TRANSFORMATORY LEARNING

IN

NURSE EDUCATION

DAWN FRESHWATER

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ABSTRACT

This study aimed to explore the effects of a transformatory learning programme in a group of Project 2000 nursing students. A secondary focus of the study was to monitor the effectiveness of reflexive action research as a tool for reducing the theory-practice gap that persists between nurse education and nursing practice. The learning programme was developed around the process of reflection and evaluated within a framework of a hierarchical model of nursing research and critical social theory.

The first level of research used formal theory to generate an action strategy with a group of first year student nurses (n=42). The action strategy was evaluated after an initial period of six months and provided the data for the level two research. The level two research facilitated a macro view of the learning situation which was then examined in more detail for the level three research. Reflection on action was adopted as the method of generating informal theory with the aim of facilitating a micro view of the learning environment. Data was collected using a variety of strategies, both within methods and across methods triangulation assisted a holistic view of the phenomena under exploration.

The process of transformatory leaning was found to be a notable factor in developing reflective and effective practice amongst student nurses. Additionally, reflexive action research proved an effective strategy for narrowing the theory-practice gap.

The insights gained from the study have considerable significance for informing the future practice of teaching in nursing, not least the challenge that teachers, like nurses, have a professional obligation to develop and review their practical knowledge and explore the effectiveness of their practice. It is proposed that reflexive action research and reflective practice are an appropriate formula for addressing these issues.

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I walk down a street.

There is a deep hole in the sidewalk.

I fall in

I am lost…I am helpless

It isn't my fault

It takes forever to find a way out.

I walk down the same street.

There is a deep hole in the sidewalk

I pretend I don't see it

I fall in again

I can't believe I am in the same place

But, it isn't my fault

It still takes a long time to get out.

I walk down the same street.

There is a deep hole in the sidewalk.

I see it is there.

I still fall in, it's a habit

My eyes are open

I know where I am

It is my fault

I get out immediately.

I walk down the same street.

There is a deep hole in the sidewalk.

I walk around it.

I walk down another street.

(Autobiography in five short chapters by Portia Nelson (1987). Reproduced with kind permission of Lifespace publishing.)

Honouring human experience is an

ordinary human exploration practised here

in the focussed context of research.

(Anderson, 1998)

Excerpt from Reflective Diary Summer 1993

It's one o clock in the morning and I can't sleep. I went to an open day in the University of Nottingham today and met Eric Hall. I only intended to talk really, but once I was there I knew what I was going to do. I feel a mixture of anxiety and excitement. It's only a short time since I completed that damned dissertation for my Bachelor's degree and I swore that was it, I would never put myself through that again. So much for me hating learning. Going back into the teaching environment was a reality shock for me, realising that the theory of student centred and emancipatory education was one thing, but putting it into practice was something else. It just doesn't suit the environment, the teachers, the students, the nurses, life, society and the universe.

I feel quite angry as I write this now; I just had a fleeting memory of myself as a student nurse, some 18 years ago. The image is of me in my first clinical placement, I have been taking temperatures and feeling like such a good nurse, new uniform and everything. I am looking for the Sterets (antiseptic wipes) to clean the thermometers with. My teacher told me that they are kept with every thermometer by the bedside and that the thermometer should be wiped after each use. Perhaps they have run out, I'll go and ask the staff nurse, this will take some courage, I am new to the ward. Perhaps I'll ask the third year student instead (this was another game soon to be learnt). She laughs in my face, "Oh, that's what they told you in school is it, yep, that's what they told me too, you'll soon learn what the real world is like". I am red faced,

humiliated, I return to the temperature round. Silently I tell myself, well, I will carry some Sterets in my pocket so that I can clean the thermometers in between readings. I also tell myself this uniform looks really stupid on me. I carry the Sterets for a while and then I don't. I start to believe what the others believe. Life feels uncomfortable for a while and then it doesn't.

As I re-read what I have just written I realize that the feelings are just as alive today as they were then. I felt powerless to challenge the tradition, whether that was the cleaning of thermometers or the theory-practice gap. How important it was for me to belong to the culture of nursing and I had been waiting for my chance to be a nurse for so long. I wasn't going let a few beliefs and values get in the way! I feel like this now with regards to my role as a nurse teacher, I have a strong belief in emancipatory education, based on my own experience but it goes against the tradition and I am new to my role. Perhaps I should just do my own thing in the classroom and tow the party line outside it. No, that would go against everything I have learnt about transformatory learning. The alternative is to liberate this part of myself and empower others to find their own voice and contact their own beliefs and values about education and caring. Someone once said groups are able to influence change more than an individual, maybe this is what I need to consider. How could this change best be appropriated?

Chapter One

Background to the study

The experience of the work should not be split from the work itself

(Freshwater, 1998)

1.1 Introduction to the thesis

This chapter began with a verbatim exemplar from my own reflective diary, this is similar to the notion of the Japanese haiku in that it contains everything that needs to be said and yet there is so much more that could be expanded upon. This thesis both expands and deepens some of the issues buried within the diary excerpt. Although the research process is presented here as a linear process, each stage was a cycle that led to an expansion outward, rather like ripples in a pond moving outwards from the initial splash. Whilst it is useful to untangle the stages and represent them in a way that facilitates the understanding of the process and guides the reader through the labyrinthine argument, I also wish to honour the circular rhythms of reflection (Johns, 1998), education (Kolb, 1984) and the action research process (Lewin, 1946; Kemmis and McTaggart, 1982).

In the first part of this chapter the research is contextualised and the structure and style of the thesis commented upon. The section entitled 'Researcher as

Subject', which draws on personal experience explaining how this shaped the choice of research topic. The second half of the chapter opens up the issues for discussion, namely those of nurse education, nursing practice and the theory-practice gap (Rolfe, 1996). Concepts that are relevant to the thesis surface at this stage and are further developed in subsequent chapters (these include nursing, nurse education, the theory-practice gap, nursing practice and nursing research).

1.2 Context

Throughout the course of this study I have been working as a teacher of nursing. I have undergone many changes as part of the broader changes in nurse education, I have been a nurse teacher, a tutor and am now a senior lecturer. I work in a College of Health Studies affiliated to a University where I have responsibilities for both undergraduate and postgraduate education. The work in this study has been completed in collaboration with student nurses undertaking a three-year undergraduate programme leading to the Diploma in Higher Education (Nursing).

1. 3 Structure and Style of Thesis

The thesis is being written retrospectively, reflecting on the process and creating meaning out of the events that took place. In the true nature of reflection new insights and interpretations have been added as the thesis has developed. I will be referring to myself in the first person throughout the text. This is based on two assumptions, firstly, traditionally the notion of objectivity and neutrality in research has been conveyed by the use of the third person, in

reality I and other writers believe that the personal beliefs and values of the researcher are always present within the research process (Webb, 1992; Hall and Stevens, 1991; de Groot, 1988). I believe, as does Hall (1986), that there is no privileged position from which to view (without interaction effects) the psyche of another individual. In reality all observation is participant observation. Secondly, it would be contradictory to the basic premise of this study; namely that learning to learn involves a process of acknowledging the subjective self. I acknowledge my self as being in this process of learning with as many parts of me as are currently available, in the words of Denzin and Lincoln (1994) I am a biographically situated researcher.

The use of the words 'nurse' and 'practitioner' will be used interchangeably. Although men and women participated in the study, in general I have used 'she' and 'her' to acknowledge that the majority of the participants were women. The names of the nurses remain as identified within the narrative; this is in accordance with their wish to be known as individuals. Where patients are included names have been changed to maintain their anonymity.

1. 4 Researcher as Subject

There have been many events which have shaped my choice of topic for this study, however the main impetus for the chosen area was that of my own experience as a student, a nurse, a counsellor and a teacher. As an educationalist and a nurse I have been part of the evolving world of nursing for 18 years. In 1989 I returned to part time education predominantly to gain the necessary teaching qualification for my post as a nurse teacher. The

teaching qualification was obtained through a BA (Hons) degree in Nursing. The course philosophy was that of adult learning and was student-centered in its approach. It involved modules which incorporated reflective practice and experiential learning, a new experience for me. Learning was something that had never come easy to me and I was on the course because I needed to be rather than wanted to be. I was in contact with my own sense of powerlessness, feeling that I had no choice, it was what the system demanded. Paradoxically, I also wanted to become a nurse teacher because I felt powerless to change the system and decided that the only way to do this was to move into nurse education. This was the first time that I had taken time out of practice since commencing my nurse training at the age of 18, some 11 years previously.

The process of learning from experience was not always comfortable, it challenged the familiar and through reflection my idea of teaching and education was also challenged. This had not been a part of my nurse training, nor was I aware of using these concepts as a teacher. Already working as a teacher, the course was to have a profound effect upon my work. This period of education and reflection not only enabled me to explore the incongruities between my desired practice as a teacher and my actual practice in teaching placements, but it also allowed me to revisit my beliefs and values about caring and nursing. This, for the first time since coming into nursing. However, whilst these were significant learning's for me, what struck me more was how much my awareness of myself had grown through the process of reflection on my experiences, not only did I become more of myself, but I

remembered parts of myself that had been dismembered. Self-awareness was not an integral part of nurse training as I remember, neither was it included in the curriculum at the time of commencing this study. The process of learning was, for me, a transformatory one (Askew and Carnell, 1998).

The transformatory approach to learning supports the idea of freeing the mind through reflective activity (Askew and Carnell, 1998). As a result of this experience my style of teaching has changed. I feel empowered enough to let go of needing to be in control externally, my locus of control feels much more internal. I have become less concerned with knowing and more able to be with the 'not knowing' in class. I found myself feeling the urge to liberate others through the process of education, whilst being aware that this was viewing myself as holding a powerful position. I noticed that I was less defensive and had more energy available. This was interesting in light of the work of Isobel Menzies-Lyth (1970), as in retrospect I was not conscious that I had been splitting myself off from the work. I became curious to discover what it was that had made the difference and came to the conclusion that I had learnt how to learn (Askew and Carnell, 1998).

The process of learning how to learn began with knowing myself as a human being with a potential for growth and expansion. Knowing myself had facilitated a sense of having more choice of how to respond, I claimed back some of my power (Belenky et al, 1986). None of this had occurred in isolation, the presence of another person acting as external facilitator had been significant. Intuitively, I knew that it was the periods of reflection on practice

that had created the mirror within which I could view myself as a human, ás a nurse and as a teacher. It seemed important then to follow this intuition, come to understand it and explore the use of reflective practice as a tool to develop awareness of self and others both in and out of practice.

1. 5 'Mind the Gap'

My colleagues did not always meet this expansion of my own consciousness with as much enthusiasm as I did myself. I returned to my role as full-time nurse teacher more connected to my beliefs and values pertaining to teaching and ready to test these out in reality. My intention was not to proselytize other members of the teaching staff, however it was difficult not to view both the teaching methods and attitudes towards learning with some disappointment. Despite the fact that the college curriculum document espoused a philosophy of student-centered learning, this was not always manifest in practice. The theory-practice gap was just as alive in teaching as it was in nursing practice. By this stage it was also uncomfortable to live with any sense of inauthenticity and as reflexivity brings with it a sense of moral obligation, I decided that in order to afford a change in the practice of nurse teaching I would need to take action. Thus the main drive for this research study came from my own experience. I say this not by way of apology, but an acknowledgement of meaningful learning, for as Fox (1982) comments:

"There is one characteristic of the good research problem - that it be of interest to the researcher" (page 80).

Furthermore, Walsh Eells (1981) writes that research is motivated by attention to inner desires and reflections and it is through the process of research that these desires are externalized and transformed. In this study, attention will be given not only to the process of acquiring maturity in learning, the shift from pedagogy to andragogy, (Knowles, 1970) and conscientization (Friere, 1972) but also to the deconstruction and reconstruction of self-awareness through the process of reflection. Through this process nurses will be able to gain more access to the self, will be come more identified with the self, will have more of the self available to act as a therapeutic tool and will therefore be able to make more conscious and deliberate use of herself in practice. This in turn will lead to an improved sense of self-worth and value and an increased feeling of meaning and fulfillment (Freshwater, 1998a; Johns, 1998).

It has been important for me to establish a research approach which both allowed for polarities to exist in order that they could be further examined and even transcended and one that was deeply rooted in reflective practice and learning by experience. My own experience also led me to identify the need for a research process that would allow me to begin to challenge established patterns of teaching and learning in nursing. From a reflective stance learning is not seen as a linear process, rather it is a cyclical, spiraling down which deepens with each turn (Gibbs, 1988; Pfeiffer and Jones, 1980).

Like a musical chord many levels can operate simultaneously. Thus the circular processes of action research, reflexive praxis research and reflective practice were brought together in an attempt to raise the consciousness of both

the participants and of myself. Hence, it was decided to embark upon a small-scale study which included myself as an integral factor in the production of the research. This approach is characterized within the thesis by ongoing self-critique. The model of reflexive research adapted from Rolfe (1996) has been framed within the action research cycle and used as the framework for this study as one which fits the determined criteria identified in Chapter Two.

1. 6 Introduction to the research process

The second part of this chapter provides an introduction to the main ideas and concepts that will form the basis of subsequent chapters within this thesis. Given that the research process is anything but logical, systematic or linear, this is a starting point and as such it is important to bear in mind that the situation, the researched and the researcher changed as the research process developed. As you, the reader, journey through this study, you will be challenged to examine your own experience and responses to this piece of work in order to legitimate, for yourself, the research endeavour (Koch, 1998). For the sake of clarity, I will attempt to record accurately events at a suitable juncture. The main impetus behind the area chosen for research is highlighted, alongside some of the events taking place within nurse education and nursing at the time.

The research aims are not necessarily clear within this first chapter, as the development of the same was a dynamic and continuous process, although they are present in embryo in the form of hunches. This represents my experience of the first stages of the research process, at times my aim was

clear and at other times I felt unsure as to what I was attempting to research. On reflection, the more I thought I had 'got it', the more elusive 'it' became. In keeping with the action research approach (Kemmis and McTaggart, 1982; Lewin, 1946) I have tried to avoid the dogma of hypothesis in this initial chapter, the first impression as such. Instead, a more detailed account of the research aims are discussed at a later stage in the thesis (see Chapters Three – Five), just as I was able to clarify the main concepts (nursing, teaching and learning) in the process of carrying out the research. It is five years since the study commenced in proper and longer still since my own educational experience thrust me into the world of research.

1. 7 The Professionalisation of Nursing

Until recently nursing in the United Kingdom could not be considered a profession based on sound 'academic' education (Allan 1989). Issues related to the nature of nursing knowledge have long been debated. Concomitantly, developments in nursing practice emphasized the emergence of the 'expert practitioner' (Benner, 1984), the 'specialist nurse' and the 'advanced practitioner' (UKCC, 1992). These and other changes, not least the move of nurse education into institutes of higher education, have set a challenge for nurse educators, within which lies an opportunity for the advancement of nursing knowledge. In 1986 the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) released the document "Project 2000: A new preparation for practice" (UKCC, 1986). It described the intended outcome of Project 2000 nurse education programmes as producing critical, problem-solving, autonomous knowledgeable professional doers, who would

be able to respond to different situations with flexibility. This publication coincided with the movement of Colleges of Nurse Education into institutions of higher education. With this movement, nursing was forced to examine critically the traditional apprenticeship model of training nurses which had prevailed.

The philosophy underpinning Project 2000 programmes presented learning processes that were congruent with the broader based academic model of higher education, that of adult learning: reflection on experience, self directed learning and independent thought (Knowles, 1984; Rogers, 1983). These changes were also reflected in the post-registration education of nurses. Developments in both the preparation of the nurse and the Post Registration and Practice Project (PREPP; UKCC, 1990) provided ideal opportunities to move away from traditional curricula and teaching methods and towards new, innovative ideas that had a foundation in both the art and the science of nursing. Unfortunately, for a variety of reasons that will be made explicit during the unfolding of this study, this opportunity has not been seized. The move away from traditional education with its focus on technical rationality and the teacher as expert is apparently not an easy one to afford.

1. 8 Nurse Education

Nurse Education has been and it could be argued continues to be in a constant metamorphosis of evolution and change (Burnard and Chapman, 1990). The direction that nurse education should take is a topic that has been surrounded

by controversy; fuelled by the prevailing social, economic and political attitudes (Jolley 1982). At the time of the radical change brought about by the implementation of Project 2000, there was also a time of economic stringency for health care in general. In 1989, Powell noted that the lack of available monies would not only impact nurse education, particularly continuing education for qualified nurses, but would also influence the future of nurse education, given the simultaneous drive for advanced nursing practice. One could question whether or not funding rather than educational principles drove the policy regarding the implementation of Project 2000.

There is little doubt that nurse education is an important area for discussion given that its development can be viewed as a means to enhance patient care through nursing care and the nursing profession (Johns, 1995b; Burnard and Chapman, 1990; Powell, 1989; Jolley, 1982). Powell (1989) recommended that nurse education acquired a deeper and higher understanding of nursing and its contributing disciplines. However, she also commented that this deeper understanding needed to come from practice and applied knowledge, suggesting reflective practice as a way forward (Schon, 1983). Atkins and Murphy (1993) are in accord with this view adding that practice experience is central to nurse education. It will be hypothesized that a way of acquiring a deeper and higher understanding of nursing is to acquire a deeper understanding of the people who carry out nursing, the nurses themselves.

Whilst schools of nursing are being asked to clarify the role of nurse education, nursing practice has been given the task of implementing clinical

supervision (UKCC, 1996; Butterworth and Faugier, 1992) and evidence based practice (Department of Health, 1989). The development of nursing theory and the acknowledgement of the differing sources of knowledge has brought to a head the argument that nursing theory and nursing practice must be founded on a scientific (research) base (Osbourne, 1991; Akinsanya, 1985). There has been much debate as to whether nursing is a research based profession. This is something that was identified in the Report of The Committee on Nursing chaired by Briggs (Committee on Nursing, 1972) which stated that 'research mindedness' should be encouraged in nurse training.

This shift of focus to *evidence-based practice* may recognize the importance of nursing but there is some doubt as to whether it sufficiently recognizes the process and experience of nursing and of nursing practice as theory generating (Page, 1996). (This is an argument that is further developed in the latter stages of the thesis). A shift such as this would sit more comfortably with the concepts of reflective practice and student-centred experiential learning and has the potential to offer nurse education access to an emancipatory curriculum. One of the most pressing problems however is that of narrowing the gap that prevails between the theory and practice of nursing (Rolfe, 1996; McCaugherty, 1991; Gott, 1984). The notion of the theory-practice gap will be more fully defined within the subsequent chapters; however, some of the salient points are highlighted here in this preliminary preamble to help place the research aims within an explanatory framework.

The theory-practice gap in nursing has an established history and has been well debated, though to some extent it remains poorly understood (McCaugherty, 1991). Clarke (1986) highlighted three main problems around the relationship between theory and practice:

- the separation of theory from practice
- reality versus the ideal
- nursing adherence to a scientific paradigm versus adherence to an arts paradigm

Nurse education (and implicitly institutions of nurse education) has been heavily criticized for espousing caring ideals that do not match up to the reality of clinical practice and a number of official reports have been commissioned to explore this (Committee on Nursing, 1972; Nuffield Provincial Hospitals Trust, 1953). Indeed the diary excerpt, which began this study, provides an example of this in action. It has been suggested that the theory-practice gap is one of the main causes of frustration and dissatisfaction leading to wastage of students and qualified nurses (Fisher et al 1994; Allan, 1989). Fisher et al (1994) categorically state that:

"Registered nurse turnover may represent the single most serious human resource issue in health care today" (page 950).

Hancock (1999) speaking at the Royal College of Nursing (RCN) Education conference informed the audience that of the many thousands of qualified nurses in the United Kingdom, a large number were not maintaining their registration. Of those that are currently on the register only 68% are in employment. The pre-registration story is no better. According to the Royal College of Nursing (RCN, 1998), there are currently 57,000 nursing students,

of which 38,000 will qualify. Added to this, recruitment of nursing students is down by 15%, despite a £2.5 million recruitment campaign (Scott, 1998). The debate around student recruitment has recently heated up as Frank Dobson, the current Secretary of State for Health, claims that:

"the current shortage of nurses is in part caused by the introduction of Project 2000 and the move of nurse education into higher education" (Hancock, 1999).

Shortages of nurses are running at the highest levels for 25 years, therefore the attrition rate amongst students is no longer just an issue for academic institutions, but for the whole of nursing, not to mention the users of healthcare, namely the public. At the 1998 RCN Congress in Bournemouth, the subject of student nurse attrition was floored and amongst the many questions posed was:

"has the increasingly academic content of courses as well as a lack of understanding of the day-to-day practice of nursing contributed and compounded the problem?" (RCN, 1998; page 2).

Allan (1989) asserted that reducing the gap between theory and practice on educational courses would assist the reduction of student wastage and the loss of registered staff thereby improving nurse education and patient care. This seems rather naïve, whilst the theory - practice gap is of great concern to the whole of the nursing profession, it is only one of the factors influencing the attrition and retention rate in nursing. More significant factors, which also have a long history, include feeling undervalued, powerlessness and

oppression within a structural hierarchy, experiencing the locus of control as external and living with a sense of disillusionment and meaninglessness (Scott, 1998; Johns, 1995a; Roberts, 1983; Friedson, 1970; Rotter, 1966). A recent report also indicated that young people considered nursing a low status activity, with poor working conditions (Department of Health, 1998).

There is little doubt that nursing and nurse education is presented with a challenge in response to these significant issues. Meeting this challenge is not simply a question of identifying where espoused theories and theories in action are in contradiction (Arygris and Schon, 1974) and, although evidence-based practice certainly demands that nurses maintain a closer compatibility between their caring beliefs and their nursing care. However, this is often approached by examining evidence as if it were external to the practitioner, with little attention to the body of evidence based practice that the nurse carries around within them (Benner, 1984). Thereby reinforcing the feeling that the locus of control is external to the nurse (Roberts, 1983).

It is argued that for the theory-practice gap to be addressed:

"there has to be recognition of the interdependent and dynamic relationship between theoretical and practical knowledge. One is not superior to the other, and both are essential to improving patient care." (Nolan et al 1998; page 275).

When addressing the theory-practice gap, it is also important to make clear that it is not that nursing theory does not describe 'real nursing', rather, it is that what is taught in the classroom is not what is practiced in the clinical situation. Attending to the theory-practice gap in the classroom by

emphasizing the value of experiential knowledge *may* be one way of addressing some of the difficulties currently experienced in recruitment and retention in nursing. However, I will argued here that this in itself will have little effect, if the nurse's who bring the experiential knowledge are not also valued. In order for this to happen a shift in locus of control is necessary, not only in the world of education and practice, but also within the practitioner herself. Nurses are also required to challenge the barriers within themselves in order to recognize and own their feelings for themselves; this includes their personal power and authority.

1. 9 'Mind the Gap' again

The external polarization described between theory and practice has also been identified as an internal split deeply embedded psychologically within the practitioner (Menzies-Lyth, 1970). I would also argue that the focus on the theory-practice gap away from the practice area and towards research and higher education perpetuates the split not only in the external world, but also within the inner world of the practitioner. The work of Isobel Menzies-Lyth (1970) on psychological defences in social systems highlighted this internal splitting process. Her work with doctors, nurses and administrators in hospital settings found that they viewed patients as objects in order to be able to cope with their strong and often ambivalent feelings towards them. The closer and more concentrated the relationship with the patient, the more likely the nurse was to experience anxiety. The process of splitting off feelings is both an inner and outer process (Briant and Freshwater, 1998; Klein, 1975). Thus the nurse manages her anxiety by splitting her feelings off both from herself (inner

world) and from her patients (outer world; Menzies-Lyth, 1970). As a result of this splitting off the nurse can become dis-identified with aspects of her own psyche and/or bodily experience. The nurse is therefore disconnected from the source of her caring - the self. This inner split was also found to be inherent in the nursing service, which advocated splitting up contact with the patient through task allocation. This was certainly my own experience as early on in my nursing career I found myself carrying out the 'observations' whilst another nurse would approach the same patient to perform 'wound care'. The same patient would be greeted by yet another new face for their 'pressure area care'.

Sadly, some of Menzies-Lyth's findings still hold strong today, with many nurses' preferring 'busyness' and 'doing' to 'relating' and 'being'. It was only ten years ago that Menzies-Lyth (1988) noted that although some things had changed in the organization of nursing, there were no major changes. She continues to argue that nurses require legitimate opportunities to understand their personal feelings, perceptions and anxieties. Jacobs (1988) further argues that the struggle to polarize object from subject involves denial and repression of self, this is energy sapping and takes up psychic space, leaving the individual practitioner with less of her emotional self available, either for herself or her patients and perhaps as importantly for the argument for the process of learning.

Being available and creating space for therapeutic work are fundamental to the implementation of reflective practice (Johns, 1998). Several authors note that

self-awareness is an essential component of the reflective process (Mezirow, 1981; Schon, 1983; Atkins and Murphy, 1993). The development of self awareness however is something that requires structured time and space for self reflection as indicated in Schon's Model 2 Learning (Schon, 1983). This is something that nurse education, despite its acknowledgement of reflective practice, does not easily provide, either in clinical practice or in educational institutions. Whilst the current argument for structured time for reflection in the form of clinical supervision is to some extent addressing this issue (Bond and Holland, 1998; Johns 1998; UKCC, 1996), this process is beset with its own difficulties. If we are to believe that the findings of Menzies-Lyth (1970) still hold some credibility today, then could it be that nursing *per se* might find the space and time to reflect on self and therein practice an uncomfortable pastime. These and related concepts are central to the development of this study and their relevance to the process of nursing and nurse education will be expanded upon in Chapters Three through to Six.

