risks of exploitation at various levels of the process of migration. The author also suggested that Kerala is an attractive recruiting source for future health-care workers, and recommended that potential migrant nurses should be provided with timely information

on the region, culture, and work-place before migration, to facilitate the easy transition of migrant nurses into the Australian culture and work-force.

The available literature suggests that overseas-trained nurses' experiences in the adopted country are unique and challenging. It is apparent from these studies that the cultural background and ethnicity of immigrant nurses play a pivotal role in their transition to the new country's culture and work. Furthermore, easier transition experiences have a strong association with job satisfaction, which would benefit patients and nurses alike.

2.6 Formal transition-to-practice programs for overseas-trained nurses

Most host nations offer transition programs for overseas-trained nurses (Xu, 2010). In Australia, these bridging/ transition programs aim to equip nurses with the eligibility to apply for registration in Australia by updating their knowledge and clinical experience. However, one major criticism of these bridging/ transition programs is that they were originally designed for domestic nurses who were re-entering the profession after a significant gap (Jeans et al., 2005).

A Canadian qualitative study conducted by Al (2012) with a sample of 62 international nurses enrolled in a bridging program followed the nurses' experiences over time: at the beginning of the program, at the completion and during the job search or clinical placement. The nurses were asked to discuss their experiences, the strengths and weaknesses of the transition program and recommendations for the future (Al, 2012). Data collection was by telephone interview. The initial interview highlighted themes such as cultural unfamiliarity, language difficulties, and differences in the health care delivery system from their native countries. Participants also made recommendations such as occupation-specific language training, and more understanding by the instructors, and some participants reported that the program was essential but many more factors contribute to the process of becoming a registered nurse in Canada (Al, 2012). Overall, the author concluded that bridging programs are necessary to equip international nurses to practise in the host country and suggested occupation-specific language assessment, more opportunities for clinical practice, in-depth orientation to

the philosophy of practice and culture of the nursing and health care system of the new country (Al, 2012).

A literature review conducted by Konno (2008) on available support in transitioning to Australian nursing practice covered a total of 12 studies. The main finding of the review was the conflict between cultures (overseas and Australian culture). This review asserted the importance of including cultural training in transition programs. This finding will be explored in greater detail within the study.

These studies examined the challenges and expectations of overseas nurses about transition programs and the findings indicated their inadequacies and made recommendations about existing transition programs. The following section explores the experiences of nurses working in the speciality of mental health.

2.7 Experiences of nurses working in the specialty of mental health

Although various aspects of the experiences of overseas-trained nurses have been investigated, there is a scarcity of literature regarding overseas-trained nurses from a specific cultural background who work in speciality areas, such as mental health. The available research includes participants from various cultural backgrounds working in a variety of settings. Moreover, mental health is a speciality where recruitment and retention remain a major challenge (Department of Health, 2014).

Several international studies have examined the experiences and challenges of mental health nurses using various methodologies. For example, McTiernan and McDonald (2011) investigated occupational stress, burn-out, and coping strategies for work-related stress of mental health nurses. The study identified that mental health care nurses work in a moderately stressful environment. The majority of participants revealed that the main contributors to stress were a lack of resources, high workload, and lack of clear organisational structure and guidelines. In addition, participants reported moderate degrees of emotional strain, “low levels of depersonalization” (p. 217) and an impaired sense of personal achievement.

In another study, Jenkins and Elliot (2004) investigated the stressors, burn-out and social support of 93 qualified and unqualified clinicians from eleven acute adult mental health

settings. Employing the various stress scales including the Mental Health Professionals Stress Scale (Cushway, 1996) the Maslach Burnout Inventory (1981) and House and Well (1978) Social Support Scale], the authors identified the lack of adequate staff as the main stressor for qualified nursing professionals. In contrast, unqualified staff noted that demanding clients and threats of physical aggression were the most important stressors. Crucially, around 50% of clinicians exhibited signs of burnout and stress, indicating that these challenges are a pervasive feature of working in the mental health care system.

Jenkins and Elliot (2004) suggested that a number of stressors have a close association with emotional exhaustion and depersonalisation. The authors observed significant differences in the perception of stressors between qualified and unqualified staff, and highlighted that there should be strategies in place for group supervision to encourage positive communication between staff.

Another theme highlighted in the literature is the stigma associated with mental illness and towards mental health nursing professionals. Sabella and Fay-Hillier (2014) found that the public perception of how mentally unwell patients are treated by nurses is incorrect. The authors suggested that the public often believe that mental health nurses restrain mentally unwell patients, seclude them and sometimes treat them like criminals. In addition, the roles and responsibilities of a mental health nurse can often be unclear to other healthcare professionals.

Sabella and Fay-Hillier (2014) reviewed the challenges faced by contemporary mental health nursing professionals, and categorised the main challenges as issues related to gaining registration, post-registration challenges, professional hurdles, and perception of the public about mental health nursing. Post-registration challenges included ensuring a graduate placement in a mental health setting and gaining experience from various mental health specialities, to later ensure a job. Initial professional hurdles included working independently in a mental health setting, and entering the work force.

In a separate qualitative study of 20 mental health nurses in Africa, clinicians expressed that they experienced negative outlook and stigma relating to their profession from other health care workers (Jack-Ide, Uys, & Middleton, 2013). This study was done in the

Niger Delta region of Nigeria. These nurses were working in mental health department of neuropsychiatric Rumuigbo Hospital. In-depth interviews with 20 nurses revealed need for further education, training, stigma and negligence towards mental health system.

Sustainability of the mental health nursing workforce has been a challenge in Australia in recent decades. Research on the recruitment and retention of mental health nurses by Harrison, Hauck and Hoffman (2014) evaluated the positive aspects of recruitment and retention in mental health nursing. The research revealed the drivers of recruitment were: nurses wanted to do something different, they were fascinated by mental health nursing, or they were motivated by others to join the profession. The reasons for staff retention were identified as an appreciation of person-centred care in mental health, passion for mental health nursing, and enjoyment in the work place. The authors suggested that these themes could be useful in recruiting graduate nurses, along with additional support strategies, such as improving clinical placement experience and preceptorship. The study also highlighted the importance of ongoing and continuous professional development for existing mental health clinicians.

In a recent study, Heyman (2012) described some misconceptions about mental health nursing, including that mental health nursing does not demand complex skills or a theoretical background, and is an area with limited opportunities to grow professionally. This study assessed the perceptions of mental health nurses and recommended that the stigma surrounding mental health nursing should be challenged to attract more nurses into this speciality. The author also highlighted the ongoing issues of recruitment and retention of nurses in mental health.

In contrast, examination of the literature regarding mental health nursing demonstrated that mental health nursing is a speciality, which demands complex skills and higher education. There is already a body of evidence that working in mental health itself is challenging, stressful and demanding (Currid, 2008). The diverse range of transition challenges faced by migrant nurses working in mental health warrants an investigation of their experience. However, the lack of studies in this specialist area might lead to the presumption that the experiences of these nurses are analogous to the challenges faced

by their counterparts working in mainstream health-care. Previous research recommendations also suggest the need for this type of qualitative studies on experiences of overseas trained nurses (Konno, 2008).

2.8 Summary of the chapter

Despite the available research emphasising the unique challenges and experiences faced by overseas-trained nurses, there is limited understanding of their transition experiences, especially those working in mental health in Australia.

Current statistics about overseas-trained nurses in Australia reveal a high representation of Kerala-trained nurses. A thorough understanding of the lived experiences of Kerala-trained nurses working in mental health in Australia would benefit stakeholders while orienting, supervising and working with these nurses. This requires a deep understanding of the transition experiences of these nurses to assist future overseas-trained nurses in gaining a positive transition experience. Ultimately, a better understanding of the factors that influence migrant nurses will benefit both mental health consumers and the nurses themselves.

Chapter 3

Philosophical Underpinnings of the Research Methodology

3.1 Introduction

This chapter describes the conceptual and theoretical frameworks, which provide the philosophical underpinning of the research design. This study followed a qualitative research design, and applied phenomenology and van Manen's (1996) six steps as the framework. van Manen's lifeworld existentials (1996) were used to guide the interview process and the data analysis. The researcher chose phenomenology since it facilitates in-depth understanding of each participant's experience of being an overseas-trained nurse from Kerala, India and working in mental health in Australia.

The chapter commences with the paradigmatic location of the research, followed by a brief overview of phenomenology. The overview includes an outline of key features in the evolution and history of phenomenology. In the subsequent section, a description of hermeneutic methodology, from the perspective of hermeneutic phenomenology research design is provided. The material presented in these sections is used to provide a basis and background for a discussion of van Manen's approach to hermeneutic phenomenology. van Manen's lifeworld existentials (1990), which are used to conceptually frame this research, are then introduced and discussed.

More generally, qualitative research approaches are used to gain portraits and understandings of aspects of human behaviour, human experiences, and human reactions to life situations. In this chapter, particular attention is given to the following elements: (a) the interpretivist paradigm, (b) phenomenology, (c) van Manen's phenomenology, (d) differences between van Manen's phenomenology and other similar approaches, and (e) criticisms of van Manen's phenomenology.

3.2 Hermeneutics/interpretivist paradigm

The concept 'paradigm' has been described in different ways by different researchers. While Creswell (2003) considers it an epistemology or research methodology, Mackenzie

and Knipe (2006) classify the main research paradigms as positivist, constructivist or interpretivist in nature.

In addition, Guba and Lincoln (2005) pointed out that any research is guided by basic beliefs that represent the researcher's world-view. Again, research methodologists, Guba and Lincoln (2005), identify that the concept of ontological or epistemological aspects or world- view in research defines the reality of the world and the relationship between the investigator and the immediate world. In research, the world-view of the study and the researcher orient the approach or methodology, and it is usually stated for the qualitative project. World-view is usually expressed through three key components: ontology, or the assumptions of what knowledge is; epistemology, or the process of attaining the knowledge or knowing; and axiology, or the values underpinning knowledge.

The constructivist worldview/paradigm/tradition makes the assumptions that knowledge is local and dependent on the social context; that no knowledge exists in a vacuum or in areas without human mental activity; and that knowledge is dynamic (Crotty, 1998). The constructivist paradigm further assumes that knowledge can only be constructed through human-human and human-world interaction. Mertens (2005) asserts that reality is created socially. Crotty (1998) noted that constructivism assumes that knowledge is not objective; rather, truth exists because of human activity. On the other hand, while supporting the concept of socially constructed reality, interpretivism believes in the person's subjective experience with the external world (Willis, 2007). According to Collins (2010) interpretivism is "associated with the philosophical position of idealism, and is used to group together diverse approaches, including social constructivism, phenomenology and hermeneutics; approaches that reject the objectivist view that meaning resides within the world independently of consciousness" (p. 38). Furthermore, the interpretive paradigm is interested in viewing the personal world of the person, based on the subjective experiences of that person. However, interpretivism offers diverse paradigms. Importantly, the philosophical basis of hermeneutics and the hermeneutic cycle is interpretivism (Boland, 1985). Hermeneutic cycle is a concept introduced by Heidegger (1962) the circular motion between parts and the while doing interpretation. It has been asserted by scholars that interpretivism

understands human experience and acknowledges researchers' background and experiences (Creswell, 2009; Cohen, 1994). Wills (2007) also suggests that interpretivism helps to understand unique contexts and experiences in a deeper way. The present study explores the lived experiences of overseas-trained nurses from Kerala working in mental health in Australia and attempts to uncover the meaning of their experience. The interpretivist paradigm is the philosophy guiding this study, as it allows the researcher to examine the lived experiences of the participants.

3.3 Introduction to Phenomenology

When debating phenomenological methods, scholars agree on the core concept, which is the rich description and meaning of lived experiences. Phenomenology is both a research methodology and a philosophy (Adams & van Manen, 2008). Guba and Lincoln (1994) pointed out that phenomenology is rooted in the constructivist or interpretivist paradigm. Phenomenological inquiry as described by van Manen was used to guide this study, and is "essentially a philosophy of the nature of understanding a particular phenomenon and the scientific interpretation of phenomena appearing in text or written word" (Streubert & Rinaldi, 2011, p. 88). In summary, van Manen's phenomenology studies human experiences within the context in which they exist. van Manen's hermeneutic tradition is based on the work of Husserl and Heidegger. It is therefore important to reference and locate the work of these two scholars to locate the features of van Manen's phenomenology.

3.3.1 Orientation to phenomenology

Phenomenology was the first methodological from, which took a deviation from positivism and explored subjective experience of a person (Bodekar, 2005). Again, Phenomenological researchers have been diverse in their concepts and application (Moran, 2000). Although phenomenology is currently committed to diverse thoughts, the mathematician Edmund Husserl (Dreyfus, 1991; Koch, 1995) first introduced phenomenology. Later, Martin Heidegger, a student of Husserl, introduced the concept of being-in-the-world (Johnson, 2000). He has also asserted that understanding is impossible without presuppositions (Johnson, 2000). Along with other scholars, another

important approach is van Manen's phenomenology. van Manen (2014) strongly supports investigating lived experience in human science inquiry.

3.3.2 Husserl's transcendental phenomenology

Descriptive or transcendental phenomenology can be attributed to the work of Edmund Husserl in early 20th century. The German mathematician and philosopher attempted to improve traditional scientific methods with a new method that describes human experiences. Husserl, also known as the founder of phenomenology posits that human experience is not independent of an individual and that specific stimuli may elicit different responses or experiences among different individuals (Crowell, 2009). Husserl's contributions to phenomenology was noticed by his postulation of the concepts 'eidetic reduction' (is a method in the study of essences in phenomenology aiming to identify the basic components of phenomena), 'constitution of meaning (the process of coming back to the world from consciousness) and 'intentionality' (the concept that all our thinking, feeling, and actions are about things in the world) (Crowell, 2009; van Manen, 2009). Husserl argues about "true reflection" (Husserl, 1973). Husserl believes that 'phenomenological reduction' is important. Further, 'phenomenological reduction' is the process of excluding theoretical understanding and avoiding 'judgement of perception' while dealing with the reflection (Crowell, 2009).

According to Husserl (1973), 'intentionality' is the only pathway to comprehend human experiences. Intentionality is defined as "attaching oneself to the world" by questioning, collecting information and developing theories (Earle, 2010, p. 287). Eidetic reduction, also known as bracketing, refers to shedding all knowledge to enhance objectivity of the process of inquiry (Kafle, 2011). In other words, these scholars are of the opinion that researcher's prior experience should not influence the research. Husserl's phenomenology is a constructivist epistemology in nature, as it assumes that knowledge arises from the description of human experiences. Moreover, Husserl was interested in an epistemological mode of analysis with exploring what appears to the consciousness as living experience (Crowell, 2009; van Manen, 2014). Furthermore, A basic theory of Husserlian phenomenological reflection is the eidetic reduction; "the eidos is a phenomenological universal that can be described through a study of the structure that

governs the instances or manifestations of the essence of that phenomenon" (van Manen, 2014b, p. 229).

According to van Manen (2014b), eidetic reduction is the evolution of "essential insights" from the description by the participant about the phenomenon (p. 228). There by the uniqueness of the phenomenon under investigation is highlighted.

To summarise Husserl's contribution to phenomenology, as the founder, he aimed to describe the essential meaning of phenomena as they appear to the consciousness. In contrast, Heidegger, a student of Husserl, argued against the concept of formulation of indubitable knowledge (Kaffle, 2011). He suggested that phenomenology is not epistemological but ontological (van Manen, 2012).

3.3.3 Heidegger's hermeneutic phenomenology

Martin Heidegger (1859-1938) was a philosopher who presented philosophical essays in which he sought to comprehend human experience rather than describing the key characteristics of the phenomenon under investigation (Thomson, 2005). Heidegger commenced his philosophical career as a student of Husserl, but his work is considered a radical departure from the work of his teacher (Crowell, 2009). In fact, Heidegger philosophically attempted to gain an in-depth understanding of human experience rather than describing the core tenets of human experience (van Manen, 1997b). In Heideggerian hermeneutic phenomenology, what a person understands is shaped by both time and context (Dowling, 2007). Further, Heideggerian hermeneutic phenomenology is interested in the meaning of human experience within the context in which it occurs (van Manen, 2012).

Heideggerian hermeneutic phenomenology is interested in the ontological perspective of human experience. Furthermore, he was first introduced the concept 'Dasein'. The term Dasein means "being there"; understanding the world or being in the world. Heidegger (1962) first raised the ontological question of "the meaning of Being" (p. 12). With this ontological question, he challenged of the Cartesian tradition of the mind-body split (Walters, 1994). Various researchers (Boughton, 1997) have also debated Heidegger's concept of 'embodiment'. According to Heidegger (1962), 'embodiment' is the unique interconnection between mind and body, and human beings interact with

the world through their lived body. Hence, unlike Husserl, Heidegger asserts that it is impossible for an interpretive researcher to completely exclude pre-understanding or the influence of the researcher (McConnell-Henry et al., 2009). This is a possible reason for the increased application of Heideggerian phenomenology in nursing. Nursing is a discipline where human- to-human interaction and understanding are inevitable. In addition, in nursing, it is difficult to exclude prior experience and knowledge.

Heidegger further argued that achieving understanding is similar to a hermeneutic circle whereby knowledge is constructed and deconstructed through human interactions (Earle, 2010). Through hermeneutic enquiry, the circular movement from the whole to parts thereby to understand the subjective meaning of the experience (Koch, 1995). Furthermore, hermeneutic tradition assists exploration of being-in-the-world and the meaning of being there (Koch, 1995; Mulhall, 2005). To conclude, the foundation of Heideggerian philosophy is to explore the subjective meaning of being-in-the-world and it can be achieved through hermeneutic enquiry.

Heidegger is the foremost portrayer of hermeneutic phenomenology (van Manen, 1997a), which involves interpretation. Interestingly, Heidegger argues that all descriptions are interpretations (van Manen, 1997b). The research question of the present study is "What is it like to be an overseas-trained nurse from Kerala, working in mental health in Australia?" This research explores the subjective meaning of that experience using the hermeneutic cycle. This research follows van Manen's six methodical steps in data collection and data analysis. The next section of this chapter discusses van Manen's approach to phenomenology.

3.3.4 Differences between van Manen's phenomenology and other phenomenological approaches

While van Manen's (1990, 1996, 1997 & 2014b) phenomenology is based on the philosophers discussed earlier, it is radically different, and offers more specific guidelines on conducting phenomenological research. His phenomenology differs from Heidegger's (1962) and Husserl's (1973) in that it is more action-oriented than the later philosophies. In addition, van Manen argues that hermeneutics differs from phenomenology, defining hermeneutics as "an interpretation of experience via some

text or some form of symbol" and phenomenology as "pure description of lived experiences (van Manen, 1990, p. 25)." Due to the lack of consensus among various scholars, van Manen uses the terms *descriptive* and *interpretive* interchangeably. It can be concluded that the major difference between van Manen's phenomenology and the phenomenology of the other philosophers is its intended use. van Manen developed an approach that is more action-oriented for social researchers, while the Husserlian and Heideggarian approaches are philosophical in nature and not originally intended to provide a framework to conduct social research (Earle, 2010). While phenomenology can be either an approach or a philosophy, van Manen's phenomenology is more of an approach to a research methodology than a philosophy. Interestingly, this was later adopted by various professional disciplines such as psychology, medicine and nursing. According to van Manen (2014), empirical methods such as interviews, observations, personal description of experiences and phenomenological reflection have been well adopted by these professions.

3.4 van Manen's approach to hermeneutic phenomenology

Over the centuries, a number of research methodologies and approaches have developed under the umbrella of phenomenology. While researchers continue to employ phenomenology and hermeneutics, they often use the terms interchangeably (Laverty, 2003). In contrast, van Manen (1990) adopted a different approach to hermeneutics, viewing hermeneutical phenomenology as an approach rather than a philosophy (van Manen, 2007). While phenomenology describes one has lived experience, hermeneutics interprets texts of lived experience (van Manen, 1997a). Henceforth, van Manen (1990) draws a link between phenomenology and hermeneutics. van Manen (2014) suggests that Hermeneutic phenomenology involves open and honest reflection on the person's lifeworld and detailed description of the lived experience of as we experience it pre-reflectively.

According to van Manen (2014b), "phenomenology becomes hermeneutical when it's method is taken to be essentially interpretive and primarily oriented to the explication of texts" (p. 132). van Manen's (1997b) approach to human science research is both phenomenological and hermeneutic. van Manen (1997) described his approach to

phenomenology as one that requires total commitment to making sense of a particular phenomenon that is of interest to the researcher. The aim of van Manen's (1997a) phenomenology is to discover and describe human experiences within the context in which they occur. Three aspects of van Manen's work (2014b, 1997a, 1997b) are presented in the following sub-sections. These are van Manen's explanation of what phenomenology, methodological tenets of phenomenological research, and his lifeworld existentials.

3.4.1 van Manen's explanation of what phenomenology is

Max van Manen has offered detailed explanations of his position on what phenomenology is (van Manen, 2007; van Manen, 1990). He has also applied his phenomenological approach to pedagogy and suggested the appropriateness of this approach in the fields of education, health and nursing (Smith et al., 2009). The main ideas that are used in this research study have been drawn from his 1990 works entitled *Researching lived experience* and *Phenomenology of practice*. van Manen's (1990) approach explores the lived experiences and acknowledges the researcher's prior understanding and experiences. van Manen states that phenomenology is intersubjective "in that the human science researcher needs the other (the reader) in order to develop a dialogic relation with the phenomenon, and thus validate the phenomenon as described" (1997b, p. 11). A summary of van Manen's conceptual framework of phenomenology is presented below.

> *'Phenomenological research is the study of lived experience' (*van Manen, 1990; p. 9)

Phenomenology is the study of the subjective world of a person as the person experiences it. According to van Manen (1990), the aim of a phenomenological study is to gain in-depth understanding of the phenomenon under investigation and what it means to the person to experience it. Even though van Manen acknowledges the importance of learning the theoretical tradition of phenomenology van Manen asserts that real understanding comes from of practicing phenomenology (van Manen, 1990).

> *'Phenomenological research is the explication of phenomena as they present themselves to consciousness'* (van Manen, 1990; p. 9).

According to van Manen (1990), consciousness is the only channel between human beings and the external world. Therefore, the experiencing person should have conscious awareness about what is happening around. The consciousness itself will not give explicit understanding of the reality. The person should be able reflect on the experience with personal meaning. Phenomenological experience is "retrospective" (van Manen, 1990; p. 10). In other words, when applied to phenomenological research the participant should be able to reflect on his experience, it has to be happened in the past. Reflection is impossible when the person is living through the experience (van Manen, 1990).

> *'Phenomenological research is the study of essences'* (van Manen, 1990, p. 10)

The purpose of a phenomenological study is to elicit the inner meaning of the lived experience. Phenomenology is not interested in facts and statistical information (van Manen, 1990). Phenomenology is interested in the essence of the experience and what the experience was like. Phenomenology mostly uses in-depth interviews led by the participant, which enhance a detailed description of the personal experience. The interviewer's role in phenomenological interview is to guiding open ended questions and also to encourage rich description of their experience (van Manen, 1996). Later the researcher can interpret the data to identify themes (van Manen, 1990). The researcher's role in data analysis is to explore the meaning from participant's description.

> *'Phenomenological research is the description of the experiential meanings we live as we live them'* (van Manen, 1990, p. 11)

Phenomenology looks at creating rich description with deeper meanings. This methodology focuses on an individual's everyday interaction with their life world, the world they live in. Phenomenology does not pay attention to the specificities of the group but experience and personal meaning.

> *'Phenomenological research is the human scientific study of phenomena'* (van Manen, 1990, p. 11)

Phenomenology is a science, as it is a systematic, elaborated, insightful study of a subject: 'lived experience' (van Manen, 1990). It is systematic, as it involves methodical steps. It is detailed as it obtains in-depth data and rich texts. Phenomenology is a human science as it investigates the lived experience of human beings in their own world.

> *'Phenomenological research is the attentive practice of thoughtfulness'* (van Manen, 1990, p. 12)

According to van Manen (1990, p. 12), phenomenology is about being 'thoughtful", mindful or attentive about living, life and "living a life". This is being attentive of the lives of others, their day today interactions and activities. Also, exploring what is it meant to them to live that life.

> *'Phenomenological research is a search for what is meant to be a* human' (van Manen, 1990, p. 12)

When a phenomenological researcher is immersed in her research, she will gain a deeper understanding and meaning of what it is like to be that person (the participant). By in-depth interview and exploration, the researcher will be able to see the life world of the person with full meaning.

> '*Phenomenological research is a poetizing activity'* (van Manen, 1990, p. 13)

For van Manen, the product of phenomenological research is poetized. According to van Manen (1990):

> "We must engage language in a primal incantation or poetizing which hearkens back to the silence from which the words emanate. What we must do is discover what lies at the ontological core of our being. So, that in the words, or perhaps better, in spite of the words, we find 'memories' that paradoxically we never thought or felt before" (p. 13).

Language and rich description have powerful places in phenomenology. Furthermore, it is also important to maintain the authenticity and originality in the results.

3.4.2 Phenomenology as a methodology: van Manen's tenets

Max van Manen (1990) has explicated the methodological tenets that are required when his phenomenology is used as an approach to research. In this section, the tenets are summarised and described.

According to van Manen (1990), any phenomenological study should be started within the *life world* of the person interested in the study. Every individual dwell in their unique world and experiences it subjectively. This experience has personal meaning to them. Hence, the phenomenological research question is usually 'what is the experience like to be…?' Implicitly the participants in phenomenological research control the outcome of the study because their real experience and the voices of the participants are presented as 'original' (van Manen, 1990).

Further, van Manen (1990) distinguishes between methods and methodology. He refers to research methodology as a "human science perspective" or philosophical assumptions underpinning a study. In contrast, he defines research methods as a set of "theoretical and practical procedures" that an investigator uses to investigate (van Manen, 1990, p. 16).

