Received: 27 September 2021 | Accepted: 6 February 2022

DOI: 10.1111/scs.13071

Scandinavian Journal of Caring Sciences

EMPIRICAL STUDIES

A comparison of perceptions of caring behaviours among women in homelessness, Registered Nurses and nursing students

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Funding information
The Swedish Research Council [no 2019-01095] and FORTE [no 2020-00169] funded the project. The funder had no influence on the research process at any stage.

Abstract

Background: The population of women in homelessness in Europe is increasing and women in homelessness experience multiple healthcare needs. However, there is insufficient understanding about how perceptions of caring behaviours compare between women in homelessness as patients and nurses in their clinical practice.

Aim: This study aimed to investigate perceptions of caring behaviours among women in homelessness, Registered Nurses and nursing students.

Methods: A cross-sectional design was used with convenience sampling to recruit groups of women in homelessness ($n = 37$), Registered Nurses ($n = 92$) and nursing students ($n = 142$) in Stockholm, Sweden. Between August 2019 and December 2020, data were collected through face-to-face interviews or online, using the Caring Behaviours Inventory-24 instrument. Data were analysed using descriptive statistics and group-comparing hypothesis tests.

Results: Overall, women in homelessness' perceptions of caring behaviours were significantly lower than nursing students ($p < 0.001$), who in turn scored significantly lower than Registered Nurses ($p < 0.001$). The *Knowledge and Skill* domain had the highest score, and the *Connectedness* domain had the lowest score in all three groups. The ranking of the individual items according to score varied between the groups. However, all three groups had the highest score for the *Knowing how to give shots*, *IVs*, *etc*., item and the lowest score for the *Helping the patient to grow* item.

Conclusion: Healthcare providers and nurse educators should consider incongruences and congruences in caring behaviours to better prepare Registered Nurses and nursing students to contribute to increased health equity, and more targeted clinical practice for women in homelessness.

KEYWORDS

caring behaviours, homelessness, nurse–patient relations, nursing students, registered nurses, women

Sophie Nadia Gaber and Anna Klarare contributed equally to this paper as joint first authors.

INTRODUCTION

Caring behaviours are considered integral to the professional identity of Registered Nurses (RNs) [1, 2] as they refer to the acts, conducts and traits that are undertaken by RNs to provide concern, protection and attention to the patient [3, 4]. Given that RNs and nursing students work and train across diverse populations and settings, it is noticeable that the operationalisation of caring behaviours has not yet extended to all populations, notably women in homelessness. Women in homelessness are seldom included in research, and this motivated the departure point of this study which was to ask women in homelessness about their lived experience of healthcare encounters [5]. Research from the perspective of women in homelessness themselves is needed to redress the potential misalignment between their healthcare needs and the provision of care by RNs and nursing students. This is important because there is limited empirical knowledge comparing the care that RNs or nursing students perceive they are providing and the care that women in homelessness perceive that they are receiving.

The professional identity of RNs has evolved from general altruistic motivation; however, the professional identity develops as RNs are socialised into the profession by meeting colleagues, patients and families [6, 7]. RNs are socialised with the same stereotypes as the general population, and their attitudes influence the delivery of care [8]. Professional encounters and relationships play an important role during times of homelessness and isolation [9], and establishing a relationship is a prerequisite for genuine caring and the creation of a healing environment to promote health and alleviate suffering [4]. Patient-perceived nurse caring is linked to overall satisfaction [9] and perceived quality of health care [10], which in turn may be crucial and even lifesaving when caring for underserved populations [11, 12], such as women in homelessness. To develop relationships characterised by compassion and an authentic presence, as well as to promote satisfaction when caring for persons in homelessness, RNs need to identify their preconceptions and prejudices regarding their caring behaviours [7].

The Ethical Code of the International Council of Nurses (ICN) outlines the four fundamental responsibilities of nursing as promoting health, preventing illness, restoring health and alleviating suffering [1]. Furthermore, the values of respect for human and cultural rights, the right to life and choice, to dignity and to be treated with respect are inherent in the professional identity of nursing. The ICN's values align with the United Nations' Agenda 2030 Sustainable Development Goals (SDGs), specifically, the right to health according to SDG 3 [13]. As homelessness is a compelling public health issue [14], and the right to health is identified as a sustainability goal [13], healthcare providers and nurse educators are challenged to better prepare RNs and graduates to serve this marginalised population's healthcare need.