The bridging of the theory-practice gap could be seen as the outer manifestation of the inner repair that could also be taking place. Perhaps the resistance of the coming together of theory and practice in nursing speaks not only to the lack of integration in education and practice, but also to the resistance of nurses themselves to become conscious of and live with the tensions or anxieties within their everyday practice and within themselves. It is argued that the theory-practice gap needs to be addressed not only from the outside in but also from the inside out and it is this that will be developed as a theme in the course of this work.

The experience of inside-out learning (Askew and Carnell, 1998) as a tool to assist nurses to feel empowered will be one of the main issues explored through this thesis. In order to feel empowered, the nurse first needs to become aware of or understand what it means to be disempowered, but as importantly of the ways that they may be dis-empowering themselves. This requires that the nurse knows themselves self as subject, and thereby her patient as subject. Thus inferring that nursing practice is a subjective experience. **It is the subjective experience of self and self as a nurse and the transformation of this experience through experiential learning that will be the main focus of this study.**

1. 10 Nursing Practice and Locus of Control

Nursing practice has traditionally been viewed through a scientific lens, depending upon a medical model which is firmly rooted in the scientific method and philosophy (Clarke, 1986). The professional knowledge that has driven nursing practice comes from a model of technical rationality that has dominated the thinking about professions and has shaped professional practice (Appleton, 1994; Schon, 1983). Historically, definitions of nursing have derived their origins from medicine with nurses being socialized into the position of having little or no voice (Johns and Hardy, 1998b). A wealth of literature is available to suggest that nurses experience themselves as dominated by the medical profession (Brunning and Huffington, 1985; Capra, 1982; Friedson, 1970).

Johns (1998a) has challenged the process of nurse education for its lack of attention to the social forces that serve to oppress nurses, claiming that this could be a projection of their own lack of voice. Could it be that nurse education is itself a form of oppression by the very fact that it does not attend to this issue? It is proposed here that nurse education attends to this issue immediately, nurse teachers need to find their own voice in order to empower their students. One way nurse teachers can do this by examining their own contradictions in educational practices and making their beliefs and values known through their work (Freshwater, 1999).

Nurses in practice, like teachers, often live with contradictions regarding their desired practice and the practice that they can carry out in reality (Johns, 1995a). Although some autonomy is afforded the nurse practitioner, many decisions are still perceived as resting with the doctor. The locus of control is seen as external (Rotter, 1971; 1966). This impacts work performance, as Mullins (1989) clearly articulates in his discussion around the attribution theory of motivation. Nurses, however, do not remain completely silent within their practice, in the struggle to have their voice heard, a game is often played (Berne, 1991; Stein et al 1990; Stein, 1978; 1967). The 'game' goes something like this, the nurse make a suggestion to the doctor in such a way that the doctors seems to have made the suggestion themselves, if the doctor joins in, then all parties feel happy and the patient gets the care that the nurse believes to be appropriate. If the doctor opts out of the game, the nurse is left feeling frustrated and may still carry out the care that she believes to be appropriate ignoring the doctor or alternatively she will carry out the doctor's orders,

ignoring herself. The nurse may then become angry with herself for 'giving in' or playing the game, at times she may take her anger out on the patient. The model of transactional analysis offers a useful perspective on this game; the nurse can shift between rebellious child and compliant child and nurturing parent and critical parent. The doctor also takes his share of roles on the stage (Hough, 1994; Berne, 1991). This is not to say that nursing practice is never based on adult decisions, nor that nurses always feel powerless. Indeed choosing to play the game represents an active stance, whether the choice is conscious or unconscious.

Active choosing is an intrinsic factor within all human actions whether preceded by reflection or not (Burns, 1982). There is however a substantial amount of evidence to support the notion that nurses have been and continue to feel oppressed, whether or not this is real (external) or imaginary (internal) is open to debate, the fact remains that it impacts retention and recruitment and thereby continuity of care (Scott, 1998; Fisher et al, 1994; Roberts, 1983; Friedson, 1970). Spencer (1986) observed that employees, when feeling oppressed, chose to leave and go to a competitor, which was viewed as relatively safe behaviour. Alternatively, the employee could attempt to change the situation through direct action and voicing. This was felt to be more risky. This research study, drawing upon critical theory, posits that reducing the theory practice gap through reflective practice and self-awareness provides an opportunity to address the perceived power imbalance through voicing and action which in turn directly and indirectly affects practice.

1. 11 Summary

This chapter has surfaced some of the main concepts to be explored within this thesis. I have revealed some of the salient points to be expanded upon as part of this research study and included a brief overview of the personal experiences which have partly created the motivation for the underpinning principles behind the research. In summary these are that the theory-practice gap is a significant issue in nursing and nurse education and can be narrowed through attending to the value and power that nurses attribute to themselves and their experience; that nurses have and continue to locate their locus of control externally and that this can be addressed through the process of education; that nurses experience themselves as powerless which leads to a sense of disillusionment and dissatisfaction; that nurses dis-empower themselves through a lack of self-awareness; that transformatory education is a tool that has the potential to facilitate self-awareness, empowerment and emancipation in nurses; that as a result of transformatory learning, nurses have more of themselves available as a therapeutic tool in patient care, thereby influencing patient outcomes. Chapter Two moves on to explore these issues from a methodological standpoint, and an action research framework is posited as a suitable approach to explore the above principles (Rolfe, 1996; Kemmis and McTaggart, 1982; Lewin, 1946).

Chapter Two

Research Design, Methodology and Method

That which is to be transformed is also the agent of transformation

(Freshwater, 1998a)

2.1 Introduction

Chapter two brings together some of the considerable deliberations that surrounded the search for a research framework that was both congruent with reflective practice and would attend to the gap between theory and practice. It may appear out of context for a methodology chapter to be placed before the main concepts are defined and the topic area is fully discussed. However, it will become evident that this chapter does not address the methods of data collection and analysis used within the study, rather it sets out to explicate the broader contextual and research frameworks used as epistemological and ontological foundations for the work. This raises a further issue, as action research is carried out within a social situation by people directly concerned with that situation, the research method cannot be divorced from the work itself.

The context is part of the research and as such influences the researcher and the research process. Separating the research methods from the practice perpetuates the theory-practice split. It therefore seems paradoxical to set aside this chapter

from the rest of the work, as it is addressing methodological issues. However, these are not separate from the context, rather the exploration of critical theory and reflexive practice as research methods are important aspects of contextualising the research frame. The main areas of exploration within the chapter relate to the action research cycle, reflexive practice, praxis and critical theory. Early on generic issues of research methodology are considered. These are then linked to the theory-practice gap in nursing and the concerns that many authors raise regarding the impact of nursing research on nursing practice. Action research is posited as one way of narrowing the theory-practice gap and it is explored as a method of critical intent and conscientization (Friere, 1972). It is then linked to the model of transformatory learning and reflective practice. Finally a hierarchical model of research is explicated and is used as the basis for the choice of methodological framework in the study. The final summary offers signposts for the research process and is followed by chapter three, which begins to define the main concepts in depth, in order that the research aims can be refined and aims clearly stated.

2.2 Methodological Considerations

Qualitative and quantitative approaches to research have often been viewed as deriving from opposing and opposite philosophies of science and the debate as to the potential merits and shortcomings of quantitative and qualitative research is as much rehearsed in nursing as in all social sciences (Webb, 1996; Duffy, 1985).

Each paradigm purports a specific methodology to gain knowledge. Mishler (1979) distinguishes the salient points of each philosophy.

Qualitative research:

a. intertwines observer and phenomena

b. has many different but equal truths

c. seeks to understand the meaning of phenomena

d. has a holistic approach to analysis

e. has increased validity

Quantitative research:

a. relies on an outside observer being separate from the phenomena

b. seeks one truth to explain a phenomena

c. examines causal relationships

d. strips the context of assumptions

e. has increased reliability

Quantitative or positivist research aims to test hypotheses, using 'objective' measures and predicting and controlling phenomena. Hypotheses are generated by logical inference from previous research, library searches and intuitive grasp (Morse and Field, 1996). Hence this deductive style of research commences with sets of concepts which are then made operational. Morse and Field (1996) state that:

"Quantitative research looks for relationships between variables so that causality may be explained and accurate prediction becomes possible. The aim is to examine the experimental variables, while controlling the intervening variables that arise from the context" (page 9).

It could be argued that the context is stripped of its meaning. In contrast qualitative or interpretative (sometimes referred to as anti-positivist) research focuses on the process of understanding human experience rather than seeking to control or predict it (Webb, 1996; Polit and Hungler 1993). Quantitative and qualitative methodologies evoke criticisms of their epistemological bases and both have their methodological limitations. Whilst it is not possible to do justice to both sides of the quantitative-qualitative debate here, some issues are pertinent to the study and will be attended to in brief.

Quantitative research methods are often criticized for reducing individuals to an object made up of separate parts rather than a dynamic whole. However, this objective approach is often viewed by the scientific world as producing more valid and reliable data as the researcher also treats themselves as an object within the research process, that is beliefs, attitudes and feelings are as far as possible kept out of the research findings. Porter (1993) likens this to 'naïve realism' and the positivist adherence to the language of neutral observation.

Qualitative methodology is often contrasted with quantitative research methodology and is reported to focus more on the subjects of the research within

their context, moving between the parts by way of perceiving the whole picture. It is a much more subjective approach recognizing both the experience of the participants and the researcher. This approach has been adopted by nursing almost without question, with many nurses being critical of the positivist paradigm which has hitherto dominated the profession. Examples include nursing theorist Parse et al (1985) who writes of a human science approach to research which is useful when working with subject matter not amenable to the experimental and investigative methods of the natural sciences. This has been built over a period of time, borrowing from the work of Martha Rogers (1970). Leonard (1994; 1989) argues that personhood cannot be approached scientifically and Newman (1994) categorically states that:

"research that produces data as outcome is not enough" (page 92).

Whilst there is little doubt that qualitative methods allow for the subjectivity of the researcher, Porter (1993) argues that it is flawed in that it still assumes the possibility of objective knowledge, this she states is mirrored in the language used. Reflexivity is posited as an alternative theoretical base and will be revisited at a later point in this chapter.

2.3 Mind the gap, Research and Practice

As nursing research is becoming more established there is an increasing interest in the variety of research approaches and their theoretical perspectives. However, many authors contest the value of nursing research which it would seem is often not used in practice.

Tierney (1996) reports that the mere existence of research cannot change practice, the research has to be used. Many authors have expressed their concern about the apparent lack of impact that nursing research has made on practice (Le May et al, 1998; Bircumshaw, 1990). Sheehan in 1986 asserted that applying research findings in nursing practice is perhaps the biggest challenge facing nursing research. Walsh and Ford (1989) for example, confronted the myth and ritual surrounding nursing practice, arguing that nurses behaved in certain ways because they had always behaved in this way. Greenwood (1984) rationalized that nurses because of a lack of knowledge and a lack of belief regarding the findings did not use research. She added that often nurses do not find the research findings relevant to their practice acknowledging that they are often not relevant concluding that:

"Nursing is a practical activity, it is aimed at bringing about change in the physical, emotional and social status of persons - the problems that confront nurses are essentially practical problems concerning what to do" (1984, page 78).

She adds that nursing research has tended to approach nursing as if it were a theoretical activity. Miller (1989) concludes that theory and research grounded in practice has far better potential for improving the effectiveness and the knowledge base of nursing practice and reducing the theory practice gap. These comments are echoed almost 10 years later in the findings of a study to explore the research culture of nursing (Le May et al, 1998).

The apparent skepticism with which nursing views research findings seems to me to be a useful vehicle for change. Isn't it the case that in teaching nurses how to apply research, they are encouraged to view research reports with a critical eye? Surely some degree of skepticism is required? The issue appears to be one of whether or not the skepticism prevents the nurse from testing out the research in her local practice to ascertain the level of match with her own hypotheses. A further dimension is also commented on in the literature concerning the implementation of nursing research in practice, namely that it is mainly carried out by people removed from the area of practice, that is academics and nursing theorists (Rolfe, 1996). Rolfe (1996) makes a distinction between the nurse-practitioner and the nurse-technician comparing this to the work of Elliott and Ebbutt (1985) who describe 'knowledge appliers' and 'knowledge generators'.

It could be argued that practitioners dominated by the medical paradigm continue to perpetuate the research-practice gap by their (unconscious) adherence to the technical rationality model. This in itself is an active stance, for although it may appear on the surface that practitioners collude with employing theory that is handed down from the dominant paradigm, the fact that the research findings are not implemented implies that the collusion remains superficial. There is an active stance in the avoidance of applying the research findings. Perhaps this is a further manifestation of the power struggle previously mentioned around the doctor-nurse game.

Whilst being actively engaged in the debate about the epistemological and the methodological credibility of research approaches to nursing is commendable, it would seem that the debate itself could be limiting. The researcher is apt to get polarized into an either/or position, rather than seeing an alternative beyond the two opposing approaches. In the heat of the debate a power struggle ensues, each researcher seeing their own paradigm as the 'right' one for the job. And although the power relationships between the participant and researcher differ in each approach, they are nevertheless inherent within the research process itself (Webb, 1996). In response to the criticisms of both the qualitative and quantitative paradigms, a third approach to social research has been developed calling itself critical science (Fay, 1987). Critical science aims at critique, its mode of inquiry is derived from the epistemological base of emancipatory cognitive interest (Mezirow, 1981). One of the aims of critical science is to expose power imbalances, through revealing to people the nature of the crisis within their lives. This requires that the individuals concerned have an interest in self-knowledge and self-reflection. By adopting an active stance towards developing critical self-awareness, the individual can take action to emancipate self; feeling empowered by their new awareness (Webb, 1989; Fay, 1987; Allen, 1985; Mezirow, 1981).

As a critical theorist and a central figure in the hermeneutic tradition, Habermas (1972) categorized human knowledge into the technical (empirical), the practical (interpretative) and the emancipatory (critical knowledge). Mezirow (1981)

frames these categories in terms of social existence relating them to work, interaction and power. Fay (1987) conceptualizes critical social science in much the same way, describing it as scientific, practical and critical. Habermas (1972) argues that one of the purposes that knowledge serves is to maintain the influence of powerful people and regimes, keeping other people down. Critical theory offers freedom from subordination through systematic reflection and critique.

Whilst Habermas (1972) appears to argue against the idea of prejudice and to some extent for neutrality (as opposed to objectivity), Gadamer (1989), who has also made an important contribution to hermeneutics, rehabilitates the notion of prejudice in the sense that he argues that a value-oriented approach is unavoidable. This argument is based on the idea that all research contains a pre-understanding originating in the researcher. Gadamer (1989) implies that rather than getting in the way, these values may make the research more meaningful to its readers. Habermas (1972) and Gadamer (1989) seem to be espousing similar ideals - the legitimate use of power, each approaching the individual situation from a slightly different stance. However, both of these concepts require a degree of reflexivity in order for the individual to be aware of their prejudices (either to transcend them or utilize them consciously).

Change is the main interest of critical reflection as Taylor (1998) remarks:

"may mean freedom from people's previous perceptions of themselves and their circumstances, and freedom to change to something that is better for them" (page 144).

For Habermas (1972), reflective activity with critical intent was the way to freeing the human mind. Critical intent is similar to the process of empowerment briefly touched upon (Fay, 1987), that is an investigation and reconstruction of moral and social involvement that aims to achieve enlightenment and emancipation. The act of bringing critical intent to bear on a problem is an act of reflection (Habermas, 1972) which may lead to perspective transformation (Mezirow, 1981). Mezirow (1981) suggests, insights gained from critical intent are only emancipatory in the sense that they transform consciousness. The individual is not only more aware of their own biography (history) but also feels more of an authority on how the story will continue to be written. However, a transformation of consciousness does not necessarily lead to a change in action. And in turn, change does not necessarily equate with improvement, as Rolfe (1996) comments:

"...although this approach (*action research*) is guaranteed to bring about *change* by impacting directly on the clinical situation, it does not necessarily bring about *improvement.*" (page, 1317). Action research is one method of carrying out critical science for change. As a research approach action research has been growing in popularity in nursing over the past decade, with nurse researchers

seeing it as a way of bridging the theory – practice gap. It is to this that I will now turn my attention.

2.4 Research as Critical Intent

Action research has been described as a tool to change society and generate knowledge, which at its best is emancipating and empowering (Hughes, 1997). Educational action research has been used to help teachers cope with the challenges of change, helping them to carry through innovation in a reflective way (Altrichter et al, 1993). Altrichter et al (1993) relate this to the climate of rapid social change that prevails, which apart from challenging stability, they argue offers exciting possibilities for building a more dynamic educational system. Lewin (1946) viewed action research as a democratic approach to research, not because it introduced democracy, but because it embodied democratic principles.

Winters (1989) identifies action research as an activity which is an integral part of professional work thus avoiding the split between theoretical and practical understanding. Action research can therefore act as a bridge between research, theory and practice (Somekh, 1995). Greenwood (1984) is a particularly strong advocate of action research claiming that it is the most appropriate method for the discipline of nursing. Critical of the poor uptake of research by nurses, she believes that action research is the way to address the theory – practice gap.

There are several forms of action research, three main types have been identified within the literature, these are technical and positivist; collaborative and interpretative; critical and emancipatory (McTaggart, 1992; Zuber-Skerritt, 1991). Zuber-Skerritt (1991) explicates the three levels of action research further:

1. Technical action research aims at effectiveness and efficiency in performance, that is changes in social practices. Participants are often co-opted and rely on an outside expert.
2. Practical action research involves transformations of consciousness of participants as well as change in social practices. The expert acts as a process consultant, engaging in dialogue to encourage both the cooperation of the participants and self-reflection.
3. Emancipatory action research includes the participant's emancipation from tradition, self-deception and coercion. The expert is a process moderator, collaborating and sharing equal responsibility with the participants. Having more involvement with the participants emancipatory action research has the potential to generate and test action theories, thereby developing and empowering practitioners. Carr and Kemis (1986) suggest that emancipatory action research is the only true action research.

In discussing the three types of action research Zuber-Skerritt (1991) does not make it clear what he means by the term expert and this can lead to some confusion, not least because action research is more often deemed to be not only

participative, but also collaborative. It would seem that Zuber-Skerritt uses the term to reflect the role of the researcher rather than the literal expert.

Cohen and Manion (1989) inform us that action research is situational, that is, it is concerned with diagnosing a problem in a specific context and attempting to solve it in that context. Action research is usually collaborative, the researchers and the participants work together. It is self-evaluative and modifications are continuously made within the ongoing situation. Therefore action research is essentially developmental, longitudinal and multi-dimensional and requires reflection at different levels. The evaluation itself consists of two stages, firstly a diagnostic stage in which the problems are analyzed and hypotheses are developed and secondly a therapeutic stage when the hypotheses are tested by a consciously directed change experiment.

The self-evaluative nature of action research is an essential component both of nursing (Greenwood, 1994) and of reflective practice (Johns, 1998a). This approach is not only suitable to learning but is particularly applicable to the current research project. One might be justified in challenging whether or not research carried out by the practitioner and involving self evaluation can ever be reported in an unbiased or undistorted way. Research that simultaneously describes and constitutes a social setting has been termed reflexive (Rogers, 1983). Rather than attempting to eliminate the effects of the researcher, reflexive researchers try to understand them, the objective/subjective dichotomy is seen as

unproductive (Porter, 1993). Kemmis (1993) points out that it is impossible to analyse praxis from a value free, neutral stance. Lather (1986) agrees stating that: "just as there is no neutral education, there is no neutral research" (page 257). Further, it could be argued that viewing action research as biased or distorted misses the purpose of action research as facilitating self reflection in the practitioner, who will therefore discover previously unrecognised distortions of action and in turn endeavour to make changes to their practice. Hence all interpretations of meaning from action will always be relative.

Reflexivity is an important concept, not only in critical science to ensure that the object of critical intent is far as possible critically appraised, but also in the carrying out of action research and reflective practice. The idea of reflexivity was central to the development of George Kelly's personal construct theory (1995). As Kelly says:

"we can turn our mind back on to itself and contemplate our own contemplation's" (page 60).

Kelly (1995) posits that in the process of reflexivity we become our own personal scientists. Rolfe (1998) illuminates a similar process in nursing through the work of Benner (1984) and Schon (1983). The reflexive practitioner argues Rolfe (1998), is able to modify their practice on the spot responding to their hypothesis testing. This cycle of continuous conscious reflection in action is recognized both in education and the research process. Examples include Kolb's (1984) experiential learning cycle (see Figure 2.1), Pfeiffer and Jones' (1980; Figure 2.2)

learning cycle and Poincare (1952) and Wallas (1926; cited in Neville, 1989) stages of learning, all of which follow a similar pattern.

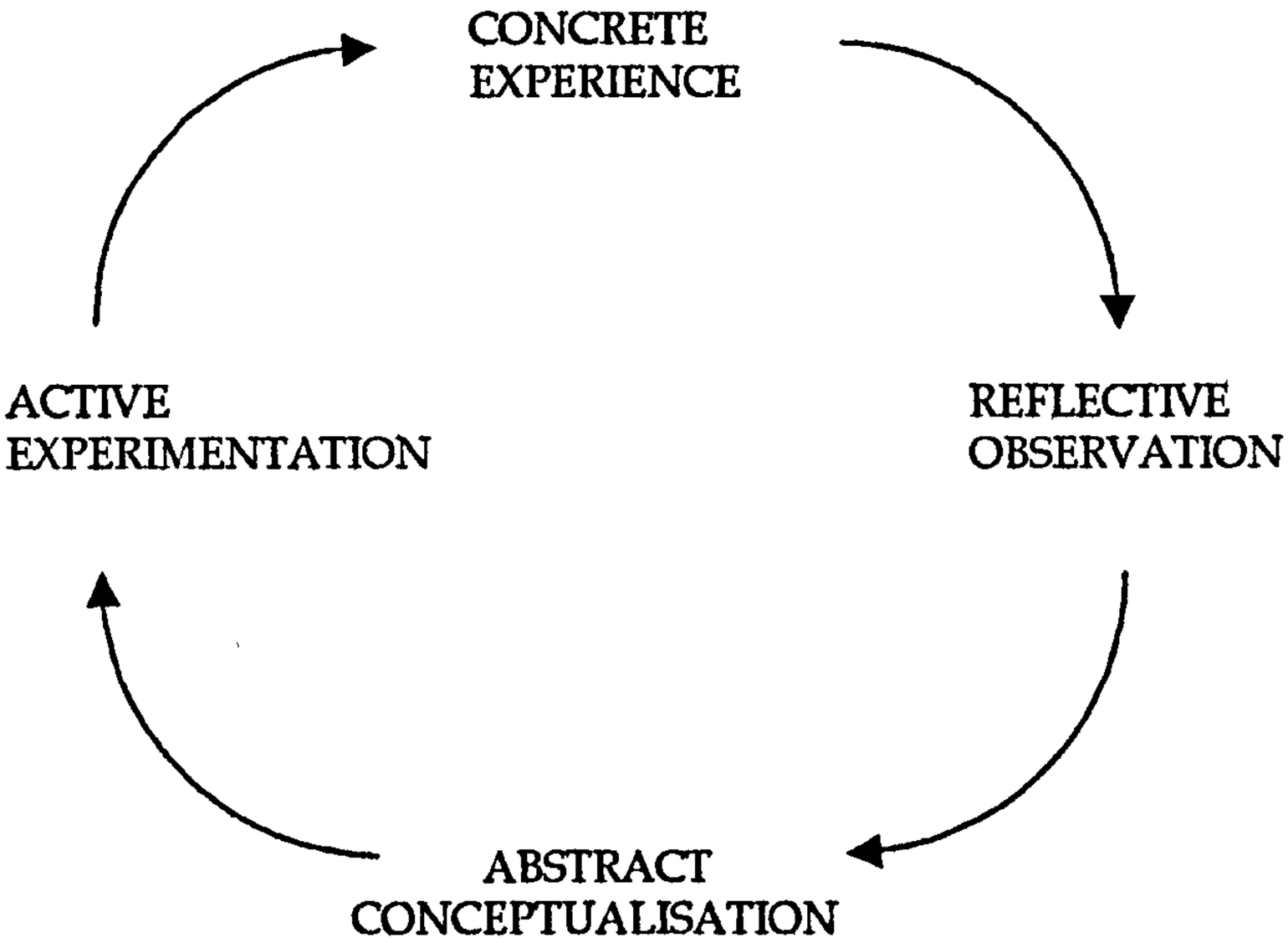

Figure 2. 1 Kolb's (1984) Experiential Learning Cycle

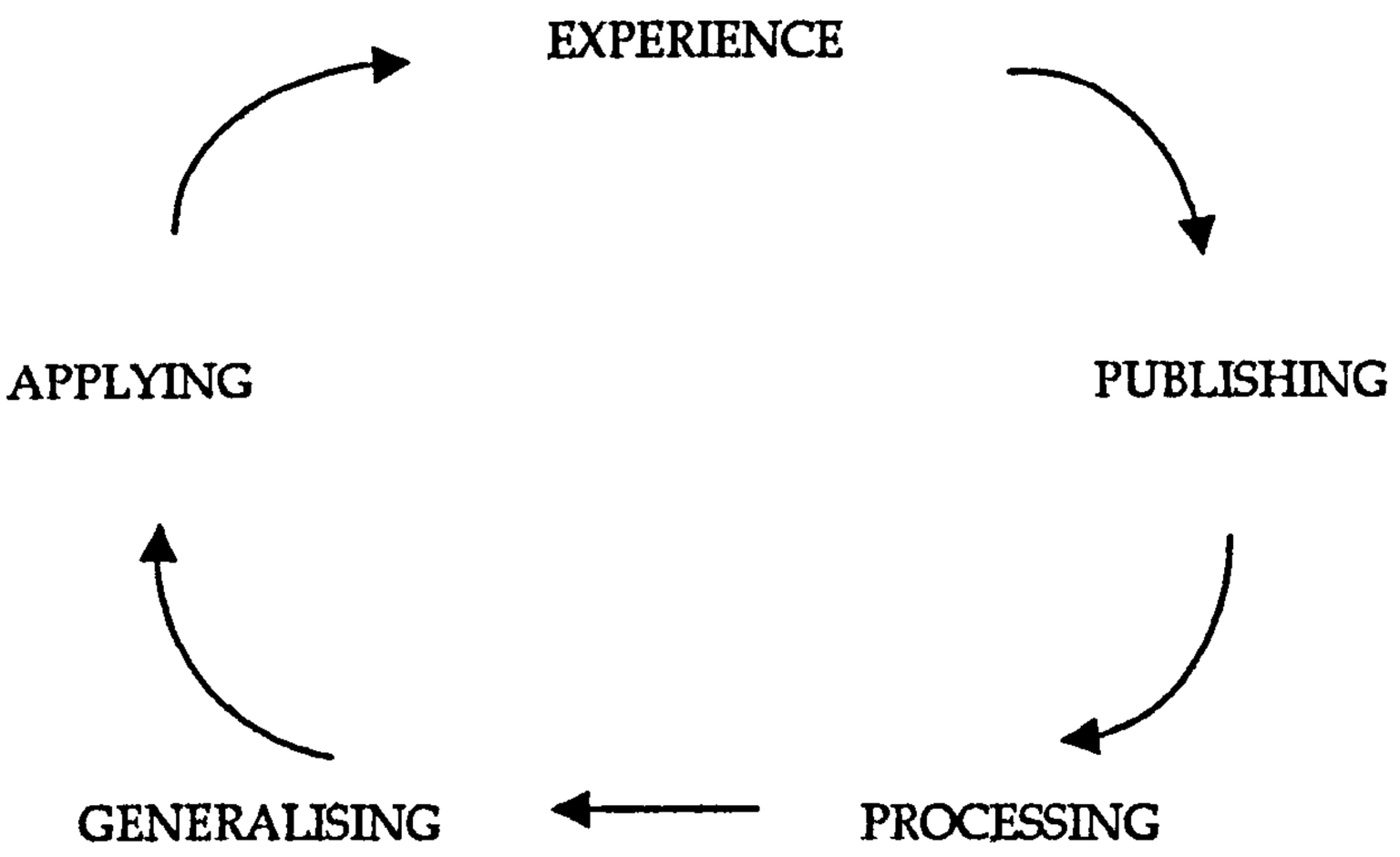

Figure 2. 2 Pfeiffer and Jones' (1980) Learning Cycle

Askew and Carnell (1998) term this action learning. Action learning and action research are central tenets to the transformatory approach to learning as defined by Askew and Carnell (1998). The underpinning philosophy of transformatory learning is further explored in Chapter Three.