In relation to van Manen's (1990) phenomenology, he considers that there are seven key tenets to the methodology. The first tenet is that the connection between a person and his or her life world is intentional. Intention or its notion is particularly important as van Manen (1990) assumes that any human activity is intentional and occurs or is because of *something.* Something denotes an object interacts with human consciousness. The second tenet is that an individual can either imagine or face his 'experiences'. The experiences and meaning are unique to that individual. The third tenet is that the qualities of human experiences are invariant and various elements shape experience. This includes the person's social and cultural backgrounds (van Manen, 1990). Hence, the experiences of people from various cultural backgrounds cannot be generalised. Fourth, phenomenological description can be used to capture characteristics of human experience through written words or symbols. Fifth, phenomenological descriptions presented to the researcher are descriptions that have already been assigned meaning by the participants. Sixth, it is possible to capture the

quintessence of human experience from experimental descriptions of individuals. Seventh, researchers who utilise van Manen's methodology are part of the descriptions, as they bring their own assumptions, expectations, interests and presumptions to the investigation. In the present research, the researcher is a migrant nurse from Kerala who is working in mental health in Australia. The seven tenets of van Manen were applied in this research.

In addition to these tenets, other relevant points have been adopted in the philosophical and methodological framing of this study. van Manen (1990) has argued that researchers should disclose their philosophical assumptions and beliefs prior to a study. He questioned the capacity of researchers to bracket their assumptions or experiences prior to a study. Rather than bracketing, an approach recommended by Husserl (1973), van Manen (1997a) argued that researchers should disclose their assumptions and their knowledge about the phenomena. He further pointed out that it is possible for presuppositions to emerge within the course of the study even after bracketing them. This position regarding researcher disclosure has informed the procedures adopted in the study. According to van Manen (1990), a researcher should investigate lived human experiences rather than conceptualised ones. Here, he suggests that an investigator should be immersed in the phenomenon to gain an in-depth understanding of its nature to avoid making assumptions. He further noted that the starting point of any phenomenological research is a researcher's personal experience. There are three ways of collecting information, observation, interviewing and writing. Interviewing can be used to create rapport and to collect data about an experience. This point has also informed the research procedures.

3.4.3 van Manen's lifeworld existentials

Like Husserl, van Manen also views phenomenology as being concerned with understanding the lifeworld (van Manen, 1996). His arguments are founded on lifeworld existentials, and therefore they are very different to the transcendental arguments posed by Husserl (1927).

Lifeworld is the world where people live. Each individual's perception of his or her own lifeworld is unique. On the other hand, everyone's lifeworld is shared with other

people's lifeworlds (van Manen, 1996). Lifeworld *(Lebenswelt)* is the subjective world immediately experienced by the individual. Phenomenological research explores the lifeworld lived and experienced by the individual with everyday situations and interactions (van Manen, 1997b). The lifeworld is simultaneously 'immanent and transcendent', as it bridges the gap between the human's inner and outer world (Asp, 2005, p. 5). The interaction can be with other individuals, objections, society and circumstances. Our interactions in this world are through our body, and the lived experience exists in time, space, and relations to people (van Manen, 1997b, Drew & Nystrom, 2001).

According to Schutz and Luckmann (1973), lifeworld is 'that province of reality which the wide-awake and normal adult simply takes for granted in the attitude of common sense' (P. 3). Lifeworld is pre-reflective. Lived experience is the dynamic interaction between the world and the human being.

Each individual's lifeworld is private to that person. Phenomenological research is often by exploring the lifeworld of the individual and bringing to the reflective awareness of the lived experience of the person (van Manen et al., 1990). It is assumable that lifeworld of an overseas trained nurse's is different from that of a native nurse. A patient's lifeworld is different from the lifeworld of a healthcare professional.

According to van Manen (1996), there are four basic lifeworld themes or "existentials": lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality) "These existential themes are the foundations of every individual's lifeworld regardless of their social, historical and cultural background" (van Manen, 1996, p. 101). Again, van Manen (2007) asserts that experiences things in "corporeal, relational, enactive, and situational modalities" (p. 14). Which include human body, relationships, time and space.

Lived space

Lived space or spatiality is the first of van Manen's (2007) life world existentials. Spatiality is one of the basic determinants of human experience. Other philosophers and phenomenologists also regard spatiality as an important aspect of lived experience. For

example, Merleau-Ponty (1945) views space as a form of external experience based on situations, rather than as a physical setting in which external objects are arranged. The links between objects in space are revealed by the subjective. Heidegger (1923) in his hermeneutic phenomenology identifies three spatial models: 'world space',' regions' and 'Dasein's spatiality'. World space is the 'container' space for objects or mathematical space. Regional space is the space we encounter in our everyday life, which is otherwise called 'functional' or *'zuhanden'* space (Heidegger and Arisaka, 1996). 'Regionality' has close association with the activities we do. Examples for functional spaces are work place, bedroom, and work area where we "contextualise". According to Heidegger (1923), Dasein spatiality has two features: "de-severance" and "directionality". De-severance is the way we exist as a process of spatial self-determination by "making things available" to ourselves. For Heidegger, in the process of making things available for ourselves, we "take in space" by "making the farness vanish" and by "bringing things close" (Heidegger, 1923). This explains the personal meaning of subjective space.

For van Manen (1990), spatiality or lived space is the way people experience their environment or place where they live. Lived space is the space the person "lives and experiences" with his actions, interactions, circumstances, conditions and possibilities (Fuchs, 2007). van Manen (1990) sees lived space as a means to "uncover" a person's daily existence and the meaning of lived life. Lived space is a two-dimensional phenomenon, one dimension being the internal formation of the space and the other being the external relationship with that space. Exploring the lived space of the person can be by enquiring about his/her world, profession, interests, background, place of birth, childhood, and so on (van Manen, 1990). In other words, "Lived space is not a mathematical space, or the measuring of the length, height or the distances between cities or where we live in the country; this is a space that can be called the home of a person, a place where we can feel protected" (van Manen, 1990, p. 102).

The concept of lived space is dynamic along with the time. An individual's appreciation of their own lived space influences their outlook towards the world, their qualities, behaviour and concepts. In a person's lived space, their interactions with people, situations, objects, real and perceived barriers determine their 'responses', which is

known as responded activity (Willi, 1999). In addition, *responsivity* is the person's capacity to react in response to his spatial stimulants (Willi, 1999). One's experience of lived space is strongly linked to one's culture and previous experience (van Manen, 1990). *Existential spatiality* is the concept of space connected to the human being (Ortega, 2004), and van Manen's lived space indicates that these are inseparable concepts (van Manen, 1990). Consequently, it is inevitable to explore the connectedness of space and lived experience.

The 'felt space' influences the person's day-to-day experiences. It is assumed that lived space has a strong impact on the lived experience of overseas-qualified nurses working in mental health. Positive and familial felt space make the person comfortable. As van Manen's (2011) example states, "walking alone in a foreign and busy city may render a sense of lostness, strangeness, vulnerability, and possibly excitement or stimulation. In general, we may say that we become the space we are in" (p. 102). In the analogy, when we consider overseas- trained nurses from diverse cultural backgrounds, it can bring forth a variety of emotions. According to van Manen, spatiality is the world where "human beings move and find themselves at home" (p. 102). Thus, the complexity of the relationship between lived space and the individual is unique.

Lived body

Lived body or corporeality is the second lifeworld existentials of van Manen's (1996). Corporeality or live body is the way our body is presented in this world. In another word, it refers to the fact that our presence in this world is through the body (van Manen, 1996). Our bodily reactions always reflect our emotions and feelings. In other words, our bodily reactions always indicate something as our internal feelings are reflected through our external body. As our body is the main channel of interactions, we meet people through their bodies. We often mimic another person's words or mannerisms, especially when actively involved and attentive (van Manen, 1990). Van Manen's (1996) example is "we might not be feeling tired but when the other person yawns we feel tired and we start yawning" (p. 103).

Other philosophers concerned with phenomenology have also commented on the lived body. Merleau-Ponty (1962) identified that lived body or "lived flesh" represents the

role of sensation in perception, and he described these body sensations as 'units of experiences'. He also argued that through these senses people perceive their unique worlds (Merleau-Ponty, 1962). Husserl (1973) considers the body as a *thing* between the objective and subjective world. According to Merleau-Ponty and his successors (Fuchs, 2003; Roberts, 2006), lived body and corporeal body are two different concepts. Lived body denotes the body we live in in this world and with all our senses; we perceive the outside world and interact with others. When the human body experiences any disruption to its normality due to illnesses or exposure to criticism from others, it becomes an object for attention and the body appears as corporeal (Fuchs, 2003). In other words, the subjective body is turned into an object. Embarrassment, emotions, criticisms, self-consciousness can make a lived body a corporeal body (Whites, 2011).

For van Manen (1990), lived body is our presence in this world, through which we interact with the external world. van Manen (1997) has suggested five experimental dimensions of the human body in the context of sickness and health. Certain aspects of these concepts are relevant to the present research. An overseas nurse's bodily experience in the external environment will change after migration. This can be due to reasons such as the new environment and being among people with dissimilar. According to van Manen (1997), these dimensions are "the body experienced as an aspect of the world", "the body experienced as observed", "the body experienced as reflective", "the body as experienced in the modality of appreciation", and "the body experienced as call" (p. 4).

Lived other

Lived other or relationality is the third of van Manen's (1997b) life world existentials. Relationality or lived other is "the lived relation we maintain with others and the interpersonal space we share with them" (van Manen, 1996, p. 104). van Manen identifies that we meet other people in direct ways with our senses by seeing, touching etc. Alternatively, for van Manen, lived other is the "the relation we maintain with others in the interpersonal space we maintain with them" (van Manen, 2006, p. 104). van Manen (1996, 1997a & 1997b) acknowledges that human beings communicate and establish relationships with each other through other means, without physically seeing

them. In these circumstances, he identifies that most of the time; we imagine their physical appearance, expressions and shape.

Relationality, the connection with the outside world through interactions, can be influenced by factors like communication skills, interaction skills and commonalities within the group. According to Merleau-Ponty (1962), relationality is expandable. Individuals often expand the radius of their relationality sphere by meeting new people, moving to other places etc. In this way, they rediscover their existence in the world (Guimond-Plourde, 2009). Ethnicity and culture might have an impact on the relationality of individuals. For example, people from certain cultures value extended relationships and contacts more than some other cultures (Zhou, 2010).

Lived time

Lived time or subjective time is the fourth of van Manen's (1990) life world existentials. Lived time is defined by van Manen (1990) as the temporal way of living in this world. It is reflection of the past, present and future. Lived time is the time we perceive as passing fast when we are with loved ones, or on the phone with our friends and as dragging when we wait for an appointment. Inquiry on temporal subjective time is exploring the person's past experiences, present life, pressures and hopes for the future. This reveals who the person was to who the person is now.

When we deeply engage in an activity, we lose temporal awareness, as we perceive flow of experiences (van Manen, 1990; Fuchs, 2005). This implicit mode of temporality needs two key conditions. One is continuity of consciousness moments and backward-forward linkage of those moments (Fuchs, 2009). Husserl (1973) views temporal succession as 'protention' (future), 'presentation' (at this moment) and 'retention' (what has been experienced). The second key direction is motivational direction, which is 'self - affection' or 'sense of aliveness'. The 'explicit or experienced time (past)' is the explicit experience of temporality super imposes on the implicit (the current/present) time (Husserl, 1973). Furthermore, when the immersion is suddenly interrupted and segmentation of temporality occurred.

van Manen (1997) asserts that description of lived experiences and interpretation of the meanings of lived experiences is possible by lifeworld existentials. The four main life world existentials described above influence everyone's experiences, even if they are from diverse social or cultural background (van Manen, 1997b). van Manen's four lifeworld existentials were employed while analysing the data for the present study.

3.4.4 Strength and weaknesses of van Manen's phenomenology

Phenomenology can enlighten and clarify human experiences, which provide rich detail and reveal meanings embedded in situations and the context of lived life. This holistic perspective is particularly essential in nursing, where researchers are more concerned with an all-round description and understanding of phenomena. van Manen's (1997b) phenomenology enables nurses to question the existence of a phenomena and provides a framework for the exploration of lived experience. The value of van Manen's phenomenology to nursing is that it allows nurses to study nurses and patients' subjective experiences that are essential to the healthcare profession. Hermeneutic phenomenology is a departure from traditional philosophical methodologies such as transcendental phenomenology. van Manen's phenomenology clearly discusses research procedures, thus reducing confusion and dilemmas in its application to contemporary social research. Furthermore, it has been postulated (van Manen, 2007) that phenomenology can be best adopted in health research. As professional knowledge involves tact, sensuality, bodily presence and contextual perception, the experience should be expressed through such language (van Manen, 1997b). Phenomenology encourages rich description of lived experience.

However, as with other methodologies, van Manen's (1990) phenomenology has certain inherent limitations. The first limitation is that it inherits all limitations that come with phenomenology. These include possible researcher bias, due to the difficulty in ensuring pure bracketing. However, in the present research the researcher kept journals and undertook regular supervision to avoid possible bias. Another practical difficulty raised as a difficulty with expressing experience is that it involves rich description (van Manen, 1990). In this research, the participants were given the time needed and no one raised this issue when checked. Another weakness of van Manen's phenomenology is that the

processes of data collection and analysis require a great deal of time (Armstrong, 2010). Furthermore, the dilemma of researchers between descriptive or interpretive phenomenology may be another challenge. However, the researcher can make the decision based on the extent of description and interpretation to answer the research question. Heidegger argues that the importance of phenomenology depends on interpretation (Racher & Robinson, 2003). van Manen also postulates that textual description is a form of interpretation.

There have been criticisms of the use of phenomenology as a research methodology (Konno, 2008). However, according to Holloway (1997), phenomenology does not prescribe strict technical guidelines or steps. Phenomenology is a suitable method if the researcher wants to explore the experiences as perceived by individuals without any assumptions. Nevertheless, van Manen (1996) suggests that it is impossible for a researcher to detach completely from his or her own experiences and presuppositions.

As human science research, van Manen, (1990) suggested a methodological structure which facilitates the dynamic interplay between six research activities: “Turning to the nature of lived experience; investigating the experience as it was lived; reflecting on the essential themes; describing the phenomenon through writing and rewriting; maintaining a strong, oriented stance toward the question; and balancing the research context by considering parts and whole” (pp. 31-33). This provides well-structured framework for a phenomenological research. Additionally, van Manen also suggests the application of lifeworld existentials to deepen understanding of the findings and strengthen the phenomenological nature of the study findings. Again, different approaches suggested by van Manen as described in chapter Four, enable isolation of the themes and uncover the meaning. These strengths of van Manen’s approach were the primary reasons for the choice of phenomenology for the current study.

3.5 Trustworthiness

The concept of trustworthiness is more discussed in positivist research. However, Lincoln and Guba (1981) have suggested four criteria to ensure trustworthiness of any qualitative study. These four criteria are credibility, transferability, dependability and confirmability.

The credibility of a qualitative research study can be ensured by the adoption of a suitable research methodology (Guba & Lincoln, 1981). In this study, voluntary in-depth informal interviews were adopted for data collection. The participants were given time to express their experience. Having a lengthy interview allowed the participants to reflect on their experience and the personal meaning. It has been suggested that thick description of the phenomena enhances credibility (Shenton 2004). Thick description is the description of phenomena with detailed explanation of the context and meaning of the experience.

Transferability or generalizability is usually a concept of concern for positivist researchers. In contrast, constructivists/ interpretivists believe that generalisability is not possible, since the research focuses on specific contexts and groups of people (Shenton 2004; Guba & Lincoln, 1981). However, in-depth description allows some aspects of the research to be applicable in certain context (Wells, 2013).

Guba and Lincoln (1981) argue that the dependability or reliability of a qualitative research study is closely linked to credibility. Dependability is the repeatability of the qualitative research. This is possibly achieved by a detailed description and the use of appropriate data collection methods (Guba & Lincoln, 1981). However, it can be an issue in qualitative studies as they involve subjective experiences and personal views.

Confirmability is another criterion criticised in qualitative research. In other words, researcher bias and previous experiences cannot be detached completely (van Manen, 1990). However, there are various suggestions to consciously avoid bias and assumptions (van Manen, 1990). In the present research, the researcher completed reflective journals and attended regular meetings with supervisors.

3.6 Validity

van Manen (2014b) is of the opinion that “measures such as content validity, criterion-related validity, and construct validity apply to tests and measures that are not compatible with phenomenological methodology” (p. 347). He argues that unlike other methods, phenomenology aims to “gather pre-reflective experiential accounts” (van Manen, 2014b, p. 311). Hence adhering to strict methodological guidelines (Terms of

References of Qualitative Studies) is almost impossible in phenomenology (van Manen, 2014b). In order to resolve the challenges involved with validity van Manen suggests four checkpoints (2014b). Those questions are (pp. 350-351):

> Is the study based on a valid phenomenological question?
>
> Is analysis performed on experientially descriptive accounts, transcripts?
>
> Is the study properly rooted in primary and scholarly phenomenological literature?
>
> Does the study avoid trying to legitimate itself with validation criteria derived from sources that are concerned with other methodologies?

These questions are further discussed in Chapter 4.

In conclusion, the hermeneutic/ interpretive paradigm has been well received for decades. Most of the criticism has been by positivists (Shenton, 2004). However, these four criteria suggested by Guba and Lincoln (1981) enhance the academic strength of research studies.

3.7 Phenomenology in nursing research

Phenomenology as a method is widely chosen by nurses as it shares similar concepts of nursing, such as examining everyday experiences, valuing individual experience, looking for the essence of experience, and sharing the experience with their good active listening skills (Balls, 2009). In addition, conducting phenomenological research demands in-depth understanding of the approach, implications and the process. van Manen (1990) best explains phenomenology as an empirical attempt to establish the deep understanding a target group of people hold regarding the meaning of their experiences with a specific phenomenon. Consistent with this argument, Creswell (2009) describes phenomenology as a study to determine the deep meaning that people's experiences ascribe to that phenomenon, which is the core of nursing research.

A number of nursing researchers have utilised phenomenology. For example, Benner (1994) has acknowledged the use of an interpretive approach. Liamputtong (2009) also asserted that phenomenology is the most commonly used qualitative methodology in

nursing. Likewise, Holloway and Wheeler (2010) also pointed that phenomenology is a popular method in healthcare research especially nursing discipline. However, there have been criticisms that nurse researchers claim the use of phenomenology without complete understanding of the concept (Crotty 1996; Giorgi 2000). At the same time, hermeneutic phenomenology has been used extensively in nursing areas such as mentoring, psychiatric nursing, cancer, surgical diseases, and internal medicine (Heinonen, 2015). Most of these studies sought to study and understand individual experiences of the participants, to gain an in-depth understanding of people. Benner (1994) and Koch (1995) suggested that interpretive phenomenology is the most appropriate method to examine a lived experience produced from the essence of meanings and understanding expressed by participants and the researcher.

3.7.1 Examples of nursing research utilising van Manen's framework

Mostly Nursing researchers are engaged in experiences form a holistic perspective, hence phenomenology as a methodological approach to explore lived experiences provides a basis on which to develop insights into these experiences. The studies summarised below illustrate the extent to which van Manen's (1996, 1997a, 1997b) phenomenology can be applied to nursing research. The studies aimed to understand 'human experiences'. Peden-MacAlpine and colleagues (2005) used the phenomenological approach to link family- sensitive care to reflective practice in nursing. The study sought to understand the lived time as experienced by nurses and how it was affected by reflective practices. On the other hand, Evans and Hallet (2007) attempted to understand the experience of hospice nurses with patients with terminal illness who were about to die. Woodgate and colleagues (2008) studied the experiences of parents with children suffering from autism. In the study, the researchers sought to describe and interpret the experiences of the parents to fully comprehend their meanings. Rutber and Ohring (2012) studied the experiences of women suffering from migraines. Interestingly, some major studies utilised van Manen's framework to investigate lived experiences of overseas trained nurses working in foreign nations. Konno (2008) explored the lived experiences of overseas nurses from various non-English speaking background working in Australia. An international study by Jose (2008) utilised phenomenology as the philosophical foundation and method to conduct the

study. This study was aimed to understand the meaning and experiences of acculturation of foreign educated nurses working in the United States (US). Similarly, Wells (2013) examined the lived experiences of Indian nurses working in the United States. This study used phenomenological approach to gain insight in to the lived experiences of Indian nurses working in the US.

Phenomenology is the thoughtful reflection of the lived experiences of a person (van Manen, 1987). While phenomenology as a method is describing rich text (Sloan, 2014), van Manen's approach is to isolate themes and interpret lived experiences (van Manen, 1990). The present research employed hermeneutical phenomenology informed by van Manen to answer the research question. The isolated themes allowed the researcher to interpret and therefore understand the meaning of the lived experiences of the respondents (Solan, 2014).

3.8 Conclusion

This chapter has focused on explaining the philosophical underpinnings of the methodology. This chapter discussed the philosophical approaches by Husserl and Heidegger, and the use of phenomenology to explore lived experiences. The use of phenomenology as a research framework has increased over recent years, especially in the field of nursing. Phenomenology provides an appropriate framework to explore individual participants' experiences of a phenomenon of interest. The current study begins from the researcher's personal experience. This research follows hermeneutic phenomenology informed by van Manen as it allows exploration and understanding of the meaning of subjective individual experiences. The following chapter explains the methods employed to conduct this study.

Chapter 4

The Application of van Manen's Research Methods to this Study

In the previous chapter, phenomenology was discussed and van Manen's (2014b, 1997a, 1997b) hermeneutic approach was identified as the most appropriate method for this study. The aim of this chapter is to describe the use of hermeneutical phenomenology to answer the research question. This chapter gives a brief overview of van Manen's (1990) four lifeworld existentials and six methodological themes. This chapter also provides an outline of the ethical considerations, and the participant risk management protocol, and data collection, data analysis and research rigour are explained.

4.1 van Manen and the lifeworld existentials

The researcher chose van Manen's (1990) approach, since it admits both the researcher's and the participant's experiences, assumptions, knowledge, beliefs and the co-construction that both can have in all steps of the research. van Manen (1990) states that "phenomenology describes how one orients to lived experience, hermeneutics describes how one interprets the 'texts' of life" (p. 4). According to van Manen (1997), "hermeneutic phenomenology is different from descriptive phenomenology as it comprehends the project of phenomenology intellectually and understands from inside" (p. 8). Other philosophers (Heidegger, 1962; Husserl, 1973) have suggested multiple ways to explore lived experiences. van Manen (1990) argues that there are *four basic existentials* founded in every human, regardless of personal, social and cultural variations. The four existentials for lived experiences are:

Lived space (Spatiality): The space that influences our feelings

Lived body (Corporeality): Our physical existence in this world

Lived time (Temporality): The subjective perception of time

Lived human relations (Relationality): The interpersonal relationships we share with others.

Phenomenology thrives to understand the meaning of the individual's personal world by encouraging reflection of the participant and researcher's interpretation and by writing in phenomenological way. Phenomenological understanding is distinctly existential, emotive, enactive, embodied, situational, and non-theoretic; a powerful phenomenological text thrives on a certain irrevocable tension between what is unique and what is shared, between particular and transcendent meaning, and between the reflective and the pre-reflective spheres of the life world (van Manen, 1997b, p. 345).

In this research, the researcher explored and the participants reflected the subjective meaning of experience of Kerala nurses, which is highly complex, unique and powerful. In the following sub-sections, the meanings of these existentials as they apply conceptually to this research are described.

4.1.1 Lived space

For overseas-trained nurses working in mental health "the lived space" is the journey through their new workplace and in the new country. Everyone has a place where we like to be comfortable and feel secure. Lived space has two dimensions: "inner" and "outer" (Sanchez, 2010, p. 3). Inner lived space is the internal feelings, e.g. isolation, loneliness and fear. Outer lived space is the social grounds of the individual, e.g. colleagues, clients. The researcher explored the lived space by exploring the experiences of transition, acculturation, barriers, enablers, actions and interactions with clients and colleagues. The researcher also asked where the overseas trained nurses find themselves 'at home'.

4.1.2 Lived body

Overseas nurses of different ethnicities with dissimilar physical appearance, skin colour and accent might experience diverse reactions from clients and colleagues. The researcher explored the life changes, challenges and experiences in general and specifically regarding the new workplace. The researcher also considered the overseas nurses' feelings and impressions of themselves. In this study, some participants described of addressing them as 'Indian nurse' or 'dark skinned nurse'.

4.1.3 Lived other

In the scope of relationality, the lived experience of overseas-trained nurses from Kerala can possibly be challenging. Overseas-trained nurses have to find their identity in the new place through the establishment of relationships. Another aspect is that real-life experience may be very different from the impressions and imagination about the new culture and new workplace practice gained through indirect relationships and information sources such as the Web and books. The researcher explored the experiences the overseas-trained nurses lived through, in the process of establishing a relational space. The researcher was also keen to identify the differences between imagination and real experience, presumed supports and hurdles versus the actual enablers and struggles. Most overseas-trained nurses still have their immediate family overseas, and the relationality sphere is therefore possibly different before and after migration. The researcher attempted to uncover the challenges associated with relationality, especially with clients, carers and colleagues.

4.1.4 Lived time

Past experiences include the way overseas-trained nurses practised and lived, their skills, language(s), relatives, and loved ones, and the journey to where they were at the time of the study. Lived time is also about their future goals or projects. Lived experience can possibly influence how time is perceived. Bergson (2001) is of the opinion that the real experience of time is in constant 'flow', the continuous progress of the past into the future (Bergson 2001). Normally, individuals do not see or notice the passing of time in the form of moments or hours, but rather perceive the time as continuous and uninterrupted. For the participants of this study, the process of migration, transition challenges might have interrupted or influenced the flow of time. This study also considered the essence of overseas trained nurses' experiences through the temporal dimension.