The social gradient of health proposes that the lower the socio-economic status of an individual, the worse their health [14]. The number of women in homelessness is increasing in Sweden as well as other parts of Europe [15], and of the 33,000 reported homeless in Sweden, 38% were women with a mean age of 39 years [16]. Viewed according to the social gradient in health, women in homelessness experience multifaceted health challenges which necessitate specific types of care and support [5]. There are a range of contributing factors to women experiencing homelessness in Sweden, including domestic violence and substance use [16]. In comparison with their male counterparts, women in homelessness experience increased rates of victimisation, abuse and violence [15], higher levels of mental health issues such as anxiety and depression [17, 18], increased risk of premature mortality [18] and additional responsibilities and stressors related to dependent children [19].

Despite these risks and healthcare needs, research suggests that women in homelessness may report a lower prevalence of unmet healthcare needs compared with women in stable housing situations due to their reduced needs perceptions and lowered expectations of the healthcare system [19]. Groups experiencing health inequities avoid and delay seeking health care [9], and interactions with healthcare providers have been identified as a substantial barrier to engagement for women in homelessness [9, 15]. Moreover, services providing care for persons in homelessness have traditionally been designed for men and may not be sensitive to the healthcare needs of women [5]. The experiences of homelessness for women are complex and intersect with different areas of their lives, including their health, well-being and relationships. Thus, to address health inequities associated with the social gradient in health, it is important to understand the extent to which women in homelessness, RNs and nursing students are aligned in their perceptions of caring behaviours.

Theoretical background

Nursing scholars have attempted to operationalise and analyse the concept of caring [2, 3, 20] and to describe caring behaviours and processes [10, 21] in systematic ways. Watson's (2008) highly influential Theory of Caring situates caring as the interaction between the nurse and patient which encompasses a holistic approach [4]. The holistic approach comprises two dimensions of caring: expressive and instrumental caring

behaviours. Research indicates that a task-orientated approach to nursing has led to an emphasis on instrumental caring behaviours [21, 22]. On the contrary, research shows that patients value receiving both expressive and instrumental caring behaviours, such as the fostering of trusting relationships, as well as the provision of medication and meeting the patients' basic physical needs [3, 21]. Earlier studies have explored how nurses experience their practice of care with persons in homelessness [23]. Other studies have focused on the perceptions of persons in homelessness regarding their healthcare needs and experiences of receiving health care [24]. However, few studies have explored caring as an interaction between nurses and patients, especially with women in homelessness as patients. This is needed to compare the nurses' and patients' perceptions of expressive or instrumental caring behaviours and to highlight potential deviations that in turn influence the way care is delivered and received.

The aim of this study was to investigate perceptions of caring behaviours among women in homelessness, Registered Nurses and nursing students. Based on this aim, the following research questions were posed:

1. Are there any differences in perceptions of caring behaviours between the three groups?
2. What are the highest and lowest perceived caring behaviours in the three groups, respectively?

METHODS

Design

A cross-sectional design and the Caring Behaviours Inventory (CBI-24) were used to collect data among the three groups comprised of women in homelessness, RNs and nursing students. This study adhered to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist for cross-sectional studies.

Participants

A convenience sample of women in homelessness ($n = 37$), RNs ($n = 92$) and nursing students ($n = 142$) was recruited to this study. The sample size was calculated to detect a 10-point difference on the CBI-24 score between the women in homelessness and the RNs and student groups, using a two-sided Mann–Whitney *U*-test (e.g. 120 vs. 130 points) with a standard deviation of 15 points. The study utilised an allocation ratio of 2:1 for students to RNs, to accommodate the larger pool of available students. This indicated the need for a sample size of approximately 35 women in homelessness, 35 RNs and 70 nursing students, accounting for dropout rates at 15%–20% ($\alpha = 0.05$; power = 0.80). The rationale for this sample was to provide a clinical perspective from RNs and nursing students, as well as a patient perspective from women in homelessness, who are underrepresented in healthcare research. By including both RNs and nursing students, this study sought to compare perceived caring behaviours between practising RNs who are already socialised into the profession and students who are currently being trained and educated to become nurses.