Action research has also been described as a cycle or a spiral of steps (Lewin, 1946; Kemmis and McTaggart, 1982; Elliot 1981 in McNiff 1988). Lewin (1946) identified these steps as planning, acting, observing and reflecting (see Figure 2.3).

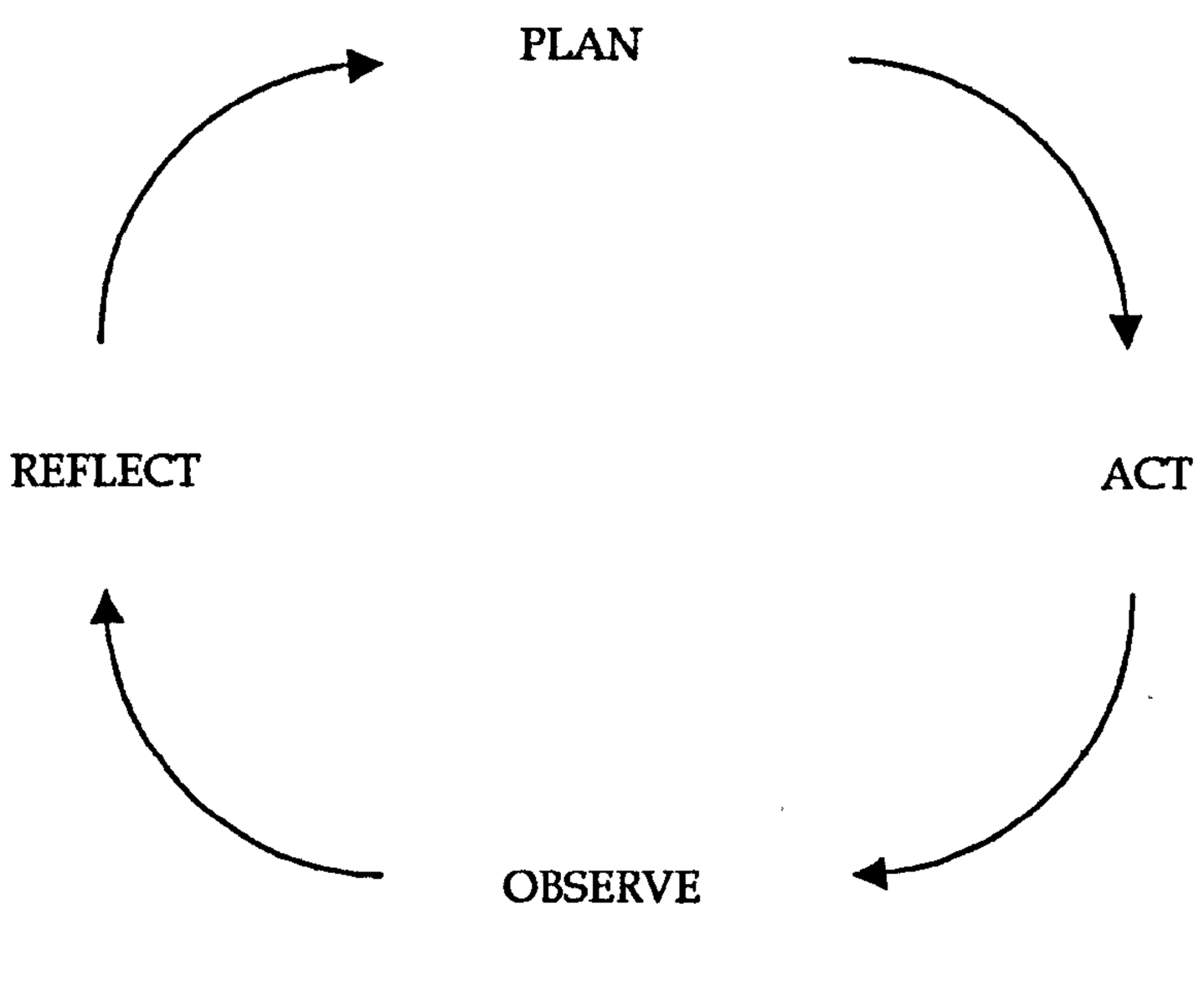

Figure 2. 3 Action Research Cycle (Lewin, 1946).

The four stages in the action research approach comprise a careful and systematic approach to developing changes and innovations in the social world. The initial step in the cycle is to design a plan of action, after the action has been executed it is followed by a period of reflection. Changes and modifications are made to the plan and the cycle is then repeated. It is important to note however, that reflection also occurs continuously throughout the cycle. Generally it is claimed that in action research any phase of data gathering and interpretation can only be a tentative step forward and not a final answer (Elliot, 1991). Indeed from a feminist standpoint reflexivity assumes that all work is incomplete and requires a responses from others positioned differently (Marcus, 1994). This serves to highlight the importance of the cyclical format and the reflexive approach to the research problem.

One of the major weaknesses as previously touched upon, is that because action research deals with local problems the findings cannot always be generalized to other situations. The word generalizability is one that is imposed from the language of traditional science and as such is contentious in what is essentially a qualitative endeavour. It is generally assumed that findings that are not generalizable do not effect practice, there are however many ways to effect practice (Rolfe, 1996a). For the purpose of this work, the broader context of the theory-practice gap in nursing practice and nurse education is a problem that is recognized on a national scale in the profession. The social and political context will have some resonance with other organizations, whilst the local factors may

differ slightly, the teaching interventions underpinning the transformatory approach to learning are transferable to any learning situation. The outcomes however will always be different as the learning is unique to each situation and each leaner and therefore cannot be replicated exactly.

2.5 Research as Conscientization

Freire (1972) introduced the world of education to the notion of conscientization. Freire (1972) presented conscientization as the ability to become critically conscious. This is not simply examining an event to see how it could have been done differently; critical consciousness is linked to critical awareness and implies a political dimension, which enables assumptions inherent in ideologies to be challenged. Freire (1972) suggests that 'false consciousness', that is consciousness that is culturally induced within individuals, can be transcended by education. This implies that there is a consciousness that is not culturally induced, I understand this to refer to the authentic self, what Rogers (1991) refers to as the organismic self as opposed to the self-concept. Although, I believe that even the organismic self is to some extent culturally influenced, perhaps through what Jung terms the collective unconscious (Jung, 1960). The notion of the 'self' and 'consciousness' is developed in Chapter Three.

The central tenet of Freires's pedagogy (1972) is the practice of transcending false consciousness in order to achieve conscientization; interpreted by Askew and Carnell (1998) as:

"coming to a consciousness of oppression and a commitment to end that oppression" (page 65).

Mezirow (1981; 1975) when discussing adult education, refers to this as perspective transformation. However, becoming conscious of one's oppression and making the commitment to end it require two different shifts. I would argue (as does Menzies-Lyth, 1988) that there is an enormous resistance to coming to consciousness and ending uncritical acceptance.

My own experience is that once one is aware of how one not only maintains but perpetuates the victim stance a certain amount of discomfort is experienced (Joyce, 1984; Festinger, 1957) which demands action. Action does not always equate with taking responsibility for the self against the perceived oppressor (reclaiming power explicitly); it may in fact mean choosing to remain unconscious (powerless) or consciously playing the power game (playing with the implied power). The latter, I feel, is particularly employed by students (at all levels). There is little doubt that the assessing tutor has legitimate power over the student, as the research examiner does over the PhD student, in this case myself. However, it could be argued that whilst another may have legitimate power over me, (the examiners) this is freely given by me (the student), therefore I do not perceive myself to be a victim of oppression. In this sense being conscious of my position places me in a position of power, what might be called a perspective transformation (Mezirow, 1981). But how conscious of their positions are

students, nurses, and teachers? This is an area that will be explored in more detail at a later juncture.

Nurses, like other groups throughout history, have been described as an oppressed group (Roberts, 1983). The cultural narration of nurse's is to be subordinate. This view is supported by a wealth of literature, which advocates that nurse's lack autonomy and control (Friedson, 1970), have a lack of self-esteem (Greenleaf, 1978), have a fear of success (LeRoux, 1978) and subscribe to the submissive-aggressive syndrome (Stein, 1978). It could be argued that the infiltration of nursing theory with the mechanistic model of medicine previously highlighted is evidence to support this viewpoint. Johns (1995a) refers to this as the barrier of medical hegemony to nursing autonomy. Hegemony referring to the extent to which there is uncritical acceptance of the dominant groups meaning systems within the health care culture (Grundy, 1987). Roberts (1983) asserts that the education system is one of the mechanisms that reinforces this position stating that:

"if the education is controlled by the powerful and limited to the curricula that support their values, little conflict occurs" (page 24). However, as above, it could be argued that students are only able to challenge the prevailing values from a position of consciousness, that is of their own values.

Conflict does occur, although not necessarily overtly. The conflict manifests itself in other ways, often as internalised self-deprecation, resulting in low self-esteem.

Individuals may not be aware that some internalised self-criticism originates in uncritical acceptance and unexpressed conflict in relation to feeling oppressed. Thus, a false consciousness develops, sometimes without the individual knowing that there may be a different consciousness. In addition to this, situations of horizontal violence, (a topic that is being more openly discussed in nursing circles), may arise (Farrell, 1997).

The notion of a false consciousness derived from Hegel and Marx is not necessarily a helpful concept, for as Johns (1998a) discusses, the notion of a false consciousness implies that there is a true consciousness. Although this might be correct, it could be added that any shift in consciousness is relative and is never an end in itself, the notion of the self-concept may provide a more helpful term (Rogers, 1991; Burns, 1982). Perhaps the shift relates more to matching the inner and the outer worlds more closely, bringing the personal and professional theories more in relation, to achieve more congruent and authentic action. One might question what is it that facilitates this shift in consciousness?

Friere (1972) posited two phases to the process of liberation from oppression, firstly unveiling the world of oppression, that is making it conscious, secondly expulsion of the myths created and developed by the old order, this involves not only personal and professional understanding of the influence of the old order, but also the injection of some energy to confront and challenge both oneself and to take action within the system. The energy required to go against the cultural

narrative is assertive energy. This also speaks to the process of action research. Action research is also a process of conscientization at differing levels, for the researcher it brings to awareness the conflict between the inner and the outer dialogue, which is often suppressed within the work setting, making the private knowledge public. It also casts light on the shadow of oppression by pedagogical attitudes within the local situation involved in the research. The local community is also partly representative of the larger political and social context and therefore any process of conscientization will have aspects which can be transferred both nationally and globally. It would seem however, that there is the risk that conscientization itself could become oppressive when it becomes normative. For example if conscientization becomes the dominant discourse to which everyone is persuaded to subscribe with uncritical acceptance then it runs the risk of falling into its own trap.

2.6 Research as Transformatory Learning

It has been mentioned that the cycle of reflection is a core component of the action research process. The processes of reflection and action learning are also major proponents of the transformatory approach to learning (Askew and Carnell, 1998). Whilst in action research, the focus is external, usually on professional practice within a particular context, action learning is primarily a personal activity with an internal focus. Nurse teachers like nurses use action research in their day to day activity in the classroom, although it is not likely to be in a formal or

conscious way. This has parallels with what Benner (1984) describes as the testing out of hypotheses in practice.

Reflecting on and evaluating teaching sessions and using this information to improve future work is utilising some of the aspects of action research. Where this is an integral part of the teachers daily work, teachers can feel empowered to make changes in their practice (Somekh, 1995). However, action research brings about change not just at the group level, but also at the individual level, this could be viewed as the internal personal focus. The idea of the nurse researcher learning about the process of researching through learning in the process of carrying out research is congruent with both the action learning and the action research cycles. Further it fulfils the notion of lifelong learning not only espoused by the U.K.C.C. (1996) but also a fundamental assumption of reflective practice. Research as transformatory education views the teacher as a learner. Askew and Carnell (1998) believe that the teacher as learner is:

"engaged in the process of action learning and action research, reflecting on experiences, developing understanding, gaining insights into practice, making important professional judgements and bringing about actions for change" (page 152).

From this vantagepoint the teacher is not seen as a technician delivering a curriculum, but a professional learner and educator. This could be translated into nursing practice as the nurse not being seen as a technician delivering a

programme of care, but as an open and professional learner/ educator in action. In point of fact, this is generally the case in the reality of clinical practice and as such the patient is always teaching the carer. The difficulty is that whilst this remains implicit it may result in qualified individuals feeling unable to acknowledge their limitations and ask for help (thus risking patient safety).

Thus this action research is being used at two levels. Firstly that of reflecting on the learning process with a particular context in order to better understand how to affect organisational change and secondly to develop an understanding of the action research process and its value as a tool for professional development. Using the self as a research instrument does invoke some criticism, not least when the researcher declares that the research is also a tool for *personal* and professional development. The validity is liable to be questioned if the researcher is not able to demonstrate a reflexive awareness of the factors influencing the various stages of the research activity (Somekh, 1995), what some authors describe as location and positioning (Koch and Harrington, 1998). Achieving the balance between the internal and the external, the personal and the professional is a delicate procedure, for as Somekh (1995) warns, too much emphasis on self in action research distracts from the substantive focus of the study. Askew and Carnell (1998) argue that to avoid falling into this trap educational action research needs to located within a wider social and political context.

2.7 Research as Reflexive Praxis

It is fundamental to the process of this research that it addresses the reality of practice, both in teaching and nursing, thereby bringing theory and practice more in relationship through research. Newman (1994) concludes that:

"nursing research must focus on the reality of practice" (page 92).

She goes on to say that research that produces data as outcomes is not enough. Nursing research should also aim to help participants understand and act on their particular situations, this is referred to as praxis research. Praxis is action informed by practical theory, which in turn may inform and transform theory. Praxis research is defined by Wheeler and Chinn (1984) as:

"thoughtful reflection and action that occur in synchrony, in the direction of the transforming world" (page 2).

Rolfe (1996) reminds us that the term praxis had its origins in Greece where it was used by Aristotle to describe a doing action and that Marx adopted the term to denote the unity of theory and practice. Newman (1994), Wheeler and Chinn (1984) and Rolfe (1996) all seem to be saying that reflection and action are essential ingredients to the successful integration of research and theory with (nursing) practice.

2.8 A Reflexive Research Model for Nursing Praxis

Rolfe (1996) contends that the nursing research should not only be concerned with what he terms formal, generalizable theories, but also with changing and

improving practice whilst at the same time generating micro, informal theory. He separates the differing aims of research into a hierarchy.

Level 4 Implementation of change

Level 3 Individual Micro understanding

Level 2 Global, Macro understanding

Level 1 Explanation

A nursing research hierarchy (Rolfe 1996, page 58).

Viewing research from this perspective is helpful in that it provides a shift away from the either/or debate of positivism or antipositivism, instead these are seen as valid and necessary steps on the way to operationalising research findings. To stop short of all four levels, he argues, maintains the theory-practice gap. Briefly he ascribes the following traits as characterizing the differences between the four levels.

Level 1 and level 2 research can be aligned with the quantitative and qualitative paradigms respectively.

Level 1 research is carried out with the intention of producing objective findings, often the reporting of the results is seen not as a means but the end in itself.

Level 2 research focuses on the meaning and interpretation of experience and as Rolfe (1996) points out, nursing literature currently enjoys a wealth of examples of research at level 2.

Level 3 research is operationalised through researching ones' own practice and is based on the process of reflection on action (Schon, 1983). Rolfe (1996) presents a convincing argument for the process of reflection on action being a research method suitable to examine nursing praxis, with its primary aim being to generate informal theory.

Level 4 research seeks to bring about change. This level of research differs from other research not in its methods, but in its aims and purpose. In its simplest form it corresponds to reflection in action (See Figure 2. 4). This level is primarily about affording change in clinical practice as opposed to collecting data and generating theory. In relation to this Rolfe (1996a) says:

"...the theory is merely an epiphenomenon of the action and the process of research is in many ways simply a means to an end" (page, 1317).

Rolfe's (1996) level 4 research can be related to the concept of the 'internal supervisor' put forward by Casement (1985). With the awareness of an internal supervisor, the practitioner is not only aware of reflecting on the process of being with the patient at any given moment, but is also available to comment on this process and adapt their responses according to the emerging situation. This skill of being present, what Zen masters refer to as mindful attention demands a great deal of presence from the practitioner. Casement (1985) referred to this as 'suspended attention', Johns (1998) terms it being available, whilst Rolfe (1996) states that reflection in action serves to focus the reflexive practitioner on the here and now. The use of the self as a therapeutic tool requires presence, that is not

only being with the client, but also being with the self. One question which comes to mind in response to these ideas is: How present are practitioners when they are so concerned with keeping up their own defences through filling every available space with doing? This question triggers another thought in relation to my own work – how available are teachers to respond to the moment when concerned with delivering the content of the curriculum (and their own agendas). These questions will be taken up to some extent in subsequent chapters.

	Level 1	**Level 2**	**Level 3**	**Level 4**
Methodology	**Positivist**	**Interpretive**	**Reflective**	**Reflexive**
Function	Explanation	Macro understanding	Micro understanding	Change
Research Questions	What?	Why? Generally	Why? Specifically	How?
Methods	Usually quantitative	Usually qualitative	Reflection-on-action	Reflection-in-action
Outcome of research	Information	Generalizable knowledge and formal theory	Personal knowledge and informal theory	Action
Relationship of research to nursing	Nursing is informed by research	Nursing is based on research	Nursing is integrated with research	Nursing is driven by research

Figure 2. 4 A New Model of Nursing Research (Rolfe, 1996, page 76).

Rolfe (1996) proposes the contemporary models of action research developed by the discipline of education (Altrichter, Posch, and Somekh, 1993; Elliott, 1991) as ideal for researching nursing praxis. He asserts that it:

"contributes to the reduction of the theory-practice gap by enabling nurse-practitioners to research their own practice; it directly brings about improvements in nursing practice by having positive change built in to the research process; and it generates informal, micro theory by focusing on the practitioner's individual nurse-patient interactions" (page, 70).

The hierarchy of nursing research presented by Rolfe (1996) on first interpretation appears to follow a rather linear progression. This, it could be argued places it back within the logical, scientific framework. A hierarchy also implies that one level, that is level 4 is better than another level, level 1 for example. My own interpretation of this is that it is like all seeming opposites, one cannot exist without the other and one is therefore dependent on the other. For me it is the level 3 research that brings the seemingly opposite paradigms into a marriage creating a possibility for the fourth level which serves as the transcendent function (Hall 1986; Kolb, 1984).

This is reminiscent of the axiom, an example of qualitative logic of pre-scientific cultures, which runs as follows:

Out of the one comes the two

Out of the two comes the three

And from the three comes the fourth as the one.

Hence, one way of viewing the hierarchy is as a cyclical model in line with other cyclical models that have been presented so far. Placing the hierarchy within a cycle does not in itself remove the suggestion of logical progress, what it does suggest it that the levels are continuously and simultaneously moving forwards and backwards between the parts in order to encapsulate the full story. The four levels also sit comfortably with the action research cycle previously outlined, when placed alongside each other, the similarities become more apparent (Figure 2. 5).

Action Learning Cycle adapted from Lewin (1982)	Hierarchy of Nursing Research adapted from Rolfe (1996)
Plan	Ex 'plan' ation
Act	Implementation of change
Observe	Global macro understanding
Reflect	Individual micro understanding

Figure 2. 5 A comparison of action research and the hierarchical model of nursing research.

Action research does not use its own particular research techniques, it is not technique that distinguishes action research from other research approaches, what distinguishes action research from other methodologies is its process. That is, the process of reflection and a commitment to the improvement of practice. Hence, it

is, therefore, not the method that makes action research unique from other more traditional approaches to research, rather it is the underlying principles. Hart and Bond (1995) devised a useful action research typology in order to make this point, asserting that action research is able to retain a distinct identity, whilst simultaneously stretching across the spectrum of research approaches. This typology of action research spans from experimental to organizational to professionalizing and empowering. Askew and Carnell (1998) illustrate that action research is a distinct entity when they explicate the fundamental differences in principles underpinning qualitative, quantitative and action research. Some of these are replicated in figure 2. 6.

The objects of study in educational action research are educational practices. Action research is validated by evaluating the impact of actions in a continuous process of data-collection, reflection and analysis, interpretation, action and evaluation (Altrichter, Posch and Somekh, 1993). Hence the rigor of action research:

"derives from the logical, empirical, and political coherence of interpretations in the reconstructive moments of the self reflective spiral (observing and reflecting) and the logical, empirical, and political coherence of justifications of proposed action in its construction or prospective moments (planning and acting)" (Kemmis, 1993, page 185).

	Action research	Qualitative research	Quantitative research
Purpose	To bring about informed change	To illuminate meaning and understanding	To increase knowledge and find universal laws and generalizations
Framing	Concerned with the whole picture	Concerns understanding phenomena	Focus on behaviour not context
Rationale for planning	Research planned to investigate practice	Research planned to investigate phenomena	Research planned to test hypotheses
Techniques	Draws on Qualitative and quantitative	Ethnography, case study	Uses measuring techniques
Rigor	Based on logical coherence, interpretations in the reflections	Through discussion of bias and constraints	Statistical analysis and meta techniques for establishing validity and reliability
Objective-Subjective Dichotomy	Enables practitioners to clarify values on which research is built	Recognition of the subjective nature of research	Sets out to be objective and value free
Evaluation	By reflective questions	Evaluated by questions related to meaning and understanding	Evaluated by questions referring to reliability and duplication

Figure 2.6. Approaches to research (adapted from Askew and Carnell 1998).

Another aspect of action research is its use of a variety of methods. Is it possible to use both quantitative and qualitative methods of data collection. Multiple methods of data collection enrich the perspectives that the researcher has on the phenomenon. The methodological mix can occur either sequentially or simultaneously, combining either a quantitative and a qualitative method or two or more methods within the same paradigm (Morse and Field, 1996). Combining methods is encouraged by some who note that the differing methods complement each other (Burns and Grove, 1987). This technique is sometimes known as triangulation. Measurement from different vantage points promotes the credibility of the research in terms of increasing reliability and validity. Mitchell (1986) asserts that triangulation is a suitable strategy to use in nursing research. Denzin (1989) has identified four types of triangulation; data, investigator; theory and methodological.

Data triangulation refers to several sources of data being generated around one topic; investigator triangulation infers that more than one researcher is involved in the same research project; theory triangulation uses two or more frameworks for analyzing the same set of data; methodological triangulation uses multiple methods to examine the same topic. Methodological triangulation can be further broken down into 'within methods' 'across methods' and 'holistic design' (see figure 2. 7 Beeby, 1997). Within methods triangulation involves the use of similar techniques within one research paradigm to collect data, whereas across methods

triangulation involves mixing methods from both the qualitative and quantitative approaches to research. Holistic design is deemed to be a more complex process increasing confidence in the research findings (Jick, 1983). Holistic design incorporates both within methods triangulation and across methods triangulation, both sets of data are then triangulated to achieve a rounded view of the phenomena being researched (Beeby, 1997).

Within Methods	**+**	**Across Methods**	**= Holistic design**
Qualitative method 1		**Qualitative dimensions**	
Qualitative method 2		**Of phenomena**	
			Rounded view
			Of phenomena
Quantitative method 1		**Quantitative dimensions**	
Quantitative method 2		**of phenomena**	

Figure 2. 7 Methods of Triangulation (Beeby, 1997).