4.2 van Manen's six-step methodological structure

van Manen's four lifeworld existentials which provide in depth understanding of the four essential aspects of lived experiences of the person. Additionally, van Manen (1996) had also suggested six methodological steps to utilise while conducting a phenomenological

study. van Manen's (1996) six-step methodological structure was used as the framework for this study. This enabled the researcher to gain an in-depth understanding of the essence of the experience of the study participants and capture the meaning of that unique experience, with the hope of prompting more studies in this particular field. In addition, this method encouraged the participants to express their experience in depth.

In Table 4.1 the six-step methodological structure (van Manen, 1990) applied to this research project is presented.

Table 4.1: The six-step methodological structure applied to this study

1. Turning to the nature of lived experience	What is it like to be an overseas-trained health professional from Kerala, India working in mental health in Australia?
2. Investigating experience as we live it	In- depth interviews with overseas-trained nurses from Kerala who meet the inclusion criteria. They re-learn and re-live their experience.
3. Reflecting on essential themes which characterise the phenomenon	Transcribing the interviews. Isolation of themes enabled by detailed reading, re-reading, highlighting, and trying to understand the themes. Reflection guided by lifeworld existentials.
4. Describing the data	Make the experiences visible by writing up thematically.
5. Maintaining a strong orientation to the phenomena	Remain focused on the research question. Be aware of pre-conceived notions and assumptions. Reflective journals and regular supervision.
6. Balancing the research context	Constantly measure and validate the overall design. Move between parts and whole (hermeneutic circle) during each step of the research.

4.2.1 Turning to the phenomenon of interest

According to van Manen (1990, p. 31) "every research of phenomenology is driven by a commitment of turning to an abiding concern". The result of a phenomenological study is always a single interpretation by a researcher, but there are always possibilities for many more complementary richer and deeper researches (van Manen, 1990), because everyone has a unique interpretation of and personal meaning for their own experience.

My personal interest in this topic originated after I lived through the phenomenon. My orientation to the Lifeworld is as an overseas-trained nurse working in mental health.

According to van Manen (1990), if a researcher finds certain aspects of human life interesting, they should explore them themselves and reflect in order to develop a research question.

> "Things turn very fuzzy just when they seemed to become so clear. To do a phenomenological study of any topic, therefore, it is not enough to simply recall experiences I or others may have had with respect to a particular phenomenon" (van Manen, 1990, p. 41).

In this research, the researcher reflected on her personal experience and the personal meaning of it that has assisted the researcher in the formulation of the research question, during data collection and while reading through the lived experience texts of the nurse respondents and interpreting them. As an overseas trained nurse from Kerala, India and working in mental health the researcher had been through some of the experiences the participants described.

The first step involves the formulation of a research question. My research question is "What is it like to be an overseas-trained nurse from Kerala, India working in mental health"? Arising from this question, the following questions are relevant: Are there shared experiences among my research participants? If so, what are the common themes"?

4.2.2 Investigating the Experience as We Live It

Phenomenology is revisiting the original experience. According to van Manen (1990), the researcher can use personal experience as a starting point, because one's own experience is readily available. In addition, in phenomenological research, the researcher should enter into the worlds of participants, and the researcher needs to actively explore the research question (van Manen, 1990).

Purposive sampling was employed to recruit participants to the study. Two key routes of recruitment were word of mouth and announcements in the Victorian Mental Health Service electronic newsletters. The interview sites and times were determined according to the convenience of each participant. The interviews were conducted over a period of six months, depending on the nurses' availability. The researcher documented the

participants' demographic details, including full name, discipline, and area of work, country of origin, year of migration to Australia and years of experience in mental health nursing before the commencement of the interview. Each participant was given a pseudonym to protect his or her identity. The interviews were audio recorded. The interview process followed the hermeneutic circle of questioning, uncovering meaning and further questioning. The researcher also took notes on non-verbal communication. van Manen (1997) supported the importance of paying attention to silence, the absence of speaking, the silence of the unspeakable and the silence of being or life itself, as it is here that one may find the taken for granted or the self-evident.

4.2.3 Reflecting on essential themes

According to van Manen (1990), a true reflection on lived experience is a conscious thoughtful process. This involves sensitivity and reflectively bringing into the nearness of experience which tends to be obscure, that which tend to evade the intelligibility of our natural attitude of everyday life (van Manen, 1990, p. 32). This included transcription of the interviews and isolation of themes by detailed reading, re-reading, highlighting, and trying to understand the phenomena. van Manen (1997) proposed the following three processes to analyse data: 1. read the data as a whole to get contextual understanding, 2. highlight the selective themes that emerge from the data and 3. undertake a line-by-line analysis of the transcribed data to understand the phenomenon.

4.2.4 Describing the phenomena: The art of writing and re-writing

According to van Manen (1990), doing phenomenological research is the 'bringing to speech' of something. A common device in phenomenological writing is the use of narration or story (van Manen, 1990). Writing is closely linked to the research as "Writing distances us from lived experiences but by doing so it allows us to discover the existential structures of experience (van Manen, 1990, p. 127). Phenomenological writing is not a straightforward activity. Writing is an art, which demands many approaches, going back and forth, visiting and re-visiting. After the completion of data collection, the data were transcribed using professional transcribers, with the maintenance of confidentiality. Credibility and trustworthiness of the transcriptions were ensured by sending the transcribed data to the participants for accuracy checking.

At this stage, the researcher carefully listened to, understood, interpreted and compared the themes emerging regarding the phenomena under study.

4.2.5 Maintaining strong orientation to the phenomena

The researcher remained strongly oriented to the basic research question. There is a possibility that researchers can deviate from the research question without awareness during the research journey. In the present research, the researcher attempted to remain focused on the research question. According to van Manen (1990), in order to establish a strong orientation to the research question; the researcher will not "settle for superficialities and falsities" (p. 33). The researcher used a reflective journal to ensure she maintained her orientation to the research question.

4.2.6 Balancing the research context

According to van Manen (1990), the researcher should constantly be validating the overall study design against the significance that parts must play in the total textual structure. During each step of this research, the researcher *stepped aside* and viewed the research from outside. van Manen (1990, p. 34) suggests that the researcher should answer the following questions frequently in the process of research: "is this study properly grounded in a laying open of the question"? "Are current forms of knowledge examined for what they may contribute to the question"? "Has it been shown how some of this knowledge glosses that overlay our understanding of the phenomenon"?

This study is about overseas-trained nurses working in mental health, and these nurses have been though diverse range of transition challenges. There are no previous studies investigating experiences of overseas trained nurses working in mental health. This might lead to the speculation that the experiences of overseas-trained mental health professionals are similar to those of their counterparts working in the mainstream health service. Importantly, previous similar research recommended the need for this type of study (Konno, 2008) and in particular, strongly argues for the need for more research in the specialist area of mental health. Moreover, it is assumed that this study will benefit overseas nurses, employers, mental health system and crucially clients with mental illness.

4.3 Data collection

According to van Manen (1990), in phenomenological research, interviews are the main means to collect and explore the data and to enable the conversation with the participants to explore their lived experience. Phenomenological reflection uncovers the essential meaning of a specific phenomenon under investigation. The aim of this study was to gain a deep understanding of the personal meaning of the experience of being an overseas-trained nurse from Kerala, India working in mental health in Australia.

4.3.1 In-depth interviewing

In phenomenological studies, in-depth interviews are inevitable (van Manen, 1996). Data collection was completed by in-depth and informal audio-recorded interviews. Interview sites and times were determined according to the convenience of each participant. The interviews were conducted over a period of six months. The researcher documented the demographic details, including full name, discipline, and area of work, country of origin, year of migration to Australia and years of experience in mental health nursing before the commencement of the interview. Each participant was given a pseudonym to protect his or her identity. The interview process followed the hermeneutic circle; questioning, uncovering meaning and further questioning. The researcher also took notes of non-verbal communication.

A variety of responses were received when the length of the interview was discussed. Before the interviews were conducted, many of the participants had different ideas about the ideal length the interviews should take. However, when conducting the interviews, the length of time did not seem to be an issue and many of the participants reflected they were not aware of the length and time. Additionally, most participants responded that they were not aware of the time and length, as they were immersed in the reflection of their lived experience. With the first participant, the author conducted four separate interviews, as originally planned. The major challenges identified by the participant and the researcher were the time gap and the loss of continuity, even though the researcher recapped the previous session and adequate time was provided for recollection and reflection. This issue was brought to the supervisor's attention and other participants were offered the option of either having one lengthy interview or a

number of different sessions. All 16 participants chose the option of the single interview as they could organize and dedicate a day for this interview, since most participants had young families and were working full-time. This was convenient for organizing the venue for the interview, especially for the interstate participants. The researcher travelled interstate and to various venues to conduct the interviews. The average interview time was three hours. All participants were warm, reactive, caring, and welcoming, especially the interstate participants who were offered food and drinks. Most of the participants expressed gratitude for the opportunity, congratulated the researcher on her endeavour, and offered future support.

There were a few unexpected experiences associated with the interview process. One interstate participant was helpful in organising venues and candidates for interviews. However, she did not proceed with the interview herself, as she was anxious about her language and her voice being recorded. In one case, after arranging a time and place agreed by the participant, when the interviewer arrived at her residence, she neither opened the door nor responded to telephone calls. During further follow up the participant reported that she was physically unwell and unable to respond at that time. Even though the researcher had offered her another opportunity, the participant refused as she was leaving the country for long overseas holidays.

Special attention was paid to the safety and wellbeing of the participants and the researcher. The participants were given information about the debrief process and the researcher always conducted a welfare check at the end of the interview. The researcher sent text messages to the supervisor before and after each interview to as a safety measure. Informed consent was obtained before the commencement of each interview and the participants were informed that they had the right to withdraw from the interview at any stage before publication. Refer to Appendix 6 for the plain language statement and consent form (Appendix 3). The interviews did not follow a structured format. They were mainly led by the participants; however the researcher had to elicit the deeper meaning of the experience, and the phenomenological themes of spatiality, corporeality, temporality and rationality (van Manen, 1990). The interviews were audiotaped and transcribed by a professional transcriber. Each interview transcript is between 60 and 94 pages.

The researcher also wrote field notes and completed a reflective journal after each interview. These are stored in a safety locker along with audio records and transcripts.

4.3.2 Participants and sampling

Purposive sampling was employed to recruit participants to the study. Two key routes for recruitment were advertisements in the Victorian Mental Health Service electronic newsletters and word of mouth for a copy of the advertisement (Appendix 4). Overseas-trained nurses (16) from Kerala were interviewed and data saturation in relation to the phenomenon was attained. The inclusion criteria for this study were determined as follows:

The inclusion criteria were:

- Overseas - trained nurses from Kerala working in mental health in Australia
- Overseas-trained nurses from Kerala with 2-10 years of experience in mental health in Australia.

The interview was conducted in English. As practising professionals in mental health, the participants were expected to speak fluent English.

Participants had to have 2-10 years of experience. Potential participants with less than two years of experience were considered as still undergoing an initial transition experience. It was therefore reasoned that their experience was not sufficient for the level of reflection required of the participants. According to van Manen (1990), reflection is bringing the memory back; it should be about something which happened in the past and which the person personally experienced. Potential participants with over 10 years of experience were also excluded, since over 10 years is a significant time gap and participants would have limited contemporaneous time when talking about their experiences.

The exclusion criteria were:

- Kerala nurses with less than two years of experience, or more than 10 years working in mental health Australia, or not currently working in mental health
- Domestic health professionals
- Kerala nurses working in general health

There are significant numbers of Kerala nurses working in general health in Australia, and they were excluded due to the specificity of the research question.

Study sample

Boyd (2001) suggests a sample size of two to 10 is sufficient to reach saturation and Creswell (1998) recommends long interviews with up to 10 people for phenomenological research. In this study, 16 overseas-trained nurses from Kerala working in mental health were interviewed. Twenty nurses contacted the researcher and three nurses could not attend for various reasons. However, rich description of the phenomena was attained. According to van Manen (2014) in phenomenological approach, sampling is not determined by numerical data or saturation. Number of participants in phenomenology is enough numbers to provide rich description of the phenomena and enable the readers to understand the life as it lived (van Manen, 2014).

The study site

This study was conducted in Australia. The participants were from three different jurisdictions in Australia; Victoria, Western Australia and New South Wales. Data collection was undertaken over a period of six months. The interviews were conducted at different venues at the participants' convenience. Venues varied from a pre-booked room in the local library, university library rooms, hospital rooms, and participants' residences. All interviews were face- to -face. The travel involved with this study was from 30 minutes to 14 hours, as there were participants from Victoria and interstate. The researcher was conscious of the potential interruption when conducting the interviews in a hospital or other formal settings. Therefore, a meeting room was booked and a *Meeting in progress* sign was posted to avoid interruptions.

4.3.3 Ethical considerations

This study adhered to the guidelines of the National Statement on Ethical Conduct in Research involving humans produced by the National Health and Medical Research Council of Australia (2007). According to Holloway (2010), a key issue in qualitative research is informed consent, as it is exploratory in nature and guided by the ideas of the participants. Common reasons for participant's vulnerability are their illness, power

relations, and lack of knowledge due to lack of detailed description of the study. Although the study participants were health professionals, participant vulnerability remained relatively low. Emotional distress was a possibility since the participants were reflecting on their previous experience. The participants were orientated to the study and were given details of this study both verbally and in writing. They all received a participant information form, which was written in plain language with all essential details of the study (Appendix 5).

Informed consent

The study received ethics approval from the Monash University Human Research Ethics Committee (Ref: CF13/3844 – 2013001976). This study was carried out according to the National Statement on Ethical Conduct in Research Involving Humans, produced by the National Health and Medical Research Council of Australia (Australian Government, 2007). The researcher also obtained informed consent from all participants. Participants were assured that all personal information would remain confidential. Privacy was maintained throughout the study. Participation in this research was voluntary. At any stage, the participants could discontinue the interview, and before publishing the data, the participants can still make a request to withdraw the data.

The data collected from the interviews was digitally recorded, and then transcribed. The recordings and the transcripts are considered confidential documents. All data is stored in a locked filing cabinet in a locked office. Audiotaped interviews, excerpts and transcripts are kept in electronic files in a password-protected computer. The researcher safeguarded her own privacy by using her university contact details including email and used this solely for the research.

4.3.4 Trustworthiness

The original concept of rigour originated from the quantitative research paradigm. In qualitative research, rigour indicates the clarity and capacity of that research (Holloway, 2010). Rigour is an ethical expectation to bring forth quality studies (Whitehead, 2003). Koch (1994) is of the opinion that, in hermeneutical research, adherence to the theoretical, methodological underpinnings during every stage of the study is a key indicator of trustworthiness. On the other hand, excessive rigour can be a barrier

(Bradbury, 1987) when phenomenological research is expected to produce rich description, and it is a poetizing activity (van Manen, 1990). A rigorous study will adhere to the pre-determined methodology during each stage of the research and fulfil the aim of the research by finding the answer to the research question. This research followed qualitative research methodology of phenomenology and utilised van Manen's six steps and Lifeworld existentials for data analysis.

The selection of a suitable methodology is also an important factor for rigour (Morse et al., 2002). The researcher has chosen phenomenology informed by van Manen (1990) as the research explored the lived experiences of overseas-trained nurses from Kerala, India, working in mental health in Australia.

Reliability in qualitative research indicates dependability and consistency (Holloway, 2012). In other words, if the same research were replicated using the same method with the same participants and situations, the research should elicit similar results. The researcher's experiences and preferences can influence the outcome to a certain extent (Holloway, 2010). Regular supervision and reflective journaling were two strategies used in this research to overcome the influence of the researcher.

4.3.5 Validity

The validity of a research study is otherwise known as its credibility (Holloway, 2010). This can be achieved by reliable data collection and interpretation. The participants' description of experience is the key factor in qualitative research. Phenomenology uses in-depth interviews mainly led by the participants. The concept of validity comes into play during the interpretation stage of a phenomenological study.

Internal validity is related to the truthfulness of the study. It depends on accuracy in answering the research question and justification of the participants' voices. This can be achieved by receiving feedback and confirmation from the participants. In this research, the transcripts were sent to the participants for accuracy checking and they have agreed to the transcripts. External validity is otherwise called generalisability. Generalisability means the possibility of generalising the particular research. Generalisability considers the following questions: if the study were done in similar setting would the results be comparable? This concept is slightly varied in qualitative research. Some scholars

suggest generalisability is not an expectation of qualitative research (Holloway, 2010) as it involves the subjective, personal meaning of the lived experience of the participants, and every individual is unique in their own world.

As previously mentioned in Chapter 3, van Manen (2014b) suggests the four questions can be applied when assessing the validity of phenomenological studies (pp. 350-351):

Is the study based on a valid phenomenological question?

In the analysis of the current study, the researcher aimed to understand the phenomenon of experience of being an overseas trained nurse from Kerala, India working in mental health in Australia. Therefore, the phenomenological question formulated by the researcher was 'What is it like to be an overseas trained nurse from Kerala India and working in mental health in Australia'?

Is analysis performed on experientially descriptive accounts, transcripts?

The analysis for this study have utilised transcripts of the participants (in depth interviews) and were transcribed by a professional transcriber. The descriptive accounts of participants' lives are presented in Chapter Five. The thematic analysis as described later in this chapter was performed and the interpretive writing as presented in Chapter Six.

Is the study properly rooted in primary and scholarly phenomenological literature? In this study, a wide range of primary and scholarly work of the original?

Scholarly works of phenomenological philosophers and researchers were explored and described in Chapter Three. The researcher has given prime importance to van Manen's methodological outline for phenomenology and Hermeneutical phenomenological approach. Primary works on van Manen's lifeworld existentials were also examined in detail.

Does the study avoid trying to legitimate itself with validation criteria derived from sources that are concerned with other (non-phenomenological) methodologies?

There have been various suggestions in maintaining trustworthiness in qualitative methods. In fact, these measures cannot be used for phenomenological studies.

Holloway and Wheeler (2010, p. 302) argues; "Researchers make judgments of trustworthiness possible through developing dependability, credibility, transferability and confirmability". In this study, the researcher has to pay utmost attention to ensure the interpretation is not biased by his/her own ideas and concepts. In this research, the researcher maintained a reflective journal and took field notes. Regular supervision was also completed as an important factor.

4.3.6 Distress management

Phenomenological research requires reflection of participants lived experience. These experiences are usually very personal to the individual. As the participants of this study were health professionals, participant vulnerability was less likely. However, emotional distress was a possibility, since the participants were asked to reflect on their previous experience. In order to manage possible distress, the researcher developed a distress management protocol. The distress management protocol used in this study is outlined below.

Table 4.2: Participant risk management protocol

Distress level	Distress management
High-level emotional distress	If the participant exhibits behaviours suggestive of high level distress: • the researcher will assess the participant's mental state • will ensure safety • will provide immediate support by removing the participant from the interview and giving quiet time • will contact/make an appointment with a GP, if the participant wishes to do so • suggest/encourage contact with triage, Lifeline or the Salvation Army counselling service • The researcher will contact the next of kin if the participant wishes her to do so • The researcher will follow the participant up with a courtesy call if the participant consents
Moderate distress	• Terminate the interview • Give quiet time • Offer support • Resume the interview the same day or on a different day, as the participant wishes
Low-level distress	• Offer termination of interview • Carry on the interview if agreed by the participant

4.3.7 Recruitment

Purposive sampling was employed to recruit participants to the study. Two key routes for recruitment were recruitment through advertisements in the Victorian Mental Health Service electronic newsletters and word of mouth. These participants' ages ranged from 28 to 55 years. Participants were also invited through snowball sampling and through a brief informal presentation of my topic in the Kerala community in southeast Victoria. Snowball sampling was by the participant who has attended the interview by referring and recruiting more participants. During the first contact, the purpose and requirements of the research were explained and written information and consent forms were provided. Later the researcher made telephone calls to organize convenient times and venues for the interviews.

Table 4.3: Demographic data of the participants

Participant characteristics	**n=16**
Males	n=6
Females	n=10
Average age	33 years
Average years of experience in mental health	8 years
Average years of experience in India	3 years
Average years of experience in Australia	5 years
RN qualification	n=16
Post graduate qualification in mental health	n= 9

4.3.8 Data management

Recorded interviews were transferred to the researcher's personal laptop and desktop computer and stored in an external hard drive. All these devices are password-protected. When the study is completed, the laptop and desktop data will be deleted. Data will be kept for another five years after the completion of the study. Participants' names were de-identified to maintain privacy and confidentiality. The researcher will follow university guidelines regarding the destruction of the data after five years.

4.4 Data analysis

The goals of data analysis are to interpret and describe the data, to uncover the subjective meaning of the lived experiences of the respondents. Data were transcribed with the maintenance of confidentiality. At this stage, the researcher carefully listened to, understood, interpreted and compared the themes emerging regarding the phenomena under study.

After completing the data collection**,** while waiting for the transcripts, the researcher listened to each interview multiple times to become familiar with the data. The researcher carefully read the entire transcripts twice to obtain an overall understanding. The researcher made notes of points, which were particularly striking, phrases that carried particular meanings, and frequently repeated and presumably important words. When the transcripts arrived, the researcher read and re-read each interview transcripts, paying attention to each line and paragraph to discover meanings and themes.

The below figure explains the framework used for data analysis. Detailed description of each step is provided later in this chapter.

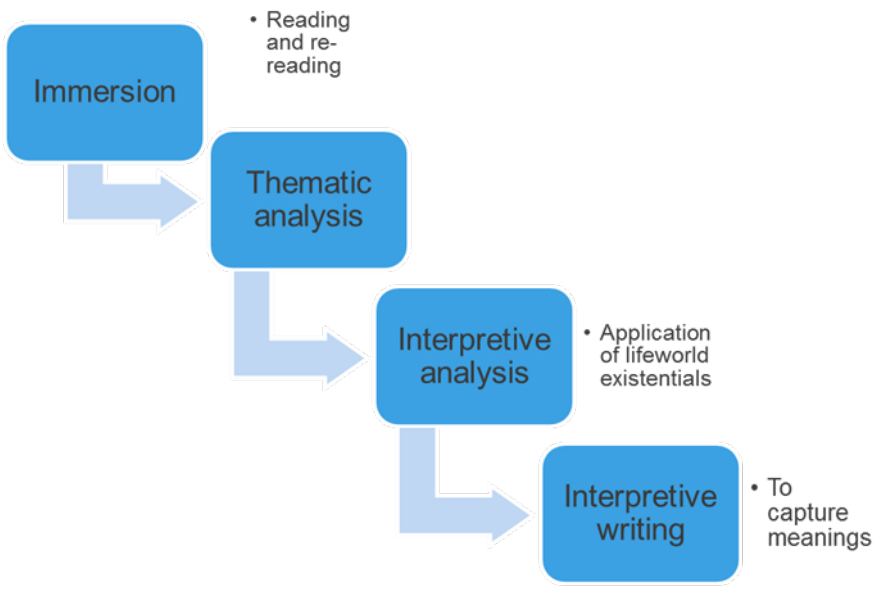

Figure 4.1: The framework used for data analysis

The participants in this study were 10 female nurses and six male nurses. Face-to-face, in depth interviews were conducted with all 16 participants after obtaining informed consent. The interviews were audio-recorded and later transcribed verbatim by a professional transcriber. The participants confirmed the transcripts. The analysis was conducted by thematic analysis followed by interpretation of the experiences to gain deeper insights. The researcher's field notes and reflective journal were consulted in the process of analysis. Regarding interpretation of the data, van Manen (2014) recommends researcher's stance and collaboration with the participants in uncovering and interpreting the meaning rather than providing pure description.

4.4.1 Isolation of themes

Phenomenological writing is a descriptive and questioning activity, which allows the reader to experience heuristic questioning, richness of the experience, interpretive depth, meaning, reflective rigor, and epiphany (van Manen, 2014). According to van Manen (1980), in a lived experience description, whether in narrative form, comments, or interviews, the person will have something to share and it is the researcher's responsibility to uncover the themes. There are three approaches to the isolation of thematic aspects of a phenomenon.

1. The holistic or sententious approach
2. The selective or highlighting approach
3. The detailed or line-by-line approach

According to van Manen (1990, p. 93), in the holistic reading approach the researcher views the text as a whole and enquires "what sententious phrase may capture the fundamental meaning or main significance of text as a whole?"

In the selective reading approach, the researcher listens to/reads the text multiple times, to identify statements or phrases that appear essential or which reveal the experience being described (van Manen, 1990). In a detailed line-by-line approach, the researcher looked at each sentence; paragraph and groups of text to reveal the experience being described (van Manen, 1990).

The following section provides examples of the evolvement of themes using three different approaches.

4.4.2 Holistic approach

Using a holistic approach, the researcher should determine the message the participant is trying to convey using her judgement and taking into account multiple factors from multiple participants within the interpretation. The text below provides an example where one participant was reflecting on her initial hurdles. She found it difficult to communicate with Australians due to her accent, their way of speaking, and their use of slang, abbreviations and jargon. She did not believe her ability to use English language is poor. Other participants also identified difficulty with communication as one of the main challenges they faced during the transition period.

> "Staff helped me a lot during early stages with everything. But accent was a major problem at that time…underneath. When they don't understand what, you are trying to say…you know…I felt bad. I don't think my English was that bad. I scored good marks for my English test, I learned English from primary school. But you repeat again and again and try different way of saying. It was scary; they use a lot of slangs and a lot of abbreviations. …When I think now I can remember the biggest problem was attending phone calls, I used to run away when the phone rings" (Robyn, p. 45).

Theme

Communication- related challenges

4.4.3 Selective highlighting approach

Here the researcher considered phrases of special interest, or which indicated a special meaning. The researcher selected those phrases, sentences of parts of sentences, which appeared to carry the meaning or a special theme. Here are some examples:

> "You know…It was very difficult…staff joke about different things and most of the time I didn't understand" (Robyn, p. 45)

"Accent was different. My English wasn't that good in terms of slangs...you know I struggled" (John, p. 28)

"I had problem with language, certain words they use with different meaning and I was confused with slangs also" (Cindy, p. 32)

"Language and accent was so difficult for me...I struggled with slangs…it was very difficult to follow what they said" (Tom, p. 10).