The inclusion criteria were speaking Swedish and either (1) being a woman with experience of homelessness, (2) a RN or (3) a nursing student. For the purposes of this study, homelessness was defined according to the European Typology of Homelessness and Housing Exclusion (ETHOS) [25].

The exclusion criteria were (1) women in homelessness who expressed severe anxiety and distress or who presented with violent and/or abusive behaviours, (2) RNs who were not clinically active and (3) nursing students who had not yet experienced a clinical practice placement. All participants were recruited in Stockholm, Sweden.

Instrument

The Caring Behaviours Inventory-24 (CBI-24)

The rationale for using the CBI-24 is that it is an empirical instrument for measuring perceptions of caring behaviours with a clear theoretical framework based on Watson's (2008) Theory of Caring [4]. The CBI-24 instrument consists of 24 items measuring perceptions of caring behaviours among patients and nurses [26]. Each item is answered using a six-point Likert scale, with the answers (scores) ranging from 'Never' (1 point) to 'Always' (6 points). The 24 items are divided into four subscales or domains, measuring different aspects of caring behaviours. Higher overall scores and domain scores indicate higher perceptions of care. The domains are as follows:

1. Assurance (eight items), covering questions about how readily available nurses are to patients' needs and security;
2. Knowledge and Skill (five items), covering questions about nurses' abilities to demonstrate conscience and competence;
3. Respectful (six items), covering questions about how well nurses are attending to the dignity of the person; and

4. Connectedness (five items), covering questions about nurses' abilities to provide constant assistance to patients with readiness.

Data collection

Women in homelessness

Data from the women in homelessness were initially collected between October and November 2019; however, data collection temporarily paused due to the coronavirus pandemic and resumed between September and December 2020.

A research assistant with experience working with women in homelessness approached the women in the waiting area of a healthcare centre catering to persons in homelessness. The women were invited to participate, provided with verbal and written information about the study and had the opportunity to ask questions. Before data collection started, the women provided written informed consent.

For the purposes of this study, data were collected via pen-and-paper questionnaires, using the CBI-24 instrument [26], in addition to general questions regarding background characteristics. However, as part of a research programme with the overarching goal of promoting equal health care to women in homelessness in Sweden, the women also completed questionnaires pertaining to general health, existential health, health literacy, exposure to violence and attitudes towards homelessness at the same time. A research assistant was present at the healthcare centre to assist with the face-to-face data collection. The women were asked to answer the CBI-24 instrument based on how they perceived nurses' caring behaviours at their latest healthcare visit. Upon completion, the women received a voucher equivalent to 25 euros, valid in national grocery stores.

Registered nurses

Data from RNs were collected in October 2019. RNs were recruited during a clinical conference at a university college by researchers who had a poster board and flyers near the refreshments area. RNs were invited to participate, provided with verbal and written information about the study, and written informed consent was obtained at the start of data collection.

SurveyMonkey software was used to collect data using the CBI-24 instrument and questions on background characteristics. RNs answered the CBI-24 instrument based on how they perceived the caring behaviours of RNs in their clinic. General background characteristics were also collected, and upon completion, RNs received a lottery scratch card.

Nursing students

Data from nursing students were collected from August 2019 to November 2019. Nursing students were recruited from a university college through a group message to all students in semesters 3–6 on the learning platform. The message contained information about the study, contact information for the research group and a clickable link to reach the questionnaires. Written informed consent was obtained before data collection on the webpage.

SurveyMonkey software was used to collect data using the CBI-24 instrument and questions on background characteristics. Students were asked to answer the CBI-24 instrument based on how they perceived nurses' caring behaviours during their last clinical placement. Upon completion of the questionnaire, the students received a voucher valid in national cinemas.