2.9 Research as Experiential Learning - the plan

Altrichter, Posch and Somekh (1993) advise that the royal road to action research is to explore it by doing it yourself and that is what has happened through the period of this study. Action research appeared to be the most fitting approach to

this research topic, for all the reasons already highlighted, it is congruent with reflective practice; its underpinning philosophy is that of experiential learning and it aims to bring about a reduction in the theory-practice gap. Therefore to remain congruent to my own beliefs about learning by experience, it has been important to learn about the research process by doing. What now follows is a description of how the evidence discussed thus far was utilized to formulate a plan of action.

Rolfe's (1996) hierarchical model of nursing research was used as a basic framework for the research as it was felt that it allowed the action research cycle, the experiential learning cycle and models of reflection to co-exist simultaneously. In retrospect, the four levels of research identified by Rolfe (1996) mirrors the process that I underwent quite closely. Consequently each chapter encompasses a reflection of the work as it progressed through these levels. Each level of research includes its own methodology section within which the data collection methods are justified and briefly discussed for validity and reliability (see Figure 2. 8). The research methodology as a whole is evaluated in chapter seven

	Level 1	Level 2	Level 3	Level 4
Methodology	Positivist	Interpretive	Reflective	Reflexive
Function	Explanation **Sample size n=85 Researcher**	Macro-understanding **Sample size n=42 and n=10 Researcher**	Micro-understanding **Sample size n=1 Researcher**	Change
Research questions	What?	Why? Generally	Why? Specifically	How?
Methods	Quantitative **Pre-test and post-test questionnaires, attrition stats, formal theory**	Qualitative **Semi-Structured interviews, critical incidents, reflective diaries**	Reflection-on-action **Reflective diaries and Reflective Process Group**	Reflection-in-action **Dynamic interventions by researcher and researched.**
Outcome of research	Information	Generalizable knowledge and formal theory	Personal knowledge and informal theory	Action
Relationship of research to nursing	**Teaching and nursing** is informed by research	**Teaching and nursing** is based on research	**Teaching and nursing** is integrated with research	**Teaching and nursing** is driven by research

Figure 2. 8 Levels of Research (Rolfe, 1996).

Chapter three starts with level one research, the problem to be studied is identified. Typically, the starting point began with experiences of discrepancies,

for myself this was the experience of the theory-practice gap in both nursing practice and nurse education outlined in chapter one. These discrepancies felt, as they often do, like an internal conflict surrounding desired practice and actual practice. The starting point for action research is reflection upon such conflict; thus the discrepancies are not lost or forgotten about in the routine of everyday work. This is congruent with the philosophy of emancipatory research which increases awareness of the contradictions hidden or distorted by everyday understanding. In attempting to clarify the starting point further, it seemed important to access and reflect upon additional knowledge to extend and refine my own experience before formulating the research aims. This diagnostic stage represents an explanation of the current situation as portrayed in the literature and in the local situation. Patterns of experience were drawn from the literature and the local situation and these are highlighted in order to illustrate the process of developing the action strategies.

A brief discussion marks a period of reflexivity before moving into the next stage of the research process. Chapter four describes the results of the preliminary research process and signals the move to level two research, the shift to understanding some of the effects of the devised action strategies in practice (see chapter five). This early period of observation and subsequent understanding took place at the same time as learning and teaching interventions were being executed as part of the action plan. This period of data collection focussed much more on qualitative aspects of understanding and interpreting meaning from the ongoing

experiences of the students involved in the research process. The exploration of the macro processes allowed changes and modifications to be made continuously. Once again data collection methods akin to the more qualitative research paradigm were appropriated - semi structured interviews. Methods of collection, analysis and subsequent findings were used to assist the shift to the next level of research.

Chapter six heralds the move towards research at level three, which in this study underlines the use of reflection on action both as a learning experience and as a research process. A case study approach facilitates a micro view of the situation. Data was collected from reflective diaries and critical incident analysis, whilst the students joined reflective practice process groups with myself as the facilitator.

Level four research, reflexive research, is used as the connecting thread throughout the whole research process. Reflection in action is inherent at each level of the research, change is addressed and action is modified of both the action strategies and the research method itself. Examples of reflexivity and on the spot experimenting are interspersed throughout the text, although it could be argued that the whole research study is an example of situated reflexivity.

As different methods of quantitative and qualitative data collection are used within the study, data is cross referenced through within methods and across methods triangulation, resulting in a holistic design (Beeby, 1997). Issues pertaining to the confidence and rigor of the research and its findings as a whole

are discussed in chapter seven along with the implications and recommendations for future work.

2. 10 Summary

This chapter has brought together some of the explorations behind the choice of research framework and methodology. Given the historical and contextual issues outlined, action research has been chosen as an appropriate methodology for research that aims to decrease the gap between theory and practice in nurse education and therefore nursing practice. Reflective practice and experiential learning have been identified as congruent with the action research process and in particular reflexive action research. These will be explored as teaching and learning methods in chapter three. A brief insight into the social context of nursing has been offered against a backdrop of critical social science. Thus, the aim of this chapter has been to link transformatory and emancipatory learning with the action research process. Chapter Three forms the theoretical statement from which the main research aims are drawn, the level one research.

Chapter Three

Level One Research

You teach what you most need to learn

(Bach, 1992)

3. 1 Introduction

Following the premise that obtaining a complete picture should be the first step in the process of change and not the last step in the a research project, this chapter provides the theoretical statement from which the research aims are developed and an action strategy devised (Nolan and Grant, 1993). As previously mentioned Level 1 research lends itself to the technical and empirical, and more traditionally scientific ways of knowing. It is akin to the more quantitative approach to research and therefore aligned to formal theory generation (Rolfe, 1996; Fay, 1987; Habermas, 1972). In this phase the state of consciousness in learning is that which Kolb (1984) refers to as registrative and the area of cognitive interest which Mezirow (1981) ascribes to work. This level of consciousness not only refers to the acquisition of the basic abilities to learn, but also it is a period of time when boundaries between the internal and external are more clearly delineated.

As the boundaries between the inner and the outer become clearer, object and subject are also more clearly defined. Discovering polarities are part of this delineation and it is through the lens of polarity that the literature is examined.

Much of the chapter is devoted to clarifying and defining the problem to be studied. Drawing upon the theory available, the literature review uses formal theory to help illuminate my own experiences as a teacher and learner. The aim, therefore of the literature review is to combine hunches with a formal and systematic analysis. In addition literature was referred to throughout the study in response to the research process. Having defined the main concepts and clarified the problem to be studied, research aims are articulated in the form of idiographic statements.

3. 2 A Systematic Review

Evaluating literature is a central part of the research process and accounts for a large percentage of the total effort involved. It follows then that the review necessitates critical evaluation of reports, articles and other forms of publication that are concerned with the research question. The current emphasis on clinical effectiveness and evidence based practice fuels the need to ensure that practice is based on knowledge derived from research rather than tradition or personal experience. With the increasing volume of nursing research available in the literature, synthesis of research through the review process is becoming increasingly popular across health related disciplines. This has led to traditional literature reviews being criticized for being haphazard, being based on only a selection of the published literature (Greener and Grimshaw, 1996).

Several writers have commented on the lack of scientific rigor in traditional reviews, suggesting that reviews which fail to apply scientific principles to the

process can be biased, reflecting only the views of the researcher (Mulrow, 1987; Droogan and Song, 1996). It must be acknowledged that whenever research literature is collected there are chances that bias and errors may be introduced. Relevant research evidence may not be included in a review because of either an incomplete search or biased selection of the published literature (Dickersin, Scherer and Lefebvre, 1994).

According to the NHS Centre for Reviews and Dissemination the aim of a literature search is to:

"provide as comprehensible a list as possible of primary studies, both published and unpublished, which may fit the inclusion criteria and hence be suitable for inclusion in the review" (1996, page 19).

Given the number of nursing and other health care journals now available, both in the United Kingdom and worldwide, this is no easy task. One way of pulling together unmanageable amounts of research is through a systematic review. Systematic reviews have been developed as a response to the criticisms of the traditional review and the drive towards evidence based practice. A systematic review can be defined as:

"the process of systematically locating, appraising and synthesizing evidence from scientific studies in order to obtain a reliable overview" (NHS Centre for Reviews and Dissemination, 1996).

For the purpose of this review a quantitative approach was chosen as currently promoted by the Cochrane Collaboration. The main databases that were searched for published articles included CINHAL, MEDLINE, ASSIA,

PSYCHLIT and ENB. Unpublished sources were also used. As part of the systematic review process, each work was summarized and subjected to content analysis and quality assessment. Standard reference works and their bibliographies were also reviewed to identify further papers of interest. All the literature that has been used has been subject to a quality assessment strategy and literature that failed to meet the criteria was reassessed with regard to its contribution to the debate. Throughout the literature review I have sought to maintain the language used within the original literature. In many cases the word 'client' and 'patient' appear to be used interchangeably, this is the case within this chapter.

3. 3. Clarification of the Problem to be Studied

3. 3. 1 Through a Lens Darkly- The Dialectic

This section begins with explicating the lens through which the majority of the subsequent literature is viewed. Firstly, the review in itself is a contradiction for it is concerned with exploring the whole and in order to do this the work has been broken down rather mechanistically into parts. In addition, and as Hall and Hall (1988) acknowledge in their work, this work is concerned with learning that is not necessarily gained from a book or reading and yet is presented in book form in order for that learning to become known. It is with this dialectic tension that this study begins and it is to this lens that I now wish to draw to the readers' attention.

Hegel (1971) was aware of this dialectic tension between the opposite ways of thinking, positing that as soon as one thought is proposed (thesis), it will be

contradicted by another oppositional thought (antithesis), although the individual is not always conscious of the opposing thought. Hegel (1971) claimed that the tension between these two ways of thinking can be resolved by the proposal of a third thought which accommodates the best of both points of view. He named this the dialectic process.

To give an example of this process, if I reflect on being, then I automatically, albeit unconsciously, bring in the concept of nothing. The tension between being and nothing is resolved in the concept of becoming. If I am in the process of becoming, then I both am and am not. These are significant ideas in relation to this study and will be expanded upon further in relation to nursing using the work of nursing theorist Rosemary Parse (1992; 1987). For nursing too is viewed with bi-polar consciousness as seen in the care or cure approach and the art or science debate. Chaplin (1998) argues for a rhythmical approach to consciousness. Rhythm, however, is nothing more than a constant alternation between two poles. Unfortunately, in Western cultures, there is a tendency to concentrate energy on one particular end of the pole to the exclusion of its opposite (Moore, 1992; Hall, 1986). It could be argued that this because living with this dichotomy is uncomfortable as it affects both interpersonal and intrapersonal relations necessitating not only a fluidity of response but also a tolerance of uncertainty.

As Chaplin (1998) states:

"To live rhythmically is to live with uncertainty, undecidedness, forever open, in process and unfinished. This would probably be too much to cope with for humans brought up on uncertainties and hierarchies" (page 152).

The individual cannot function as an open system indefinitely, a period of closure is necessary for integration to occur.

Nursing and nurse education which until recently has functioned via a mechanical hierarchical system based on a task oriented medical model of care, has also tended towards extremes. The shift towards more holistic and humanistic models of care, which value the uniqueness of the individual, can be seen as an attempt to live more rhythmically, although this in itself can swing to the extreme before finding a balanced rhythm. This necessitates not only a complete reinterpretation of the past system, but also a recognition that the present system being forever open, is constantly being reinterpreted. This, as Chaplin (1998) has already commented, is not always a comfortable task and depends upon our capacity for openess. This thought is echoed by Stolorow, Atwood and Brandchaft (1994) who point out that the extent to which the person can be reinterpreted depends upon the capacity for openness of the interpreted self.

It could be argued that nurses, nursing and nurse education to date has operated as a 'closed' system (Liaschenko, 1998; Menzies-Lyth, 1970). This was manifest in nursing care being taught in relation to a particular bodily system, resulting in the nurse approaching the patient on the ward as a malfunctioning body part. The human body (and mind) has been objectified,

viewed as a closed system and the current trend is towards nurse's, nursing and nurse education operating in a more subjective, open system (Liaschenko, 1998). Knowledge of the whole patient experience requires a re-positioning of the nurse so that her gaze moves from the body as an object of intervention to the body of someone living a life. This can only happen within an environment that is willing to recognize and value the individual and subjective experience not only of the patient, but also of the nurse.

The following sections use relevant literature to highlight the polarization's in general education, nurse education, nursing and self. The history of education and nursing as closed systems are tracked and discussed in relation to models of education, nursing and self which can be conceived of as open systems. Here, the distinction between an open and closed system will refer to the description advocated by Van Hooft (1995), that is the open system corresponds to:

"a behaviour pattern which arises from an ability to respond to input from the environment in a variety of ways" as opposed to the closed system which is "a behaviour pattern which is so fully ingrained as to be closed to any variation which might be occasioned by learning" (page, 123).

3. 3. 2 Introduction to the nature of Nursing and Nursing Knowledge

Nursing presents many polarities between theory, education, management and practice. I begin here to explicate some of those polarities, namely science versus art, cure versus care, technologist versus humanist and rational versus emotional.

The nature of nursing and nursing knowledge has been and still is the subject of debate for health professionals. After Nightingale, who described nursing as both an art and a science, the emphasis moved away from nursing to medical knowledge. Historically nursing has been grounded in the natural sciences such as physiology and chemistry. Many of the early textbooks were written for nurses by doctors saying more about medical specialties than nursing care (Toohey, 1953; Moroney 1950). This has led to nursing practice being guided by the medical model, in which human beings are seen as biological beings, made up of cells, tissues and organs which come together to form systems, a 'closed' system (Liaschenko, 1998; Pearson and Vaughan, 1986). Nursing itself, has been traditionally defined in relation to physical care giving, needs based models and the carrying out of technical procedures in a predominantly medical setting. These definitions reflected the view of nursing as subservient to medicine, emphasizing the role of the nurse as the doctor's assistant. One of the most often quoted traditional definitions of nursing is that of Henderson (1966):

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible" (page 96).

The focus in this definition is on the nurse assisting, doing something for or to the patient, there is no mention of the word care or caring. This definition of nursing is echoed by Campbell et al (1985) who write that: "nursing is the diagnosis and treatment of human responses to actual or potential health problems" (Page 111).

The implicit risk in this approach to nursing is the ease with which nursing interventions could be reduced to a set of tasks to be performed, with no wider awareness of the totality of the nurse's role or patient care. The emphasis on the task-centered approach to nursing care has followed a medical model. The dangers inherent in the functionalist approach have been debated in the literature and it has been pointed out that if nursing interventions are reduced to a set of actions, these can easily be performed without an awareness of the nurse's total role in patient care. Ultimately the completion of the tasks becomes more satisfying than patient centred care, (Kitson, 1993; McClean, 1973). Furthermore, it is argued that nurses who base their practice on the medical model view their patients as physical beings and ignore the broader characteristics of human nature.

Here the patient is treated not as a whole but rather as a fragmented object (Parse, 1987). This view of the person resembles the Cartesian psychosocial dualism of Rene Descartes in which the mind and body are viewed as separate entities (Lavine, 1984). However, it is not just the patient that is divided up into parts, it has already been mentioned that the functionalist approach epitomizes the nurse as the doer. She is usually directed by others, whether by other nurses or doctors and her own beliefs and values are often separated

from the work task that is being performed (Johns, 1995a). Science is undoubtedly a large part of the nurses work, the knowledge of physiology and mechanical and pharmacological interventions is an essential component of the nurses daily activity. Although this reductionist approach has been invaluable in the advancement of scientific knowledge, providing society with innumerable specialists, each an expert in dealing with one part of the whole person, it has been challenged with the advent of holistic caring practices. Whilst the nursing process attempted to organize nursing, the focus was on tasks and outcomes rather than caring (Aggleton and Chalmers, 1986).

A review of the more recent literature on nursing reveals that caring is central to nursing (Roach, 1997; McKenna, 1993; Watson, 1988; Armstrong, 1983; Leininger, 1981), with the emphasis shifting to nursing as an art (Parker, 1990) and the science of caring (Watson, 1988). The research of Gilligan (1982) and the writings of Noddings (1984) have demonstrated the centrality of caring, conceived as a distinctly feminine quality. Hence, contemporary definitions of nursing move away from medicine and task oriented care, focussing on the importance on the individual therapeutic relationship within a specific social context. Kirby, for example, (1995) states that nursing is carried out within relationships and is in essence a special form of relating. These words are echoed by other nursing commentators (Roach, 1997; Watson, 1988; Sarvimaki, 1988; Chapman, 1979).

Johns (1995a) compares the more contemporary philosophical approach to caring with the functionalist approach to nursing thus:

"The philosophical approach -nursing defined in terms of practitioners' beliefs and values	The functionalist approach -nursing defined in terms of task it does and roles"

(page 253). This indicates that the philosophical approach to nursing draws upon the practitioner's beliefs and values. The risk of the functionalist approach to nursing is that the practitioner is struggling to comply with some stereotype as to how she should behave rather than responding with authenticity and appropriateness to the situation (what Friere (1972) might term false consciousness). This, as Jourard (1971) comments, may lead to a sense of self-alienation resulting in a reduction in the nurses capacity to use herself as a therapeutic tool.

Not all writers are in favour of the struggle for humanized care, Webb (1992) for example, makes a plea for the physical care and comfort of the patient, which as Salvage (1990) quite rightly points out is the immediate concern of the patient when in pain and discomfort. In addition, the task oriented approach to nursing helped nurses to avoid the experience of anxiety, guilt, doubt and uncertainty that emotional involvement with their work might bring (Menzies-Lyth, 1970). Where emotional distance and defensiveness once prevailed, we now see the humanistic approaches encouraging engrossment and involvement as a means of being empathic (Salvage, 1995). This represents a swing from tight rigid structures to less structured boundaries and speaks of a shift from the rational to the emotional, from the head to the heart. It is inevitable that some polarization may occur before a balance can be

found. In the meantime how is nurse education responding to this paradigm shift?

3. 3. 3 Nurse Education

The move towards a more holistic approach to care, coupled with the drive for professionalism and accountability, has required a paradigm shift in the theoretical framework for nursing practice. As the knowledge base of nursing has and is continuing to broaden, so nurses are being directed to question their practice. Nursing is a practice based profession which requires the learner not only to acquire a wide range and depth of knowledge, but also to be able to apply that knowledge when working with clients in numerous care settings. One of the most problematic and enduring issues for nursing is the observation that what happens in clinical situations rarely, if ever, matches what the textbooks say ought to happen (Rolfe, 1996)

The two existing views of nursing, the traditional task-oriented, activity based model and the contemporary, relationship forming, holistic model, require very different methods of knowledge and theory generation and it could be argued require very different skills in order for them to be actualized in caring practice. Moreover, these differing ways of viewing nursing require the nurse to respond from a place that is more deeply connected both with herself and the patient. Nurse education, along with other disciplines concerned with adult education, faces the challenge of responding to this shift proactively. Traditional nurse education, like education in general, has used the classic model of education in which learning is viewed as the transmission of the

cultural norms and values. Sociologists from the Marxist and functionalist schools of thought argue that education is aimed at producing a labour force (Haralambos, 1985) and it could be argued that this is the aim of nurse education, providing a workforce that is fit for practice. Perhaps then, as Burnard and Chapman (1990) suggest, a definition of training would be more appropriate to nurse education.

Definitions of training emphasize the production of the standard nurse with importance given to the development of pre-defined skills. In the process of training all students attain the same skills and there is little room for self-expression. Training, therefore is symbolic of a 'closed system'. This mode of task oriented training ran concurrently with the traditional task oriented nursing and it is difficult to assert which one came first. The role of the teacher in training is that of 'custodian', the aim is to get through the curriculum, meeting the statutory competencies along the way (U.K.C.C., 1986; Willower et al, 1973). The teacher employs the role of expert and the motivation of the students is assumed to be extrinsic. The teaching process in training may not be explicitly viewed as a parallel process for the process of patient care, nevertheless, it does model a particular stance towards interpersonal relations. Whilst one might question whether or not nurses are custodians of their clients, this is certainly what the process of training role models to student nurses.

Over the last half of this century, the philosophy of education has moved away from didactic teaching towards a more humanistic approach. This has largely

been based on the work of Abraham Maslow (1954) and Carl Rogers (1983). The humanistic philosophy recognizes the developmental needs of individuals and the notion that the subject matter should not be imposed, but rather sought after by the student. The student is viewed as an 'open' system. The role of the teacher is to act as facilitator to assist the student in their search. Contemporary nurse education is attempting to make the move away from a product oriented curriculum to a more humanistic, process led curriculum (Murphy and Atkins, 1994; Bevis, 1978). This mirrors the shift to the more humanistic approach to patient care previously discussed. Allen (1989) suggests that definitions of education involving freedom of thought and self expression would be better suited to the discipline of nursing. This approach to education allows the individual to develop and deepen awareness of personal knowledge, skills and attitudes in order to attend to the needs of the client. In addition, humanistic education offers a model of interpersonal relations that respects the uniqueness of the individual, favouring empowerment as opposed to guardianship. The following section further defines and explores these approaches to education against the backdrop of some of the more traditional models of teaching, learning and knowing.

3. 3. 4 Andragogy

Up to this point in the study, the terms teaching and learning have not been identified as separate entities. However, experience suggests that teaching and learning could be mutually exclusive. In other words students will learn despite the teaching they receive rather than because of it. As Moore (1992) states:

"Teaching, the process by which one person brings about learning in another, is not essential to learning" (page 39).

Papert (1980) makes this point when he comments that children do not need teachers or curricula to learn, indeed they have already started to exercise their huge learning potential by the time they have started school. This is not to say that teaching is irrelevant, rather an acknowledgement that given certain conditions, most children and adults engage in learning that is self-motivated. This statement is based on the humanistic belief that the individual has a self actualizing tendency that is the basic directional force within all people to make sense of their world and to strive for fulfillment (Rogers, 1961). It is the individual's capacity for self development, intellectual growth and desire to learn that underpins the theory of education known as andragogy (Knowles, 1970a).

Andragogy has become a well known term in adult education and is associated with a particular approach to the education of adults (Knowles, 1990; Nottingham Andragogy Group, 1983). Knowles is regarded as the conceptual father of andragogy since he has been mainly responsible for its popularization. The term is derived from the Greek words 'aner' meaning man, plus 'agogus' meaning leader of and is compared with pedagogy literally means the art and science of teaching children. Andragogy is based on five main assumptions:

1. changes in self concept
2. role of experience
3. readiness to learn

4. orientation to learning

5. motivation

These assumption are based on the premise that as people grow and mature, their self concept moves from one of total dependency to one of increasing self directedness and it is at this point that they become psychologically adult. Knowles (1990) suggests that resentment and resistance is likely to occur if the adults wish to be self-directed is thwarted. As individuals mature they accumulate an expanding reservoir of knowledge and experience which becomes an increasingly rich learning resource, and at the same time facilitates integration and transfer. If this experience is ignored, they may feel that it is not just their experience which is being rejected, but themselves as people in their own right. Knowles (1990) argues that the adults' time perspective differs from children in that they have a need for immediacy of application. This has implications for adult education and thereby nurse education curricula.

Despite support for nursing curricula to move towards an andragogical approach (ENB, 1987), nurse education has been somewhat slow to recognize the advantages of the concepts of andragogy as opposed to pedagogy. Gott (1984) and Alexander (1983) found that nurse teachers have a tendency to instruct and spoonfeed their students, believing that their obligation to the student is fulfilled once the information has been imparted. In 1991 Osbourne contested that these findings still applied in many cases. Those curricula that have adopted the term andragogy have had to battle to support its continued use within their documentation (Milligan, 1995). This is due to the fact that

andragogy has come under heavy criticism in recent years and is reported to be a poorly defined and unnecessary theory (Darbyshire, 1993). Others have challenged the viability of andragogy as an educational theory and in particular some of Knowles' early work (Darbyshire, 1993; Jarvis, 1983; Nottingham Andragogy Group, 1983).

The main criticisms are surrounding the developmental differences between adults and children described by Knowles. Knowles (1990) proposed that the developmental differences between adults and children necessitated a different teaching style, although the style is dependent upon the individual's level of maturity. Knowles (1990) suggests that when individuals have reached a level of social maturity in which they can assume responsible positions in society, they can be regarded as an adult. Therefore the distinction between childhood and adulthood is not absolute, the process of transition is both gradual and continuing. What constitutes a responsible position in society? Many nursing students are catapulted into a position of responsibility on entering the nursing profession, when they find themselves in a busy ward having had very little practical experience. The majority of these students are 18 years old and at least 50% of them are under the age of 22. One could question whether social maturity is bound by age or experience, or both.

For some writers level of maturity is seen to be more than an assumed biological age, it is more about the ability of the individual to critically contextualise past and present experience (Goulbourne, 1997) and autonomy (Knowles, 1984). It is assumed that as children have less life experience they

are less mature. Similarly student nurses are often deemed to be unable to function within an adult learning environment which values the experience of the learner, due to their lack of practical nursing experience. Benner (1984) for example based her work 'From Novice to Expert' around the premise that the novice nurse does not have a repertoire of paradigm cases upon which to base their actions. And it is probably true that the student nurse does not have the formal propositional or practical knowledge pertaining to nursing on entering the profession. Despite this, the novice nurse is expected to function with some autonomy once in the clinical environment, and as much anecdotal evidence suggests, it is more often the case that students are left to their own devices than not.