The participants were revealing that communication was a challenging experience for them during their initial days in Australia.

4.4.4 Line-by-line approach

In the line-by-line approach, the researcher carefully read each sentence to determine the meaning. Here terms such as 'struggle' 'difficulty' 'problem' stood out. These indicate the initial hurdles around communication and language.

"I struggled with communication

"I felt scary underneath…"

"It was difficult for me..."

"I didn't understand what they said"

"I was confused with slangs…"

Main Theme

Communication-related challenges

4.4.5 Example of thematic analysis for the entire group of participants

In a life story text, the extractions are very rich. Isolating themes from statements can be challenging for the researcher. It is the process of identifying patterns and meanings across the whole material. Initially each interview was read multiple times and dwelled in the data. In this study, many participants mentioned the theme "living in two cultures" multiple times.

Description

> *My cultural beliefs are strong and I never changed it…to me it is not accepting…it is more of understanding the Australian culture...At home we practise Indian culture, since I grew up in that culture...I know it can be confusing for kids for example keeping a close relationship with the family, respecting elders especially men by standing up when an elder person arrive etc. I always encourage my kids to follow positives of Australian culture too saying hello to everyone is an example. But I try to maintain a balance between Australian and Indian culture"* (Robyn, p. 79).

In this text, the participant asserts that her past culture is important to her, she follows it at home, and she urges her children to do the same. She realizes that this can be 'confusing for the kids'. She acknowledges that she is 'not changing'. Similar ideas were raised multiple times in many other interviews.

Theme

Still following own culture. Concerned about confusing children

Description

> *I follow typical Indian culture...I want my kids to follow that…We speak Malayalam at home...every other day they talk to their grandparents over the phone...I eat with my hands and my kids too...I am trying to maintain that cultural bond...but they are growing here….they are going to adapt Australian culture...I am typical Indian…my kids will struggle...so it is going to be a trauma for them…I worry about my children and my wife too she started worrying about them"* (John, p. 40).

The process of searching for similar themes in each interview was repeated. In the above text, the participant states that he wants his children to follow Kerala culture. He acknowledges that his children might struggle with living in two cultures, and states that his family is worried about this.

Following own culture at home. Concerned about future generation

Description

> *We follow Kerala culture...I know I can't push my kids. We try to do things the way, they never lose their contact with our family and culture. We go to India every year, we call them...we show kids Indian movies and music. So, they understand (the culture). My elder one has god idea about India and she loves India. But sometimes I have to do certain things in Australian way too...since they started school…example...I cook western food home sometimes…but I worry about the social and party life of teenagers. I don't like that. I don't want my children to adopt that...I know it will not happen and I don't want to" …* (Preethi, pp. 25-26).

Preethi raised a similar theme. She understands that she cannot force her children to follow her home culture but she tries to encourage them to gain an understanding of Indian culture by showing them films and other art forms. She points out they keep in close contact with the family back in India. She asserts that she cannot accept certain aspects of Australian culture.

Practices Kerala culture and home concerns about children

Practising some aspects of past culture while at home

When the researcher focused on the transcripts for a key concept of transition to the new culture, it was clear that many participants shared similar ideas. The similar significant concepts were highlighted. In the random sample of texts provided above the researcher diverted her focus from key words to themes. All sixteen transcripts were examined for this theme and statements with similar themes and concepts were grouped together.

Key concepts → Sub-themes → Themes

Theme: living in dual cultures

The themes and categories were revisited multiple times and the researcher paid constant attention to test the themes against descriptions. Credibility was ensured by in-

depth engagement with the participants, by detailed analysis. All participants were encouraged to read the transcripts and themes to ensure their authenticity.

4.5 Chapter summary

This chapter has outlined information about the methodological framework and the practical methodological procedures used for this study. The steps involved in this research, such as the ethical considerations, including risk management, in-depth interviewing, data analysis using van Manen's method, and data management, have also been discussed. This chapter has also explained how themes were isolated, with examples used to highlight. The following chapter introduces the participants.

Chapter 5

Findings - Overseas-trained nurses from Kerala, India working in mental health in Australia: Introducing the participants

5.1 Introduction

This chapter provides stories about the sixteen participants, presented in a summative narrative style. These narratives were composed after interviewing each of the nurses about their experiences as nurses from Kerala, working in mental health nursing in Australia. These stories highlight the participants' lives, commonalities and differences in their education, previous experiences and current position. The main purpose of this chapter is to establish an understanding of the interpretations of the lived experiences provided in the next chapter. It is believed that these narratives will enable the reader to gain an understanding of the participants. It is also believed that a detailed description of the participants will give a human touch and individuality to their voices and the experiences they shared. Again, van Manen's (1980) phenomenological approach aims to provide an insight into human experience. In order to gain that insight, it is essential to understand the lives of each participant. Pseudonyms were given for all participants. Some participants were given with English pseudonyms as their names were already English names.

5.2 The participants

5.2.1 Robyn

Robyn currently works as a community mental health nurse. Robyn, who is in her mid-thirties, has nine years of experience as a mental health nurse in Australia.

Robyn finished her Bachelor of Nursing degree in Kerala and stated that she chose nursing as a career because her parents suggested it to her due to the availability of jobs and chances for migration. She expressed the difficulties and challenges she experienced during the initial stages of her nursing studies. The challenges were mainly related to communication and difficulties associated with transitioning into the new culture. She

has also mentioned that India and Kerala are far behind Australia with regard to the growth of the nursing profession. Robyn emphasized that she was passionate about mental health nursing after her first placement in mental health. However, she chose to work in the Emergency Department after the completion of her course. Later she obtained a job as a clinical instructor in mental health, which reignited her passion for mental health.

Robyn asserted that the decision to migrate to Australia was influenced by her friends. Migrating to a foreign nation is common in Kerala. Robyn had friends and classmates who were working in the UK, the US and Ireland. Robyn and two friends prepared for the English test (IELTS). Robyn secured sufficiently high band scores to move to any English-speaking country. She then consulted with a migration agent and made the decision to migrate to Australia. In her interview, Robyn stated that did not have much awareness and understanding about the new country and its culture, but she was ready to face the challenge. The agency charged her around AUD$20,000 dollars for migration and a three-month bridging program. Her father arranged a bank loan to assist her financially. Robyn migrated in 2005 at the age of 25 along with her two friends.

After her arrival in Australia, Robyn had to complete a three-month generic bridging/ adaptation program. She found the language and culture difficult to follow, even though her English language was good. She stated that some of her colleagues and supervisors were very supportive but others were not so. There were moments when she felt like going back to India. She stated that she did not feel comfortable asking questions, but on the other hand, she depended largely on a few staff with whom she felt comfortable.

She was on a three months' visa and she had to find a job in a very short time to stay in the country. Her agent helped her to apply for positions and she found a job in the acute adult mental health service. Later after 3years of fulltime work as a registered nurse, she became Associate Nurse Unit Manager in aged mental health. She then completed Master of Mental Health Nursing. Her first job was challenging for a number of reasons, including a few non-supportive colleagues, her lack of experience in Australia, her lack of knowledge about Australian culture, communication difficulties, lack of assertiveness

and other emotional reasons due to migration. Robyn stated she misses Kerala and wants to go back if circumstances permit.

5.2.2 Cindy

Cindy also migrated to Australia in 2005, aged 24. She gained her basic nursing qualification in Kerala. She is the ninth child in her family. She stated that she chose nursing because she wanted to be a nurse from a very young age and her mother and other siblings suggested it. She described her initial days of hospital-based nursing training as challenging, but she survived with the support of her teachers and friends. She had to complete a month of clinical placement in mental health during her second year, which she found 'heart-breaking' due to the poor conditions of mental health care in Kerala. When she finished her nursing course, she started working as a voluntary worker in one of the charity mental health rehabilitation centres in Kerala. In the meantime, she completed all the requirements to migrate to the US. Cindy's motives for migration were better pay, better opportunities and career growth. The process took longer than she expected. Later she approached a migration agent who assisted her to move to Australia. She stated that her relatives supported her in finding AU$20,000.

In Australia, Cindy completed her adaptation program at a University in Australia. She found the initial days in Australia challenging. She described mixed experiences with clients and colleagues during her first placement in Australia. Later she secured a job in an adult acute in-patient unit and completed Master of Nursing in Mental Health. She found her initial days in mental health in Australia to be challenging due to communication- and culture-related difficulties. Later she worked in a community care unit and is currently a manager in an adult acute in-patient unit. Cindy is a very confident person with very high career goals who is willing to work hard to achieve those goals.

She describes Australia as a land of opportunities and enjoys the flexibility of work. She described her spirituality and the moral support of her mother as the two strong pillars of her survival. Cindy seemed satisfied with the new country and working environment but still follows the culture of Kerala.

5.2.3 Sindhu

Sindhu is in her early thirties and arrived in Australia two years ago. Sindhu is from a middle-class Christian family in Kerala. All her aunties are nurses who work abroad. Sindhu's father first suggested nursing and she was willing to follow his suggestion. Sindhu stated she enjoyed her mental health placement but the condition of the service was not good. After completing her nursing course, she started working in the medical ward and did not enjoy working there. Later she joined one of the psychiatric hospitals in Kerala as a registered nurse. Sindhu stated that mental health care and mental health nursing in Kerala are very behind compared to Australia. Sindhu always wanted to migrate to a foreign nation. Her friend who had migrated to Australia encouraged her to move to Australia. A migration agent assisted her with the visa processing. Sindhu's motive for migration was to support her parents and family financially.

Sindhu had to complete an adaptation course, which she stated as being not very helpful, although she found it challenging. In Australia Sindhu struggled with the language, communication, lack of assertiveness and time management. Sindhu mentioned that her expectations were different from the reality especially communication and work environment. After completing the three months' adaptation course Sindhu found a job in an adult acute in-patient unit. She described her initial experience as anxiety provoking and scary. Working in Kerala and Australia were completely different. The concept of the Recovery model was new to her. Sindhu stated that drug abuse is not very common in Kerala while issues with alcohol abuse are common. Her initial days were challenging, as she did not know the legal framework and the mental health system. Some clinicians were supportive. She felt comfortable in seeking help from other Indian and Kerala nurses in the same workplace.

Lack of assertiveness was a challenge for Sindhu. During the interview, Sindhu mentioned multiple times, that she could not say 'no' so she agreed with all requests from colleagues. Currently Sindhu is doing a post-graduate qualification in mental health. However, Sindhu has no intention to expand her career. She wants to continue to work as a registered nurse in the in-patient unit. She is currently satisfied.

When talking about her transition experiences, Sindhu stated that she still follows Kerala culture at home, she cooks Indian food and she wants her children to grow up in the Kerala culture. She still struggles with the clash of conservative Kerala culture and Western culture. She misses Kerala and her relatives. She has a strong urge to go back to Kerala when she retires.

5.2.4 Smitha

Smitha is another participant in her early thirties. She completed her Bachelor of Nursing in Kerala. Whilst Smitha liked her mental health placement and the speciality subject of psychiatry, she had no intention of working in mental health. Later she worked in an ICU and started looking for migration opportunities. Smitha's motives for migration were better working conditions, professional growth and financial betterment. Smitha migrated to Ireland in 2007 and started working in a psychogeriatric facility. She found the place and people to be supportive. Smitha spent 4 years in Ireland while her family was still in Kerala. Even though the work environment was good and she was enjoying the financial benefits, the extreme cold weather was intolerable. Then in 2012, Smitha started process of applying for permanent residency in Australia.

In Australia, Smitha secured a job in an adult acute inpatient unit. She was not required to do a bridging course as she had had experience in Ireland. The initial months in the adult acute inpatient unit were challenging, as she had no experience in adult and acute mental health. She struggled with the new mental health system, the terminology and the jargon. Smitha described herself as a shy person. She found some clinicians to be helpful. Although Australia and Ireland are English-speaking countries, she stated that the people and attitudes to overseas-trained nurses are different. Smitha mentioned her lack of assertiveness and the difficulties associated with that. She found that other Kerala nurses already working in the unit were very helpful during the initial days. She stated that she has come across negative racial attitudes from clients many times but could overcome them.

Currently Smitha lives with her husband and two young children while finishing a post-graduate qualification in mental health nursing. Smitha raised her intention to return to Kerala in 10 years.

5.2.5 Krishna

Krishna is in his late twenties. He stated that he wanted to do medicine but as his scores were not sufficient, he chose nursing. He did not like the profession initially but later he enjoyed it. After finishing his Bachelor of Nursing, Krishna worked in an ICU for a year. His girlfriend was in Australia so he started the process of applying for a visa to Australia. He passed his English test and moved to Australia. Here he had to complete a six months' adaptation program (Previously, there were two types of adaptation programs in Australia; those who have gained English scores of 6.5 had an option to complete 6 months' program instead of 3 months) which he enjoyed. Later he accepted his first job offer from a newly started mental health unit in rural Australia. They gave him a one-week induction course and he started working there. He commented about the rare racial attitudes of clients and colleagues and his inattentiveness to them as his coping strategy.

Krishna found the language, accent, jargon, terminology and his lack of awareness about Australian culture as challenging. Later he moved to a metropolitan mental health service. He has plans to do a post-graduate degree in mental health nursing and further his career. Krishna has many friends in the country and he loves the Australian culture. He also follows some aspects of Indian culture. Krishna's choice of mental health nursing was due to the job availability at that time but he continues in mental health. Now he enjoys doing mental health nursing.

5.2.6 Mary

Mary has worked in an assessment prison for the last two years. She gained her basic qualifications in Kerala and is in her late forties. Mary stated that she wanted to do a Bachelor of Medicine; however, some of her relatives who were doctors advised her to do nursing since they thought it more family-friendly for a Catholic female. Mary identified herself as a high achiever.

Mary had a brief clinical placement in a mental hospital during her third year, which she found to be interesting. She described the mental health system in Kerala as poor, with increased seclusion rates, lack of skilled staff and poor hygienic conditions. After completing her Bachelor of Nursing, she worked as a cardiology nurse in a leading

hospital. Meanwhile, she completed a postgraduate diploma in cardiology nursing. Later she worked as a lecturer in medical surgical nursing in one of the universities in Kerala. Her husband, who is a lawyer, encouraged Mary to migrate to New Zealand, to explore the place.

Mary migrated to New Zealand in 2008. There, she worked as a casual bank nurse. She had to do shifts in forensic mental health, which instilled in her a passion for the speciality. Later she was offered a job in a forensic mental health unit managing forensic clients with intellectual disabilities. After six months, she became the associate manager of the unit.

In 2013, she migrated to Australia because of the better educational opportunities for her children. She started working in an adult acute inpatient mental health unit. Mary stated that she did not enjoy working there as the management and her colleagues were unsupportive. She worked there for three months and then had a conflict with the manager and resigned from that job. Then she applied for a job in forensic mental health and started there. Her initial days in forensic mental health were challenging, but fortunately, her manager and colleagues were supportive. Mary has started doing a post-graduate course in mental health nursing. Currently she works as a senior assessment clinician in a forensic assessment unit and enjoys working there.

5.2.7 Thomas

Thomas is in his late forties. He completed a three-year diploma in nursing in Kerala. His choice of nursing was influenced by his relatives who were nurses and working abroad. He wanted to become a mental health nurse even during his first clinical placement. After the completion of his diploma in nursing, he was required to undertake a six months' mental health placement. Later he worked as a mental health nurse in one of the specialist hospitals then he joined an intensive care unit and worked there for two years. He also commenced study for a Bachelor degree in Nursing.

After finishing his course, he migrated to the UK and started working as a mental health nurse. He struggled to adapt to the Western culture and the English language though he had a supportive manager. He mentioned the racist attitudes of clients, but he could cope well. Later he became the team leader of the unit. In 2007, Thomas and family

migrated to Australia due to the extreme climate conditions in the UK. He joined an adult acute inpatient unit. In Australia, he found the Mental Health Act, slang and jargon to be challenging. He still follows the traditional values and culture of Kerala. He currently works as an Associate Nurse Unit Manager. He is very satisfied with his current role and does not have any intention to go back to Kerala.

5.2.8 John

John, in his mid-thirties, gained his Bachelor in Nursing in Kerala. He was forced to take up nursing by his parents due to the overseas job opportunities. Initially, he struggled as he thought that nursing is meant for females. Later he started liking the subjects, including mental health. He became passionate about psychiatry after his placement. Later he migrated to the Middle East and worked in a medical ward, which he did not enjoy. After two years, he returned to Kerala and started working in mental health.

In 2007, he migrated to the UK and obtained a job in a forensic mental health in-patient unit. He was required to undertake a two-month orientation program to become an RN. This intense orientation program helped him to understand the culture of the country and the workplace. He mentioned occasional racist discriminatory comments by clients. He stated that his coping strategy for racism was his resilience. He had a supportive manager and colleagues at his workplace. He was satisfied with the workplace, but had to leave the place because of the extreme weather conditions.

In Australia, he found a job in an acute adult in-patient unit, where he met other Kerala nurses. He liked to work with Australian nurses, but found that nurses from multicultural backgrounds were not supportive and were unhealthy competitors. He could not cope with the workplace politics.

Later, he joined an adult prevention and recovery unit, which offered twenty-eight days stay for clients between the ages of 18 and 24. Although he found the work very satisfying, it generated apprehension about his children growing up in the Western culture. He found the Australian slang challenging at times. He strictly follows Indian culture at home and encourages his children to speak the Keralan language. He has strong intentions to return to Kerala in a few years' time.

5.2.9 Preethi

Preethi migrated to Australia in 2009. She is in her thirties. She chose nursing as she had friends and family members who were working as nurses. Her parents encouraged her decision because of the job opportunities abroad. She did not like the course initially, but survived with the support of her friends.

Preethi described her first exposure to mental health as a scary experience, but later started enjoying it. She never thought of working in mental health and started working as a lecturer in nursing after the course.

In 2006, she migrated to Ireland and started to work in a paediatric disability service. Her motives for migration were better quality of life, better income and to explore the world. There she completed a one-month paid adaptation program. She struggled in the new country initially. She received mixed reactions from parents of disabled children, as she was the first migrant nurse working in that service. Gaining trust from parents of children and colleagues was the initial obstacle. However, it was a supportive workplace.

In 2012, she migrated to Australia due to the extreme climate conditions in Ireland. Since she had experience in an English-speaking country, she did not need an English exam or adaptation course. In Australia, she found a job in child and adolescent psychiatry. Even though she had peer support and support from management, she found it very hard to work with adolescents with mental health problems. She felt she could not handle it. She described herself as a person with very low assertiveness, which made it difficult to work in the adolescent unit. Later she moved to a drug and alcohol unit. Realization of the mental health issues and drug abuse in the new country made her think about her own children. Preethi stated that clinical supervision helped her to survive during that time. She strictly practises Kerala culture at home and encourages her children to follow her. She is planning to return to India after retirement. She does not want to work as a nurse in India as the nursing profession is much less advanced compared to Australia.

5.2.10 Anita

Anita is in her mid-forties. She completed her Bachelor in Nursing at one of the universities in Kerala. She stated that she was always passionate about mental health. After her first placement, she decided that she would become a mental health nurse. She started working as a general nurse and later as mental health nurse in India. Later she finished her Master of Mental Health Nursing at one of the leading psychiatric hospitals in India. One of the differences between nursing in India and Australia is the poor status of the job in India. India still follows the medical model in mental health care. Poor staffing, infrastructure and low health care standards were also highlighted. Anita had no intention to migrate to foreign nations, but she was encouraged by her friends to apply for a visa to Ireland. When she got the visa, she took 2 years leave from the public mental health service and migrated to Ireland.

Anita liked exploring the new country. The mental health practice in Ireland and Kerala were very different. Her strong language and theoretical knowledge helped her to survive in Ireland. She started working in mental health in Ireland. She found the place and people supportive.

After three years in Ireland, she got a job in Australia and migrated. Her intention was to explore the new place. She started working in an adult acute inpatient unit, where she had mixed experiences with colleagues. She felt her experiences and qualifications were not acknowledged. Later she requested to move to another unit and worked as a team leader. She enjoys her input into decision-making and the management of clients with mental illness. One of the differences she highlighted between the client profile of Kerala and Australia is the higher number of clients diagnosed with personality disorders. She described herself as a proud, assertive mental health nurse who cannot tolerate discrimination and racism.

Her dream is to complete another post-graduate qualification in mental health and become involved in training. She is planning to return and settle in India.

5.2.11 Leela

Leela currently works for a rural mental health service. She is in her early forties and lives with her husband and two teenage children. Leela had not had experience in mental health when she joined an acute aged in-patient unit in 2009. She accepted her first job offer in Australia from a newly created mental health service.

She finished her Diploma in Nursing and Midwifery at one of the Government hospitals in Kerala. Leela stated her motivation for the choice of the nursing profession was from her parents due to the job opportunities. After completing the course, she secured a job in the government sector. She was working in a general medical ward and had no thoughts of migration until her friends started to take long leave and move to Europe for work. She became interested in the financial betterment of her friends. She migrated to Ireland in 2006 and started working in a nursing home. She had to complete a month of paid supervised practice. She found the colleagues and manager supportive. Initial challenges were communication difficulties and lack of awareness of the host culture. Later her family also migrated to Ireland.

In 2011, Leela and family moved to Australia due to the extreme weather conditions in Ireland. Her initial struggles in Australia were a lack of friends, accents (both Leela's and Australian's) and her lack of orientation to the Australian mental health system. She did not have experience in psychiatry, but her senior colleagues and manager helped her during the initial days.

Currently Leela is working as an associate nursing manager in an aged in-patient unit. She does not have any formal qualifications in mental health and has no intention to advance her career.

5.2.12 Sophie

Sophie is in her mid-twenties. She completed her Bachelor of Nursing in Kerala. However, she did not want to be a nurse, but her parents, who were abroad, encouraged her to take up nursing. She found the course to be very challenging, especially the clinical practice. She liked psychiatric nursing during the clinical

placement. She described the mental health system in Kerala as of low standard with poor infrastructure.

After finishing the course, Sophie started as a clinical instructor in psychiatry. She finished her English exam (IELTS) and moved to Australia in 2010. Her motives for migration were her parents' wishes, financial betterment and career advancement. She had to complete a three-month adaptation program, which she found very generic and felt unsupported during clinical placement. She was homesick and wanted to return home though she survived with the help of her parents. She found the new culture, food and even way of dressing to be uncomfortable. It was difficult to understand Australian English, even though she studied in an English-medium school and had gained high scores in the IELTS. During her clinical placement, she had a few unpleasant experiences with staff and patients, mainly due to communication difficulties. It was difficult for her to follow the Australian jargon and accents of the staff. Later, she joined a public mental health hospital as a graduate mental health nurse. During this program, she had rotations around various community and inpatient settings. Later she received a job offer from one of the inpatient units, where an unwell patient assaulted her. This affected her confidence. She has attended clinical supervision and counselling but resigned from her job and took a position in the psychogeriatric unit of the same mental health service.

Currently she is working as an associate nurse unit manager in a regional mental health service and is doing a post-graduate degree in mental health. She described herself as living in a dual culture. Her ambition is to become a clinical educator in mental health.

5.2.13 Jisha

Jisha is in her mid-twenties. Jisha chose nursing as she did not get into medicine and she has aunties working abroad as nurses. She found it hard to adjust, especially to the physical health care aspects during her first year. India still follows hospital-based nursing programs where students must undertake on-going clinical placement throughout the year. Some universities offer blocks of clinical placements and theory classes. By late in the first year she started liking nursing. She did her mental health

clinical placement during her second year. She also mentioned the distinct hierarchy between nurses and doctors and the medical model of care.

After finishing her course, she started working as a lecturer in nursing where she taught various subjects, including mental health. During that time, she got married (arranged by her parents) and her husband was working in Australia. Jisha then joined her husband. She completed her six-month adaptation program and gained her Registered Nurse qualification in Australia. She described a negative experience during her clinical placement caused by one of the preceptors and failed that placement. Jisha appealed against the result and made a complaint about the particular preceptor. The university reviewed her performance by another educator and she passed. During that hurdle, other nurses in the unit supported her and they guided her through the appeal process.

After her qualification as a Registered Nurse, Jisha found a job in the adult acute in-patient program of a newly started mental health service. She enjoys the unit and the supportive colleagues. Her initial struggles were loneliness, communication difficulties, especially over the telephone, her lack of awareness about the culture, lack of orientation to the mental health system and discrimination by clients and some colleagues. She was able to overcome these hurdles by asking questions, being resilient, practising the language and reading. Now she works as an associate nurse unit manager after completing a post-graduate qualification in mental health.

5.2.14 Rony

Rony is in his mid-twenties, completed his three-and-a-half-year Diploma in Nursing in India. Nursing was becoming a popular career choice among men in Kerala during the mid-2000s due to increased opportunities for migration. Rony had friends and family who were nurses and working abroad during that time. Rony enjoyed the course, especially the six months' mental health placement. He stated it was scary initially but he wanted to become a mental health nurse by the end of the placement, as he was not interested in the physical health care aspects of nursing. After finishing the course, Rony worked in Kerala for 18 months. In 2011, Rony came to Australia on a student visa to do the post-basic nursing course (Bachelor of Nursing program for Diploma holders). He spent AUD$40,00dollars on course fees and living expenses.

During the initial days, he found it difficult to communicate, but he described himself as an extrovert who found many local friends especially in the local church and started becoming involved in local activities. This helped him with language, communication and understanding the culture. His friends were mainly seniors and they were helpful. After finishing the degree, Rony got a job in the drug and alcohol rehabilitation unit of a newly- created public mental health service. Later he requested rotations between the adult in-patient unit, adolescent psychiatry and drug and alcohol rehabilitation to widen his experience.