Ethical considerations

Participants were given oral and written information about the study, with opportunities to ask questions. Participants were informed that their participation was voluntary and that there would be no consequences if they withdrew from the study. Nursing students were informed that their university coursework and grades would be unaffected by their participation or non-participation. Written informed consent was obtained from all participants, and the data were collected anonymously. In accordance with the Helsinki Declaration [27], this study underwent ethical review and was granted ethical approval by the Regional Ethical Board in Stockholm, Sweden [number 2019-021130].

Statistical analysis

Overall and domain scores were calculated as the mean value of all item scores within a CBI-24 domain. Categorical data are presented as frequencies and percentages, *n* (%), whilst continuous data are reported as means with accompanying standard deviations (SDs). Tests of differences between independent groups were performed using the Mann–Whitney test when comparing two groups and the Kruskal–Wallis test when comparing more than two groups. All statistical analyses were performed using R 4.0.0. (R Foundation for Statistical Computing, Vienna,

Austria), with two-sided p-values < 0.05 considered statistically significant.

Validity and reliability

The CBI-24 instrument has been used extensively and research has shown that it is equivalent to the 42-item CBI instrument in psychometric properties, including high internal consistency and good test–retest reliability when administered by nurses to patients in hospitals [28] and when used by nursing students [29]. As part of the overarching project concerning women in homelessness in Sweden, an earlier study utilised forward and back translation in order to translate the CBI-24 instrument to Swedish and to cross-culturally adapt it for a Swedish healthcare context (CBI-24 SWE) [26]. Cognitive interviews with women with experiences of homelessness ($n = 5$), RNs ($n = 5$) and nursing students ($n = 5$) established good face and content validity [26]. Psychometric analysis of the CBI-24 SWE with RNs ($n = 92$) and nursing students ($n = 142$) indicated that it was a psychometrically acceptable instrument for use in Swedish research contexts, such as the one used in this present study.

RESULTS

Participant characteristics

Tables 1 and 2 present the background characteristics of the 37 women in homelessness, 92 RNs and 142 nursing students, respectively, who participated in this study.

Most of the women in homelessness had experienced homelessness for <5 years (56.7%) and had up to a secondary-level education (75.7%). Their mean (SD) age was 48.4 (10.4) years, which was higher than the corresponding values of the RNs, 45.2 (11.3) years, and nursing students, 31.2 (7.9) years. A high proportion of the RNs (91.2%) and nursing students (92.3%) were female, but their experience levels varied. Most of the RNs (64.1%) had >10 years of experience, whereas being enrolled in the third (29.6%) and fifth (19.7%) semesters were the most and least common answers among the participating nursing students.

Domains of caring behaviours perceived among the three groups

The three groups differed significantly (all p-values < 0.001) in their perceptions on caring behaviours according to the mean scores for the four domains as well as the overall score (Table 3).

TABLE 1 Characteristics of the 37 participating women in homelessness

Variable	Value
Age, mean (SD; range)	48.4 (10.4; 26–68)
Education level, *n* (%)	
Not finished primary school/Other	3 (8.1)
Primary school	11 (29.7)
Secondary school	14 (37.8)
College/University	9 (24.3)
Length of homelessness, *n* (%)	
≤1 year†	8 (21.6)
>1 year but <5 years	13 (35.1)
5–10 years	11 (29.7)
>10 years	5 (13.5)

Note: There were no missing values for any of the reported variables.

Abbreviation: SD, standard deviation.

†Including one woman stating that she had been in homelessness 'for periods'. Homelessness was defined according to the four categories of the European Typology of Homelessness and Housing Exclusion (ETHOS) [25]: (1) rooflessness; (2) houselessness; (3) living in insecure accommodation; and (4) living in inadequate accommodation.

On average, the three groups perceived caring behaviours between 'Occasionally' to 'Always' (mean scores: 3.6–5.4 points). Across all four domains as well as the overall score, RNs perceived the highest level of caring behaviours, and this was significantly higher than the women in homelessness (all p-values < 0.001) as well as the nursing students (p-values between <0.001 and 0.008). Likewise, the nursing students perceived a significantly higher level of caring behaviours compared to the women in homelessness (p-values between <0.001 and 0.038), with the latter consistently perceiving caring behaviours at a lower level.