Some writers have suggested that some experiential learning methods utilized within adult education are not suitable for novice nurses, one such method is reflective practice (Burrows, 1995; Schank, 1990; Miller and Malcolm, 1990). These are erroneous assumptions generally based on such premises as biological age and respective maturity. Whilst age is obviously a factor that promotes maturity, it is the sharing and reflecting on these experiences which is paramount for developing the maturity appropriate to the adult learning theory. The learner does bring with them a history of personal experience, informal theories and caring beliefs which can be expanded upon, integrated with other learnings and transferred to other situations through the educational process to facilitate maturity in learning. As the theory of andragogy assumes that students are less reliant on extrinsic motivation and more concerned with intrinsic motivation in learning situations, it could be argued that an individual

has achieved social maturity when they have an internally located locus of control, it would be interesting to explore further whether or not age has an impact on the individuals perceived locus of control.

Although further criticisms are made in relation to the polarization that Knowles created when contrasting the aims and methods of pedagogy with andragogy (Darbyshire, 1993), Knowles (1990) does acknowledge that this was erroneous. One of the many positive aspects of Knowles' work is that he encouraged many teachers to reassess the ways that learning has been planned, facilitated, assessed and evaluated.

The concept of andragogy does seem to fuel vigorous writing and this is also the case in nurse education (Milligan, 1995; Cohen, 1993; Nielson, 1992). Some writers have successfully shown some consistency between the salient features of andragogy and descriptions of caring (Boykin and Schoenhofer, 1990). The features of andragogy posited by the Nottingham Andragogy Group (1983) demonstrate clear parallels with the concept of caring:

- Mutual respect
- Trust, openness, care and commitment
- Equality
- Non-prescription
- Continuous negotiation
- Valuing process as part of learning
- Integrated thinking and learning
- Problem posing and knowledge creation

and so on.

This is particularly appropriate when viewed in terms of the relationship developed between the student and the facilitator, with that required of the nurse (Burnard, 1992). Andragogy, therefore, offers the advantage of mirroring the dynamics of the nurse/patient relationship as being based on mutual respect and equality, rather than an asymmetrical power relationship (Cohen, 1993; Sweeney, 1986). Learning takes place through a parallel process. Inevitably there is some power attributed to the role of teacher – as there is to the role of the nurse – the parallel process can serve to mirror how this power can be used to empower self and others.

The work of Houle (1980), Mezirow (1990), Schon (1987) and Knowles (1990) in adult education has helped to inform the teaching and learning practices in caring courses. Mezirow's (1990) transformative theory of adult learning describes the reconstruction of meaning. Such reconstruction occurs though reflection on experience, reflection connecting the internally personally constructed reality (private) with the external socially constructed (public) reality. Mezirow (1990) defined learning as a process of making new or revised interpretations of the meaning of an experience. The revised interpretations then guide subsequent understanding and action. This definition of learning requires that multiple modes of teaching and learning be used.

In summary the key elements of andragogy as described by Milligan (1995) are the:

"facilitation of adult learning that can best be achieved through a student-centred approach that, in a developmental manner, enhances the student self concept, promotes autonomy, self direction and critical thinking, reflects on experience and involves the learner in the diagnosis, planning, enaction and evaluation of their own learning needs" (page 22).

This summary says much about the experience of the student in the andragogical approach to learning and identifies the student centred approach as a way of facilitating adult learning. Traditional teaching styles based on behavioural theories of education have been criticized as being inappropriate for nurses, several studies have concluded that nurses, despite their biological age, are adult by the very nature of what they do in practice (Burnard, 1990; Richardson, 1988; Sweeney, 1986). Nursing practice requires the nurse to be self-motivated and creative, often expecting the practitioner to think on their feet. Further more, if, as was discussed in chapter one, Project 2000 programmes are intended to produce nurses that are autonomous, flexible, critical and professional (U.KC.C., 1996) an approach to teaching and learning that fosters such characteristics should prevail. Merchant (1989) makes this point rather more succinctly:

"Nurse learners are adult and will be expected to assume professional responsibility and maintain safe standards of practice. They, therefore, need to learn to judge their own performance and that of others" (page 311).

This study assumes that student nurses are adult learners and proposes experiential learning as a model of facilitating self directed learning in the same.

3. 3. 5 Student Centred Learning

Student centred learning is defined in the literature as placing emphasis on the participation and involvement of the student. The student is recognized as an individual with valuable experience and is encouraged to develop and express unique attitudes and values (Brandes and Ginnis, 1986; Rogers, 1983). The role of the teacher in student centred learning is that of facilitator of learning experiences and the learning experience is based on the definition of education as leading out. This is crucial to the development of self-efficacy, for as Bandura (1995) postulates students don't just need to know what it is that will make then successful, they need to feel the experience of success.

The client-centred roots upon which the student centred approach to learning were founded (Rogers, 1961) have been criticized as over-emphasizing personal meaning, understanding and personal power, without addressing the constraints in society which may affect the realization of this potential (Askew and Carnell, 1998). Askew and Carnell (1998) contend that the goal of the student centred model of education is to:

"enable young people to fit into society rather than to challenge social injustice" (page 89).

Building on the client centred work of Rogers (1961), they propose that a liberatory approach to education (Friere, 1972) goes someway to redeeming this omission. Both the liberatory model of education and humanistic theory

espouse a reflective process of learning, accepting subjective reflection and action for change. So, whilst this criticism is accepted, it would seem that a client centred approach might be an appropriate way to facilitate the reflective process, which in turn may lead to emancipation and to the challenge of social justice. The process of reflection is examined in a later section at which point the capacity of reflection to raise awareness of moral and social responsibility will be explored.

3. 3. 6 Experiential Learning

The roots of experiential learning are seen in the humanistic school of psychology. Dewey (1933) for example, suggests that life experiences are the foundation for the learning process, whilst Rogers (1983) believed that all meaningful learning took place through experience. McLeod (1996) captures this point saying:

"From a humanistic point of view, learning is always experiential in nature and is always a process that occurs in a relational context" (page 143). Experiential learning can be described as a way of learning as doing (Dowd, 1983). Heron (1982) defines the experiential learning technique as one which involves the whole person and his experience to a greater or lesser degree. Learning experiences are designed to be a process of personal discovery, encouraging the learners to inquire as to how they and others have come to know caring and the caring practices of nurses. However, not all learning involves learning to do.

"Understanding what others communicate concerning values, ideals, feelings and moral decisions is of great importance to adults" (Lebold and Douglas, 1998, page 19).

Rogers (1977) argued that experiential methods of teaching were particularly meaningful for adults, who may be impatient of learning which is detached from reality. Burnard (1990) identifies three main tenets of experiential learning, personal experience, reflection and transformation of knowledge and meaning. Personal experience refers to the involvement of the student and the life experience that he or she brings with them. The reflection process presents an opportunity to explore feelings, whilst the acquisition of new meanings and a deeper understanding is the transformation of knowledge.

Experiential learning is considered to be an effective means of nurse education and there are strong indications for its use (Burnard, 1992; Heron, 1991; Raichura, 1987; Dowd, 1983). Nursing is a practice based discipline and therefore learning by experience is an integral part of nurse education, in addition as already highlighted the students are all adults who bring with them their own experiences and will benefit from being given experiences from which to learn. However, this mode of teaching calls for a radical alteration in the conception of what nurse education entails. Much of the learning about what it means to be a nurse occurs informally when students identify with all the attitudes and practices displayed by tutors and other nurses. In experiential learning the roles of the nurse teacher and the student nurse become less differentiated with the learner being actively encouraged to take responsibility

for their own learning through the process of facilitation (Bradshaw, 1989). Jourard (1971) states:

"if teachers will show a greater interest in knowing the real selves of the students whom they teach, they will doubtless foster greater acknowledgment of their real selves by the students" (page 187).

This acknowledgement leads to a process of empowerment in the student and as already mentioned this process of empowerment of the student parallels the process in practice of empowering the patient.

Experiential learning has been adopted in pockets in nurse education and its benefits are documented in localized research studies. In 1991 McCaugherty carried out a study to explore the use of experiential learning as a method to reduce the gap between theory and practice. Amongst his findings he concluded that that experiential teaching model is able to circumvent many of the difficulties that underpin the theory-practice gap. He describes the experiential approach as an active method of learning and places it firmly within andragogy (Knowles, 1970).

Burnard (1992) reporting the findings of a research study, highlighted that experiential learning is active rather than passive, involves personal learning and requires reflection. Hence experiential learning is not simply learning by doing, for knowledge at this level remains public. In addition there needs to be interaction both with the material and the inner world (private domain) of the learner through reflection in order to make the learning personal. As Burnard (1992) comments the key issue is to remember to reflect, drawing upon

Reyner (1984), he adds that it is easy to let life occur and to not notice what is happening. Reflection calls for a conscious decision to notice what is happening and to study what is happening to you.

There have been few attempts by researchers to evaluate the effectiveness of experiential learning in terms of changes in the participant's behaviour in the work setting. It could be argued that nurses are a good sample for research of this kind as they are in the unique position of being both a student in the classroom and a nurse in practice. Much of the research that has been carried out suggests that experiential learning leads to a greater sense of control over one's life, that is the locus of control is felt to be more internal as opposed to external. This is related to self-efficacy, Bandura (1995) for example correlates internality with positive self-concept, increased self-esteem and social influence and decreased anxiety. It is contested here that the shift towards an internal locus of control is a positive move for nurses.

Knowles (1990) mooted that activity that involves personal learning involves the self. Where there is a change to something personal, the sense of who one is, is also changed. In Burnard's study (1992) two outcomes of experiential learning dominated the findings, these were the development of self-awareness and the development of interpersonal skills. The idea of self-awareness links directly with reflection, any shift in self-awareness necessitates even a small amount of inward reflection. In other words the development of self-awareness is an active and reflective process (Kenworthy and Nicklin, 1989).

As Burnard (1992) notes:

"To come to know who you are first involves reflecting on what is going on inside" (page 158).

Experiential learning can be felt to be threatening; it has already been noted in this study that experiential learning causes discomfort and challenge. In a further study by Burnard (1989) it was found that one of the reasons for students finding experiential learning threatening was that it was 'personal' as opposed to the more impersonal approaches such as lectures. Exploration of experiences and connected feelings is potentially an anxiety provoking situation and students can sometimes feel awkward and unsure of what is expected of them (Burnard, 1989; 1989a). Exploration of feelings can also be threatening for the teacher. Students are liable to make discoveries for which the teacher had not planned and high levels of emotion can be expressed. Hence, a certain level of anxiety and discomfort is likely to be felt by both the student and the teacher. Although as Hunt (1971) and Joyce (1984) remind us, discomfort is a precursor to growth.

Joyce (1984) poses the question how can the learner be made comfortable and uncomfortable simultaneously. The work of Heron (1982) implies that participating in experiential learning should be voluntary and states that the student should be allowed to withdraw from the situation at any time. However, this is not always an easy opportunity for the leaner to afford, students may feel the need to conform to the group norm and as such feel oppressed. For students to feel comfortable enough to make these sorts of

uncomfortable choices there needs to be a climate of trust, support and acceptance (Quinn, 1988).

Knowles (1970) identifies a learning climate as one in which adults feel physically at ease, psychologically accepted and respected and where there is allowance for freedom of expression without fear of ridicule. Various methods have been used to create this relaxed atmosphere. Exercises such as 'warm up' exercises and 'icebreakers' are commonly employed, although some students find these 'relaxing' exercises threatening in themselves. Indeed it has been argued that some of these exercises are 'unadult' in themselves (Burnard, 1989b).

Given that much of the literature gives the impression that it is the teaching method that is responsible for success, there is little wonder that methods of teaching and learning are a matter for concern and debate. Jacono and Jacono (1994) however, assert with some enthusiasm that it is the individual characteristics of the teacher which are most important to the success of any teaching situation. They are in accord with the nursing theorists Margaret Newman (1994) and Rosemary Parse (1987) who believe that if one relates to another as one truly is, one will help illuminate the meaning of the situation. This could be re-conceptualised as being congruent facilitates therapeutic use of self (as teacher/ nurse). This, say Jacono and Jacono (1994) is what teaching is all about and contemporary nursing theorists suggest that this is what nursing is about (Watson, 1998; Roach, 1997).

As previously mentioned the role of the teacher in experiential learning is that of facilitator. It has been stated that all that is needed to facilitate learning is human experience itself (Knowles, 1990), this view appears to be harmonious with that of Jacono and Jacono (1994), Newman (1994) and Parse (1987). Facilitation itself can be defined as making things possible for another through a process which makes it simpler for the individual to achieve their goal (Bradshaw, 1989). It is suggested that the role of facilitator makes specific demands upon the facilitator, namely that the facilitator requires a high level of self-awareness gained through ongoing self-exploration. The facilitator is also encouraged to be congruent at all times, implying that the facilitator is expected to match their own words with their actions (Bradshaw, 1989; Rogers, 1983).

Kagan (1985) points out that unease and anxiety in the facilitator - which may be caused through lack of experience- could possibly lead to an atmosphere of discomfort. Others would argue that unless there is some unease and anxiety in the facilitator then learning will not be maximized (Joyce, 1984). It could be said that whether or not the facilitator is anxious is immaterial, what matters is that the facilitator is aware of and congruent with how they are feeling.

The literature supports many practical ways of working with experience - role play for example is felt to give immediate and long term benefits bringing together thinking, feeling, and doing (Wibley, 1983). Role play features a person playing someone they are not, learning takes place either by participation or observation (Burnard, 1990). The facilitator encourages a

climate of safety in the group to give support and is seen to be available. The facilitator is required to know their own limits in order to maintain an overview of what is learnt. It is vital that a de-briefing period is allowed following the role-play to allow the student to return to their real world and the person they were before the role-play. The experience alone however is not sufficient and reflection is encouraged as a way of integrating the new experience with the past. This type of reflection requires a great deal of self-monitoring and discipline, but encourages learner autonomy by facilitating in the learner the ability to check their own development. Other ways of working with experience include simulations, discussion, critical incident analysis and brainstorming.

A development in experiential learning method is that of learning through reflection. Reflection offers a way of accessing deeply embedded personal knowledge. Schon (1983) purports that thinking, via reflection, adds theory to the action whilst it is occurring, making theory and practice inseparable. Osbourne (1991) recommended that this form of learning needed to be considered further, arguing that both teacher and learner should take the opportunity to learn and reflect together. It has already become apparent that the focus of experiential learning is very much on praxis, that is reflection on experience. Kolb (1984) proposed a model of experiential learning which described a four stage cyclical process and incorporated reflection as a significant phase. This model can be seen in figure 1, chapter 2.

The next section is devoted to exploring reflection and reflective practice as an experiential approach to learning, it is asserted that reflective practice is a

learning method that values the student, placing them at the centre of the learning and is compatible with the principles of adult learning and transformatory education.

3. 3. 7 Reflexivity, Reflection and Reflective Practice

Reflexivity refers to the human capacity to monitor reactions to situations, actions and inner feelings. Humanistic theory places emphasis on the importance of persons as capable of reflecting on experience. McLeod (1996) comments that:

"The possibility of choice arises from reflexivity, since the person does not respond automatically to events but acts intentionally based on awareness of alternatives" (page 136).

Reflexivity, however, brings with it another dimension aside from choice, that of moral obligation. With the existence of choice comes the necessity to examine beliefs and values which underpin the choices. Intentional human action leads the individual to become aware of moral responsibility, locus of evaluation becomes an external and an internal consideration, in other words, becoming aware of the inner world brings with it a necessary awareness of the outer world and one's responsibility to that, that is the other and society

Nursing along with other professions has seen an increasing interest in the potential of reflection as a learning tool and as a means of integrating theory and practice (Osbourne, 1996; Atkins and Murphy, 1993; Clarke, 1986; Schon, 1983). Most of the literature around reflection is deliberative and there is still much debate over what constitutes reflective practice (Osbourne, 1996).

Atkins and Murphy (1993) for example, undertook a review of the literature on reflection and concluded that the available literature is complex and abstract. It is the legacy of the traditional positivist paradigm that drives us to know exactly what reflection is, knowing the thing that we work with enables us to control and manipulate it to certain ends. Nevertheless there has been a considerable amount of literature produced on the subject and it is an important part of the process to explore the development of our knowledge of reflection thus far.

Early attempts at defining reflection drew upon the work of philosophers and one of the earliest was posited by Dewey (1933):

"active, persistent and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends" (page 84).

Since this early viewpoint, many other writers have followed on with their own definitions, these are nearly always linked to learning from experience, some of which share some commonalties, Boyd and Fales (1983) for example describe reflective learning as an internal process in which an issue of concern is examined. Thus, meaning is created and clarified in terms of self, resulting in a changed conceptual perspective. Boyd and Fales (1983) are asserting here that through reflection the individual may come to see the world differently and as a result of new insights may come to act differently. The significant part of this definition is that is it involves a change in the self, it is not just the behaviour that has changed but the person. Here, we are getting a hint of the transformative potential of reflection.

Johns (1995) interprets reflection as being:

"the practitioner's ability to access, makes sense of and learn through work experience, to achieve more desirable, effective and satisfying work" (page 24).

For Johns the issue of concern that Boyd and Fales (1983) allude to comes from the experience of conflict in practice. This is the thrust of the work of Arygris and Schon (1974) who discussed the notion of action theories. All human actions reflect ideas, models or some kind of theoretical notion of purpose and intention and how these purposes and intentions can be executed (Freshwater 1998; Langford, 1973). These notions can be called action theories. Agyris and Schon (1974) noted that people often say one thing and do another. Thus, an individual has a personal theory but when it is operationalised, there is often a contradiction. Based on this idea, Arygris and Schon (1974) developed the concept of espoused theories, the stated purpose or intention, and theories in use, the attempt to put stated intentions or purpose into action. Espoused theories are those to which individuals claim allegiance: theories in use are those theories which are present when action is executed. Human action, therefore is never atheoretical or accidental, even if the theory involved in the action is implicit or tacit. It is argued that reflection is a way of redeeming theories in use which may be tacit (Greenwood, 1998).

As already mentioned nurse teachers and nurse practitioners have been criticized for espousing caring beliefs that do not match up with theories in use. And as discussed, with increasing emphasis being placed on evidence

based practice, there is a growing demand for nurses to maintain a closer compatibility between their espoused theories (caring belief) and their theories in action (nursing care). Johns terms this gap the conflict between desired care and actual care (Johns, 1998a).

Reflection has been predominantly defined in terms of a learning tool. Schon (1983) has done much to surface the role of reflection in professional education. In addition, he has raised issues surrounding the application of theory to practice. Schon (1983) describes the limitations of knowledge derived from technical rationality for practice, that is

"the application of research based knowledge to the solution of instrumental choice that dominates the epistemology of professional practice" (page 13).

Schon (1983) argued that practitioners have difficulty in utilizing this type of knowledge as it is generated in situations that are context free, thereby ignoring the context of the actual practice situation. Schon (1983) also drew attention to the fact that practitioners do not as a rule make decisions based on technical rationality, but on experience.

Schons' (1983) work has been criticised by many writers, mainly in relation to the concept of reflection in action, which it is suggested, needs further clarification (Eraut, 1995; Day, 1993). Eraut (1995) has made a comprehensive critique of Schons' work arguing that some of his work remains unclear.

In the nursing literature Greenwood (1998) criticizes Schons' (1983) model of reflection, arguing that it does not recognize reflection before action; this is a valid point. The figure below sets out a personal model of reflection in which vision is used as a metaphor to illustrate the different types of reflection that may occur within reflective practice.

Schons' Model of Reflection (1983):	Vision as a metaphor for reflection
Reflection On Action	Hindsight
Reflection In Action	Insight
Greenwood (1998) adds Reflection before Action	Foresight

Figure 3. 1 A Metaphor for Schon's (1983) Model of Reflection

This is a longitudinal view of reflection based within a linear timeframe, drawing upon Western logic, reflection however also has differing levels of depth. These levels of reflectivity are discussed by Mezirow (1981). The levels of reflectivity fall into two broad categories, consciousness and critical consciousness. Figure 3. 2 outlines the levels within each category.

Consciousness	Critical Consciousness
Affective reflectivity	Conceptual reflectivity
Discriminant reflectivity	Psychic reflectivity
Judgmental reflectivity	Theoretical reflectivity

Figure 3. 2 Mezirow's (1981) levels of reflectivity.

Mezirow (1981) suggest the idea of a continuum from consciousness to critical consciousness towards perspective transformation.

One of the problems of having a range of definitions of reflection is that where reflective practice is concerned a variety of different frameworks will be generated from the various definitions. Frameworks provide a useful starting point as the process of constructing an experience becomes so taken for granted that we only become aware that it is a process when we break it down.

Greenwood (1998) has explored this idea in depth and proposes that two types of framework exist in relation to the process of reflection, she identifies these as single loop and double loop learning. Generating the concept of single and double loop learning from the work of Arygris and Schon (1974) she posits that the reflective practitioner may respond to a reflection on a situation in two ways. Firstly, the practitioner may search for an alternative means to achieve the same ends, the actions are changed in order to achieve the same outcomes, this she terms single loop learning. Secondly, the practitioner may respond not

only by exploring alternative means to achieve the intended outcomes, but also examines the appropriateness of the chosen ends. Thus double loop learning:

"involves reflection on values and norms and, by implication, the social structures which were instrumental in their development and which render them meaningful" (page 1049).

This could be interpreted to mean that the practitioner is actively engaged in examining themselves and themselves in relation to other, in this instance the social structure within which they operate. This type of reflection requires a great deal of self-monitoring and discipline, but encourages learner autonomy by facilitating in the learner the ability to check their own development.

Greenwood's (1998) notions of single and double loop learning equate with practice of surface and deep learning. So that reflection in itself becomes subdivided into an open and closed system. In other words reflective practice is technically rationalized through the use of the frameworks which inspire reflection as a means to an end (Richardson, 1995; Greenwood, 1998). In this way the frameworks which have been devised to allow for recognition of the uniqueness of individual experience are prescribed and rigidly adhered to, instead of espousing reflection as a tool for emancipatory learning. Hence, reflective practice is party to the same risk of other models developed to overcome oppression, namely that it becomes oppressive itself when it becomes normative. Thus questions are raised concerning the intended outcomes of reflective frameworks, for example has reflection taken place if no new understanding or changed perspective has occurred?

Greenwood (1998) quotes Smyth (1989) as being particularly insightful in the realms of double loop learning. Smyth's (1989) framework is presented along with Johns (1998) model of structured reflection below as examples of double loop and single loop learning respectively.

Write a description of the experience.

What are the significant issues I need to pay attention to?

Reflective cues: What was I trying to achieve?

Why did I respond as I did?

What were the consequences of that for: the patient

Others

Myself

How was this person(s) feeling?

How did I know this?

Personal: How did I feel in this situation?

What internal factors were influencing me?

Ethics: How did my actions match with my beliefs?

What factors made me act in incongruent ways?

Empiric: What knowledge did or should have informed me?

Reflexivity: How does this connect with previous experience?

Could I handle this better in similar situations?

What would the consequences be of alternative actions for:

Patient

Others

Myself

How do I now feel about this experience?

Can I support myself and others better as a consequence?

Has this changed my ways of knowing?

Figure 3.3 Johns' model of Structured reflection (Johns and Freshwater, 1998).

- Describe - what did I do?
- Inform - what does this mean?
- Confront- how did I come to be like this?
- Reconstruct- how might I do things differently?

OR

- What do my practices say about my assumptions, values and beliefs about nursing?
- Where did these ideas come from?
- What social practices are expressed in these ideas?
- What is it that causes me to maintain my theories?
- What views of power do they embody?
- Whose interests seem to be served by my practices?
- What is it that acts to constrain my views of what is possible in nursing?

Figure 3. 4 Smyth's (1989) framework for reflection on action

Greenwood's (1998) work on reflection provides a useful discussion point particularly in relation to the current study, main points when extracted can be illustrated as in figure 3.5.

Single Loop Learning	Local knowing	Surface learning	Closed system
Double Loop Learning	Social -political knowing	Deep Learning	Open System

Figure 3. 5 A model based on Greenwood's single and double loop learning (1998)

On reading the literature it would be easy just as in research, to slip into devising a hierarchy of reflection, as Greenwood (1998) does, putting double

loop learning as superior to single loop learning. This is not useful as it argues for a gap reminiscent of the theory-practice. And as previously indicated deep learning can only be made known by coming to the surface. It is preferable to advocate an approach to reflection which provides a structure within which structures can be deconstructed. In other words a reflective framework needs to be used flexibly and dynamically. Indeed all work surrounding reflection and its development needs to be relative and evolutionary, paralleling the true nature of reflection.

Whilst defining the term itself may have caused a few conceptual headaches, it would seem from the literature that it is easier to describe the process of reflection and it is to this that I will now turn my attention. However, before moving on there is one further comment to be made regarding the arrival at a definition of reflection. Taking up the point made by Atkins and Murphy (1993) that if authors do not share a common definition of reflection then it is difficult to make comparisons across studies, which in turn makes it difficult to assess the value of reflection in influencing patient outcomes. This seems to miss the point that reflection is an individual process of learning which reflects individual experience and meaning. It is by its very nature localized and there will therefore be some differences in how it is understood and processed and at the same time there will be some shared commonalties which can be generalized.

Newell (1994), it seems, is closer to the mark when he argues, with some vehemence, that reflection needs to be defined in a way which allows its

efficacy on nurses and client care to be tested. This is not only a valid point but allows for individual definitions of reflection to be operationalised in the pursuit of evidence based practice.

And so to the definition of reflection that will be utilized within this study. The definition put forward by Boyd and Fales (1983) closely matches my own understanding of reflection and correlates with the definitions of transformatory learning which place the self as central to the learning process and is therefore deemed a suitable working definition of reflection for the purpose of this thesis.

The definition runs as follows:

"The process of creating and clarifying the meaning of experience (present or past) in terms of self (self in relation to self and self in relation to the world). The outcome of the process is changed conceptual perspective" (page 101).