He stated that he had no formal training in mental health and no orientation to the Mental Health Act when he started. Rony wants to undertake a post-graduate degree in mental health nursing once he is financially settled. Rony likes to explore different places, cultures, and meeting people. He wants to travel around Australia and other countries in the future. Rony stated that even though he misses Kerala, his relatives and culture, he likes Australia. He likes to live here. His career ambition is to work in community psychiatry.

5.2.15 Paul

Paul is in his late thirties. His choice of nursing was because of his sisters and aunties who were nurses and working overseas during that time. Even though he passed the course, Paul did not enjoy it. Paul wanted to do engineering. While waiting for admission to engineering his aunty who is a nun asked him to do some voluntary work for a charity mental health rehabilitation centre. Paul agreed and he enjoyed the work. Later he moved to an adult acute in-patient unit and worked as a registered nurse. In 2003, he moved to Singapore where he worked in a mental health unit. He did not enjoy the job in Singapore due to the rigid rules, lack of patient rights and the poor image of nursing. In 2005, Paul moved to Australia with his family.

Paul found mental health nursing in Australia much more advanced. Initially he struggled due to slang, abbreviations and his lack of orientation to the mental health system. Paul has now completed a post-graduate qualification in mental health and works as an associate nurse unit manager and sessional clinical teacher. Paul described occasional discrimination and racial attitudes of clients and colleagues, especially during the early

days. He stated his seniority and position in the unit, assertiveness and resilience made a difference in the attitudes of clients and colleagues.

He strictly follows Kerala culture at home and is worried about his children following Western culture. His wife and children are moving back to Kerala in late 2016 to live with his parents. He has plans to visit them every six months. He will work in Australia for another 5 years to ensure their financial stability and then return to Kerala.

5.2.16 Jyothy

Jyothy migrated to Australia in 2007. She is in her early thirties. Jyothy chose her mother who a nurse was working in Saudi Arabia suggested nursing as it. After completing her Bachelor of Nursing, she started working in a medical ward. Later she moved to mental health, as she liked mental health and had wanted to try it since her clinical placement.

In 2007, Jyothy passed her IELTS exam and applied for a visa. After her arrival in Australia, Jyothy had to complete a three-month adaptation program to gain the RN qualification. She struggled with assignments, communication, and in understanding Australian culture. This course was a combined re-entry/ adaptation program. She was required to undertake eight weeks of clinical placement as part of the program. She found it difficult when others mentioned her accent was difficult to follow. She concentrated on pronunciation, vocabulary and terminology.

After the course, Jyothy found a job in an acute aged in-patient unit. She completed a post- graduate Diploma in Mental Health Nursing and works as Clinical Nurse Specialist. Jyothy described the initial struggles she underwent to gain the trust and acknowledgement of her clients and colleagues. She described her transition experiences as challenging. Jyothy follows Kerala culture at home and is in close contact with her family in India. Jyothy stated that Australia is a country that is much more flexible and much better for nurses than India.

5.3 Summary

This chapter has presented the summarised accounts of the sixteen participants, shared aspects of their lives as they transitioned from living and working as nurses in Kerala, and made their geographical and cultural shifts to being mental health nurses in

Australia. Each participant is described according to their age, reason and circumstances for migration, decisions about becoming a nurse and then transitioning to mental health nursing, obtaining employment in Australia and their issues and challenges. These descriptive profiles of participants were provided to offer the context of the study. The common themes identified in the stories above are: 1. Mixed experiences from colleagues, 2. Lack of experience, 3. Lack of knowledge about Australian culture, 4. Communication-related difficulties, 5. Lack of assertion, 6. Emotional responses due to migration. In addition they experienced racism from both colleagues and consumers. These narrative expressions have formulated as themes and are discussed in greater detail in the chapter six.

Chapter 6

Findings – Lifeworld Existentials

In this chapter, the major themes and sub-themes that emerged from the interviews with the Kerala nurses are identified. Quotations by the participants are used to illustrate each theme and sub-theme. The reporting of the themes is followed by a summation of the findings; this includes some interpretation of these using the four lifeworld existentials of van Manen (1996). The analysis incorporates the researcher's understanding of the views of the participants as expressed during the in-depth face-to-face interviews. The stories and reflections of the participants themed into lived experiences (existentials) are about becoming a nurse, becoming a mental health nurse, their experiences of making transitions into Australia, and their experiences of transitioning into mental health nursing in Australia.

Applying existentials in this way enabled strong orientation to the lifeworlds of the participants, and deeper understanding of the meanings of their experiences. The chapter is written five sections. In the first section, the major themes associated with the lived experiences of Kerala trained nurses who migrated to Australia and who now work in mental health are introduced. In three of the sections each of the three themes are presented; these are described and illustrated with participant quotes. In the final section of the chapter a summation of the findings (inclusive of the lifeworld existentials generally) is offered.

6.1 Overview of the themes, sub-themes and existential findings

In the previous chapter, the participants and narrations that record lives of the participants were described. In keeping with van Manen's phenomenology once understanding of each participant's story had been achieved the analysis by reading re reading comparing the stories and proceeded to drawing out the themes that resided between them related to their experiences of being an overseas trained nurse from Kerala and working in mental health in Australia. As previously described in the

methodology and methods chapters that van Manen's life-world existentials of lived body, lived space, lived human relations, and lived time were central to exploring the stories and deriving the themes that gave evidence towards answering the research questions.

The overarching themes are named 'Transitioning from general to mental health nursing', 'Cultural transition experiences' and 'Transition experiences of working in Australian mental health services'. The lifeworld existentials associated with the lived experience of the participants were intertwined within each theme.

The recordings of these interviews were transcribed and a reflective journal was kept throughout as described in Chapter 4; this textual material was then subjected to analysis and interpretation. The themes, sub-themes and associated lifeworld existentials were identified using the processes described in chapter 4 and are summarised in Table 6.1.

Table 6.1: Major themes and sub-themes from the participants' voices

Main themes	Associated Subthemes	Dominant Lifeworld Existentials in the theme
Theme 1: Transitioning from general to mental health nursing	Sub-theme 1.1: Motivations for choosing nursing • Collective decision-making • Being practical due to entry scores • Passionate choice Sub-theme 1.2: Transitioning to mental health nursing • Positive clinical placement experience • Opportunities • Something new	The lifeworld existentials of lived body, lived time and lived relations were most dominant in the theme of 'becoming a nurse'. Then in 'becoming a mental health nurse' three existentials (lived body, lived time and lived space) were evident in the narratives provided by the participants.
Theme 2: Culture transition experiences	Sub-theme 2.1: Motivations for migration • A better future for children • Career advancement • Financial betterment Sub-theme 2.2: Realising dreams • Living in dual cultures • Loneliness • Discrimination • Feeling incomplete • The urge to go back to Kerala: A cultural and emotional call • The future post-migration	All the fundamental lifeworld existentials lived body, lived space, lived relations and lived time were evident in the texts associated with the participants' 'transition experiences'.
Theme 3: Transition experiences of working in Australian mental health services	Sub-theme 3.1: Acknowledging differences in mental health nursing in Australia • Getting started, getting settled: new identity • Became anxious due to communication related challenges • Stress related to volatile work environment • Internal and external support Sub-theme 3.2: Career flexibility	The lifeworld existentials lived body, lived space and lived relations were the main ones associated with the theme 'experiences in mental health nursing in Australia'.

6.2 Theme 1: Transitioning from general to mental health nursing

When sharing stories about themselves the participants often revealed their motivations for choosing nursing, and then why later they chose to become mental health nurses. Most of the stories were shared in forms of lived body (felt passions, motivations, and

making choices), lived time (past, present, and anticipated future) and lived relations (who was in the situation and what they meant to the participants). These findings are described in the following sub-sections.

6.2.1 Motivation for the choice of nursing as a career

There were significant motivations that influenced the choices of the participants in becoming a nurse. In this section participant' thoughts, situational demands and influences on decisions to become a nurse are described. This decision was the foundation of participants' past, present and future professional lives. Notably for most of these participants' significant life events, especially migration also occurred after becoming a nurse.

The analysis revealed three emerging motives for the choice of nursing as a career. The participants' stories and meanings revealed three powerful influences on their choices. These are described as 'collective decision-making', 'Practical choice due to entry scores', and 'passion'.

Collective decision-making

Several participants mentioned that they made the choice of nursing because of the influence of parents and relatives. Some participants also revealed they had minimal awareness about the roles and responsibilities involved in nursing when they enrolled.

Kerala follows a strong collectivistic culture, where parents and relatives have a strong influence in the decision-making of the next generation, thus determining nursing as the most appropriate choice. The existential relationality in this context is closely related to spatiality. Collectivistic culture and collective decision-making are influenced by space. In a collectivistic space, the actions of the individual are affected by the ideas and opinions of family and extended family. This group affiliation is important for a sense of belongingness.

> It was inspiration by my relatives who are nurses especially working overseas. I wasn't thinking of nursing, but I have aunties who are nurses and working overseas and they suggested nursing. So, I chose the nursing profession (Thomas, p. 2).

In this quote, Thomas makes two important points. First, parents and relatives influenced his decision. The second point was an emphasis on opportunities for jobs outside India.

Other participants also confirmed the collective decision-making process:

> For me, my parents suggested nursing because of better opportunities especially overseas and I joined (John, p. 3).
>
> I did not have much awareness. But my parents suggested and I joined for nursing (Sindhu, p. 2).

The 'collective decision-making' sub-theme is an excellent example of the ways in which lived relations or the role of others influenced the choices of many participants. As seen from these examples Thomas, Sindhu and John noted the influence of their relatives in the decision to become a nurse and for migration. As members of a collectivistic culture, these participants followed the suggestions of their parents and relatives regarding their decisions. The participants gave more value to their relationships than their individual preferences in their world. They expressed a sense of obligation to and respect for the suggestions of their parents and relatives in important decision-making. They believed that it is good for them and contributes to the sense of belonging.

Practical choice due to entry scores

Entry scores to tertiary education made a difference as whether the participants became nurses or doctors. Of the 16 nurses interviewed, 6 nurses mentioned that studying for a Bachelor of Medicine was their first career choice. However, due to the stringent entry requirements to train as a doctor in Kerala, and because they did not meet medicine entry scores these participants chose a nursing career. After becoming and being nurses, none of the participants mentioned plans to join the medical school and become doctors.

Krishna stated:

> I wrote the entrance exam and my first option was medicine, my score wasn't good enough, so I chose nursing (Krishna, p. 3).

Another participant also mentioned that her first option was medical degree but her scores were not high enough. However, later she started enjoying the nursing course and does not regret the choice.

> I did not get enough score for medicine. Then I had to choose nursing. Never regretted about that decision (Anita, p. 2).

Krishna and Anita were aiming to go for Bachelor of Medicine course. They both have not gained enough scores and they made a practical decision and opted nursing. Anita mentioned that even though nursing was a forced decision she never regretted about it. Others also shared similar reasons for the choice of nursing as a career.

The lived body and lived time embedded in the experiences of becoming and being a nurse were evident in the participants' stories. For instance, in stories associated with having initially wanted to be a doctor, motivations and feelings changed as the nurses experienced being a nurse. For some participants, entering the nursing course was a time of despair, as they initially wanted to become doctors. However, 'as time passed I started enjoying nursing' (Krishna p. 3, Preethi, p. 2). One participant stated 'time went too slow initially as then as I was engaged in nursing studies and I started enjoying, time flew' (Preethi, p. 3).

Nursing as a passionate choice

Within the subtheme 'nursing a passionate choice' for some participants, the nature of the nursing profession was the main motivation for their choice. Nursing is considered as a profession that involves care and service. In this study, four participants described their reason for choosing nursing as being to serve and care for people. For example, Cindy wanted to become a nurse because she wanted to care for sick people.

> I wanted to become a nurse, from a very young age. I have seen nurses in the local hospital and the service they give. I was attracted by the caring nature. I like to help others (Cindy, p. 3).

Smitha also stated that the caring aspect of nursing attracted her. She also mentioned her passion for nursing from childhood.

> I knew I will become a nurse. It is a profession which needs a caring mentality and willingness to help others. I have that. Nursing is my passion (Smitha, p. 1).

Lived time and lived body was important in this sub-theme. Some participants mentioned that they had the desire to become nurses from a young age. For these participants, their long-awaited desire and decision were different from those who made quick decisions based on the influence of relatives or parents. For example, Cindy (p. 3) stated that 'my dream came true when I got admission for nursing I was excited at that time'.

Three main motivations for the participants making the choice to become nurses have been described. Phenomenologically, for many of the participants, embodied motivations and understandings influenced their choices, temporality enabled reflection on the past, and the influence of relationships in their lives and decision-making to become nurses was important.

After completing their nursing course, eight participants became mental health nurses in Kerala and the others after coming to Australia. How and why the participants chose to become mental health nurses is the subject of the next sub-theme.

6.2.2 Choosing mental health nursing

All participants spoke about their education, experiences and the process of becoming a mental health nurse. They also described the motives for their decisions to become mental health nurses. The subtheme 'choosing mental health nursing' revealed the existentials of lived body, lived time and lived space. For nurses who became mental health nurses after migrating Australia, that embodied decision was influenced by time and space. For example, one stated 'I had to make decision to stay back in Australia' (Anita, p. 5). For a few participants, the choice of mental health nursing was due to the time factor and the opportunity to remain in Australia. Their current visa was due to expire and they needed an employer to sponsor them for new visa. Jisha clearly stated 'I didn't have time to wait for another job offer, I got my first job in mental health, I accepted it' (Jisha, p. 6). Some participants stated that the decision changed their prospects and gave new meaning to their career. Three key motivating influences on

these choices were identified as ‘positive clinical placement experiences’, ‘opportunities’ and ‘something new’.

Positive clinical placement experiences

Several participants revealed that the decision to become a mental health nurse arose after attending an undergraduate clinical placement, with five participants using the term ‘positive clinical placement experiences’. Lived body, lived space and lived time are evident in the selected quotes. The following quotations exemplify the distinctive differences in the experiences of the participants.

> Initially the placement was scary, but later I started enjoying it. My teachers were really good. I could see every symptomatology in those patients, and I decided to become a mental health nurse (Sophy, p. 7).

In India, male nurses can opt for an extended placement during the final year. A few participants stated that the positive clinical exposure encouraged them choose mental health nursing later. Thomas stated:

> You see…, in India, at that time, we had the option to do 6 months of Psychiatry instead of Midwifery so I did my extended placement and I really liked it. I decided I will be a mental health nurse (Thomas, p. 7).

Some participants mentioned that during the initial days of clinical placement they were not comfortable. Later, with support they settled in. Participants recognised and reflected on the impact of positive clinical placement experience. They revealed that it facilitated self-awareness and insight and therefore caused them to think about their future career. They stated it significantly contributed to their knowledge base. It also created a passion for the speciality.

Opportunities

A number of participants stated that becoming a mental health nurse provided opportunities. After completing the transition program for overseas-trained nurses in Australia, six nurses accepted their first job offer in order to remain in Australia. Accepting the job offer was essential for their visa and permanent residency.

Leela stated:

> I had to accept my first job offer for visa (related) reasons, which was in mental health, they offered my support with post-graduate studies which helped me and I started to like the speciality, now it is my passion I won't move back to general now (Leela, p. 9).

Cindy had a similar experience:

> I took the first job offer but I always wanted to go back to neurosurgery, which was my passion at that time. But slowly I started enjoying mental health. It is my 9th year, I am doing a managerial role and, and now I want to make changes [to the mental health system] (Cindy, p. 12).

These participants became mental health nurses through opportunity, not passion or choice. However, none of them mentioned the urge to return to their previous nursing specialty. Every single participant stated that later they became passionate about the speciality. Lived body, as experiencing and living mental health nursing, and lived space working in mental health and being resident in the new country, and lived time making transitions into mental health nursing were evident in the experiences of these participants. Most of the participants had stated that post-graduate studies and are currently in managerial and leadership roles.

Something new

The motivating experience of 'something new' was associated with participants who had opportunities to choose, and chose mental health to try something new. The search for an innovative venture is exemplified by the quotations below:

Rony commented:

> I wanted to try something new for a change and that was mental health nursing, and I am still here. That means I like it (Rony, p. 7).

Like Rony, Jyothi also decided to try something different and uncommon. Her previous experience was in general nursing.

> I wanted to participate in an area of nursing that was still unclear and uncommon, that was mental health nursing. I like to try new areas. Now I like it (Jyothi, p. 14).

It is clear from the transcripts that the group of participants, who initially chose mental health nursing to try something new, later enjoyed the speciality and continued to work there. The experience of something new was embodied, and carried across time while the participants had the possibility of living in a new country and experiencing a new type of nursing work.

In this section of the results, it was revealed that the participants in this study became mental health nurses either by choice or due to their circumstances. Three motivating factors influenced their choices, these were positive experiences of mental health nursing while they were on placement as nursing students, opportunities to work in mental health nursing, to gain employment and to live in Australia, and the active position of wanting to try something new and giving mental health nursing a go. As in the section on becoming a nurse, lived body and lived time were central existential themes in the narratives; however, they appeared to be more influenced by lived space than lived relations.

6.3 Theme 2: Culture transition experiences

In relation to the theme 'transition experiences', most of the participants stated that they had motives and dreams when they migrated to Australia. However, they were not completely aware of the extent of transition and transformation necessary. The challenges and complexity seemed to be of the same intensity in all the participants.

In the theme transition experiences, two sub-themes emerged. The first sub-theme reflects the participants' motivations for migration. Migration is not a new phenomenon and different aspects of migration are discussed in Chapter Two. In this study, participants expressed their personal reasons for migration as wanting a better future for their children, the opportunities for career advancement and the possibilities of financial betterment. In the first sub-theme, lived body and lived relations are particularly powerful existentials associated with the motivation for migration.

The second sub-theme 'realising dreams' is about their real life experiences during the transition period in Australia. Every participant had personal dreams and motivations when they decided to migrate to Australia. However, experiencing transition challenges and whenthey adjusted to life in Australia delivered both affirmations and challenges to their choices to migrate. Experiences embedded in the transitions were the needs to live in dual cultures, dealing with loneliness and feeling incomplete, managing discrimination, being drawn back home to Kerala and the future post-migration.

Most of the participants revealed they did not have much awareness about the culture and practices of the host country, Australia. They articulated their motives for migrating to Australia and the reality of their experience. This gives an insight into the transition experiences of these nurses from Kerala.

6.3.1 Motivations for migration

Most of the participants revealed that they had set goals when they decided to migrate. Some of those goals concerned their children, financial betterment and career advancement. The following section explicates these motivations.

A better future for children

Some participants stated that they migrated for their children's future. Lived relations were a mediating existential in determining a choice for migration. Unlike their own decisions to begin nursing as influenced by parents, in this case as parents themselves they considered migration for the dreams and hopes of better futures for their children.

Due to limited educational and job opportunities in Kerala, India, some of the participants considered migration as an option. Some nurses reported that professional education is a highly competitive field in India. They stated that there are no other pathways such as 'mature age entry' in India. If someone has not achieved high, enough entry scores for higher education they cannot gain entry to a particular course. They believed that Australia had better education and job opportunities for their children.

> We migrated for our kids' future… we thought it [migration] will benefit our children and their education (Leela, p. 36).

Another participant stated:

> We were in New Zealand ...we migrated for our son… he wanted to join Victoria University. I struggled a lot… (Mary, p. 42).

Two other participants also had similar reasons for migration. For them, Australia was the best option for their children's future. They were satisfied with the previous work they were doing. Mary stated that she was restructuring a mental health unit in New Zealand while working as the manager of that unit. However, her priority was her children's future and she therefore migrated to Australia.

Career advancement

The younger participants were career-oriented, they identified that further education, and career advancement opportunities motivated them to migrate to Australia. Career flexibility is comparatively poor in India. Australia was seen as a place with flexible career opportunities and advancements. This situation was appealing for many of the nurses. Jyothi stated:

> I always wanted to complete my Master of Nursing from a western country and Australia was always there in my dreams from a very young age. Next year I am going to complete my Masters and my ultimate goal is to become a nurse educator, once I gain a bit more experience (Jyothi, p. 52).

Another participant mentioned career advancement. Robyn stated that in India nursing is a full-time job and there is no option to work part-time whilst studying:

> I wanted to do my Master of nursing… I cannot do that in India while I am working. When I approached the immigration agent, he suggested Australia is good for post-graduate studies. Then I did my own research too. Yes, post-graduation was also a reason for migration (Robyn, p. 11).

Many other participants also mentioned the career advancement opportunities in Australia. Migrating for career advancement demonstrated embodied hopes and intentions that the new space of living and working in Australia could offer.

Financial betterment and duty to family

For some participants, their financial betterment was a motivation. In some cases, this was inspired by the gains achieved by other relatives who were living and working overseas. In Kerala, it is common for nurses to work overseas. Shaji stated:

> I had my friends and aunties working overseas. Seeing them coming for leave and getting financially better inspired me (Shaji, p. 36).

Participants pointed out that nursing is not a well-paid profession in India. However, only some pursued the dream of earning more money and being able to help their families and themselves with a reliable income. Some participants mentioned that they are from middle- class families and their parents paid for their entire education and supported their migration financially. Further, they desired to re-pay their parents struggle in raising them and providing education.

> I am from an average middle-class family. One of nine children. My eldest brother who is well settled in every way, supported financially with my studies and with expenses associated with migration, which was around 20,000 dollars. I repaid his money and I think now it is my turn to support my family (Cindy, p. 43).

However, participants mentioned that this was a personal feeling and not an expectation by the family.

> I feel like it is my responsibility to support my parents even though not expected (Mary, p. 43).

Some other participants mentioned similar themes of their own financial betterment and desire to assist their family financially. Participants stated that it is not usual to work part-time when studying. Therefore, the participants' nursing studies were completely supported by their parents.

Phenomenologically, financial betterment and obligation to the family seemed to be mainly about lived body (making the best decisions for self and family), and lived relations as the continuation of family and support of family was a mediating aspect of

choice. Lived time as hope for a better financial future and lived space as life in a new country were expressed as aligned with the motivation and decision to migrate.

6.3.2 Realising dreams

The second sub-theme 'realising dreams' reflects the participants' actual transition experiences. The participants lived experiences and personal meanings after moving to Australia were central to the aspects in this sub-theme. The phenomenological themes that emerged from the transition experiences are living in dual cultures, loneliness, and discrimination, achieving the goals but feeling incomplete and the urge to go back to Kerala, and the future post-migration. The participants told stories of their dreams and the reality. The sub-theme provides insights into the personal lives and emotions of the participants. These aspects of the sub-theme transition experiences are closely linked to all the fundamental lifeworld existentials: lived body, lived space, lived human relations and lived time.

Living in dual cultures

Living in dual cultures is defined as the practice of Indian culture at home and Australian culture at work and outside. Participants stated that they were born and grew up in the strong culture of Kerala. They revealed that their cultural beliefs are strong. They considered that it is not easy for them to adapt to the Australian way of life completely. Robyn pointed that she tries to maintain a balance between the two cultures:

> My cultural beliefs are strong and I never changed it… to me it is not accepting… it is more of understanding the Australian culture… At home, we practice Indian culture… since I grew up in that culture… But I try to maintain a balance between Australian and Indian culture (Robyn, p. 79).

Krishna also follows Indian culture and Australian culture:

> I practice my Kerala culture…. I live in Kerala way at home…. I can't say everything but more or less we try to maintain and practice our culture (Krishna, p. 24).

They acknowledged the difficulties their children might experience as they were born, are growing up and studying in Australia. It was apparent that some participants were apprehensive regarding this situation:

> That is my worry is how long I can make son to practice pure Kerala culture, I thinking I am confusing my 9 years' old son by practising two cultures (Shaji, p. 56).

John stated that he tries to establish a bond between the two cultures. However, he expressed his worry about his children's struggles, especially when they grow up and observe the Australian way of life:

> I am trying to maintain that cultural bond… but they are growing here… they are going to adapt Australian culture…. I am typical Indian… my kids will struggle ...so it is going to be a trauma for them. I worry about my children and my wife too (worries about children) (John, p. 40).

Sindhu also expressed her worry about her children:

> I will get my children to learn our culture and language… I have a mild worry but once they are old enough I will let them do what they like" (Sindhu, p. 78).

Krishna expressed his own practical way of managing conflict between two cultures without causing stress:

> I will definitely teach them Kerala culture but if they can't cope, they have to give priority to Australian culture as they are going to live here (Krishna, p. 24).

While some participants expressed their concerns about children adapting Australian culture, Krishna thinks that as the future generation are going to live in Australia, they have to give priority to Australian culture.

Participants agreed that living in dual cultures and pressing children to practice Indian culture potentially causes confusion and conflict, and various participants repeatedly voiced this apprehension. Living in dual cultures reflects all four existentials. The dual cultures reveal the importance of living in the space and embodying Australian culture especially in the public and work spaces. While the need to maintain and sustain

cultural practices from Kerala in their embodied and relational forms at home in the private and family spaces reveals deeply held values that require expression and sustenance at the same time. 'Living in dual cultures' reveals the participants' continuing attachment to Kerala culture while living and advancing in an Australian context and culture. Both cultural expression was affected by past, present and future time.

Loneliness

Even though they followed their dreams and migrated to Australia, some participants expressed that they feel lonely and incomplete. Notably, most of the interviewed participants arrived in Australia alone, leaving their family behind. This might be one reason why they concurred that it was a challenging experience and they had no option but to struggle through it.

Participants reflected that they went through a stage of loneliness and isolation, especially during the initial days. They had to wait for months for their family to be reunited. As most participants were not confident enough to interact socially with their colleagues, they relied on their family back home. A few participants made deliberate efforts and established social relationships with the local community and colleagues.

While most participants accepted being away from extended family as a reality, others, particularly the men, adopted several coping strategies, such as engaging in hobbies, going out with friends and making new local friends.

> I missed my family and I was feeling lonely and isolated when I am by myself, so I deliberately engaged with the local community, and spent time together did various activities such as fishing and travelling (Rony, p. 57).