There were also similarities in the perceptions of caring behaviours between the three groups. The *Knowledge and Skill* domain was perceived at the highest level in all three groups, with mean (SD) values of 4.5 (1.1), 5.4 (0.5) and 5.2 (0.7) in the women in homelessness, RNs and nursing student groups, respectively. Conversely, the *Connectedness* domain was perceived at the lowest level in all three groups, with mean (SD) values of 3.6 (1.3), 4.6 (0.7) and 4.2 (1.0) in the women in homelessness, RNs and nursing student groups, respectively. The women in homelessness perceived the *Respectful* domain (mean 4.2; SD 1.2) at a slightly higher level than the *Assurance* domain (mean 4.1; SD 1.2), whereas the nursing students perceived *Assurance* (mean 5.0; SD 0.7) at a higher level than the *Respectful* domain (mean 4.7; SD 0.8). The RNs

TABLE 2 Characteristics of the 234 participating Registered Nurses ($n = 92$) and nursing students ($n = 142$)

	Registered nurses		Nursing students
Variable	**Value**	**Variable**	**Value**
Age, mean (SD; range)	45.2 (11.3; 25–76)		31.2 (7.9; 20–55)
Female sex, *n* (%)	83 (91.2)†		131 (92.3)
Years in the profession, *n* (%)		Semester, *n* (%)	
≤2 years	2 (2.2)	3rd	42 (29.6)
3–5 years	10 (10.9)	4th	33 (23.2)
6–10 years	21 (22.8)	5th	28 (19.7)
>10 years	59 (64.1)	6th	39 (27.5)

Note: There were no missing values for any of the reported variables.

†Excluding one individual who answered 'Don't want to state'.

TABLE 3 Results on CBI-24 domains for women in homelessness (WIH), Registered Nurses (RNs) and nursing students (NS)

	WIH	RN	NS	*p*-Values			
Domain	**Mean (SD)**	**Mean (SD)**	**Mean (SD)**	**WIH ↔ RN†**	**WIH ↔ NS‡**	**RN ↔ NS§**	**Overall¶**
Assurance	4.1 (1.2)	5.3 (0.5)	5.0 (0.7)	<0.001	<0.001	<0.001	<0.001
Knowledge and skill	4.5 (1.1)	5.4 (0.5)	5.2 (0.7)	<0.001	<0.001	0.008	<0.001
Respectful	4.2 (1.2)	5.3 (0.5)	4.7 (0.8)	<0.001	0.007	<0.001	<0.001
Connectedness	3.6 (1.3)	4.6 (0.7)	4.2 (1.0)	<0.001	0.038	<0.001	<0.001
Total	4.1 (1.1)	5.2 (0.5)	4.8 (0.7)	<0.001	<0.001	<0.001	<0.001

Note: Tests of differences between † WIH and RN, ‡ WIH and NS, and § RN and NS using the Mann–Whitney *U*-test, as well as ¶ overall using the Kruskal–Wallis test.

perceived the *Assurance* and the *Respectful* domains at the same level (mean 5.3; SD 0.5).

Caring behaviours perceived at the highest level among the three groups

Table 4 shows the three highest and lowest ranked caring behaviour items among the three groups.

There was a consensus that *Knowing how to give shots, IVs, etc.*, was the highest ranked item in all three groups, with scores of 4.89, 5.77 and 5.38 points in the women in homelessness, RNs and nursing student groups, respectively. According to both the women in homelessness and the nursing students, *Helping to reduce the patient's pain* was the caring behaviour perceived at the second highest level (4.57 and 5.31 points, respectively). However, the women in homelessness jointly perceived *Giving the patient's treatments and medications on time* and *Helping to reduce the patient's pain* at the second highest level (4.57 points). *Helping to reduce the patient's pain* was not among the caring behaviours perceived at the highest level by the participating RNs, instead RNs perceived *Showing concern for the patient* (5.71 points) at the second highest level. The caring behaviours perceived at the third highest level were *Encouraging the patient to call if there are problems* for the RNs (5.66 points) and *Showing concern for the patient* for the nursing students (5.22 points).