What the literature regarding reflection does have in common is that the process of reflection is discussed. Most authors identify stages or levels of reflection, Mezirow (1981) levels of reflectivity have been indicated previously, Schon (1983) identified three levels of reflection, these being reflection, criticism and action, others have also been posited (Van Manen, 1977). Atkins and Murphy (1993) in their assessment of the literature discovered that there were three key stages in the reflective process that were shared by most authors. Figure 3.6 attempts to synthesize some of these. Several authors have devised reflective cycles to illustrate the integral and circular nature of the reflective process (Gibbs, 1988; Kolb, 1984).

First Stage	Awareness of uncomfortable feelings and thoughts Schon (1987) - experience of surprise Boyd and Fales (1983) - inner discomfort Mezirow (1981) - affective, discriminant, judgmental reflectivity
Second Stage	Critical analysis of the situation Schon (1987) - reflection and criticism Mezirow (1981) - Conceptual, Psychic and Theoretical reflectivity Boud et al (1985) - association, integration, validation and appropriation
Third Stage	Development of new perspective Mezirow (1981) - perspective transformation Boud et al (1985) - cognitive, affective and behavioural changes Schon (1997) – action

Figure 3. 6 The process of reflection.

Criticisms of reflective practice mainly centre on its failure to demonstrate its usefulness through research studies, Day (1993) points out that how reflection changes practice is unknown and as such these criticisms can be anticipated (Atkins and Murphy, 1993). This criticism stems from the argument that the studies which have been carried out relate only to the process of reflection and the practitioner's experience (Hargreaves, 1997). These criticisms are wide of the mark as the value of reflection is inherent in the experience of the process. As Heath (1998) argues:

"Reflective practice focuses on practice 'as it is' and aims to enhance practice from that starting point..." (page 291).

The positivist voice is present in this criticism which ignores the focus of reflective practice as a starting point in favour of a defining point. This is understandable in light of the drive towards evidence based practice, although one could question where the evidence of effective practice is located.

There is, however, some evidence, albeit minimal, that reflective practice has links with client outcomes. Powell (1989) attempted to access tacit knowledge, often described as defying explanation, using reflection. Powell's (1989) study used Mezirow's levels of reflectivity as signposts to monitor the depth of reflection undertaken by a group of practitioners. Although a small sample was used in this local study, it provides a useful benchmark for development to explore how levels of reflection may enhance practice outcomes. Other research studies that have examined the link between reflection and client care include McCaugherty (1991); Crandall and Getchell-Reiter (1993); Gray and Forsstrom (1991); Johns (1998a); Hodgston (1995) to name a few.

Whilst skeptics accept that reflection offers valuable insight into interactions surrounding client care (Tolley, 1995), the main area of contention continues to be about the relatively small gains that are accumulated over time by individual practitioners. It would appear that to be of value benefits must be large and rapid with measurable outcomes (Heath, 1998). This relates to Rolfe's (1996) hierarchy of nursing research and is a reminder that quantitative research, level one formal theory, which can be generalized to a large population, is still viewed as superior to smaller more localized studies which generate informal theory, despite the fact that these studies are much closer to

the world of practice (the swampy lowlands, Schon, 1983). In other words these criticisms perpetuate the schism between theory and practice and the two continue to remain polarized.

Much of the research that has explored reflective practice as a teaching and learning tool in nursing has been carried out with post registration nurses (Wong et al, 1995; Richardson and Maltby, 1995; Powell, 1989). Rationale for this is often around the point made earlier concerning the ability of student nurses to make use of reflection as a learning process. David McCaugherty (1991), however, examined a teaching model to promote reflection with first year student nurses in the clinical area. Although his findings supported the use of reflection with junior nurses, very little other work seems to have been undertaken with such junior nurses, and not specifically in the classroom. This is certainly an area for further exploration.

In summary then, it would seem that definitions of reflection are flexible and dynamic, mirroring the process of learning from experience. The process of reflection involves an awareness of uncomfortable feelings and thoughts are followed by a critical analysis of feelings and knowledge leading to the development of a new perspective. Thus as Atkins and Murphy (1993) conclude:

"Reflection, therefore, must involve the self and must lead to a changed perspective" (page 1191).

With the infusion of reflective practice in nursing it would seem that awareness and evaluation of self, experience and others is not only

recommended skill but a requisite of nurse education. This might lead one to question the purpose of nurse education - is its purpose to achieve professional competence or self-actualization, (the caring-competence dichotomy)? Boydell (1976) argues that they are both the same. Personal experience certainly indicates that one is very closely linked with the other. From whatever vantagepoint, the notion of the self assumes a central position.

3. 3. 8. The Self and Self-Concept.

The literature on the topic of self is large and diverse. It ranges from theories of self in philosophical terms (Satre, 1956), to theories of self in psychological terms (Freud, 1963; Lacan, 1966), to spiritual and transpersonal theories (Wilber, 1981) to biological theories (Ginsburg, 1984). The concept of self possessed by a person is a product of both personal reflection and social interaction (McLeod, 1996). Dawson (1998) cites Priest's (1991) definition of the self as:

"an individual that is conscious of the individual that it is while at the same time being conscious that it is the individual it is conscious of" (page163).

The self is an important concept in nursing as often when patients are ill, either physically or psychologically:

"the most striking and consistent feature reported is a changed self concept" (Dawson, 1998, page 164).

Dawson (1998) argues that the conception of self most commonly used in nursing is one of Cartesian duality. These comments are harmonious with those of nursing theorists Parse (1987), Rogers, (1970) and Newman (1994).

The experiencing self as described by Bohart (1993) and Maddi (1989) is essentially anti-reductionist in nature. Life is apprehended through experiencing, which involves an interplay of thought and feeling, without either of these concepts being conceived of as polar opposites (Bohart, 1993). Humanistic psychologists describe the self as conceived of separate entities. Rogers (1991) for example speaks of the organismic self and the self-concept. The organismic self is that aspect of the self which is essentially the real inner life of the person and is present from birth. The organismic self consists of the basic force which regulates the individual's physiological and psychological growth, growth and maturity are seen as the central aims of this aspect of the self. (Hough, 1994; Rogers, 1991). Therefore the focus of the organismic self is essentially internal.

According to Burns (1982) self-concept is:

"forged out of the influences exerted on the individual from outside, particularly from people who are significant others" (page 9).

This definition is in accord with the humanistic school of psychology, which views the self concept as the individual's perception of himself, based on life experience and the way he sees himself reflected in the attitudes of others (Rogers, 1991). The self-concept is acquired very early on in life and is continually reinforced by ongoing communications with significant others throughout life. As the self develops it needs, to feel loved and accepted and as a result the organismic self is neglected in favour of the self-concept. This is a point that Maslow (1970) illustrates in his hierarchy of needs (figure 3.7).

Need for

Self actualization

(am I myself?)

Recognition Needs

(am I successful/ respected?)

Belonging needs

(am I loved, Do I belong?)

Safety Needs

(am I safe/ comfortable?)

Physiological Needs

(will I Survive?)

Figure 3. 7 Maslow's hierarchy of human needs (1970).

These ideas are not dissimilar to the theories of self-developed by Carl Jung (1960). The self-concept can be likened to Jung's idea of the persona, with the psyche sitting closely to the organismic self. For Jung the self was buried in the unconscious and full of creative potential. Jung believed that the aim of the psyche was towards individuation, that is the growth of an individual towards becoming aware of all aspects of their personality, which leads to a better balance between their internal and external worlds and an integration of opposites. Through the process of socialization, the self is repressed and thwarted, a persona is developed as the individual becomes absorbed in enacting roles. Thus the individual becomes alienated from who they are and who they might become. The goal of Jungian therapy as with emancipatory and liberatory education is to facilitate the emergence of the authentic self

(and to transcend false consciousness in Friere's (1972) terms. (Hall, 1986). It is for this reason that the Jungian concept of self will be utilized in this study.

The focus of the self-concept is predominantly external. Rogers (1991) believed that the tendency of the organismic self was towards harmony and integration of discomfort arising as a result of inconsistency in ideas and feelings between the organismic self (the inner) and the self concept (the outer). Burns (1982) contends that the self-concept has three roles, one of which is that of maintaining consistency, the other two being determining how experiences are interpreted and providing a set of expectancies. Where consistency is not maintained a degree of dissonance is experienced (Festinger, 1957), the discomfort that this causes is likely to motivate the individual to take action towards harmony and comfort, at any costs. This process mirrors the three key stages of reflection previously identified: awareness of discomfort; critical analysis of the situation; development of a new perspective/action, although this process may not necessarily be a conscious one.

3. 3. 9. Self-Consciousness, Awareness and Nursing.

The 'I' being self-conscious disappears in repetitive doing and is only found again when reflected upon (Spinelli, 1989). It could be argued that the repeating of routine tasks and focus on doing by nurses leads to a loss of 'I' or self. Reflection is proposed as helping the nurse to reform her identity through being in relation with herself and others, instead of having an identity that is forged by her surroundings (see Jourard 1971). Without reflection the nurse

may not be aware of the loss of self, which may manifest itself in physical and psychological symptoms such as burn out and a sense of meaninglessness.

Self-consciousness or awareness, it is said, is a 'good thing' for nurses (Bond, 1986). It is contested that in order to begin to understand and help other people, nurses need to be aware of themselves (Woods, 1998; Burnard, 1992). It is claimed here that self-awareness does not only benefit relations with clients, but is crucial to the health and well being of the nurse. There is much talk about the therapeutic use of self in the nursing literature (Jacono and Jacono, 1994; Murray and Huelskoetter, 1987). Emphasis is placed on the necessity for the nurse to act with intention when acting in a therapeutic way, suggesting a degree of self-awareness is required (Ersser, 1998). This is not to deny the therapeutic value of natural spontaneous emotional displays for patients but one must have a self available and be aware of that self in order to use it therapeutically.

It has been suggested that knowing self is a frequently unmet challenge by nurses. Nurses have such an inclination to focus on the behaviour and potentials of others that they rarely seek self-appraisal (Reres, 1974). Although paradoxically it is the focus on other that very often brings appraisal. One frequently asked question in the literature is 'Are there characteristics and qualities which nurses need and which should be identified at selection interviews?' Some writers indicate that there is what could be called a 'typical' nursing personality (Cooper et al, 1976). This is like asking the question: Is there an average nurse? The answer to this has to be no, just like there is not

an average patient. There may be some similarities in characteristics, but as Lacan (in Macey, 1988) points out, the individual does not have a set of fixed characteristics hence one can never be totally defined. So, just like each patient undergoing surgery will respond differently to the same operation, each nurse will interact in their own unique way with the clinical environment.

The word personality is used to describe the way people are perceived in relation to others. Their personality is the thing that distinguishes them from others. As indicated in chapter two, the cultural narration of nurse's is to be subordinate. There is evidence in the literature to support the fact that students within the nursing profession lack autonomy and control (Friedson, 1970), have a lack of self-esteem (Greenleaf, 1978), have a fear of success (LeRoux, 1978) and subscribe to passive- aggressive behaviours (Stein, 1978). But does nursing attract this 'type' of person, or are people socialized to be this way during the process of professionalisation. These are difficult issues to differentiate and therefore diagnose. For as Kolb (1984) explains

"Environments tend to change personal characteristics to fit them" (the process of socialization), however "people tend to select themselves into environments that are constant with their personal characteristics" (page, 143).

So, nurses face a struggle to assert nursing values against a gradient of professional dominance and are socialized into passive, subordinate, powerless roles. This dominance is in turn rationalized due to a need to be valued (Buckenham and McGrath, 1983). Some authors have framed these characteristics of the nurse against those of the oppressed woman, arguing that

the majority of nurses are women and bring with them a history of oppression (Street, 1991; Reverby, 1987). In addition, caring is often viewed as an extension of being a woman and is therefore not valued as work in its own right.

There is little doubt that such external factors affect work performance. The greater the external pressure we feel being imposed upon us, the less attractive the faced activity becomes, the greater the emotional dissatisfaction and the poorer the performance. Mullins (1989) suggests that the quality of working life is affected by the interaction between the goals of the individual and the goals of the organization in which they work. This relates to the attribution theory of motivation which enforces that behaviour is determined by a combination of perceived internal and external forces (Mullins, 1989). Further, it is posited that work performance is closely aligned with the practitioner's locus of control; that is, whether practitioners perceive outcomes as controlled by themselves or by external factors. Much has been said pertaining to the idea of locus of control thus far. Perception of control is important to all individuals whatever their walk of life. This idea was developed by Rotter (1966) who maintained that certain individuals believe that there is a strong link between what they do and what happens to them (originators of behaviour) while others deny or minimize this link and explain events on the basis of fate, luck or chance (non originators). Hence when individuals perceive the event to be dependent on their behaviour, they have an internal locus of control. If, on the other hand they believe that they do not have any control over events and attribute success or failure to outside forces, they have an external locus of

control (Reber, 1995). Behuniak and Gable (1981) remark that perception of control is of particular significance to students as it increases student autonomy and promotes ownership of learning and courses.

Mullins (1989) states that:

"Employees with an internal control orientation are more likely to believe that they can influence their level of performance through their own abilities. Employees with an external locus of control are more likely to believe their level of performance is determined by external factors beyond their influence" (page 327).

Hence if nurses are more inclined to an external locus of control, they will tend to believe that they have no control over their level of performance. Paradoxically with a fear of success and a low self-esteem, the same nurses will probably have the tendency to blame themselves for poor standards of care and ineffective practice.

3. 3. 10 Self as Learner

If factors such as locus of control and assertiveness influence work performance, then it is reasonable to assume that these factors will also have an impact on the individuals capacity to learn. As already revealed Jung's opinion of the self mooted several different aspects to the personality, which strive to become integrated. He included in these, attitudes towards the outer world and ways of perceiving the world. Jung (1971) indicated four predominant ways of perceiving the world: thinking, feeling, intuition and sensing, in addition, individuals approach the world from either a

predominantly extrovert or introvert manner. Although it should be noted that Jung maintained that a person's psyche contains all of these aspects, but in their development identify with a preferred way of translating information. Scales have been devised to measure the extent to which an individual has a preference for ways of relating to the world (Myers, 1980; Jung, 1971), Similarly, it is debated that individuals have a preferred style of learning (Kolb, 1984).

The concept of learning styles, based on the work of David Kolb (1984), and previously Pask (1976) has become a popular method of assessing and explaining the learning methods of student nurses. In order to assist this process Kolb (1984) devised a tool for measuring learning styles known as the Learning Style Inventory. The Kolb learning style inventory (LSI) is a theory based, self report instrument. The LSI measures a person's strengths and weaknesses as a learner. However, learning styles are only one component of a whole process and the Kolb LSI is only one means of measuring preferred learning styles (Brazen and Roth, 1995).

The Kolb Learning Style Inventory is a tool used for assessing components of the Experiential Learning Model (Kolb, 1976). Kolb (1984) like Jung, advocates that the learner must have some of all four abilities. The Kolb Learning Style Inventory (LSI) assesses the scores of an individual on each of the four stages of the learning model, producing a measure of the extent to which an individual emphasizes abstractness over concreteness (AC-CE), and that of action over reflection (AE-RO). The last two components of the LSI

are often represented by a graph with AC-CE being the vertical axis and AE-RO the horizontal axis. Representing scores in this way leads to the plotting of AC-CE versus AE-RO into one of four quadrants, each quadrant representing a learning style. The quadrants are labeled converger, diverger, assimilator and accomodator. The validity and reliability of the LSI has been questioned and can be pursued in Sims et al (1986).

Considerable research has been undertaken into student nurses learning styles in recent years, (Cavanagh et al, 1995; Highfield, 1988), not just to optimize the students learning potential, but also as a tool to improve success and reduce the attrition rate. Findings have demonstrated little of note. Examples include, Merritt (1983) and Johanson (1987) who found no statistically significant relationship between age and learning style in nurses, whilst Laschinger and Boss (1984) found no relationship between learning style and the specialty students were studying. Osbourne (1991) stated that:

"Further research is called for concerning various learning styles, for example, reflection in action with reference to the planning of student experiences and the encouragement of mature entrants (*who may well be equipped to use this learning style*) to nursing" (page 349).

But the value of this sort of research is debatable for several reasons.

A person's learning style is his or her preferred way of learning, but it is suggested that a person's learning style is not actually learned (Kolb, 1984). Furthermore, learning style implies a consistency of approach on the part of the learner, that is, the learner must show a particular type of behaviour

consistently in order to be categorized. Thus, there is some dispute as to whether or not learning styles should be matched by teaching styles in order to maximize learning potential. Not only are consistent learning styles debatable but as the ENB report of 1994 suggests:

"they (learning styles) may also be incompatible with the reality of students' learning responses in a complex environment". (page 8)

The report goes on to say that:

"it is unproductive to assume or to look for consistent learning styles when the very essence of successful learning is students' ability to use their repertoire of skills adaptively and flexibly. Such flexibility may depend on students' ability to perceive 'correctly' what is wanted in the situation and to adapt their learning accordingly." (page 9).

Joyce (1984) also contests the matching of teaching and learning styles but for different reasons:

"Rather than matching teaching approaches to students in such a way as to minimize discomfort, our task is to expose the student to new teaching modalities that will, for some time, be uncomfortable to them" (Page 29).

Given that one of the intended outcomes of the Project 2000 programme is for the practitioner to be flexible, it would seem that learning to learn flexibly is not only desirable but crucial for the student nurses' professional development. Perhaps what researchers ought to be studying are not nurses' learning styles, but rather their perceptions of and interpretations of situations and their ability to respond from multiple realities. It could be suggested that an understanding of personal perceptions and responses to learning situations can help the

learner to develop a broader and more complex range of learning styles and therefore responses. In this way the process of education would indeed be a process of individuation (Jung, 1971). One method of helping the learner to develop a wider range of interpretations and therefore responses is to talk with students about their practical experiences and to help them make sense of them, that is through the reflective process (Schon, 1983).

3. 4 Research aims

In summary several significant points have been raised and discussed within the preceding theoretical statement, namely that:

- The theory-practice gap is a significant issue in nursing
- The theory-practice gap may be reduced by attending to the value that nurses attribute to themselves and their experience
- The theory-practice gap is symbolic of internal contradictions buried deep within the nurse's psyche
- Traditional approaches to education perpetuate the theory-practice gap and the individuals experience of powerlessness
- Nurses locate their locus of control externally, experiencing themselves as powerless.
- Nurses often dis-empower themselves through a lack of self consciousness
- Transformatory approaches to education potentially reduce the theory-practice gap through a focus on inside out learning

- Transformatory education has the potential to facilitate increased levels of consciousness, improve self esteem and expedite a shift in locus of control leading to a feeling of liberation
- Transformatory learning is operationalised through an ethos of andragogy, it is a holistic and organismic model of learning
- The self is central to the transformatory learning process
- Integrity is essential to the development of the self
- Integrity is linked to the development of ethical knowledge
- Reflection is an essential part of both transformatory learning and nursing practice
- Reflection is a valid learning method for developing self consciousness and critical consciousness
- Nurses can be helped to become aware of and act upon these issues through the development of critical consciousness facilitated by experiential learning
- Reflection encourages the nurse to act with congruence, thereby enhancing integrity.

Given the theoretical position explicated, it is now possible to draw together the research aims. The overall aim of the research is to explore the effect of a transformatory learning approach within the nurse education curriculum. Particular aspects to be explored are those of self-awareness development and the consequences of this on patient care. This aim is to be operationalised through experiential teaching and learning interventions, predominantly that of reflection. A data analysis strategy conducive to the evaluation of self-

awareness is to be developed to facilitate an in depth understanding of the process of reflective learning. This overall aim can be further divided into time and context bound idiographic statements:

- Does an experiential learning ethos in the project 2000 programme enhance self-awareness in student nurses, if this is the case, how is the professional competence of the student nurse influenced, if at all.

- What level of reflectivity can the student nurse achieve through experiential learning and personal development and are they able to transfer this learning into nursing practice.

- What is the student nurses experience of power in the learning situation.

- Can reflective practice assist the student nurse in integrating theory and practice through practical reasoning?

- How meaningful are reflective learning interactions both for the student and the facilitator.

The idiographic statements above form the research questions for this study and each will be addressed accordingly.

3. 5 Summary

This chapter has provided the theoretical statement from which the research aims have been generated. Formal theory has been explored to illuminate, in

depth, the main concepts of the research project. This has been linked to level 1 research in the hierarchical model of research presented by Rolfe (1996) and is part of both the planning and acting phases of the action research cycle (Lewin, 1946). Hence the level 1 research is not the end but the means of creating an 'open' system. Chapter Four explores how the research aims were formulated into an action strategy and introduces the reader to the participants of the study.

Chapter Four

Developing an Action Strategy

4. 1 Introduction

Chapter four begins with a discussion surrounding the development of the initial action strategy. Details of the participant sample are outlined along with pertinent demographic data. The subsequent discussion signposts some of the early deliberations that I underwent as a result of being a situated researcher. These reflections are of significance to the project as they bear witness to my own learning processes in the early stages of the research; as such they are a response to the self-posed question 'what is going on during the process of researching?' As previously mentioned (see Chapter Two) this is essential to research that is grounded in reflexivity. This position is informed by Gadamer (1989) who described hermeneutics not as a procedure for developing understanding, rather a way clarifying the conditions in which understanding takes place (Chapter Five expands upon the notion of philosophical hermeneutics). Thus, it is hoped that these reflections will enable the reader to follow the trail of both the researcher and the participants.

4. 2 Action Strategy

Having formulated the above statements it was necessary to develop an action strategy and to further refine the research aims. An action strategy forms part

of the planning and action phase of the action research cycle and can be defined as:

"actions which are planned and put into practice by the teacher-researcher in order to improve the situation or its context" (Altrichter et al 1993, page 158).

An action strategy can be thought of as an experimental solution to the issue being investigated by the researcher and will often consist of several co-ordinated actions planned on the basis of the research. Planning action strategically means being prepared to learn from the outcomes of the 'first wave' of change, so as to inform the 'second wave' (Kemmis and McTaggart, 1982). An action strategy can be deemed to be successful if it:

- results in an intended improvement of the situation
- has not caused any unintended negative side effects which detract from the main positive effects
- if the improvement is not short term

An action strategy was devised for the purpose of trying out an experimental solution to the theory-practice gap in nursing and to address the perceived need for conscientization in student nurses. Based on my own experience and the formal literature I envisaged that a programme of experiential learning based on the individual needs of the student population involved in the research might go some way towards achieving this action strategy. I decided to undertake the action strategy with student nurses as there is currently little evidence of the effect of reflection on experience with student nurses. As previously indicated there are some assumptions that junior student nurses lack the experience to be able to make effective use of reflective practice as a

learning tool. The experiential learning programme that was devised was to be in complete contrast to the programme of other student groups within the host college, in that I would be spending a great deal of time working intensively with the students developing an ethos of adult learning and facilitating deepening levels of consciousness through skills of self awareness and reflective thinking. Much of the curriculum content would be focussed on personal experience of the particular areas of study. Each session was to be planned in conjunction with the students who would also be expected to facilitate small group work. Each session would start with a 'check in', time in which the students would be encouraged to discuss reflections, thoughts, feelings. Sessions were to focus on process as opposed to product, although I did not view this as exclusive, rather a matter of the point of emphasis (see figure 4.1).

Being Product Focused ———	**Being Process Focused**
Emphasis on producing a Practitioner with specific Feelings, attitudes and behaviours	Emphasis on enabling a practitioner to become fulfilled

Figure 4.1 Continuum of process versus product focus (Johns, 1998a)

Focussing on product sees the practitioner as essentially an object to be manipulated, whilst the focus on process views the practitioner as a human being. This was felt to be congruent not only with the humanistic theories of learning but also with the concept of nursing as holistic.

I was interested in the use of reflective writing, this was something that I had developed as part of my own learning process, and had seen research projects that had incorporated journalling as part of the data collection methods. I was also aware of trying to combine my research with existing developments within the college and reflective writing was being explored as a strategy for assessment in the college. I thought that I might encourage students to maintain reflective diaries for the purpose of self-development, as an aide memoir and to enhance their process skills in reflective writing. This would also serve a practical purpose of assisting students in the development of their writing skills for the written assignments.

Evaluation of the teaching programme would be taking place continuously, both through the reflective diaries and through the negotiation of the time tabled sessions. In order to gain access to a macro view of the situation as it was being experienced, I included the possibility of conducting semi-structured interviews to after a six-month period. This seemed both a reasonable and more importantly a practical time to evaluate the first wave of the action strategy as the students neared the completion of the first part of their programme, and were dividing up into smaller groups for the second part of the course. I knew that I would want to follow the action strategy up with the smaller groups for a period of one year - until the completion of the common foundation programme. But I felt it best to leave the practicalities of the how this would look until after the initial phase of action had been evaluated.

4. 3 The Sample

I decided to use a sample of student nurses at the beginning of their three year project 2000 programme leading to a Diploma in Nursing (H.E.). The scheme of study consists of four parts. The first two parts of the course are known as the common foundation programme and last for 18 months. For the first two parts of the course all of the students work together despite their speciality, although students are divided up into smaller groups for specific modules, they are not divided up by their chosen speciality. Parts three and four of the course consist of a branch programme offered in specialist fields of nursing adult; mental health; learning disabilities and children's nursing. The scheme runs two cohorts per annum, spring and autumn, and numbers in each intake vary.

Although the college has several sites, the pre registration programme is run concurrently on two of the larger sites, which are 45 miles apart, although within the same county. To maintain the confidentiality of the college, for the purpose of this study the two sites will be referred to as Site P and Site C. The two programmes are delivered to ensure that students on each site attend the same sessions if not on the same day, usually within the same week. The sessions are not always taught by the same teacher, although this frequently happens.