Rony found people were friendly and supportive. He also deliberately initiated interactions with locals as his way of overcoming feelings of loneliness.

Another participant recalls:

> I was single, and it was heart breaking to leave my parents. I used to ring them every day. Even now…. I still struggle (Robyn, p. 47).

Another participant described similar feelings about leaving the family behind with no social contacts or friendships in Australia. The coping strategy was to engage in conversation with family back home:

> Yes of course it was difficult. I didn't know anyone here. I feel sad, lonely without friends, and family. I used to have conversation with my family every day (Anita, p. 32).

The same participant went on to express another strategy she tried, which was making a deliberate effort to talk to colleagues and initiate social relationships. She stated that eventually she felt supported:

> My colleagues supported me when I initiated conversations and started discussing general matters. Later I felt more comfortable (Anita, p. 32).

Participants in this study expressed that initially they felt lonely in the new place. This can be linked to corporeality as this emotion was experienced through the body. They were very unfamiliar in the new country and workplace. The feeling of loneliness was mainly due to the lack of common themes or mutuality with others, especially local colleagues.

Robyn stated that she did not have much awareness of Australian culture, art, sports, politics or trends. These were the common topics discussed socially among staff. She decided to deliberately read about those fields to become updated. She started watching television and reading newspapers. Robyn stated:

> I felt a distance from my colleagues. I was so alone I wanted to get involved in discussions. So, I started to watch television and newspapers… Which gave me confidence to talk (Robyn, p. 34).

Another strategy used to overcome loneliness in the new space was utilizing existing relationships. Most of the participants stated that they used to call parents and family back in Kerala frequently to share their feelings and experiences. The importance of family and personal relationships highlights the relational existentials that mattered to

the participants as they established themselves and their lives in the new physical and cultural space in Australia. Existential loneliness was a common aspect of transition.

Discrimination

The experience of working in mental health and living in Australia was also marked by the sensitive problem of racial discrimination. Most of the participants attested to having experienced discrimination. Negative experiences such as racism and discrimination were mainly experienced at work and mainly from mental health consumers. However, a few participants mentioned experiencing discrimination from staff and outside work.

Robyn and Jyothi stated that racism and discrimination used to upset them initially. Jyothi mentioned a staff member with whom she had negative experiences of discrimination. She stated she felt "horrible" and had strong personal emotions of anger and sadness. However, she managed her feelings by withdrawing. Jyothi worked hard to avoid confronting situations with that staff member. Later she revealed this situation to her clinical supervisor who assisted her seek formal conflict resolution. According to Jyothi:

> Eventually I thought, I am a migrant nurse, my skin colour is different but I have qualifications, knowledge and skills to work with her. Then why do I undergo this (discrimination). I was losing my confidence. So, I took the matter to higher level and I felt so much relief. She has changed since. Now I am her manager. She might have forgotten but I haven't and I will not. My experience was that bad. I don't want to talk about it anymore. But now I don't show any negativity towards her (Jyothi, p. 53).

It is clear from this excerpt that discrimination and racism may have deep and distressing consequences in a person's lifeworld. The bodily expressions were withdrawal, anxiety and reduction in confidence and self-esteem. All participants who mentioned racism and discrimination affirmed that eventually they were able to tackle the situation. Some participants referred to experiences of racism from clients. Interestingly, experiences of racism from clients were excused, due to their mental

state. This rationalisation was used as a mechanism for coping with the unpleasant experience.

Whilst most participants stated that they had never experienced discrimination from other health care workers three reported having experienced racism from colleagues. Robyn and Preethi also experienced racism from both clients and colleagues.

> I had to cope with racism many times from patients…but at least they are unwell… but I had a particular staff challenging me negatively on many occasions … I am resilient person. I intervened (Robyn, p. 62).

> I had experience of racism many times from clients. And I had a colleague being racist and made some negative racist comments to me …. I am a strong person… I am well qualified... I am really proud of myself… so I ignore racism…they feel so powerless that's why they [clients and colleagues] show racism (Preethi, p. 52).

Thomas stated:

> Yes, clients can comment racially…what do you know…you black nurse etc… when they don't get things done as they wanted… especially when you work as in-charge and when I had to make decisions (Thomas, p. 53).

Every participant who experienced racism from a consumer excused the experience as caused by the consumer's mental state. The three participants who experienced racism from their colleagues were confident enough to intervene. They all commented on support from the health service management, and asserted that racism and discrimination was not a common experience.

The quotes reveal that for some participants that their own existential strengths (lived body) and support from colleagues and management (lived relations) were important in dealing with discrimination. Similarly, there is a sense of appreciation that racial discrimination in their workplaces coming from mental health clients also needs to be understood.

Feeling incomplete

'Feeling incomplete' was a theme that reflected the inner feelings of the participants. The participants expressed their dreams in the new country and their plans for the future. Most revealed that they had set goals when they decided to migrate related to their children's futures, financial betterment and career advancement. Relatively young nurses with young children mostly mentioned this theme. They moved to Australia to fulfil their dreams and most of the participants considered that they had achieved their initial goals. However, when they reflected on their personal life, they still felt incomplete.

> I have gained everything I originally wanted…I have my own house here and back in India, premium car… bank balance… but still sometimes I feel empty. I lost my mum she was only 57… I was very close to my mum... I couldn't spend much time with her... that gave me sudden realization… I miss my home (John, p. 67).

After achieving all their material goals and settling in Australia, they expressed inner feelings of 'lacking something'. Most of the participants reasoned that they still miss home and regret leaving parents and family behind.

> Yes… I achieved all I wanted … but I miss something, I am sure it is my home and parents (Sindhu, p. 72).

Preethi had a similar view:

> Yes, all our dreams came true…. but we are not complete … maybe missing home (Preethi, p. 101).

The experience of 'feeling incomplete' was an important aspect of transition experience to discover. According to van Manen (1990), the body is used as the medium to reveal and conceal oneself. Experiences of emotions are felt though the body. Feeling incomplete appears to be an embodied expression of cultural transition, the accompanying shifts in lived space; lived relations and lived time may all be influencing the sense of incompleteness that the participants reported experiencing.

The urge to go back to Kerala: A cultural and emotional call

Missing the space of Kerala, while being settled in Australia was an experience felt by many of the participants. Several of the participants felt this as an urge to go back to Kerala. The urge was a cultural and emotional call in the present to return to home.

Many participants expressed difficulties in maintaining a balance between the two distinctive cultures of Australia and Kerala. They are aware of the potential disconnection from Kerala culture especially by the future generation Shaji, Jisha, John and other participants raised this concern. Paul stated:

> I am a strict parent when it comes to following our home country's culture. I make my kids to speak 'Malayalam' [the language of Kerala] so they can talk to my parents and other family members back home. They are doing that now. I don't how long they continue doing that. They are growing here. They started questioning (Paul, p. 54).

Paul has clear worries about his children drifting away from Kerala culture. It also appeared to be a sensitive issue for a number of other participants. This apprehension formed the basis of the thought of returning to Kerala. Shaji, Robyn, Sophy and John talked about their plans to return to Kerala.

Robyn stated:

> We wish to go back… we started thinking seriously about going back in a few years' time… we built our house in India … now the urge is getting stronger… I know it is really hard… kids might not cope…and it is expensive (Robyn, p. 113).

Younger nurses were more likely to express this intent. Some stated that, despite all the happiness and the achievements, they experience a sense of loss. Thus, they have made the decision to return to Kerala.

Sophy was concerned about her child growing up in a Western culture. She believes that her child will eventually adopt the independent Australian culture. Therefore, she wants her child to commence her schooling in Kerala:

> I like Australia. But I am concerned about my child adopting Australian culture and the next generation losing touch with our family back in India. So, we will go back. If we can't cope we will come back (Sophy, p. 57).

Participants value their culture and relations from the past. It forms their 'being'. Some participants were able to make social relationships in Australia. However, their beliefs and emotions remain in the past.

Some of the participants stated that their ultimate goal is to go back to Kerala and settle there on retirement. Through further discussion, they revealed that they were aware of the possible challenges and difficulties with that decision. Most declared they would not continue their profession in Kerala for reasons including the low salary, low reputation of nursing and the inflexible working hours. Majority of the participants acknowledged it is an emotional call and are aware of the challenges around the practicalities of this call:

> I miss people…parents… we will go back… it is a big decision (Krishna, p. 62).

It is notable that the participants who migrated for a better future for their children have made Australia their home. In addition, those participants with older children seemed more comfortable and satisfied in Australia. For example, Thomas and Leela stated:

> I am happy here, my kids are at uni. I will retire here and I have no intention to go back and live there [in Kerala] (Thomas, p. 112).

> We migrated for our kids. And we are here. Kids are in high school. They like Australia. We are settled here. We have no intention to go back permanently to Kerala (Leela, p. 78).

The urge to go back, as an emotional call reveals the deeply seated influences of the Kerala and its culture in the lives of the participants. The narratives and quotes above reveal deep familial concerns and the importance of relational existentials in the lives of these participants. This transitional element is deeply embedded in lived time, lived space and lived body. This aspect of transition was also linked to 'missing the space'.

The future post-migration

Migration divided the participants' lifeworlds into pre-migration time and post-migration time. Most of the participants expressed the view that they have utilised time and achieved their goals. However, the future remains undecided journey for most of the participants. Shaji stated:

> I worked really hard to achieve my dreams. I got everything I want including post- graduate studies. But still I am not feeling satisfied. I think I miss home and people there. I miss the culture and celebrations (Shaji, p. 54).

Other participants expressed similar feelings. It is clear that these participants miss their past. The present is an on-going journey of transition but some participants mentioned the apprehensions they have about future generations. This is mainly related to confusing the next generation by practising both Western and Kerala cultures.

Nevertheless, some participants are satisfied with their present situations and have clear plans for their future. While reflecting on the past, they expressed that their motivation for migration was their children and their future. This influences their attitude to the future. Thomas is a middle-aged male nurse who migrated for the betterment of his children. He stated he was aware of the reality when he migrated to Australia:

> I knew I am going to lose my culture, might not be us [our generation] because I grew up in Kerala…. but our kids for sure… I have to be away from my parents and relatives. But we decided to migrate for our kids. Now there is no point in crying about that now. I like Australia. My kids enjoy here (Thomas, p. 112).

Various participants regarding their post migration experience expressed different viewpoints and mixed opinions.

All the participants talked about their transition experiences in the new country and workplace. The existential theme of spatiality questions where a person belongs in the new space, and their feelings and experiences in positioning themselves in the new space. The hopes that participants held for their lives on migration were in the process of being realised as they encountered life in Australia. In this section of the findings, the motivations and hopes for migration were powerful influences in the choices that

participants made. Once migration had been achieved, the realities of adjusting to life in a new country were experienced as transition experiences. All existentials – lived body, lived space, lived relations and lived time were central to the participants adjusting their lives and living as they transitioned in to the new culture. These were evident in the experiences that the participants reported as being part of their transition experience. They dealt with existential loneliness and feeling incomplete. Racial discrimination was encountered as a challenge. In addition, for the participants creating a lifestyle where they could live with dual cultures was a way of managing and maintaining an adjusted way of life.

6.4 Theme 3: Transition experiences of working in Australian mental health services

In the theme 'experiences in mental health in Australia', participants talked primarily about two main aspects: 'working in mental health in Australia' and 'career flexibility'. Various sub-themes contributed to the theme 'experiences in mental health in Australia'. These are 'getting started, getting settled: new identity', 'became anxious due to communication related challenges', 'and 'internal and external support'. Based on the experiences, the predominant existentials identified are lived body, lived space and lived relations.

The overall experience of the participants associated with working in mental health in Australia is the focus of this theme. While each participant's motivation for migration was different, most agreed that they have acknowledged the differences and have adjusted to the new workplace. The differences include models of care, legal boundaries, communication, and consumer profiles.

6.4.1 Acknowledging differences in mental health in Australia

Most of the participants expressed that the mental health systems in India and Australia are dissimilar. A few participants mentioned poor management, poor infrastructure and the model of care that they followed while working in India. According to many, India and Kerala still follow a much-medicalised model of care. When asked in detail about working as a mental health nurse in Kerala, participants noted that mental health

nursing is neither a reputable nor an independent profession in India, compared to the Australian context. In their words:

> You just follow doctor's orders there [Kerala] and I feel nursing profession is at least 25 years (behind) in India compared to western countries (Robyn, p. 22).

> There, [Kerala] nurses don't get much time to spend with their patients. They mainly give out medications. They (Health care system in Kerala) follow medical model (Sindhu, p. 14).

Participants often felt that the initial days of working in Australia were challenging. The challenges included the process of getting started and getting settled, communication-related challenges, anxiety, and the need to prove themselves. Later they described the internal and external support they received.

Getting started, getting settled: New identity

Some of the participants felt that they had to work hard to gain acceptance in the new workplace. As the circumstances and people were new, they felt they had to change to adapt to the new work environment and the people.

> Initial days were difficult. No one knew me; no one knew my background or experience, so I worked hard, made all opportunity to prove my skills and knowledge (Robyn, p. 4).

> Early days were challenging, totally unfamiliar environment, as a new Indian nurse, everything was new to me. I had to learn a lot and work hard to prove myself (Paul, p. 3).

> I was the very first migrant nurse here, so it took time to get their acceptance. They didn't know much about Kerala or India and our education or experience (Sophy, p. 6).

Participants felt they had to prove themselves, especially in places that had not employed migrant nurses prior to them.

Became anxious:

- Related to communication

Nurses revealed anxieties related to communication. Even though everyone had met the English language requirement to work in Australia, communication was described as challenging. Participants stated that Australians have their own way of using English with much slang. Participants also frequently felt anxious due to their inability to communicate effectively during their initial days in mental health. They encountered more difficulties with real-time verbal communication than written communication.

> I didn't know how to respond to the situation when I didn't understand the slang or jargon they used. Mostly, I wasn't confident to seek for the meaning of that slang. I used to get very anxious (Robyn, p. 43).

Similarly, language-related struggles were equally challenging while dealing with consumers with mental illness. John, who had experience in an English-speaking country, and worked in the UK before migrating to Australia. He stated that he found the British accent more comfortable to understand. However, initially he was anxious:

> Most of the time I mimicked the person's facial expression when I didn't understand what they are talking about. I used to get worried. Now it is not a big problem (John, p. 28).

Cindy also described her experiences related to communication:

> It was very anxiety provoking when I didn't understand street names of drugs I didn't want to ask the client to repeat because they can get easily agitated, at the same time, I didn't want to cause any harm to the client because of my lack of awareness (Cindy, p. 31).

All the participants agreed that various levels of anxiety marked their transition process.

-Related to new work place

According to the participants, they were so anxious about commencing work as mental health nurses in Australia, it nearly overwhelmed them.

> I was so nervous; still get the very same feel when I think about my first day in the acute inpatient unit (Robyn, p. 28).

Robyn's description provides a strong indication of the level of anxiety she experienced. She stated that the thought of the first day remains unpleasant even today. This indicates that the early experience is still strongly embedded in her mind.

> I didn't know where to start, how to react, I didn't feel welcomed at all…I still remember the very first morning. It was morning handover, a room full of people. They must be nurses, I said Hi. I'm a new staff ... a few smiled, a few didn't even make eye contact … no place to sit …. It added a lot more to my existing anxiety level (Robyn, p. 29).

Cindy also added:

> Full of apprehension, didn't know what to expect... [I] had 2 weeks' orientation classes where they covered theory, but this is my first exposure to the real world (Cindy, p. 18).

Cindy and Robyn have expressed anxiety and apprehension in the new work place. Robyn had commented on the unwelcoming work atmosphere and the impact of that on her mental state.

Stress related to a volatile work environment

The work environment in mental health is rapidly changing and unpredictable. Several nurses stated that acute in-patient units often caused additional stress. In particular, nurses with no prior experience in mental health found the initial days very stressful. Two participants reported that they had suffered serious physical assault by clients. Nevertheless, participants reported both positive and negative experiences during their stressful time in mental health. Krishna stated that his initial time in mental health was stressful, especially when dealing with impulsive acutely unwell clients. He felt that as a male nurse, he had to take leadership roles in de-escalating situations.

> I was the only male nurse most of the time in that newly started mental health unit. Once I was seriously assaulted by a client, while injecting him. It

> exacerbated my stress. I took some time off...No I didn't get the support I expected (Krishna, p. 41).

Jyothi also described that it was very stressful to work in mental health initially. She had no prior experience in mental health and completed a graduate program in mental health in Australia. She stated that she was passionate about mental health nursing from her clinical placement in India. However, she found that it was different in Australia. She found that in Australia there is a high rate of drug-induced psychosis and more personality-related issues. Jyothi revealed:

> It was very stressful for me. Screaming and abusive clients, but I pretended that I am very courageous. Once I got assaulted by a male patient. Twisted my hand badly. I had to take 2 weeks off. I lost my confidence. But my manager was very helpful. She offered me [a move to] aged psychiatry…and now after 4 years, I am one of associate managers there (Jyothi, p. 34).

Other participants also reported similar thoughts and experiences.

Felt valued

Participants stated that they enjoy the status of the nursing profession in Australia and considered that they can apply their knowledge and skills to patient care. They felt that nursing in India is not well structured. Some mentioned that they contribute to treatment decisions and patient care. They felt respected and valued, in addition to enjoying the higher reputation ascribed to the nursing profession in Australia.

Preethi stated:

> Nursing is considered as profession in Australia, and nurses can make decisions, use critical thinking skills, you are consulted regarding patient management, this aspect is the most liking part in working as a nurse in Australia. I feel valued (Preethi, p. 42).

Others also felt that their knowledge and skills were under-utilised in India. They had to take more responsibilities for patient care in Australia and felt respected as a result.

Krishna stated:

> I feel responsible, I have to know my client really well as I am involved in every stage of decision making process. I feel respected (Krishna, p. 31).

It is clear that the scope and functions of nursing and nurses are different in India and Australia. In addition, the importance placed on professional equality surprised these Kerala nurses. Participants stated that Kerala follows the recognised hierarchy of the medical profession.

Cindy pointed that in India, nurses usually follow orders from doctors. She also mentioned hierarchy differences between nursing management and junior nurses.

> There (in Kerala), you are not allowed to question anything done by doctors. You just follow their orders. I was amazed seeing the equality here (Cindy, p. 21).

Other nurses also applauded the recognition of the nursing profession in Australia.

Internal and external support

Although most of the participants experienced initial difficulties in the new workplace, they felt supported. They declared that their managers were supportive and approachable. Given the challenges that they faced in those initial days within the Australian context, some highlighted internal and external support.

Krishna commented on his supportive manager:

> My manager was very supportive…I felt like I can approach him anytime (Krishna, p. 34).

On the other hand, Anita thinks clinical supervision supported her during initial days.

> I used to attend group clinical supervision and I found it really helpful...A forum where you can freely discuss all your work related concerns (Anita, p. 23).

Smitha mentioned about her buddy nurse being very supportive:

> My buddy nurse was very helpful, I had other Kerala nurses working in the same area, they also shared their experience, and I was able to discuss all my concerns with them (Smitha, p. 41).

Some participants reported that they felt more comfortable seeking support from other Kerala nurses, as they found they could share all their problems and feelings. Shaji's words:

> I had other Kerala nurses working in the same area, they also shared their experience, and I could discuss all my concerns with them. I could share my feelings too (Shaji, p. 41).

Several participants mentioned that their parents were a source of strong external support. They reported that they have strong relationships with their parents. As reported previously, some participants used to call home every day to speak to their parents; this was not just related to needing cultural connection, but also for receiving external support.

> My parents were my pillars during that time, I used to call them every day and cry most of the days (Jyothi, p. 5).

Cindy had a different experience. She expressed about the strong support from her mother.

> My mum is my role model and support, she has never travelled overseas, she has no nursing background…her advice during any crisis…I value that more than anything (Cindy, p. 57).

In the above section participants expressed about the internal and external supports, they have received and found useful during their transition period in the new work place. The main internal supports were clinical supervision and buddy system. Some participants have described family as their external support during the transition period.

6.4.2 Career flexibility

Participants openly revealed that Australia provides a better working environment, with more flexibility in terms of working hours, workplace choices and nurses' roles. This perhaps explains why most the participants have pursued postgraduate qualifications in mental health, and some stated that they were about to commence postgraduate studies. Most of the participants work in acute in-patient units full-time or near full-time

and one participant works as part-time teacher in addition to her role in an acute in-patient unit.

> In Kerala, if you want to study full time you have to take break from your job, but here you can work and study. It is great (Cindy, p. 9).

Participants felt that they had more opportunity to widen their career scope and proceed with postgraduate studies in Australia.

> I like the flexible working hours and long leaves in Australia. I work part-time and I am studying. I have a young family. If I was in India I would not be working (Jisha, p. 14).

A few other participants have also claimed that they enjoy the career flexibilities and opportunities for career growth in Australia.

The section detailed the experiences in mental health nursing in Australia. In another word, the participants discussed their lifeworld in mental health in Australia. Every single participant mentioned that experiences in mental health involve mixed experiences from getting started getting settled, language related challenges, experiencing the differences in the actual job are few examples. The existential theme spatiality portrays the person's subjective experience in the new space. These nurses had to strive to gain a new identity in their new work place which was essential for the journey of survival in the new work place. Again, the existential relationality interrogates the person's relationships in the space. As newly started nurses from a different culture background, the participants had to create new connections in the workplace which later became a support factor for transition. Additionally, the existential corporeality is also a relevant existential in this theme as all the emotions and interactions has felt and occurred through the body. Stress and anxiety are examples. While reflecting on the support factors participants mentioned about external supports from family. Hence all the interactions with family in Kerala was facilitated by technology lived cyborg can also be considered as a relevant existential.

6.5 Conclusion

The themes that evolved from the transcripts have provided a vehicle to demonstrate the experiences of nurses from Kerala working in mental health in Australia. The main themes were 'Transitioning from general to mental health nursing', 'Cultural transition experiences' and 'Transition experiences of working in Australian mental health services'. Each theme has been further expanded using participants own quotes to reveal sub-themes that unravel the real experiences of Kerala nurses working in mental health in Australia. It is evident from the reflections that the transition to work in mental health in Australia was a journey of mixed experiences. Initially the participants struggled to understand the workplace, language and model of practice in their new stressful mental health work environment. However, most of the nurses eventually adapted to the new workplace. They have pursued growth opportunities in their careers and education. Majority of the participants expressed high level of satisfaction in working as a mental health nurse in Australia.

Overall satisfaction was expressed as different levels by different participants based on their motives behind migration. Participants those who have achieved their migration goals were expressed high level of satisfaction in Australia. Participants being a migrant in the new country brought forth different views regarding their future including dreams, plans and apprehensions. Their worries were mainly around future generations' completely adopting western culture. Furthermore, at various times during interview the participants asserted on the importance of the native culture in their lives. Additionally, some participants revealed the feeling of incompleteness mainly caused by missing family in Kerala and missing Kerala culture. Therefore a few participants expressed wishes to go back to Kerala and live there in a few years' time.

This chapter has also included relevant life existentials related to each theme. The application of lifeworld existential has provided deeper insight into the experience of overseas trained nurses. They provide rich understanding of the lived experiences of the study participants. Moreover, everyone experiences their real contextual world through basic lifeworld existentials. It was evident that phenomenological themes and lifeworld existentials were intertwined. The participants of the study reflected on their past

experiences, portrayed the present life and dreams for future. Revisiting the basic four existentials; lived body or corporality reminds us phenomenologically that we are always bodily in the world. The existential lived space or spatiality expressed as the connection human beings have with their environment and how they feel in the spaces they inhabit. Again, lived time is the felt time in the space. Lastly, the existential lived relations are the relationships we maintain with others in the space we live. Hence, the existential spatiality is greatly applicable to the participants. The experiences they had in the new space was unique, it is evident from their reflections that they had to make deliberate efforts to adapt to the new space.

In conclusion, thematic analysis of the data from the reflections of the participants and applications of lifeworld existentials provided an indepth description of phenomena of experiences of overseas trained nurses working in mental health in Australia.

In chapter seven the findings of this study are compared with other relevant studies. In contrast to previous studies, this study considered the experiences of a homogeneous sample of nurses working in the specialty of mental health. It is also notable that some of the findings of this study are not similar to the findings of previous studies. These themes are explicated.

Chapter 7

Discussion, Conclusion and Recommendations

There is limited information available on the transition experiences of overseas-trained nurses working in mental health care in Australia. Previous studies have observed that the transition experiences of nurses from non-English speaking backgrounds can be difficult, and that nurses are generally under-prepared for work in Australia (Smith et al., 2011). This suggests that the field would benefit from further study of the experiences of overseas-trained nurses transitioning into the Australian mental health care system, to inform the design of processes to facilitate the easy transition of these nurses into the new system.

The aim of this study was to qualitatively explore the experiences and challenges faced by overseas-trained nurses from Kerala, India working in mental health in Australia. Hermeneutic phenomenology is an approach that focuses on the reflection of lived experiences of people. According to van Manen (1984) "A phenomenological work is always on a real person, who in the context of a particular individual, social and historic life circumstances set out to make sense of certain aspect of their existence" (p. 40). van Manen's four lifeworld existentials of hermeneutic phenomenology were employed to explore the personal significance of the lived experiences of these nurses. Wells (2013) has suggested that as members of a collectivist culture, Indian nurses express their experiences with constant reference to culture and family. Hermeneutic phenomenology is therefore an appropriate methodology, as it provides an avenue to qualitatively assess these experiences.

Three main themes were developed from the research that describes the important features of the lived experiences of participants:

1. The beginning of the journey: Transitioning from general to mental health nursing

2. Cultural transition experiences: challenges of entering into the Australian culture and workforce
3. Realising the dream: Transition experiences of working in Australian mental health services'.

Each of these main themes is reviewed in relation to the available literature. Ultimately, the purpose of this research was to develop an understanding of the lived experiences of overseas-trained nurses working in mental health in Australia, and inform the development of strategies to improve their experiences and transition.