Caring behaviours perceived at the lowest level among the three groups

As shown in Table 4, *Helping the patient to grow* was the caring behaviour with the lowest score among the women in homelessness (3.11 points) as well as RNs (4.07 points) and nursing students (3.73 points). The caring behaviour perceived at the second lowest level was *Returning to the patient voluntarily* for the women in homelessness (3.30 points) and *Spending time with the patient* for the nursing students (3.83 points). RNs jointly perceived *Meeting the patient's stated and unstated needs* and *Giving instructions or teaching the patient* at the second lowest level (4.61 points). The caring behaviour perceived at the third lowest level was *Giving instructions or teaching the patient* for the women in homelessness (3.46 points) and *Being patient or tireless with the patient* for the nursing students (4.34 points).

TABLE 4 Highest and lowest ranked caring behaviours among the women in homelessness, Registered Nurses and nursing students

Group	Item	Mean score	Domain
Women in homelessness	Highest ranked		
	– Knowing how to give shots, IVs, etc.	4.89	Knowledge and skill
	– Helping to reduce the patient's pain	4.57†	Assurance
	– Giving the patient's treatments and medications on time	4.57†	Assurance
	Lowest ranked		
	– Giving instructions or teaching the patient	3.46	Connectedness
	– Returning to the patient voluntarily	3.30	Assurance
	– Helping the patient grow	3.11	Connectedness
Registered nurses	Highest ranked		
	– Knowing how to give shots, IVs, etc.	5.77	Knowledge and skill
	– Showing concern for the patient	5.71	Assurance
	– Encouraging patient to call if there are problems	5.66	Assurance
	Lowest ranked		
	– Giving instructions or teaching the patient	4.61†	Connectedness
	– Meeting the patient's stated and unstated needs	4.61†	Respectful
	– Helping the patient grow	4.07	Connectedness
Nursing students	Highest ranked		
	– Knowing how to give shots, IVs, etc.	5.38	Knowledge and skill
	– Helping to reduce the patient's pain	5.31	Assurance
	– Showing concern for the patient	5.22	Assurance
	Lowest ranked		
	– Being patient or tireless with the patient	4.34	Connectedness
	– Spending time with the patient	3.83	Connectedness
	– Helping the patient grow	3.73	Connectedness

†Tied.

DISCUSSION

Regarding research question one, the results showed that the mean score for the four CBI-24 domains of caring behaviours as well as the overall mean score differed significantly between the three groups and that women in homelessness perceived caring behaviours at a significantly lower level than RNs or nursing students. This incongruence in perceptions of caring behaviours corroborates earlier research which identified differences in perceptions of caring behaviours between patients and RNs [3]. Earlier research has focused on caring behaviours among other patient populations and settings, such as oncology and psychiatric care [3]. However, to the authors' knowledge, this is the first study exploring caring behaviours using the CBI-24 instrument from the perspective of women in homelessness as patients, in comparison with RNs and nursing students. There is an impetus for increasing knowledge about the perceptions of caring behaviours among women in homelessness, RNs and nursing students to align the care provided by RNs and nursing students more closely to the healthcare needs of women in

homelessness, as a growing [16] and underserved patient population [11].

Whilst this study identified incongruences in perceptions of caring behaviours among the three groups, the results also revealed nuances in perceptions of caring behaviours, including a degree of congruence among the three groups. For all three groups, the *Knowledge and Skill* domain had the highest score and *Connectedness* the lowest. The *Knowledge and Skill* domain encompasses behaviours that are more commonly associated with instrumental dimensions of caring in Watson's (2008) Theory of Caring, including questions about nurses' professional skills and confidence with patients [4], whereas the *Connectedness* domain includes behaviours more commonly associated with expressive dimensions in Watson's (2008) Theory of Caring, including *Spending time with the patient* and *Helping the patient grow* [4]. Thus, this study's results suggest that there is a need for healthcare providers and educators to adopt a more holistic view of Watson's (2008) Theory of Caring. This approach would consider expressive caring behaviours in addition to instrumental caring behaviours, according to the perspectives and wishes of patients [22]. This may provide a more balanced and holistic approach to care interventions which are aligned with patients' needs.