The curriculum document supporting the project 2000 programme makes explicit reference to student centred learning, emphasising the value of the individual, suggesting that each individual should be a partner for their own educational process. However, as this is not currently monitored, it is difficult

to assess how individual teacher's are translating the curriculum ideology in the classroom. Anecdotal evidence and module evaluation forms suggest that most teachers employ didactic teaching strategies, further, where student centred learning is employed, it often takes the form of a guided study package. The philosophy of education espoused within the college reflects the concept of adult learning, again it is difficult to gain a sense of how this is being operationalised within the college, although a quality assurance study is at present being undertaken to explore such issues as the quality of teaching and learning. As yet students have not been approached directly for their opinion on this matter and the report was not available at the time of completing this study.

The attrition rate at the two centres over recent years is in line with the national average (R.C.N. 1998). Table 1 shows the number of students recruited to a programme and the number completed for the two sites in the three years prior to the study. This is a significant factor as already highlighted in chapter one. Recruitment to nursing is down by 15% and it is doubtful that the profession can afford to lose a third of those students that are recruited (Scott, 1998). I was curious as to how the difficulties with attrition would manifest themselves with the sample group and how they may influence the study. I also realised that the research study provided me with an opportunity to get closer to the phenomena of attrition.

	Site C		Site P	
Cohort	Commenced	Completed	Commenced	Completed
Sep 91	48	41	48	34
Feb 92	59	44	49	35
Aug 92	49	39	53	41
Feb 93	58	48	48	36
Sep 93	42	37	48	42
Feb 94	49	32	46	36

Table 1 Recruitment numbers

In putting together the demographic data I was already discovering things that I had not previously considered important. Table 2 for example illustrates the levels of attrition in each centre by percentage. The attrition rate is significant ranging from 14.50 % to 34.00%; nearly a third of the students commencing the course in September 1991 did not complete the course. I observed that the percentage of attrition was usually slightly higher in site P than that of site C. I allowed myself some preliminary wondering on this issue. It is interesting to note that site C is based on the same site as a large reputable teaching hospital with a well known 'name' in a very affluent and thriving university city, which makes the programme on that site more attractive. Students attracted to site C are from more diverse areas, thus the majority of students moving to site C live in accommodation on the campus. This could be one reason for the reduction in losses on this site, in comparison with centre P, which tends to recruit from local school leavers, with more people living off campus. There is no doubt that there is implied status amongst the students in relation to the site at which the individual student is training. It may even be the case that students at site P already feels undervalued in comparison to students commencing the course at site C. To date no research has been carried out to compare the type of person that is recruited to site C with those of site P,

variables such as age, gender and personality type have not been examined. I found it stimulating to note that there may be some perceived oppression inherent with the groups recruited to the two different sites. This excitement set the seed of using the two cohorts in the research project and I started to consider the appropriateness of comparative group methods. This resulted in the subsequent demographic data was viewed from within this lens.

The sample used for this study were the cohorts commencing the project 2000 programme in October 1994. These cohorts were chosen for no other reason than it was opportune in terms of timing, in addition I had been the cohort leader for the February 1994 cohort and felt it was important to establish an action strategy with a group that I had no involvement with (either as a personal tutor or any overall responsibility for management of the programme). This is in contrast to Powell (1989) who researched her own students, justifying this on the basis that reflection requires a prior relationship with the researcher. This was not felt to be an issue in this research study as I intended to work very closely with the sample from the beginning of the course as a facilitator and would therefore be building up a relationship as a facilitator/researcher, rather than as a personal tutor or programme manager.

4. 3. 1. Age

The mean age in site P was 25.76, the youngest student being 18 and the oldest aged 46, compared with 23. 93 in site C, the youngest being 18 and the oldest aged 41 years. Site P cohort had slightly more mature students in terms

of biological age with only 59.5% of the students below the age of 26, compared with 74.4% in site C.

As previously indicated the literature suggests that age is an influential factor in the learning process (see Chapter Three). Collecting the demographic data caused me to reflect on how the age of the participants in the sample group would effect their learning, if at all. Concerns related to the ability of novice nurses and implicitly young adults, to think reflectively have already been discussed (Burrows, 1995). A study in the early 1990's indicated that most college students are not ready for mature critical reflection (Schank, 1990). This study argued that individuals pass through seven phased of cognitive growth with the last one occurring after the age of 25. Thus students commencing higher education at the age of 18, which includes the majority of most nursing students, would not have the reached the level of cognitive growth for critical reflection to take place. However, it is argued that it is not just biological age and cognitive growth that is a precursor for learning from experience. Several authors comment on the importance of clinical experience for reflective thinking to be effective (Burrows, 1995; Leino-Kilpi 1990; Clarke, 1986). Burrows (1995) recommends that:

"In addition to cognitive ability, nurse teachers need to consider whether the level of students' clinical experience is sufficient for the development of reflective thinking" (page, 348).

Given the mean age of the students in the two cohorts it could be argued that they are at an optimum age for the development of critical thinking, however,

more than 50% of the group in site P were under 26, a significant number falling below the age established for mature cognitive growth. Additionally, the students all being new to nursing had very little formal nursing experience to draw upon. Based on the literature it would be expected that at least half of the students would fail to utilise the experiential learning on the course to any significant level due to their biological age. Further, it could be stated that the majority of the group would find it difficult to appropriate the reflective process as a learning method due to their lack of experience. My own informal experience contradicted the literature and I felt that the students, despite the lack of age and experience, with effective facilitation could develop critical consciousness and as such would be able to make effective use of reflective skills. I was curious to see how this unfolded.

4. 3. 2 Branch

The branches are the specified area of nursing that the students had opted for at the beginning of the course of studies, students wishing to change branch having started their common foundation programme are very unlikely to have their request granted, unless a swap can be arranged. The October cohort recruits for adult, mental health and sick children's nurses. The P cohort consisted of 30 adult branch nurse students, 7 mental health students and 5 paediatric nurse students. This compared with 27 adult nurse students, 10 mental health students and 6 paediatric nurse students in site C.

4. 3. 3 Gender

In terms of gender, although there has been an increase in recruitment of men to nursing courses, it is still the case that nursing is predominantly a female profession. This is reflected in the sample chosen for this study. The cohort in Site P comprised of 38 female and 4 male students, Site C was made up of 37 female students and 6 male students. This is a point of note for this study as women are more likely to engage in learning situations that are experience based (Belenky et al, 1986). And more importantly it has been posited that women student nurses enjoy learning that is based on their life experiences or experience whilst practising in the clinical setting (Sweeney, 1994; Griggs et al, 1994).

Overall, although no significant differences were found in age, gender or choice of speciality across the two sites, collating the demographic data raised some thought provoking issues pertaining to the recruitment of nursing students in the college.

	Site C				Site P			
Cohort	**Commenced**	**Completed**	**Number Lost**	**Percentage Loss**	**Commenced**	**Completed**	**Number Lost**	**Percentage Lost**
Sep 91	48	41	7	14.58	48	34	14	29.17
Feb 92	59	44	15	25.42	49	35	14	28.57
Aug 92	49	39	10	20.41	53	41	12	22.64
Feb 93	58	48	10	17.24	48	36	12	25.00
Sep 93	42	37	5	11.90	48	42	6	14.28
Feb 94	49	32	17	34.00	46	36	10	21.73

Table 2 Attrition rates by percentage for site P and site C

4. 4 Ethical Considerations

There are a number of concerns when carrying out any kind of research study involving human subjects. As the researcher it is important to be conscious of the potential for power differentials and where possible to create a situation of mutuality, equality and sharing. In order to address some of these issues and to achieve high ethical standards in this study, I, as the researcher was particularly concerned with the following issues:

1. The protection of anonymity and confidentiality

Assurances of anonymity and confidentiality were given. Student information would be identifiable only by a code that was known only to me. None of the students were my personal students and I did not keep records of their progress in training.

2. That the participants have the opportunity to give informed consent to participate in the study

In addition to a letter of consent for the student to take part in the study, a further letter was also sent to the students obtaining consent for the results of the study to be published (see appendices 1- 4).

3. The participants should not feel coerced into taking part in the study and that participants have the right to withdraw from the study at any stage.

No student was coerced into taking part in the research study, although it is debatable as to whether or not students within the first week of a new course would feel able to opt out of any study conducted by a perceived authority figure. Students were provided with as much information as possible in order to facilitate informed consent.

4. 5 Method

The week before the two groups were due to commence their training I was still of the mind that I 'should' somehow find a way to include students from both cohorts in the research project. Realistically I was aware that it would be impossible for me to be involved in an experiential learning programme on both sites, I had other duties to attend to in my role as teacher. However, at this point I had become attached to this notion and felt unable to let it go. With this in mind I considered progressing via a static group comparison (Campbell and Stanley, 1963). This involves the use of naturally occurring groups as 'experimental' and 'control' groups.

On reflection I feel that I was trying to assert some from of control over a process that I did not really perceive myself to be in control of. Although I was not so conscious of it the time I was certainly experiencing a great deal of uncertainty in the early stages of the research, both in relation to my ability and to my planned action strategy.

Armed with this uncertainty I decided that I would meet the groups in the first week of their training to discuss the possibility of being participants in the

research project. I felt that I needed to take something into the group and so I prepared the explanatory letters (appendices 1-4). I also chose to take a selection of questionnaires designed to increase self-awareness into this initial session. The questionnaires were usually an integral part of the first module but were not normally administered so early in the course. I began to think that the questionnaires would prove a valuable source of data particularly as they specifically explored areas relevant to the project. Hence I considered using them as a pre-test with a view to administering them again at the end of the common foundation programme.

This was an interesting move in that I would probably not have chosen to use the questionnaires as a source of data had I been an 'outside' researcher. Being an 'insider' I knew that the questionnaires were used as part of the curriculum and I think I was actively trying to maintain the status quo whilst at the same time attempting to challenge it in the carrying out a radical experiential learning programme. I had made a note in my research diary that I was experiencing some of the anxiety about 'standing out' and having a voice that I have discussed at an earlier point in this thesis (see excerpt at beginning of Chapter Four).

The students in both cohorts were approached initially in a group situation during the first week of their training. Having shown an interest and agreeing to participate in the research at this early stage all students (n=85) were asked to complete the pre-test questionnaires (see appendix 5).

The tests that were applied were the Fibel-Hale (1978) Generalized Expectancy for Success Scale. This is an American test designed in 1978 by Fibel and Hale measuring expectancy for success, defined as the expectancy held by an individual that in most situations she will be able to achieve desired goals. The Eysenck Personality Inventory (1964), a widely used British test of personality measuring the degree of extroversion/introversion. That is the extent to which people are carefree, sociable, spontaneous, rather than quiet, retiring serious individuals. Rotter's (1966, 1971) scale measuring beliefs about external and internal control, that is the beliefs that rewards come from either one's own behaviour or from external sources and Gambrill and Richey's (1975) assertiveness inventory which is designed to measure the degree of discomfort felt in certain situations linked with the likelihood of behaving in an assertive way in these situations. The Kolb (1984) learning style inventory was also used to ascertain whether or not any specific learning styles dominated in the group of student nurses and as a means of comparison across sites.

The aim of applying these tests were firstly to raise awareness of these subjects in the students, with a view to deepening this awareness at a later stage and secondly to ascertain whether or not this group of nursing students were made up of a particular personality type and learning style. In relation to level 1 research, these tests were aimed at explaining and describing the situation at the outset of the research, attending to the question 'what'? As previously mentioned it was intended to apply the tests again at the end of the

period of research to assess whether or not the socialisation process and educational interventions had created any significant changes

Previous studies using similar tests describe results for groups of nurses who had already begun training. Hence, it could be argued that when they took the tests the nurses might have already been socialised into their nursing environment in certain ways therefore affecting the results. To overcome this problem the tests were carried out within three days of the students commencing the course.

4. 6 Findings and Discussion

The findings of the pre-test questionnaires can be seen in appendix six which lists the central tendencies for the tests by site. The results of the learning style inventory (Kolb, 1984) have been plotted to illustrate the preferred orientation to learning across the two cohorts (see appendix six).

As befitting the action research cycle (Lewin, 1946), this discussion is reflective in nature. Here I attempt to present a faithful description of the decisions taken about the methodological choices and therein the action strategy, leaving what is sometimes termed a decision trail (Koch, 1998).

Overall, there were no significant differences in the data across the two sites and the individual variation within the tests was far to great to posit such a thing as a 'typical' or 'average' nurse. As the 'standard nurse' was not identified, it could be argued that standardised training is not an appropriate method of

educating nurses. It would seem reasonable to assume that student nurses are not 'closed' systems. This concurs with similar studies that have been carried out using the pre-test/post-test method (Wittmeyer et al, 1971; Singh and Smith, 1975). These studies focussed on the use of personality information for recruitment purposes. There authors found no clear evidence to suggest that there was a particular type of personality that made a good or a bad nurse. Reflecting on the meaning of the results of the pre-test questionnaires and how to utilise this data it came to me that I was in fact guilty of splitting up the students into (manageable/measurable) parts, just as Menzies-Lyth (1970) had described in her own study about nurses and their patients. I then realised it was of course paradoxical (and meaningless) to use such measures of 'averageness' in a study which espoused a philosophy of nursing based on uniqueness and individuality. This is not to invalidate the tests in themselves, in fact most of the tests used have previously been validated for their statistical reliability (Sims et al, 1986; Lefcourt, 1982; Gambrill and Ritchey, 1975; Rotter, 1966).

In order to be congruent with my own beliefs I would need to re-think my use of the data collected from the questionnaires and the original plan to use students from both cohorts within the research project. This would mean abandoning what was known and sacrificing my attachment to a script that I had already constructed. Within the research frame it was tempting to construct this pointless and as wasted time. It took some time to reframe this and see this as an essential part of learning the research process. I was falling into the traps that I was expecting the students to avoid. Like Portia Nelson

(1987) in her autobiographical poem, I knew the hole was there but I still fell into it.

Kidder and Fine (1997) offer a perspective on the evolving research process saying that reflexivity in theory and practice is an essential part of the research enterprise. Although research begins with a responsible intent the methodology often evolves and changes during the research. Braud (1998) points out that it is the intention that the researcher needs to focus their attention on. And so I was challenged to re-consider my intention. Meditating on Braud's (1998) three motivations for research enabled me to further clarify my intention and therein the methodology (see figure 4.2).

Motivations for research
• To learn about the world in order to predict and control, using large and random samples to facilitate recognition of general principles • To understand the world in the service of curiosity and wonder • To appreciate the world and delight in the myriad of its entities in the service of discovery and surprise

Figure 4. 2 Braud's (1998) Motivations for Research

My motivation centred on the latter two points and as such I felt I required an approach which added meaning as opposed to diminishing it. It was therefore decided to drop the initial idea of working with both of the student groups in the form of an experimental group and a control group, this felt meaningless in response to my research aims. I made a decision to work with one group only

and to move to a more interpretative and meaningful approach concerned with understanding the student nurses' experience of themselves whilst in the educational process.

4. 7 The plan of interventions

Having decided to continue with the experiential learning programme with one cohort of students, I opted to work with those students at site P for practical reasons, this being my own base site. Although the majority of the data generated from the pre-test questionnaires has been excluded from this project, a small part of it will be referred to here by way of validating the choice of teaching /learning interventions. In a sense collecting the data from both groups proved helpful in 'normalising' the group from Site P, as far as any group can be normalised. Given the results of the pre-test questionnaires it seems reasonable to infer that the sample group are 'typical' of a group of nursing students.

The results of the learning style inventory indicated an orientation, in both groups, towards concrete experience and active experimentation, with active experimentation scoring the highest at 19.05 in site P and 17.86 in site C (see appendix six). This is a common pattern in nursing and is supported by Griggs et al (1994) and Brazen and Roth (1995). The students did not score so highly in either of the areas of abstract conceptualisation or reflective observation. An orientation towards active experimentation emphasises practical applications, focussing on a pragmatic concern with what works as opposed to observing. People scoring high in this category value having an

influence on the environment around them and like to see the results. An orientation towards concrete experience means that the individual students focus is on being involved in experiences and dealing with immediate human situations in a personal way. Emphasising feeling as opposed to thinking, concrete experience is concerned with the uniqueness and present reality as opposed to theories and generalisations. People with such an orientation value relating to others and being involved in real situations (Kolb, 1984).

The learning style that incorporates both the strengths of active experimentation and concrete experience is known as the accommodative style. The greatest strength of this learning style lies in doing things, carrying out plans and getting involved in experiences. Kolb (1984) argues that the accommodative style is best suited to situations in which one must adapt oneself to changing immediate circumstances. He goes on to say that situations where the plan or theory does not fit the reality, those with an accommodative style will be most likely to discard the plan or theory. In addition students with an accommodative learning style often rely on other people for information rather than on their own analytic ability. For expanded detail on individual learning styles see appendix seven.

The findings of the remaining tests highlight a marked tendency towards extroversion which compares with other studies of degree of extroversion in nurses (Eysenck and Eysenck, 1964), in which the average for nurses was 12.06. An expectancy for success that fell slightly below the average of 112, compared with other undergraduate students (Fibel-Hale, 1978). Whilst the

students fell in line with the average score measuring discomfort with assertiveness (average score 96), they were below average in the scores for the scale measuring the response probability (Gambrill and Ritchey, 1975).

In the test for locus of control, 0 was taken to be the average and a plus score indicates an internal locus of control, with a minus score indicating an external locus of control. The students on both sites demonstrated an orientation towards an external locus of control, although the scores of those students in Site P were markedly higher (potentially making experiential learning more of a challenge). No similar studies undertaken with nurses were found to enable comparisons to be drawn. Rotter (1975) however noted a general tendency for males to have a more internal locus of control than females, which may have some bearing on the findings in this sample.

These findings are congruent with not only the theoretical statement, but also with personal experience. In reality much of nursing involves practical doing and problem solving with very little time given over to reflective understanding. It could be posited that the student nurses within this group (n=85) are representative of the overall person attracted to nursing. It could also be argued that the students joining this course are predisposed to viewing their work as a product as seen in the concern with achieving results in their work and having an influence on the environment (Kolb, 1984). This is an interesting finding when placed alongside the literature concerning the oppression of nurses. It appears paradoxical that nurses, who have a tendency towards action and influencing change find themselves in submissive roles

(Stein, 1978). This is interpreted in the accommodative learning style as relying on others for information and not trusting in one's own capabilities (Kolb, 1984). In relation to nursing, the other that is relied upon is most usually the doctor, or else in the case of the student nurse, the nurse tutor the Sister or Staff nurse. This argument is also linked to and supports the findings of the test for locus of control which indicated an orientation towards externalisation. The findings also demonstrated that the students in the sample groups were more extrovert than introvert, which is congruent with the active learning styles.

It could be suggested that the nurses in the sample groups, as active problem solvers, would be inclined to promote action or solutions before fully analysing the problem. There could be any number of reasons for acting on a situation quickly. One such rationale is it that nurses lean towards action as a way of dealing with the pain of watching their patients suffer. This implies that rather than explore a range of options in the clinical situation, the nurse opts for immediate relief, not just for the patient, but also for herself. This argument would espouse that as concrete experiencers, these nurses paradoxically have a preference for operating from a feeling mode and at the time same find it difficult to contain feelings. Thus, a task oriented 'fix-'it' type mode of practising is adopted. This would offer continued support for the findings of Menzies-Lyth (1970) regarding the development of defence mechanisms as a way of dealing with anxiety indicating that feelings towards the self and other may be what directs action, whether consciously or unconsciously.

As already mooted reflection is one way of enabling an awareness of self which may lead to either a change in action or more deliberate action. In order to meet the students at there own starting point, reflection would need to be based on experience, that is experiential learning. Reflection is not a means of reducing the level of emotion or action, nor is it deemed superior to the same. Here, it is seen as a way of enabling the student to become more aware of their way of functioning, so that deliberate choices can be made in practice. Reflection can also allow informal theory to be linked with formal theory in a personally meaningful way, thus facilitating the use of abstract conceptualisation, bringing theory and practice into the real world of the student. In addition, theories and concepts are less likely to be discarded if they have been fully examined through reflection, and those that are discarded, will not necessarily be discarded in total.

This sort of approach would implicate learning strategies which would not only be based in the student's experience, valuing what the student brings with them (Rogers, 1983), but which would also assume an introvert stance in equal proportion to an extrovert stance. In other words, the learning strategies need to match the students in their abilities for concrete experience and active experimentation, but also bring in enough reflective observation of their own experience and abstract conceptualisation to create a dynamic disequilibrium (Joyce, 1984). Thus requiring the facilitator to achieve a balance between challenge and support. Theories and concepts will thereby interact with, be integrated with and transformed into personal experience. Traditional nurse

education, with its emphasis on theories and abstract concepts, although creating a dynamic disequilibrium, does not value what the student brings with them and socialises the student into the submissive role by 'handing down' abstract concepts and theories which are not made personal through the process of teaching.

It should be noted that learning styles are only one component of the whole process of teaching and learning and Kolb's (1984) learning style inventory is only one means of measuring preferred learning styles and the validity of this instrument has been challenged (Highfield, 1984). There is however, little doubt that action, involvement, relationships and feelings figure highly in the favoured learning styles of this particular group of students and it could be argued, other groups of student nurses. This has implications for the approach to learning taken within the classroom, namely that the students are predisposed to being active participants in their own learning process. Given these findings, a plan of learning interventions was tentatively made available for the purpose of raising self-consciousness, facilitating reflection upon experience and integrating theories and concepts. This will now be discussed in brief, however, one final link that could be made pertains to the process of research in nursing and confirms the use of the chosen research methodology. From these findings it could be reasoned that the action research cycle is a suitable approach for nursing research, in that it involves not only active experimentation and concrete experience, but these are also combined with reflective observation and abstract conceptualisation.

In order to execute the action strategy a variety of learning interventions were utilised. During the initial six-month period a total of 250 hours student contact time took place with the student group on site P. No contact was made with the students on site C, other than the initial session previously discussed. Tutors involved in teaching students on site C were asked to keep a record of teaching methods for their sessions. This allowed me to examine the predominant methods used by other tutors and to take this into account when analysing the findings of the study. The 250 hours contact time was with the whole group, that is 42 students, although a significant part of the learning took place in small group work.

Whilst it is not possible to list all of the interventions that took place during this time, what follows are some of the underpinning principles and practicalities. Much of the initial learning surrounded the self and self-awareness. This learning took place through a variety of strategies. One of the first tasks was that of creating an optimum environment for the students to feel safe not only to explore themselves but also to self-disclose. Rogers' (1983) core conditions were central to this process, that is: unconditional positive regard; authenticity and congruence; genuineness and empathic understanding. The group drew up a contract based on some of their expectations of each other (Figure 4. 3).

Group Contract:

Confidentiality within the large group and only to bring in other people's experiences from small group work with permission.

Mutual respect and trust

Group participation as much as feel able to

Punctuality and attendance to be taken seriously

Sharing ideas and learning

Being open to challenge

Approaching situations with honesty

Figure 4. 3 The group contract

The experiential learning cycle was used as it incorporates reflection as a key component of the learning process. The main learning interventions utilised could be said to be projective and narrative. Stimulated recall implies an assumption that students know more than they can tell and consequently require some assistance from the facilitator in retrieving experiential material that is transient or pre-verbal. Projective methods work with this assumption. Methods such as making up stories, finding images, collage and creative artwork, showing slides and photographs were employed, students were encouraged to express themselves through metaphor and symbolic language (Branthwaite and Lunn, 1985; McLeod In Woolfe and Dryden, 1996).

Narrative, myth and storytelling were also adopted. This included the use of characters from literature, mythology and archetypal psychology. The use of narrative drawn from personal experiences and literature, is said to expose the caring dimensions of practice that are often hidden from public view and was

therefore felt to be particularly appropriate for the students on this course. Sharing stories of experiences with another creates a sense of community, demonstrates the importance of simple acts, and facilitates interpersonal skills development (Gersie, 1997). The space that was provided for this type of learning was that of a reflective process group in which students were encouraged to explore their myths and stories concerning nursing. These sessions were completely unstructured and took place weekly for a period of 2 hours over the six months. Further detail regarding the facilitation of the reflective process group can be found in Chapter Six.

The development of interpersonal skills was also a central consideration in the early phase of our work together. A strong component of the nursing curriculum is human behaviour and interpersonal relationships and it is posited that the process of experiential learning offers opportunities which help to maximise the development of interpersonal skills (Raichura, 1987; Dowd, 1983; Kagan, 1985). Good patient care hinges on the quality of the nurse-patient communication as expressed in Heron's experiential learning cycle where a deeper encounter is seen to lead to better practice of skills (Heron, 1991). Hence, the emphasis was on the quality of the student-student and student-teacher communication, in the anticipation that these skills would be transferred into practice. In this instance the development of interpersonal skills was through extensive use of exercises in trios and sometimes pairs with emphasis on the importance of feedback. After an exercise and feedback within the trio feedback was taken in the large group, enabling students to see their experience in a wider context (figures 4. 4 – 4. 6).

Method of working in threes.

The role of the observer and giving constructive feedback

The role of the observer

Observer gives direct feedback to the listener and the speaker, avoiding being drawn into discussion of the speaker's subject or experience. Feedback should be specific and concrete; describing what is seen and heard. As the observer, it is important to sit close enough to hear and see, but out of eye contact with the other members of your trio. The task of the observer is to concentrate on what is happening between the listener and speaker rather than on the story. The feedback is important to the listener in developing their communication skills.

Bear in mind that feedback is a shared activity. It is an exploration of the meaning of what has happened. The meaning the observer attributes to the event is rarely the same as that attributed by the participants. Feedback needs to be offered with respect and openness.

Figure 4. 4 The role of the observer

Guidelines for constructive feedback

Exchanging comments on interpersonal skills is valuable but needs to be done with care. Feedback is a way of learning more about ourselves and the effect our behaviour has on others. Constructive feedback increases self-awareness, offers options and encourages development. It opens the way for positive and honest communication and enables feedback in both directions. Constructive feedback does not mean only positive feedback. Negative feedback if skillfully given, can be useful.