Developing an understanding of overseas-trained nurses' professional lives before migration, including their personal motives for migration have facilitated a better understanding of their experiences. This study identified challenges for overseas-trained nurses working in mental health, including difficulties in communication, understanding legal frameworks, and challenges specific to working with mentally unwell clients.

7.1. The beginning of the journey: Transitioning from general to mental health nursing

This theme illustrates the *motivations* for choosing to become a nurse and the process of specialising in mental health. The analysis revealed three sub-themes that steered the decision-making process:

1. Collective decision-making
2. Entry scores
3. Passion for the profession

7.1.1 Collective decision-making

Some participants noted that the choice to become a nurse was guided largely by family discussion, and driven by increased overseas job opportunities. This is a feature that has been identified in previous studies of Kerala-trained nurses (George, 2005; Kodoth & Jacob, 2013). As India is a largely collectivist culture, the actions and decisions of Indians are heavily influenced by the opinions of family and social networks (Hofstede Research Centre, 2016). In these societies, the individual commonly feels compelled to work

towards satisfying the aims of the family and social networks as a method of exhibiting loyalty and strengthening relationships. Participants also asserted the importance of collective decision-making later in their life. According to Jyothy:

> Even now we consult with our family [born family] if we make an important decision like buying a house and I always go with my husband's decision if I want to change job or do studies. A few times my Australian colleagues were surprised, I told them it's our culture (Jyothy, p. 16).

Heggertveit-Aoudiac (2016), a diversity specialist, has illustrated the importance of understanding the individual's culture and values in interpreting their behaviour. Cultural understanding is also essential in establishing trust and effective intercultural communication (Heggertveit-Aoudiac, 2016). Consistent with this, local nurses might have had trouble in understanding the behaviour and reactions of the participants. This is seen in the above quote by Jyothi, and other participants' responses also commenting about the confusion and questions asked by Australian nurses regarding certain practices of Kerala nurses.

As with previous studies about Indian and Asian nurses, another reason for selecting nursing as a career was the failure of participants to achieve adequate entry scores for higher ranked bachelor degrees (George, 2005; Jose, 2008). In the present study, a few participants mentioned their first preference was a 'medical degree'. Being a doctor is considered a dignified profession in India (Abraham, 2004; George, 2005), and there is a significant hierarchical difference between the medical profession and the nursing profession. In the present study, participants repeatedly commented on the relative lack of hierarchy and the reputation of the nursing profession in Australia.

Other participants selected nursing as a career as they were passionate about nursing from a young age. Some nurses who entered the profession found it easy to cope with nursing courses during the initial days of the courses. Others struggled, especially during the first year of their nursing degree, but survived. Although three different reasons were given for their initial choice of nursing as a career, no significant difference was identified regarding job satisfaction. Again, none of the participants mentioned about leaving the profession.

When evaluating the decision of participants to specialise in mental health nursing, the analysis revealed three further sub-themes that guided the decision-making process:

1. Positive clinical placement experience
2. Provided opportunity to migrate
3. Trying something new in their career

The below section provides discussion on each theme in relation to the relevant literature.

7.1.2 Positive clinical placement experience

The majority of participants described how a positive clinical placement experience fostered their interest in mental health nursing. These results are consistent with those of Happell et al. (2008), who noted that a positive experience in mental health clinical placement could assist in creating a positive outlook towards mental health nursing in students. In addition, Dawood et al. (2012) conducted a study on nursing students (n=114) undertaking mental health placement at King Saud Bin Abdulaziz University for Health Sciences – Riyadh. The objective of this study was to determine the nursing students' attitude toward psychiatric and mental health nursing and their intentions to pursue psychiatry as a future career. Findings of this study suggested that the experience during clinical placement has direct impact on future career decisions. The researchers added that this also assist with recruitment and retention in mental health.

7.1.3 Provided opportunity to migrate

A noteworthy finding was that in some cases, mental health was selected as a specialisation for visa-related reasons. Participants did not necessarily wait for an opening in their preferred choice of specialisation. Rather, they selected positions that allowed them to remain in Australia, regardless of their previous experience in the role. The ability of nurses to work in an area, despite having no previous experience in the specialisation, was driven by a shortage of mental health nurses. These participants reported that they struggled more than nurses with prior experience in mental health, along with their transition-related challenges. These nurses had to learn the basics of mental health nursing, including establishing therapeutic alliances, specific psychiatric diagnoses and specific medications used in psychiatry. These nurses also found their

initial experiences more stressful than their experienced counterparts did. This group of nurses benefited from a thorough orientation, including brief training in basic mental health nursing skills. A participant reflected:

> I struggled initially, I had no previous experience in mental health, and I was working in medical surgical nursing for 15 years. It was hard. A basic courses and good orientation could have been useful. I did so much reading and [also] copying [copied] other nurses (Leela, p. 15).

7.1.4 Trying something new

A few participants chose the speciality to try something new. This is one difference between this study and the existing literature. These nurses also reported initial struggles. However, all these participants reported undertaking post-graduate studies. Post-graduate studies were identified as one of the enablers of a positive transition to work by some nurses, especially those who had no prior experience in mental health. According to participants, there were differences between employers in providing support for overseas-trained nurses undertaking post-graduate studies, whereby some employers supported the post graduate studies financially, some have given study leave and other academic supports while others were not provided with any form of support. The nurses felt that engaging in post-graduate studies with Australian students helped them to understand the 'Australian model' of mental health nursing. Likewise, an American study reported that overseas-trained nurses received acknowledgement when they were able to perform nursing in a western way (Wells, 2013).

7.2. Cultural transition experiences: challenges of entering the Australian culture and workforce

Challenges of entering the Australian culture and workforce were described as one of the major dimension of experience in Australia. Participants expressed that the experience was different from their expectations. The differences between Australia and India in terms of mental health care and nursing were more than they expected. They came across unique challenges in the process of getting started and getting settled in Australia. Most of the participants stated communication related challenges as one of

the significant hurdle. This theme provided significant insights into the main research question. Four sub-themes were identified. Those are:

1. Acknowledging the differences between Australia and India in mental health treatment
2. Getting started and getting settled: Gaining a new identity
3. Communication-related challenges
4. Internal and external support

7.2.1 Acknowledging the differences between Australia and India in mental health treatment

Participants commonly noted differences between the Australian and Indian mental health nursing models and systems. Awareness of the mental health system and model of practice in Australia was low among these participants, and they felt that they were inadequately prepared to work in the field. For example, Paul (p. 4.) stated:

> I [had] never heard of the term 'recovery model' before. I didn't get any education on that before starting. In India, we still follow [a] medical model where doctors take decisions.

The recovery model of practice is a contemporary mental health care model utilised extensively in Australia, where empowerment of patients' choices and decisions are emphasised as a means of treatment (Department of Health, 2011). This model focuses on a person-centred, goal-oriented approach, whereas the medical model focuses on treatment goals, where the treatment team (Department of Health, 2013) manages decisions. It was revealed that many study participants had not received training in the recovery model of practice before they started working in mental health in Australia. This lack of adequate preparation of nurses working in Australia has been noted previously (Smith et al., 2011; Stankiewicz & Connor, 2011). Numerous studies of overseas-qualified nurses from non-English speaking backgrounds have revealed major differences in several vocational aspects, such as clinical skills and models of care, exist between the country of origin and the adopted country (Jose et al., 2008; Smith et al., 2011; Wells, 2013).

7.2.2 Getting started and getting settled: Gaining a new identity

Participants regularly described difficulty in entering the Australian mental health workforce. Some respondents were the first migrant nurses employed by a particular health service, and described mixed reactions from locally trained nurses:

> I was the very first migrant nurse here, so it took time to [gain] their acceptance. They didn't know much about Kerala or India and our education or experience (Sophie, p. 6).

Most of the participants reported that they had to work hard to prove their abilities, knowledge and skills, in order to gain approval from Australian colleagues and clients. These results are consistent with those of previous studies that have reported that the initial time in the workplace was challenging for overseas-trained nurses working in foreign nations (Brunero, 2008; Jose, 2008; Konno 2006; Wells, 2013; Zhou, 2010). Nevertheless, a Canadian study reported that newly graduated domestic nurses in mental health also faced challenges in 'gaining confidence' to interact with mentally unwell clients (Pfaff et al., 2014). It is important to note the additional trials of transition the participants had to overcome.

7.2.3. Communication-related challenges

Fear and anxiety associated with communication were common emotions the participants reported upon entry into the Australian workforce.

> Mental health is all about communicating. It was very difficult to understand [the] Australian accent and slang. I used to get nervous when I didn't understand and [the] client was expecting a response from me (Sophie, p. 12).

English language-related challenges have been widely documented in studies on immigrant nurses in Australia and other western countries (Brunero, 2008; Jose, 2008; Walters, 2005; Zhou, 2010). Accent was identified as one of the major challenges affecting effective communication. This includes the accents of both migrant and native language speakers. Similar findings were identified in two American studies (Jose 2008; Wells, 2013). While challenges related to communication have been previously described, the heavy dependence on communication in mental health treatment

exposed participants to additional communication-related problems. Furthermore, the communication capabilities of mental health consumers and carers may be moderated, adding further pressure to treatment situations.

Another source of anxiety was unfamiliarity with the workplace, staff, and clients/ patients with mental illness. Findings highlighted that some participants did not experience a positive welcoming attitude on their first day in the new workplace.

> I didn't know where to start, how to react… I said hi, "I'm a new staff" ... a few smiled, a few didn't even make eye contact … no place to sit …. It added a lot more to my existing anxiety level (Robyn, p. 29).

Previous studies also reported similar findings such as difficulty with communication, isolation and gaining new identity (George, 2005; Konno, 2005; Jose, 2008). However, the stressful atmosphere of the mental health care setting may further increase anxiety levels. Stress and anxiety related to mental health nursing has been previously described. For example, Currid (2008) highlighted that experiences of aggression and violence in mental health nursing can cause anxiety and stress in nurses.

> I started working in adolescent psychiatry … I never worked there before … screaming adolescents ... one minute they like you next minute they abuse you. I couldn't cope. I was very anxious (Jyothy p. 7).

The combination of the challenges of working in mental health care and in a foreign nation may contribute to increased anxiety. Furthermore, lack of adequate orientation of overseas-trained nurses has been associated with elevated stress levels (Stankiewicz & Connor, 2011). However, no studies to date have identified that a new mental health work environment may increase anxiety levels.

7.2.4. Internal and external support

The participants' internal and external support networks during the initial period of working in the Australian mental health sector were examined. Participants generally noted that supportive management and colleagues were beneficial to entering the workforce during the transition period. Positive support provided by other migrants from similar ethnic backgrounds has been previously noted in an American study on

overseas nurses (Wells, 2013). Some participants highlighted that they found other Kerala nurses working within the department helpful, as they have experienced many of the same issues. However, there were few Kerala-trained nurses already working in some workplaces. A Canadian study on local nurses entering mental health identified managers and interdisciplinary teams as two strong support strategies (Pfaff et al., 2014).

Clinical supervision was described as a strong enabler of transition into the new workplace. Clinical supervision is a process where two or more professionals meet to reflect and discuss clinical practices with the goal of proving support to the clinician and consequently improved consumer outcomes (Department of Health, 2014). Most of the participants noted that clinical supervision fortified their ability to assimilate into the new workplace. This process of clinical supervision should be encouraged to support the transition of overseas-trained nurses into the workforce.

Participants also emphasised that family was an important resource. Interdependency and inter-reliance on family are key characteristics of collectivist cultures (Gray, 2000). This is another difference between this study and the existing literature.

7.3 Realising the dream: Transition experience working in Australian mental health services

This theme provided insights into the experiences of Kerala-trained nurses as they transitioned into the Australian workforce. The following sub-themes emerged:

1. Motivations for migration
2. Living in dual cultures
3. Discrimination
4. Loneliness
5. Achieved the goals, but feeling incomplete

7.3.1 Motivation for migration

Participants revealed that their main motives for migrating to Australia were because it provided a better future for their children, improved pay and work conditions, and

enhanced career advancement opportunities. This finding is congruent with the 'push-pull' factors of migration, where migrants leave their home country to escape poor conditions to move to a place where conditions are better (Australian Bureau of Statistics, 2015).

Some participants highlighted that they made the sacrifice of migrating to Australia to ensure that their children are provided with good jobs, houses and financial capacity. This is consistent with the findings of Konno (2008), Walters (2005), and Zhou (2010), who all described that an improved future for children was one of the motives for migration to Australia. Generally, participants who migrated to provide a better future for their children expressed high satisfaction levels with their decision to move to Australia. These participants regularly stated that their children were enrolled in high school and university, and that they consequently have no intention to move back to Kerala.

Financial betterment and career advancement were other common goals expressed by participants. Nursing is a poorly paid profession in Kerala, and nurses from Kerala tend to migrate to Western countries where salaries are better (Kodoth, 2013). The access to improved financial conditions was commonly expressed as a benefit to both the participants and their families, as in previous studies (George, 2005). Career advancement as a goal for migration to Australia was commonly noted by younger participants, which has previously been established as a motive elsewhere (Jose, 2008; Walters, 2005; Wells, 2013).

While it has previously been reported that migrants wanted to return to their country of origin due to failure to reach their migration goals (Jose, 2008), it was interesting to note that some participants in the current study reported a feeling of emptiness at times, even though they had achieved many of their goals. This was particularly common in participants with young children. According to Hedge and DiCicco-Bloom (2003) and Wells (2013), the longer migrants spend in a foreign nation, the more satisfaction they express regarding their lives. Participants in the current study had between 3 and 10 years of post-migration experience in Australia. Most of the participants who raised this theme had migrated between 3 and 5 years ago. It is worth following up these

participants in a few years. The reasons for their desire to go back included a sense of responsibility to look after ageing parents, fear of their children adopting Australian cultural values, and fear of loss of the next generation in Kerala. Traditionally, in Indian culture it is the responsibility of the younger male child to take care of parents during their old age. In addition, these participants also expressed concerns about children eventually following Australian culture and losing contact with extended family in India. Concerns and conflicts with future generations are documented in the literature dealing with culture (Foner & Dreby, 2011).

7.3.2 Culture

While participants stated that culture held great value in their everyday lives, there is a lack of previous research on how migrants from Kerala assimilate culturally into foreign countries. Although the participants had made a conscious decision to migrate to Australia, they had not rejected their Keralan culture. The majority of the participants stated that they attempt to adopt the Australian cultural norms at work and socially, while at home and in the Australian-Kerala community, they follow the norms of Keralan culture.

According to Schwartza and Ungerb (2010), individuals are considered bicultural or dual-culture when they speak the language of their native place and the language of the host country, interact with friends from both cultural backgrounds, and socialise in both cultural contexts. Many participants stated that they live in dual cultures, and were aware of the importance of understanding and accepting Australian culture because it is where they live and work:

> We live here. Work here. So, it is important to understand [and] respect the culture. Initially it was very difficult and complicated, especially when it [came] to relationships (Robyn, p. 6).

Consistent with previous research, some participants raised concerns about their children growing up in Australia and the possible influence of Western culture in their children's lives (Zhou, 2010). Participants in the present study also raised concerns about children not adopting the values of Keralan culture. It is evident that cultural expectations contribute to the anxiety felt by migrant parents, and it has been

suggested that differences in culture, beliefs, and values can create conflict between generations of immigrant families (Foner & Dreby, 2011; Kishi et al., 2014). While some participants indicated concern about cultural issues and concerns relating to their children, no participant indicated any conflict with their own children on these issues.

In addition, some participants raised concerns about experiencing possible 'reverse cultural shock' if they returned to Kerala. Reverse culture shock refers to the unexpected re-entry experience when they have spent significant time in a foreign country (Tsang-Feign, 2015). Many participants noted that it would be difficult to work as a mental health nurse in Kerala, as mental health nursing practice is different in the two countries.

7.3.3 Discrimination

In accordance with previous studies, participants in the current study noted the occurrence of discrimination from both patients and colleagues (Alexis et al., 2007; Higginbottom, 2011; Wells, 2013). Experiences of racism and discrimination have powerful impacts on participants' lives. A few participants stated that it was traumatic to experience discrimination. They stated that it had more impact on them when co-workers exhibited racism and discrimination. As one participant said:

> I had negative experiences from patients. At least they are unwell; I can ignore them to some extent, but discrimination from colleagues. I had one staff always underestimate me all the time. She used to talk so negatively about nurses from non-English speaking backgrounds over and over … then say sorry, I didn't mean everyone. I used to get upset … it was hurting [sic] (Robyn, p. 3).

Participants repeatedly noted that the mental status of the patients they were providing care for contributed to the greater incidence of discrimination and racism experienced. This is an important consideration for immigrant nurses working in mental health care. It also important to provide support including counselling for immigrant nurses who experience racism.

7.3.4 Loneliness

It was common for participants to express feelings of loneliness as they were away from their family and working in a new country. This feeling was stronger during the initial days, especially when they were single. For those with partners, family reunion after immigration generally took over a year. Participants felt alone when they had no friends, and little awareness of the host country or its culture. It was also common for participants to live alone and be unaware of common ways to socialise within the workplace.

While the incidence of loneliness, isolation and rejection in immigrant nurses has been documented (Rodríguez, Angélica-Muñoz & Hoga, 2014), in the present study, participants stated that they made deliberate efforts to socialise with local staff members, and follow sports and television shows in order to take part in conversations. A few participants stated that they socialised with the local community and engaged in outdoor activities such as fishing:

> Putting deliberate effort in engaging with [the] local community helped me to learn the slang, culture and interests of Australians (Rony, p. 15).

Linking up with local people or having a mentor from the domestic workforce may be useful strategies to facilitate smooth integration to the new country.

7.4. Outcomes of this transition journey: Physical and psychological transition

This study sought to further understanding of the transition experiences of overseas-trained nurses from Kerala and their current situation. As Indian and Kerala nurses, have become a significant proportion of the nursing workforce in Australia (ABS, 2013), it is vital to understand the outcome of their journey of transition. It was evident that the participants had to live through challenging sociocultural adaptation experiences after migrating to Australia. The findings of the study lead to the conclusion that transition and adaptation took place both physically and psychologically. Physical adaptation of the participants has taken place over time. Most of them have bought houses, their children have started school and they have advanced in their careers. Another aspect of physical

adaptation is changes adapted in clothing, hairstyle, trying Australian food and Australian lifestyle to a certain extent. One participant mentioned that she has never worn jeans or coloured her hair before, but enjoys Australian style now. This indicates that the experiences of participants in this study identify with bidimensional acculturation to a certain extent. A relevant study on an Indian population in America also highlighted bicultural identities among Indian migrants (Mathur, 2000). Mathur (2000) indicated the participants also expressed mixed attitudes towards towards Western culture. These findings are relevant to Kerala nurses working in Australia especially when discussing about acculturation and identities. Participants of this study have also expressed challenges associated with accepting certain aspects of Western culture such as individual's freedom and concepts around upbringing children. Again, some participans commented on struggling to find identitiy in the new country. Another similar American study highlighted that acculturation and integration needs of Indian females were different from traditional needs of basic factors such as language, housing and skills training (Kankipati, 2012). Furthermore, the study participants were educated, English language proficient and employed in various professions (Kankipati, 2012). Again, Kankipati (2012) suggests that participants' needs were largely based on socio cultural and psychological integration to the new culture (Kankipati, 2012).

In this study, the participants were employed in mental health nursing with minimal communication barriers. However, they voiced challenges associated with acculturation and transition, specifically around individualistic features of Western culure as mentioned in the previous paragraph. Being followed closely knitted collectivistic culture in the past, some participants expressed they found the concept of individualism and getting permission from clients to involve family in care was a new concept especially during initial days.dditionally they have pointed out they struggled to find an identity in the new country and had to work hard to gain trust from clients and other staff. Similar to Mathur's (2000) findings, some of the participants expressed a negative bias towards their children adopting Western cultural norms and behaviours. Nevertheless, most of the participants appreciate and follow the aspects of the Australian way of living that they perceive as positive.

However, social adaptation remains limited. Most of the participants stated that their social interaction with Australians mainly happens at work. They tend to socialise with other migrants from Kerala. From participants' statements, it is evident that they are still undergoing psychological transition. Some of the participants are continuing to strive to make decisions about where they want to live, while other participants expressed a strong desire to go back to Kerala. The concept of delayed psychological adaptation has been proposed (Harlem, 2010). The present study indicates that psychological adaptation is an on-going process. Berry (2005) identified that various factors can influence the process of psychological adaptation. These factors are individual traits, personality and life history.

The participants in this study repeatedly asserted the importance of their previous collectivistic Kerala culture and the importance of the sense of belongingness to their family. Research relating to acculturation and adaptation (Berry, 2005; Harlem, 2010) rests on the assumption that the influence of past culture is one of the reasons for these participants delayed psychological adaptation in Australia. However, most participants stated that they are able to balance Kerala and Australian culture. Moreover, concepts related to acculturation and transition enabled better understanding of the experiences of migrant nurses from India. Acculturation theories provided in chapter one offered an insight into the multifaceted challenges and multilevel interactions between the migrants and the host culture.

7.5 Limitations, Implications & Recommendations

7.5.1 Limitations

A key limitation of the study is due to the methodological constraints of researching a very specific population. The relative homogeneity of the sample allowed deeper exploration of the lived experiences of these participants, though it is not representative of all Kerala-trained nurses or other migrant nurses. One of the limitations of phenomenological studies is the lack of generalisability and replicability (Holloway, 2012). Whilst the findings of the study may be applicable in other fields of nursing, there are certain exceptions, such as features specific to mental health, which must be carefully considered before generalising the study results.

7.5.2 Implications of findings

This study presents the individual stories of overseas-trained nurses as they transitioned into the Australian culture and workforce. While there have been some studies of the experiences of overseas-trained nurses working in Australia and overseas, none have assessed the experiences of these nurses working in the specialty of mental health. Mental health nursing is a challenging and rewarding specialty, where communication and therapeutic relationships play an important role in the workplace (Ryan, 2013). The results of this study may contribute to the understanding of factors that impact on the transition of these nurses, and provide insights into how the ease of this transition may be improved. Specifically, these findings can be utilised to guide the design of educational and workplace programs for migrant nurses, in addition to future research.

Education

There may be differences in the preferences of learning techniques among people from different cultural backgrounds (Kaya, 2014). According to Kaya (2014), a sociologist who focuses on the impact of culture on adult learning, the importance of understanding cultures assists in avoiding the marginalisation felt by students, and aids to minimise obstacles to learning. With an understanding of Kerala nurses' prior learning background, educators may be better equipped to modify the delivery and content of mental health education. From the researcher's personal experience and participant's view, content and pedagogy of mental health training and teaching in India is different to Australia. This knowledge may also assist educators to adequately orientate migrant nurses to the new work environment, as it was noted that participants felt a lack of understanding of the legal framework and the model of care in Australia.

The findings of the current study stress the importance of a well-structured orientation to the mental health care setting, which may be improved by the provision of Australian cultural orientation programs, the current model of practice, and the legal framework of working in mental healthcare. It was noteworthy that participants who received clinical supervision highlighted that it was an effective support to their transition to the Australian workforce.

The findings contribute to the existing knowledge of the importance of culturally inclusive practice in education and adult learning theories. Alhassan (2012) suggests that it is important to understand the factors that affect the learning of adults and culture is an important influencing factor. Having an understanding of the life experience, cultural background and personal goals of each student can enable a tailored approach when dealing with culturally diverse pupils. The findings contribute to understanding of the learning needs, goals and challenges of this significant group of nurses working in mental health in Australia.

Practice

The findings of the present study provide insights into the participants' personal and professional lives in Australia. Culture, ethnicity, and past experiences can shape an individual's outlook on learning and practice (Alhassan, 2012). The findings of this research may assist the local workforce to have a better understanding of their multicultural colleagues and the challenges they face.

Clendon and Walker (2012) conducted a study on internationally qualified nurses in New Zealand and identified similar workplace challenges. The authors recommended that a smooth transition into the adopted culture and workforce is essential to improve the retention of nursing staff. Their study (Clendon & Walker, 2012) demonstrated that the importance of a good understanding of the experiences and expectations of international nurses might help their learning priorities in terms of practice.

In this study, it was evident from the participant's words that there was no standardised orientation program for mental health. The orientation programs and policies differed from employer to employer. Some were extensive and some were brief. In common with other studies (Ea, 2007; Kennedy, 2006; Walker & Celdon, 2012), the present research suggests that a well-structured framework is essential to support the integration of overseas-trained nurses, benefiting both domestic and overseas trained nurses. It is believed that a comprehensive integration program will provide overseas-trained nurses with information related to culture, professional expectations, legal frameworks and safe practice. This will also have a potential positive impact on local nurses in having equally confident colleagues. These results are also relevant for

stakeholders, employers and managers working in mental health care, when recruiting and orienting overseas-trained nurses. It is vital to understand that nurses such as those included in this study are undergoing significant challenges whilst transitioning into the Australian culture and workforce. It is important therefore to provide them with time to adapt and flexibility to acquire skills and confidence in the new workplace.

Research

Due to the shortage of nursing staff in Australia, there is a heavy dependence on migrant nurses. Future studies could assess the experiences of patients who are cared for by these foreign staff as well as their families and significant others. Further research is recommended on the experiences of Kerala nurses working in general health.

One issue not considered in this study relates to gender differences and experiences of transition. It is worth studying the different coping strategies used by different genders and the effects on transition experiences. This was suggested in an American study (Wells, 2013).

This research used a qualitative approach, future research using quantitative methodologies would add to the body of knowledge regarding migrant nurses in the Australian healthcare system.

Lastly, the participants of this study were quite homogeneous. It is worth examining the differences in expectations and experiences of overseas nurses from other parts of world working in mental health.