With respect to research question two, the ranking of the individual items of caring behaviours elucidated potential tensions between the three groups regarding which three items were given the highest scores. The three items with the highest scores among the women in homelessness were more closely related to instrumental caring behaviours (*Knowing how to give shots*, *IVs*, *etc*.; *Helping to reduce the patient's pain*; *Giving the patient's treatments*; *and medications on time*). By comparison, the three items with the highest scores among the RNs (*Knowing how to give shots*, *IVs*, *etc*.; *Showing concern for the patient*; *Encouraging the patient to call if there are problems*) and nursing students (*Knowing how to give shots*, *IVs*, *etc*.; *Helping to reduce the patient's pain*; *Showing concern for the patient*) may be perceived as both instrumental and expressive caring behaviours. By contextualising these results according to Watson's (2008) Theory of Caring, one may discern a tension about 'doing' as opposed to 'being' caring [4]. The results suggest that the RNs and nursing students perceive that they engage in both 'being' caring through expressive caring behaviours, such as *Showing concern for the patient*, as well as the action of 'doing' caring behaviours through their provision of instrumental caring behaviours, such as *Knowing how to give shots*, *IVs*, *etc*. This juxtaposes the women in homelessness who perceived that they received caring behaviours that are confined to the action of 'doing' instrumental caring behaviours, instead of spending time or helping women to develop. Social interactions and connectedness may be especially valued in times of homelessness [9], and failure to do so, in light of the ICN (2012) Code of Ethics and RNs' obligations to respectfully alleviate suffering, is alarming [1].

Furthermore, it is somewhat surprising that RNs did not identify *Helping to reduce the patient's pain* as one of the caring behaviours perceived at the highest level, whereas the women in homelessness and nursing students did. This highlights a specific caring behaviour where the RNs' perceptions do not align with the perceptions of caring behaviours among the potential patients' (women in homelessness), or indeed the nursing students. There is limited research addressing pain and pain management among persons in homelessness. However, research indicates that persons in homelessness can perceive poor quality care or the denial of care for chronic pain, as well as mental illness and substance abuse [30]. This has been attributed to a clinical bias, as the person in homelessness perceived that clinicians were reluctant to provide care when they were aware of their housing status [8, 30]. The alleviation of pain is a component of health [4] and the SDG 3 of Agenda 2030 states that all members of society, including women in homelessness, have a right to health [13]. Thus, the results from the present study, as well as earlier research, underline the need for RNs to scrutinise their potential implicit clinical bias and their pain management caring behaviours, to better meet the needs of women in homelessness and to align with nursing students' training and perceptions. Otherwise, there is a risk that as newly qualified RNs are socialised into the profession, they will adopt stereotypes and attitudes of the general population [7], and of their more senior colleagues, further perpetuating discrimination and stigma towards women in homelessness within healthcare services.

The three groups agreed that *Helping the patient to grow* was the caring behaviour perceived at the lowest level. However, there was not a clear pattern concerning the other caring behaviours perceived at the lowest level among the women in homelessness (*Returning to the patient voluntarily*; *Giving instructions or teaching the patient*), the RNs (*Giving instructions or teaching the patient*; *Meeting the patient's stated and unstated needs*) and nursing students (*Spending time with the patient*; *Being patient or tireless with the patient*). One may infer that the caring behaviours perceived at the lowest level involve expressive caring behaviours which are relatively more time-consuming, for instance *Being patient or tireless with the patient*, compared with the caring behaviours perceived at the highest level, which included the execution of more instrumental, short-term and task-orientated caring behaviours [21], such as *Knowing*

how to give shots, *IVs*, *etc*. The potential neglect of more expressive caring behaviours that foster health and growth for patients is contradictory to Watson's (2008) Theory of Caring which emphasises that caring should promote health and individual or family growth [4]. However, women in homelessness often have multiple and complex healthcare and social care needs that may be challenging to separate and subsequently require a systematic approach [15]. It is possible that for these underserved women, receiving the basics of short-term, task-oriented caring behaviours seems reasonable, since they live on the outskirts of society and may have experiences of being denied social rights of health and healthcare services [5]. This suggests that healthcare providers and nurse educators need to consider ways to support the health and growth of women in homelessness whilst being cognisant of the multiple barriers that this patient population perceive in accessing health care [9, 23], in particular a lack of stable accommodation, which may challenge long-term caring behaviours, and perceived stigma and discrimination in healthcare service encounters, which may inhibit caring relationships [5].