7.6. Conclusion

Examination of the life experiences of study participants assisted in providing a holistic understanding of their journey. Three themes revealed in the study, provided a medium to illustrate '***what it is like to'*** be an overseas-trained nurse from Kerala working in mental health in Australia'. Most of the participants stated that the choice of nursing was a decision made as a family unit. The motivations for migrating to Australia were financial betterment, improved future for children and career advancement. It is notable that many of the participants did not have experience in mental health nursing prior to starting their career in mental health in Australia. This made their initial time in

Australia challenging. Without a well-structured transition and orientation program, participants' initial days working in mental health care were typified by high levels of stress and anxiety. The volatile work atmosphere in mental health care added to these anxiety levels. Participants often felt isolated without family and friends in Australia and they commonly stated that they had to struggle to gain approval and identity in the new mental health workplace.

Enablers of their successful transition were supportive managers, colleagues and family back in India. Even after years in Australia, participants expressed that they live in dual cultures. Participant's affinity towards their past culture was repeatedly mentioned, with worries about children adopting Australian culture. A few participants stated that they still feel 'empty' even though they have achieved all their goals. Finally, the study results were interpreted using the lifeworld existentials of van Manen (1990). Viewing the participant's experiences using lifeworld existentials provided deeper understanding. Every aspect of a lifeworld existential had significance in participants' lives. The journey they started from the past, with hopes and dreams living in the reality at present with hopes for the future. Participants have dreams and aspirations for their future. The experience of working in mental health in the new country had positive and negative impacts on their body, perception of time, personal relations and their subjective space.

Despite significant emotional hurdles, participants generally enjoyed working in mental health care in Australia. They felt valued in their workplace, noted that their clinical skills and knowledge were recognized, and that their input into the management and care of patients was esteemed. The differences in duties and responsibilities between Australia and India were commonly noted. This perceived value contributed to the enjoyment of nurses working in the profession. This has been similarly described in other studies of overseas-trained nurses (Alexis et.al, 2007; George, 2005; Jose, 2008). Consistent with previous research, participants in the current study described increased workplace flexibility compared to work in India, and improved access to opportunities for career advancement (Konno, 2008).

7.7 Recommendations

7.7.1 Integration to country and work (mental health)

The results of this study have highlighted the importance of a comprehensive standardised orientation package. It was clear that participants had many unexpected experiences. Advanced preparation prior to migration can possibly deal with the situation in a much better way. The differences were significant in view of culture, legal frameworks, the mental health model of care and opportunities. Information in advance regarding these aspects would provide more clarity for overseas trained nurses. Mental health care systems and job expectations are different in India and Australia. It is important to provide tailored information on health care system, mental health system and roles and responsibilities of mental health nurses. The existing transition program is not tailored (Stankiewicz & Connor, 2011) for specialties such as mental health.

7.7.2 Structured support systems in the new workplace

It was noticed in this study that support systems in mental health varied widely between organisations. For example, clinical supervision was suggested as a strong support strategy, yet only a few employers offered it. Stakeholders should consider developing early on-going support systems based on the personal needs of the individual. Based on the interviews it is evident that these cohorts of overseas-trained nurses have different levels of experience and skill sets. Mechanisms should be established to identify the level of experience and differences in skill levels of employees. This process can be best initiated at the time of recruitment. It is necessary to have general and local policies and guidelines in facilitating transition to work in the new country.

7.7.3 Peer support network

The participants highlighted the importance of reciprocal learning. Developing a peer support network can be beneficial. This can possibly include sharing stories by overseas-trained nurses who successfully transitioned to mental health. This could enhance meaningful learning. Support by allocated domestic mentors and buddies might also have advantages to assist nurses in understanding more about the culture and thereby gaining confidence. This will possibly benefit employers in terms of recruitment and retention in mental health.

7.7.4 Formal professional development programs

Participants repeatedly highlighted the benefits of professional development including post-graduate studies. However, no formal pathways or guidelines are in existence in relation to professional development. Participants who received support to pursue professional development, especially in the mental health specialisation, seemed to benefit more in terms of positive transition to work and professional growth in comparison with nurses who received minimal support. We recommend national guidelines for minimum mandated professional development, and potentially, post-graduate qualifications for overseas-trained nurses who decide to work in the speciality of mental health.

7.7.5 Buddy system

Clinical education plays an integral part of orientation to the new work place. It can be done by buddy system. Participants in study who had buddy nurses to work with during initial days highlighted the advantages. It was asserted that buddy system made them feel welcomed and assisted them to learn routine care in the hospital. Additionally, buddy system can be recommended as a cost-effective way facilitating orientation and adaptation in mental health settings.

7.8 Summary

Australia has had to recruit overseas trained nurses to meet ever-increasing workforce demands, especially in mental health. Over the past decade, there has been an influx of migrant nurses from Kerala, India. Background analysis and a literature review revealed that migrant professionals have specific transition needs and that there are particular challenges associated with working in mental health. The aim of this study was to explore the lived experiences of overseas trained nurses from Kerala and working in mental health in Australia. Hermeneutic phenomenology informed by van Manen was the methodological approach used in the study. The participants were overseas trained nurses originally from Kerala, India who had been working in mental health in Australia. The findings identified three key themes: ‘Transitioning from general to mental health nursing’, ‘Cultural transition experiences’ and ‘Transition experiences of overseas nurses working in Australian mental health services’. Lifeworld existentials associated with the

lived experience of the participants were intertwined within each theme. Those lifeworld existential are lived time, lived space, lived body and lived others. Key findings included challenges related to transition from general nursing to mental health, challenges and experiences related to living in the new culture and mixed experiences of working as an overseas trained nurse in mental health in Australia. The experiences of the overseas trained nurses highlight the specific unique challenges and hurdles that migrant nurses tackle with during the transition period and in their ongoing lives in Australia. Implications of this study indicate the need for ongoing educational and clinical support for overseas-trained nurses working in Australia. Based on the findings, this study also recommends further research in this topic.

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Appendices

Appendix 1. Ethical Approval

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number:	CF13/3844 - 2013001976
Project Title:	An Exploration of the Experiences of Being an Overseas Trained Nurse from Kerala, India and Working in Mental Health in Australia: A Phenomenological Study
Chief Investigator:	Prof Wendy Cross
Approved:	**From:** 18 March 2014 **To:** 18 March 2019

Terms of approval - ***Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.***

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Nip Thomson
Chair, MUHREC

cc: Assoc Prof Cheryle Moss, Mrs Bindu Joseph

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
[redacted] http://www.monash.edu.au/researchoffice/human/
ABN 12 377 614 012 CRICOS Provider #00008C

Appendix 2. Participant Information and Consent Form

MONASH University
Medicine, Nursing and Health Sciences

Please read this session carefully, as this explains your rights, information about this research and your involvement as a participant. Please clarify all your questions with Bindu Joseph.

Title

An exploration of the experiences of overseas trained nurses from Kerala, India working in mental health in Australia: A phenomenological study

My name is Bindu Joseph and I am a **Student Researcher undertaking a PhD. My supervisors are** Prof. Wendy Cross and Ass. Prof. Cheryle Moss. I invite you to participate in this research project.

Introduction

There are significant numbers of nurses from Kerala working within the Australian mental health system. There are a few national and international studies on overseas-trained health professionals, and a significant gap exists in the understanding of overseas-trained nurses' experiences of migration and re-settlement. Therefore, exploring and understanding the experiences and challenges of overseas-trained nurses working in mental health in Australia is vital. This study will explore the experiences of overseas-trained nurses from Kerala working in mental health in Australia.

Purpose of the study

- Explore the experiences of overseas-trained nurses from Kerala, India working in mental health in Australia

Participation in this research is voluntary

You are invited to participate in this study because you are an overseas-trained nurse from Kerala working in mental health. Your participation will involve approximately five, 90-minute interviews at an agreed venue and time to suit your and the student researcher's convenience. The interviews will be conducted in English and will be audio-recorded. The student researcher will gather basic demographic information from you. Your participation will remain private and all your data will be de-identified. Only aggregate data will be reported.

Benefits

This is an opportunity to share your experiences. The results of this study will assist in understanding the experiences of overseas-trained nurses from Kerala working in mental health. The results of this study may benefit future overseas-trained nurses intending to work in mental health in Australia.

Risks

It is unlikely that there will be any risks to participants involved in this research. However, some participants might feel emotional as they reflect on their experiences. The interview will be terminated if the participant wishes to do so and referral to a support person will be provided.

Confidentiality

Your identity will not be disclosed at any stage of this study. You will be given a pseudonym. You may withdraw from this research at any stage before publication.

Storage of information

All interviews will be transcribed by an external professional and stored in a locked cabinet in the School of Nursing and Midwifery, Monash University for a period of 5 years. After five years the data will be destroyed.

Your information

A copy of the interview will be sent back to you to check. The findings from this research will be published in a thesis, in peer-reviewed nursing journals and presented at appropriate conferences.

Ethics Approval

The Monash University Human Research Ethics Committee has approved this study as a Low Risk Project Involving Humans (Ref: CF13/3844 – 2013001976).

Further Questions, Contact information and Concerns or Complaints

If you require any further information regarding this project or if you have any concerns/complaints related to your involvement in the project, you can contact;

Research Supervisor

Prof. Wendy Cross
Monash University
Clayton

Appendix 3. Consent Form

Full Title of the project

An exploration of the experiences of being an overseas trained nurse from Kerala, India and working in mental health in Australia: A phenomenological study

Research Supervisors: Prof. **Wendy Cross**

Asso. Prof. **Cheryle Moss**

Monash University

Clayton

[redacted]

Research Site: Australia

I have read, and I understand the purposes, procedures and risks of this research project as described within the information sheet. I have had an opportunity to ask questions and I am satisfied with the answers I have received. I understand that the information gained during the study may be published, I will not be identified and my personal details will remain confidential.

I freely agree to participate in this research project, as described.

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed): ……

Signature: **Date:**

Declaration by the Researcher:

I have given a plain language statement and verbal explanation about the research project, steps involved and risks and I believe that the participant has understood those explanations.

Researcher's Name: BINDU JOSEPH

Signature: **Date:**

Appendix 4. Advertisement

A. Questionnaire

An exploration of the experiences of being an overseas trained nurse form Kerala, India and working in mental health in Australia: A phenomenological study

Are you a Registered Nurse originally from Kerala, India and now working in Mental Health in Australia?

Do you feel your experiences are different and unique?

Would you like to talk about your experiences?

We are interested in exploring your story.

You are invited to participate in a research project

This research entails interviews with you about:

- Your experiences of working in Kerala and working in mental health in Australia.
- Your insights into what is important to making the transition country to country.
- Your future goals.

This research is being undertaken by Bindu Joseph, a PhD student at Monash University.

Participation is voluntary and all information will remain confidential.

If you like to participate please contact **Bindu Joseph**.

Mob: [redacted]

[redacted]

Supervisors
Prof. Wendy Cross
Assoc Prof. Cheryle Moss
Monash University
School of Nursing and Midwifery
Clayton

[redacted]

B. Advertisement letter

To

Kim Ryan, Executive Officer
Australian College of Mental Health Nurses

From

Bindu Joseph

PhD Candidate

Monash University

Clayton

Dear Kim,

I am a credentialed mental health nurse currently doing my PhD at Monash University under the supervision of Prof. Wendy Cross and Ass. Prof. Cheryle Moss. My research topic is **An Exploration of the Experiences of Being an Overseas Trained Nurse from Kerala, India and Working in Mental Health in Australia: A Phenomenological Study.** My study will involve in-depth unstructured and audio-recorded interviews of overseas-trained nurses from Kerala working in mental health.

I hereby wish to request to advertise my research through the ACMHN and the International Journal of Mental Health Nursing.

Kerala nurses are well represented in the current mental health workforce. It is my assumption that this study will benefit overseas nurses, employers, the mental health system and importantly clients with mental illness.

Yours Sincerely

Bindu Joseph

C. Advertisement

Australian College of Mental Health Nurses

Are you a Nurse from Kerala working in Mental Health?

Do you have a minimum of 2 years of experience in Australia?

Do you have some time to spare?

Would you like to voice your experience?

If your answers are 'YES', you are invited to participate in a research study.

This research is being done by Bindu Joseph, a PhD student at The University of Monash. Participation is voluntary and all information will remain anonymous. If you like to participate please contact Bindu Joseph.

[redacted]

[redacted]

Supervisors

Prof. Wendy Cross

Asso Prof. Cheryle Moss

Monash University, Clayton

Appendix 5. Conference Presentations

Year	Type of Conference	Presentation
2015	International	Joseph, B., Cross, W.M., & Moss. C. (October, 2015). Shifting trends in mental health nursing: experiences of nurses from CALD backgrounds working in mental health. Paper presented at International Conference on Mental Health Nursing, Brisbane.
2014	International	Joseph, B., Cross, W.M., & Moss. C. (October, 2014). Working towards shaping the future, little known; An exploration of the experiences of being an overseas trained nurse from Kerala, India, and working in mental health in Australia. Paper presented at International Conference on Mental Health Nursing, Melbourne.
2013	National	Joseph, B. Cross, W.M., & Moss. C. (August, 2013). Sustainability and workforce diversity: understanding the experience of overseas health professionals working in mental health. Paper presented at the Victorian Collaborative Psychiatric Nursing Conference, Victoria.
2012	International	Joseph, B., I. Munro. (October, 2012). Mental Health Nursing; a tapestry woven in the woven in the loom of diversity. Paper presented at the International Mental Health Nursing Conference, Perth.
2011	International	Joseph, B., Cantely –Smith, R. (October, 2011). Physical Health Monitoring in Mental Health. Paper presented at the International Mental Health Nursing Conference, Gold Coast.

Appendix 6. Research School Presentations

Year	Presentation
2015	Joseph, B., Cross, W.M., & Moss. C. (February, 2015). My experience of in-depth interviewing. Paper presented at Monash University Research Week, Victoria
2015	Joseph, B., Cross, W.M., & Moss. C. (November, 2015). An exploration of the experiences of being an overseas-trained nurse from Kerala, India working in mental health in Australia. Paper presented at Peninsula Health Research Week**.**
2014	Joseph, B., Cross, W.M., & Moss. C. (December, 2014). Exploring the experience of being an overseas-trained nurse from Kerala, India working in mental health. What has been said? Finding the gap. Paper presented at Monash University Research Week, Victoria
2014	Joseph, B. (November, 2014). An exploration of the experiences of being an overseas-trained nurse from Kerala, India working in mental health in Australia. Paper presented at Peninsula Health Research Week
2014	Joseph, B., Cross, W.M., & Moss. C. (November, 2014). An exploration of the experiences of being an overseas-trained nurse from Kerala, India working in mental health in Australia. Paper presented at 3M thesis faculty final.
2014	Joseph, B., Cross, W.M., & Moss. C. (August, 2014). An exploration of the experiences of being an overseas-trained nurse from Kerala, India working in mental health in Australia. Paper presented at 3M thesis.
2014	Joseph, B., Cross, W.M., & Moss. C. (February, 2014). Exploring the experience of being an overseas-trained nurse from Kerala, India working in mental health. Paper presented at Monash University Research Week, Victoria.
2013	Joseph, B., Cross, W.M., & Moss. C. (September, 2013). Experience of being an overseas-trained nurse working in mental health. Paper presented at Monash University Research week, Victoria.
2013	Joseph, B., Cross, W.M., & Moss. C. (August, 2013). Sustainability and workforce diversity, understanding the experience of overseas- health professionals working in mental health. Paper presented at the Victorian Collaborative Psychiatric Nursing Conference, Victoria

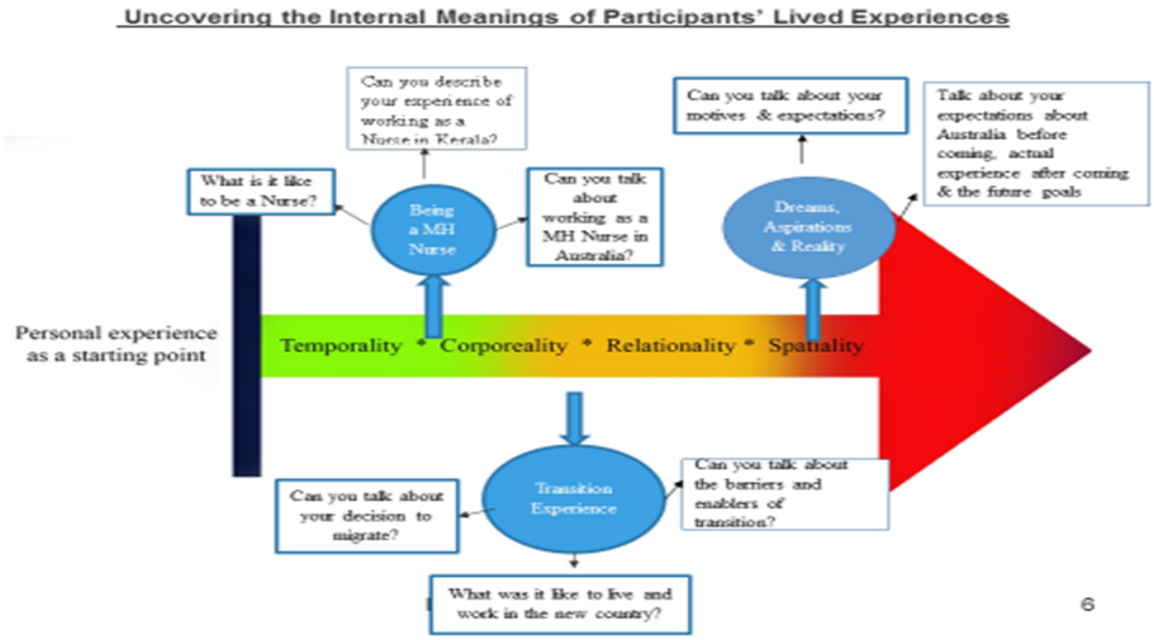
Appendix 7. Awards

Year	Position	Award
2016	Winner	**Best Research Oral Presentation**, Peninsula Health Research Week, 2016
2014	Winner	**Best Scientific Oral Presentation**, 40th International Mental Health Conference of Australian and New Zealand College of Mental Health Nurses, 2014.
2014	Winner	**First Prize** Three-minute thesis competition, School of Nursing and Midwifery, Monash University, 2014
2013	Winner	**Best Scientific Poster Presentation** Peninsula Health Research Week, 2013.
2012	Winner	**Best Scientific Poster Presentation** Peninsula Health, 2012.

Appendix 8. Publications and plans for publications

Title of the Article	**Status/Time frame**	**Journal**
The mental health work-force, a tapestry woven on a loom of diversity: Experience and challenges of nurses from diverse cultural backgrounds working with the Victorian Mental Health System. **Joseph, B; Munro, I & Taylor, B**	Published (abstract)	International Journal of Mental Health Nursing
Adjusting to mental health nursing in Australia. **Joseph, B; Moss, C & Cross, W**	Published	Australian Nursing & Midwifery Journal, 2015, Vol.22(8), p. 42(1) [Peer Reviewed Journal]
Shifting trends in mental health nursing: Experiences of nurses from CALD backgrounds working in mental health. **Joseph, B; Moss, C & Cross, W**	Published	International Journal of Mental Health Nursing
Experiences of overseas trained nurses working in mental health: A Literature Review	Drafting in progress	Journal of transcultural nursing
Exploring the experience of being an overseas trained nurse from Kerala, India: Working in mental health	Drafting in progress	International Journal of Mental Health Nursing
Transcultural application of lifeworld existentials: Report on research design	Drafting in progress	Nursing Research
Contemporary issues and recommendations: Mental health nursing workforce	Drafting in progress	Collegian OR Journal of Nursing Management

Appendix 9. Interview Guide



Appendix 10. Publications

International Journal of Mental Health Nursing (2012) *21* (Suppl. 1), 1–28 doi: 10.1111/j.1447-0349.2012.00878.x

The mental health work-force, a tapestry woven on a loom of diversity: Experience and challenges of nurses from diverse cultural backgrounds working with the Victorian Mental Health System

B. Joseph, I. Munro, B. Taylor

Monash University, Victoria

Mental health nurses are diverse in the level of experience, attitude, skills, and outlook towards mental health and mental illness. On the whole the diversity makes a beautiful design on the fabric of mental health nursing. There are significant numbers of nurses from culturally diverse backgrounds working within the mental health system. Mental health is one area where communication is a core element of practice. Understanding the meaning of colloquial words and commonly used slang can be a challenge for nurses from linguistically diverse backgrounds Fear of making language and cultural mistakes worries some overseas qualified nurses (Brunero et al., 2008). This study aims to explore the experience, challenges and practice satisfaction of nurses from culturally diverse backgrounds working with various inpatient mental health settings. The author is aiming to use mixed methodology. Mental health Nursing is a tapestry with complex and rich designs and images woven with the threads of diversity. The inclusions of culturally diverse nurses add to teamwork and leadership strengthens the tapestry.

REFERENCE

Brunero, S., Smith. & Bates, E. (2008). Expectations and experiences of recently recruited overseas qualified nurses in Australia. Contemporary Nurse, 28 (2), 101–110. 2012 The Authors

Adjusting to mental health nursing in Australia. (Focus--Mental health) Joseph, Bindu; Moss, Cheryle; Cross, Wendy

Australian Nursing & Midwifery Journal, 2015, Vol.22(8), p. 42(1) [Peer Reviewed Journal]

Full Text:

Mental illness represents a leading cause of disability burden in Australia; approximately 45% of adults have a mental health disorder in their lifetime (Australian Institute of Health & Welfare 2009; The Royal Australian & New Zealand College of Psychiatrists 2011).

Australia needs a multicultural nursing workforce, and nowhere is communication and cultural understanding more important than in mental health nursing. Ironically, to be able to provide this culturally expert nursing care, nurses who have migrated from other countries need to culturally adapt to the Australian healthcare System generally, and mental healthcare in particular.

Background assessment identified that mental health nursing workforce consists of many overseas trained nurses, with a significant percentage from India. For example, in 20112012, 35.5% of the overseas trained nurses migrating to Australia arrived from India (Health Workforce Australia 2011). Kerala is a small state located in the south west of India, however traditionally Kerala nurses represent about 80% of these migrating Indian nurses.

It is clear that the experiences faced by migrant professionals are different from that of domestic professionals especially with a diverse range of additional 'transition' challenges in the new country. Available research in this topic highlight themes such as isolation, separation Issues, communication problems, underestimation by patients and colleagues, Issues related to enculturatlon and lack of orientation to the new healthcare system and new culture (Department of Health 2009).

In addition, contemporary mental health practice In Australia focuses on primary care and client-led recovery models of care with ongoing carer participation and collaborative planning. It also demands teamwork, assessing clients in their cultural context, engagement, communication and working within the specific legal boundary. Above all, this is likely to be a new experience for migrant professionals, since most of the developing countries still follow a 'medical model' rather than a 'recovery model'. Previous international research in this subject matter mainly focused on overseas nurses working in general nursing areas with a minimal number of studies completed in Australia.

Aware of these cultural challenges for nurses, Bindu Joseph, a PhD student at Monash University and a Clinical Educator at Peninsula Health Mental Health Service decided to investigate this social process more fully. Currently, Bindu is interviewing nurses from Kerala, India and working in mental health In Australia so as to gain insight into what it has been like to make the shift in their work and life cultures, and to contribute to mental healthcare. The project is being supervised by Professor Wendy Cross and Associate Professor Cheryle Moss, who are both interested in cultural issues confronting the nursing workforce. This research will help nurses working in mental health in Australia to understand these transitions and should inform workforce practice and policy.

References

Australian Institute of Health and Welfare. (2009). Health Workforce in Australia and Factor for Current Shortage (1). Melbourne. Retrieved from www.ahwo.gov.au/

Department of Health and Ageing. (2009). Victorian Mental Health Reform Strategy, 2009-2019. Retrieved from http://docs.health.vlc.gov.au/docs/doc/Because-Mental-Health-Matters-Victorlan-Mental-Health-Reform-Strat-egy- 2009-2019

Health Workforce Australia. (2011). National Health Workforce Innovation and Reform (Strategic Framework for Action 2011-2015. (Retrieved from https://www.hwa.gov.au/sltes/uploads/hwa-wir-strateglc-framework-foraction

The Royal Australian and New Zealand College of Psychiatrists. (2011). Support World Mental Health Day. Retrieved from https://www.ranzcp. org/News-policy/Media-Centre/Medla/Support-World-Mental-Health-Day.aspx

Australian College of Mental Health Nursing 41st International Mental Health Nursing Conference –*'Mental Health Nurses: shifting culture, leading change'*

First published: 24 September 2015

DOI: 10.1111/inm.1217

Shifting trends in mental health nursing: Experiences of nurses from CALD backgrounds working in mental health.

Bindu Joseph,1 Wendy Cross,2 Cheryle Moss3

1Peninsula Health, Monash University, 2Monash University, Clayton, Australia, 3Monash University, Clayton, Australia

To meet Australia's multicultural health needs, we need a multicultural nursing workforce and particularly in mental health where communication and cultural understanding additionally important. Ironically, to be able to provide this culturally proficient nursing care, nurses who have migrated from other countries need to culturally adapt to the Australian health care system generally, and mental health care specifically. The mental health nursing workforce consists of many overseas trained nurses, with a significant percentage from India. Indeed, in 2011–2012, 35.5% of the overseas trained nurses migrating to Australia arrived from India (Health Workforce Australia 2011). About 80% of these migrating Indian nurses come from a small state located in the south west of India, Kerala.

This research explored the lived experiences of overseas trained nurses from Kerala working in mental health in Australia using the phenomenological approach informed by van Manen. Data were collected through in-depth interviews of 16 nurses from Kerala, working in different states of Australia. Thematic analysis highlighted themes such as 'feeling vulnerable', 'struggling for identity and approval', 'flexibility', 'sense of loss', 'job satisfaction', and 'ambivalence and apprehension'. This research captured the essence of lived experiences of Kerala nurses. This research has implications for further research, mental health policy making, health workforce development, and education. Even though the researcher explored experiences of particular group of nurses, Kerala nurses, these stories are generalizable to any overseas trained nurse working in mental health in Australia.

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