Limitations

Previous research suggests that different cultural and contextual perspectives can influence perceptions of caring behaviours [31, 32]. However, the language inclusion criteria and the recruitment from a single healthcare centre in Sweden may have limited the potential diversity of this study's sample of women in homelessness. There was an absence of EU migrants or members of the Roma community at the recruitment site for women in homelessness, but had they been present they would have been invited to participate. Moreover, the recruitment of women in homelessness in a large city, such as Stockholm, may limit the generalisability to other smaller cities or more rural areas. Therefore, future research would benefit from broadening the inclusion of participants and considering different cultural and contextual perspectives, particularly aspects of intersectionality related to gender, culture and the experience of homelessness.

This study sought to address the scarcity of research from the perspective of women in homelessness as healthcare users themselves. Research with vulnerable persons is only justifiable if it is responsive to the health needs or priorities of this group and if the research cannot be carried out with a non-vulnerable group [27, 33]. Thus, the involvement of women in homelessness was justifiable due to this study's focus on the women's perceived caring behaviours during their own healthcare encounters. The use of a proxy on behalf of the women, or an alternative group, may have undermined the autonomy of the women in homelessness. Women in homelessness are rarely involved in research and their insights are valuable for this study which forms part of a research programme with the overarching goal of promoting equal health care to women in homelessness [5]. Furthermore, women in homelessness frequently interact with nurses during their healthcare encounters and this was evident at the healthcare centre used to recruit the women in this study. This partly motivated the focus on RNs and nursing students in this study; however, the results have implications for healthcare providers and educators in general. Future research may benefit from exploring perceived caring behaviours among multidisciplinary clinical teams who also work with women in homelessness.

To promote a person-centred approach to data collection, participants were given the option to complete the CBI-24 instrument through a face-to-face interview or online. This was especially important for the women in homelessness who may not have stable access to the internet. Moreover, the women in homelessness were invited to respond to additional instruments as part of the overarching project exploring health issues among women in homelessness in Sweden. Differences in the format and delivery of the CBI-24 instrument may have impacted the results, including the interruption in data collection due to the coronavirus pandemic. Whilst it is beyond the scope of this study, the impact of the coronavirus pandemic on the experience of homelessness, as well as education and clinical practice [34], should be considered in subsequent research. A further methodological limitation was that the CBI-24 instrument has only been psychometrically evaluated among RNs and nurse students, not among women in homelessness.

CONCLUSION

This study's results suggest that the women in homelessness perceived unmet healthcare needs that the RNs and nursing students may be unaware of. This is evidenced by the women in homelessness who perceived receiving caring behaviours at a significantly lower level compared with the RNs and nursing students who perceived providing caring behaviours at a higher level. This study substantiates earlier research among other populations that indicates that instrumental caring behaviours are perceived at a higher level than expressive caring behaviours. This study has identified specific caring behaviours that require consideration to address the social gradient in health and to ensure that the caring behaviours in clinical practice more closely align with the needs of underserved populations and the ICN Code of Ethics. Thus, there is a

need for RNs, healthcare providers and nurse educators to consider both instrumental and expressive dimensions of caring behaviours. This may better prepare RNs and graduates to serve the healthcare needs of women in homelessness and increase the trust in healthcare providers among women in homelessness.

ACKNOWLEDGEMENT

We thank all participants for their contributions to this study.

CONFLICT OF INTEREST

None.

AUTHOR CONTRIBUTIONS

AK, AR and EM designed the study; AK, EM and a research assistant collected data; AR performed all statistical analyses; SNG, AK, AR and EM drafted the manuscript. All authors read and approved the final manuscript.

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How to cite this article: Gaber SN, Klarare A, Mattsson E, Rosenblad AK. A comparison of perceptions of caring behaviours among women in homelessness, Registered Nurses and nursing students. Scand J Caring Sci. 2022;00:1–11. https://doi.org/10.1111/scs.13071