Figure 4 . 5 Guidelines for constructive feedback

Suggestions for feedback:

- Be clear about what you want to say. Start with the positive.
- Be descriptive- base what you have to say on what you saw or heard.
- Be specific, pinpoint what was said or done
- Only refer to behaviour that can be changed
- Own the feedback, use 'I'.
- Time the feedback well, try to give feedback as soon as you can after the event.
- Check out your feedback with the recipient, check out how it has been understood.

Feedback usually says something about the person giving it as well as the person receiving it.

Figure 4. 6 Suggestions for feedback.

Interpersonal skills were a focus for development and included:

Active listening: Paraphrasing

Non verbal responses

Reflection of feeling

Reflection of meaning

Open and closed questions

Summarising

Use of silence

Use of language

Challenging

Use of immediacy

Self disclosure

These were mainly based around the work of Egan (1994) and the model of the skilled helper. Although Heron's (1990) six category intervention analysis was also used quite extensively. A small selection of the types of exercises used is briefly illustrated below (see figures 4. 7 – 4. 8).

How you were helped

On you own, think of a situation where you needed help and were helped, make some brief notes.

Find a partner and share in turn your experience working through the following points:

What were your feelings at the time of needing help?

What was the attitude of the person who was helping you?

What were the words and feelings that helped/ did not help?

Pair up with one other couple and discuss the differences and similarities of people's needs and feelings.

Work though the following question:

How might a patient feel needing help from a nurse?

How might your attitude influence the situation?

Feedback was taken in the large group.

Figure 4. 7 How you were helped.

Learning to be a nurse through being a patient.

Usually students learn to attend to the hygiene needs of the patient through learning how to bed bath a dummy. This is normally demonstrated by the tutor leading the lecture. This group were asked to bring in a towel, soap, toothpaste, toothbrush and a hairbrush. Working in pairs, the students were asked to wash each other's hands and face, brush each other's teeth and comb their partner's hair. The exercise was firstly de-briefed in pairs and then in groups of four. Feedback was taken in the large group. A rich discussion around feeling helpless, vulnerable and out of control took place.

Figure 4. 8 Learning to be a nurse through being a patient.

Photo language technique was also employed, students were presented with photographs and brought in some of their own and asked to note their subjective interpretation (Devere, 1994). Debriefing would focus on such issues as stereotypes, images, fixed ideas, surprises etc in order to help the students gain insight into their perceptions. I felt it important to use pictorial as well as verbal language as this entails moving through three interpretational levels – the formal facts, the social norms and the personal. The students were encouraged to read below what was factually evident and to explore what norms, cultural myths and stereotypes were attributed the photographs. The students were then assisted to reflect at the deeper personal level of their own experience. This was felt to be a useful approach as stereotypical images have a powerful role to play in perpetuating and sustaining dominant ideologies (Devere, 1994), the challenging of which is central to the current research project. Figure 4. 9 illustrates one example of a photo language technique.

What is the role of the nurse?

An art gallery of photographs was created in the classroom. When the students entered the room they were asked to view the photographs in silence. Having explored the art gallery sufficiently, the students were encouraged to draw their own picture to submit to the gallery. The piece was to be entitled 'The Role of the Nurse'. The large group then broke into four and each group nominated a tour guide. The tour guide took the remaining students on a tour of the art gallery, interpreting the paintings and their meanings. Students were encouraged to ask questions and dialogue with other members of their tour concerning the guides interpretation. At any point the tour guide could nominate someone else in the party to take over the role of the tour guide. Feedback took place in the large group and related to the nature of nursing, the role of the nurse and stereotyped images.

Figure 4. 9 The role of the nurse

4. 9 a-d The role of the nurse.

It is important to stress that all experiential work was flexible and dynamic, responding to changes within the environment, the students and the facilitator. For as Giorgi (1970) exerted, over emphasis on technique is one of the main obstacles to understanding the patient. Here, the word student could be substituted for patient. All experiential learning included and was followed by a period of reflection. The main purpose of the reflection at this point was to foster self-consciousness and to relate personal experience to theories and concepts. In relation to nursing practice reflection has been developed as a way of assisting practitioners to take control of their own practice and to generate knowledge from that practice.

Spinelli (1989) suggests that this is done by reflecting on straightforward experience, Spinelli (whose work has been heavily criticised (Crotty, 1996) goes on to explain that it is only while reflecting upon experience that any conscious sense of the 'I' emerges. As the awareness of an 'I' emerges, the individual is able to explore the boundary between the personal experience of

the 'I' and experience of the other, whether through reading or verbal communication. To expedite this awareness students were encouraged to maintain a reflective diary based loosely around John's (1998) model of structure reflection, a research diary was maintained simultaneously by myself (Morse and Field, 1996). This facilitated a more introvert stance towards the learning that had taken place in the classroom.

4. 8 Summary

Chapter Four has attempted to make known some of the decisions made in the process of the current research. An action strategy has been formulated and a plan of learning interventions has been described. Chapter five explores how these interventions have impacted on the student after an initial period of six months. Moving onto level 2 research, qualitative methodology is practised through the application of semi-structured interviews. Themes and categories are reported in the findings before a reflective discussion is initiated. This period of observing and reflecting leads to the development of some further planning prior to implementing a revised action strategy.

Chapter Five

Level Two Research

If you have come to help me, you are wasting you time.

But if you have come because your liberation is bound up with mine, let's work together.

(Lilla Watson, 1992)

5. 1 Introduction

Chapter Five uses methods of data collection and analysis from the qualitative research paradigm. Building upon the research aims established in level 1, this chapter explores the research at level 2, which focuses on the meaning and interpretation of experience (Rolfe 1996). This phase of the research matches Mezirow's (1981) area of cognitive interest known as interaction and the state of consciousness in learning which Kolb (1984) refers to as interpretive and is a higher level structure than that of registrative consciousness. Emphasis is on interaction between internal personality dynamics and external social forces, and is explored by using semi-structured interviews six months into the experiential learning programme.

Although the semi-structured interviews form part of the observation phase of the action research cycle; they took place during the action phase of the

research cycle, the experiential learning interventions were ongoing. It was felt that to ensure that the research was truly reflexive, I needed to observe the effects of the research in action, as well as reflecting upon the research following action. I felt this would allow me to make adjustments to the action strategy whilst in the process of putting it into practice. After an exposition of the philosophical underpinnings of the qualitative research methods used, the method of data collection and analysis is specified. This is followed by a presentation and a discussion of the findings. Some tentative conclusions are inferred and the action strategy is reviewed.

5. 2 The Research Aims – revisited

The overall aim of the research at this level is to understand the intricacies of the student nurses experience of the educational process. The broad research questions are drawn from Chapter Three and relate to self-awareness development, developing skills of reflectivity and professional competence:

Does an experiential learning ethos in the project 2000 programme enhance self-awareness in student nurses, if this is the case, how is the professional competence of the student nurse influenced if at all.

What level of reflectivity can the student nurse achieve through experiential learning and personal development, and are they able to transfer this learning into nursing practice.

What is the student nurses experience of power in the learning situation.

Can reflective practice assist the student nurse in integrating theory and practice through practical reasoning?

How meaningful are reflective learning interactions both for the student and the facilitator.

In selecting an appropriate methodology to address the research questions I felt it was important to draw upon a method that was both philosophically congruent with the process of reflection, practice, andragogy and experiential learning and allowed for the 'insider' perspective, that is the situated researcher. Hermeneutic phenomenology presented itself as a congruent and therefore useful philosophical approach and methodology as it respects the capacity of the person for self–knowing, a belief that is central to the concepts being explored in this project.

5. 3 An Introduction to Phenomenology and Ontology

Koch (1995) comments that: "...the terms phenomenology and hermeneutics are used interchangeably in the nursing literature" (page 827). However phenomenology and hermeneutics are not always grounded in the same philosophy. Within mainstream phenomenology there are separate and distinct schools. Nursing research has not always differentiated Husserlian transcendental phenomenology and Heideggarian hermeneutic phenomenology (see Koch for an in depth analysis of this point). There are critical differences between these two schools related to epistemology, ontology, validity, the involvement of the researcher and hermeneutics (Crotty, 1996; Walters, 1995). These distinctions are consequential as they have implications for the methodology practiced. The literature surrounding phenomenology is notoriously arduous to read and apply in practical terms, it

is however, crucial to clarify the underpinning principles upon which the methodology is built. What follows now is an attempt to distinguish the particular phenomenological approach employed within this research.

Phenomenology is a philosophy, a research approach and a methodology (Cohen, 1987). With its focus on human phenomena, phenomenology is currently deemed to be a method consistent with the values and beliefs of nursing, which is essentially a humanistic discipline (Munhall, 1994; Munhall and Oiler, 1986). Indeed, nursing has become increasingly interested in the appropriateness of phenomenological methods to study nursing phenomena, this is evidence in the plethora of phenomenological research studies emerging in the nursing literature (Appleton, 1994; Parse et al, 1985). Yet, not all phenomenological philosophy is underpinned by holistic ideals.

Phenomenology as a philosophy was established by Edmund Husserl, a German mathematician. Husserlian phenomenology was the culmination of the Cartesian tradition. Descartes, also a mathematician, is known for his philosophy which represented the model of the mind and body as separate. Husserlian phenomenology comprises three dominant notions: intentionality; essences and phenomenological reduction (or bracketing) (Spiegelberg, 1960). The Cartesian metaphor in which the body is viewed as a container for the mind is evident within the Husserlian principle of essences. Koch (1995) presents a logical and accessible interpretation of Husserlian principles drawing upon the work of Dreyfus and Dreyfus (1987) and (Benner and

Wrubel (1989). She claims that essences are explored through cognitive processes and adds that:

" Cognitivists view a person's knowledge, understanding, intentions and actions as originating in the mind, where the mind is the only source of meaning and interpretation" (page 828).

Benner and Wrubel (1989) argue that the Cartesian mechanistic model is inappropriate for nursing research, this is a stance that has already been clarified at an earlier point in this thesis in response to the approach to nursing care and nurse education. Although Husserlian phenomenology offers an alternative to the traditional experimental scientific paradigm it continues to present us with the object/subject dichotomy. When using Husserlian methods the research questions are answered by a process of phenomenological reduction, the first stage of which is to eliminate all pre-conceived notions, termed bracketing (Husserl, 1962).

Husserl's student Heidegger reacted against his tutor's principles, in particular the maintenance of the Cartesian tradition and the objectivist viewpoint. Heidegger spawned a branch of phenomenology, sometimes described as existential phenomenology. Heideggarian phenomenology is based on two essential notions, namely the historicality understanding and the hermeneutic circle (Rowan, 1981).

Hermeneutics, originally a technique for discovering the correct interpretation of ancient religious texts, has been developed as a philosophy of human

understanding and interpretation (Gadamer, 1989; Heidegger, 1962). Heideggarian hermeneutics argues that as historical beings we cannot ever totally transcend our historical position, there is no such thing as a transcendental ego as advocated by Husserl. It is therefore impossible to escape pre judgements through a process of bracketing, these pre judgements are with us in the world (Rowan, 1981). This is based on the premise that the world and the person cannot be separated. Rowan (1981) writes that:

"Once this historicity of human experience is realized, it is clear that we must distinguish between some notion of an 'objective' understanding or interpretation which is unattainable and meaningless and reach for an interpretation which is 'intersubjectively valid for all the people who share the same world at a given time in history" (page 133).

The hermeneutic circle is a metaphor for describing the movement between the whole and the parts. Hence meaning is co-created within the context of research, researcher and participants. Not only is meaning co-created by all the subjects involved in the research process, but the subjects are also being created by the meaning. Understanding occurs through a 'fusion of horizons' (Gadamer, 1989; Heidegger, 1962).

5. 4 Hermeneutics as method in nursing

Hermeneutics is the art and science of interpretation in which wholeness and context are important (Benner, 1994). It is an interpretative strategy which aims to produce deeper understanding of human existence. It does not seek to

simply describe a phenomenon but to provide new insights. It is an ongoing process and the phenomena are continually open to discovery. Hence, it could be argued that phenomenology functions as an 'open system' in its approach to research.

As a method hermeneutics assumes that the researcher has an understanding of the phenomena being studied. The aim of the research is to gain deeper understanding and new perspectives through the interpretative process (Leonard, 1994; 1989). Gadamer (1989) has said that hermeneutics are used to clarify the condition in which understanding takes place as opposed to developing a procedure for understanding.

Nursing research drawing upon the hermeneutic tradition has come under attack in recent years. Crotty (1996) for example, contests that much phenomenological nursing research falls in the category of 'new' phenomenology, that is phenomenological hermeneutics, citing 30 articles as examples of this argument. He describes the 'new' phenomenology as individualistic and subjectivist, informed by the emergence of humanistic psychology and is critical of the so called 'new' phenomenology for being too subjective and not critical enough.

Crotty (1996) states that:

"A phenomenology more in tune with that of the tradition (mainstream phenomenology) would not only be more objective; it would also be more

critical. The phenomenology of the phenomenological movement is a thoroughly critical methodology" (page 4).

It appears that Crotty (1996) is falling into the tendency to create a hierarchical structure, placing mainstream phenomenology in the superior position above the 'new' phenomenology based on its ability to claim objectivity. This, I feel, is the statement of an unwitting positivist and one which misunderstands the dialectic of caring and the notion of reflection.

5. 5 Phenomenology and Reflection

Phenomenology assumes that people are beings for whom things have meaning and significance (Leonard, 1989) and makes a clear distinction between experience as it occurs and the subsequent interpretation of it, these are known as straightforward experience and reflective experience respectively. Straightforward experience is action based, it cannot be talked about directly as it happens and any description or statement must occur subsequent to the experience. The various attempts to describe or explain experience take the individual into the realm of reflection (Spinelli, 1989). Hence phenomenology and reflection are closely aligned, as Van Manen (1990) reported:

"The purpose of phenomenological reflection is to try to grasp the essential meaning of something. Insight into the essence of a phenomenon involves a process of reflecting appropriately, of clarifying, and of making explicit the structure of meaning of the lived experience" (page, 77).

As this study is concerned with learning from straight forward experience through reflection, the principles of phenomenology are deemed appropriate to underpin the research methods used in level 2 and 3 of this study.

According to Mullaney (1997), the point of phenomenological research is:

"to borrow other people's experiences, and their reflections on their experiences, in order to be better able to come to an understanding of the deeper meaning of, or significance of, an aspect of human experience, in the context of the whole of the human experience" (page 165). The experiences that have been borrowed here are those of the students participating in the experimental learning programme.

5. 6 The Role of the Researcher

Phenomenology calls into question meanings that have been taken for granted, throwing suspicion on everyday experience. In Huserlian phenomenology the researcher does this by laying aside their everyday perceptions and accepted understandings so as to return to the pre-reflective, pre-predicative experience, or as Crotty (1996) states:

"to our experience as it is immediately given to us before we make sense of it" (page 4).

The laying aside of one's own perceptions is known as "bracketing", (Van Manen, 1990). Crotty (1996) speaks of bracketing as suspending meanings, other writers identify such concepts in terms of being present or being available (Johns, 1998) and suspended attention or creating potential space

(Casement, 1985; Winnicott 1971). Bracketing is deemed to be an important strategy in the control of bias in reflection on experience and as such interpretive methods are believed to be adequate if the bias of the researcher is suspended. Thus the rigour of the research is enhanced (Oiler, 1982).

As already noted, Heideggarian phenomenology challenges the notion of objectivity and bracketing. From the Hedeggarian perspective meaning cannot be totally neutral but instead is informed by the interpreter's background. It is this standpoint that I have chosen to adopt within this research project, chapter one is a clear example of me including my own historicality in the development of the research interests. To record my own participation in the making of the research data I kept a written account in the same way as the participants, through the maintenance of a personal and methodological journal (Morse and Field, 1996). Locating the self in the research process and returning to the self with a critical gaze is congruent with both reflexivity and hermeneutics.

Qualitative research methods are not usually preceded by a theoretical statement or a review of the literature (Yucht and Mariano, 1998) as it is imperative that the researcher remains open to ideas, concepts and hunches as the research unfolds. Oiler (1982) recommends delaying the review of the literature until the data has been generated to comply with Husserlian beliefs about bracketing. Heideggarian hermeneutics however reasons for a continuous reviewing of the literature recommending that its influence be noted. It is this approach that has been taken in this thesis.

5. 7 Data Collection

From the phenomenological viewpoint the data gathering part of the research process is partly seen as a space for the educational development of the researcher. In the same way using Heideggarian phenomenology, I envisaged that I could create a space for the student nurses to give voice to their own educational experience in an open and unstructured way.

A number of steps have been distinguished as being common to all interpretations of the phenomenological method (Spiegelberg, 1960), in this study these steps have been used influentially rather than directly applied. This is fitting for an approach such as phenomenology, as to be truly phenomenological in nature, the researcher must proceed as the experience indicates, rather than to follow an imposed structure. The data collection and analysis are not neatly separated in the phenomenological method, Colaizzi (1978) advises that data collection and analysis should occur simultaneously. For the purpose of reporting the process, that data collection method is now described and an outline of the process of analysis is presented.

The method of gathering data was through semi-structured interviews. Interviewing as a research method takes many forms (Sorrell and Redmond, 1995). The choice of interview strategy depends upon the sort of project being undertaken; the method must be suitable to the research question posed (Rose, Beeby and Parker, 1995). Semi structured and unstructured interviews are most commonly used in qualitative research studies. When using semi-

structured interviews the interviewer asks certain major questions the same way each time, allowing the interviewer to focus on particular issues of importance. However, the interviewer is free to alter their sequence and probe for more information, therefore the research instrument is adapted to the respondent. When using the naturalistic approach to research interviews, the researcher aims to build a trusting relationship with the respondent in order to engage a cooperative dialogue. One of the main principles of interviewing for qualitative data is that questions should be as open ended as possible (Koch, 1996; 1995).

Open questions allow the respondent the freedom to answer in a number of ways and are particularly useful for exploring personal information (Hargie, 1986) and affords access to spontaneous information rather than rehearsed responses. However, just as important is the way the questions are used by the interviewer. The questioning technique should encourage respondents to communicate underlying attitudes, beliefs, and values through reflecting meanings and feelings, structuring through summarizing and probing through clarification.

It is accepted that the interpretation of interview material can never be totally objective and is influenced by the life experiences and intellectual ability of the interviewer (Sorrell and Redmond, 1995). As previously discussed objectivity is not sought in this study. Interviews are influenced by many other factors such as memory fade and decay and the relevance of specific events for the individual. This has also been the subject of debate in the area

of reflection (Newell, 1992). Participants may repress painful, threatening and confidential material from the interview, telling the interviewer what they think the interviewer wants to hear (Sorrell and Redmond, 1995).

For the purpose of this study a total of ten individual semi-structured interviews were conducted with students from the cohort. As the group was large enough (at this stage) to practice random selection, the interviewees were chosen at random from the group, choosing one interviewee in every four. The ten interviewees all agreed to undertake the interview. Face to face contact with the participants both initially and during the interview established rapport and confirmed interest in the project. The data was collected at the six month stage of the students training. Some thought was given to the setting in which the interviews would take place.

In order to facilitate an environment conducive to personal communication a small discussion room in the college of health studies with windows and comfortable chairs was chosen. Seating was arranged in order to facilitate verbal interaction and as the interviewer, I attempted to minimize the likelihood of interruptions (Hargie, 1986). The interviews were tape recorded with the permission of the participants, each lasting between 35 and 50 minutes. All the conversations were recorded using an audio-cassette tape-recorder to ensure accurate data collection, field notes were also made throughout. Taping the interview not only ensured identical replication but also provided an insight into the performance of both the interviewer and the interviewee.

It has been suggested that the quality of information generated in an interview is entirely dependant on the interviewer's behaviour (Barker, 1991). Mindful of this, I started with an explanation which reminded the student of the purpose of the interview and reiterated confidentiality, questions were invited before proceeding. Probing questions were used as a means of clarification and exploration and the skills of reflection of feeling and meaning facilitated exposure of a deeper awareness in the participant (Egan, 1994).

When translating my research questions into an interview schedule I was aware of the need to balance keeping the interviews as unstructured as possible with the need to address the research questions (see appendix seven). It was decided to use a modified version of the semi-structured interview in that the interviews were non-directive but were based on an interview guide. The interview schedule consisted of only three questions. I opened each interview with the same question, "what has been your experience of your learning on the course so far?" This question was used in order to elicit non-specific general information relating to the research questions. Further spontaneous questions were asked in response to the student's stories, although often silence was used as a way of prompting. My second question related to the experience of being in clinical practice "what has been your experience of learning in the clinical environment?" I hoped not to have to ask this question out of context, but rather assumed that the participants would bring in their clinical experience as part of the ongoing conversation.

The interview used only open questions, which allowed the participant's scope for introducing topics that they considered relevant and important, but concluded with a question which addressed the focus of the research, "what was your preferred method of learning"? Data was obtained through a verbal exchange, a conversation with a purpose. Only one interview took place on any given day and this allowed time for reflection in between participants. Following the interview each interview was transcribed in full, this was a lengthy task and one which I chose to complete myself.

An awareness of interviewee and interviewer bias was held throughout the interviews. It is possible that the students felt a need to please me, especially as I had been working with them on a fairly intimate basis for a reasonable period of time. I was also aware of the dangers of seeking out answers and information that supported my preconceived ideas (Mullaney, 1997; Morse and Field, 1996). I used my research journal to note my own subjective impressions of the interview immediately following each interview.

5. 8 Ethical Considerations

In addition to the ethical considerations already outlined in Chapter Four, participants were guaranteed the following principles prior to the semi-structured interviews:

- Security of written accounts, these were kept in a locked file when not in use and were transcribed by the researcher
- Tapes used in the recording of the interviews were also secured

5. 9 Rigour in Phenomenology

The criteria for achieving rigour in scientific positivist research is reliability, validity and objectivity. However, as Beck (1994) points out, reliability and validity may not have the same meaning in the logical empirical paradigm and the phenomenological perspective. Indeed, Georgi (1970) questioned whether the terms reliability and validity should be used at all in phenomenological research. Koch and Harrington (1998) discuss their frustration with qualitative researchers preoccupation with methodological rigour and argue that "borrowing evaluation criteria from one paradigm of inquiry and applying it another is problematic" (page, 883).

Instead it is argued that the legitimacy of the knowledge depends upon the trustworthiness of the study. Trustworthiness involves making practices visible and auditable (Sandelowski, 1993). Sandelowski (1993) suggests leaving a decision trail enabling the reader and other researchers to follow the progression of events and logic in the study as a way of establishing trustworthiness. She proposes that twelve elements should be evident in a qualitative research report, indicating a degree of rigour:

- How the researcher became interested in the subject matter of the study
- How the researcher views the issue being studied
- The specific purpose of the study
- How the subjects or pieces of evidence come to be included in the study
- The impact the subjects or evidence and the researcher had on each other
- How the data was collected

- The nature of the setting in which the data was collected
- How the data were reduced or transformed for analysis; interpretation, and presentation
- How various elements of the data were weighted
- The inclusiveness and exclusiveness of the categories developed to contain the data and the specific techniques used to determine the truth value and applicability of the data

(Sandelowski, 1986).

Rigour within phenomenology arises in capturing, adequately, succinctly and creatively the lived experience of learning for those involved. The data represents the views of the participants through an act of interpretation and analysis on the part of the researcher and are arrived at inductively. The following section describes the process of analyzing and interpreting the transcribed data.

5. 10 Data Analysis

There appear to be many different approaches to handling qualitative data, although many employ similar processes, following a structured framework (Mullaney, 1997). I chose to use Colaizzi's (1978) framework for data analysis as I felt it followed logical and understandable steps (figure 5. 1).

To obtain data from the transcribed text the interview transcripts were studied carefully to gain an overall sense of them. Reading each of the transcripts and listening to the audiotapes a number of times I was able to become immersed

in the data, listening for intonation, mood and emphasis. Before extracting significant statements I made several copies of the original transcripts so that I could refer to the whole whilst examining the parts. Phrases that related to the student nurses experience of teaching/ learning methods were highlighted. I started to use different coloured highlighter pens to indicate phrases of importance, a vast amount of data was generated. Research literature often gives the impression that this is a straightforward step in the research process. I did not find this to be the case, I expected to be able to make easy distinctions between significant statements and dross, in reality very little of the transcribed material could be considered dross (Morse and Field, 1996). Phrases which initially seemed unimportant took on new meaning after re-reading. Statements were extracted using the name of the participant rather than a code.

The significant phrases were then formulated into meanings, the formulated meanings are represented in the exemplars later on in this chapter. This occurred only after each statement was read repeatedly and reflected upon. This required some reliance on intuition and creativity and as such I did not find this to difficult, although I still felt immersed in the analysis mire. I was soon able to recognize repeated words and concepts which began to organise themselves around themes. It was at this point that I started to highlight and colour code the statements in relation to the emerging themes.

At this stage the tapes and notes were constantly replayed and field notes re-read to facilitate the interpretation of the data. The formulated meanings were

then organized into themes, the structures of the experience, which in turn where grouped into theme clusters. This was a time consuming and difficult process as many of the themes arising interrelated and fell into more than one cluster.

The process of reduction through reading and re–reading and returning to the original transcript continued until eventually I was able to see theme clusters developing into theme categories (figure 5. 2). The information was categorized and ordered so as to make sense of the data and to enable the writing of a final report which reflected the transcripts (Brink, 1989). The interpretation involved a systematic analysis of the whole text, as the interpreter I was seeking commonality in meanings, situations, practices and bodily experiences (Benner, 1985).

Participants were involved at all stages of the data analysis. All ten respondents were asked to read the initial interview transcript to validate the content, they were also offered the opportunity to remove anything that they did not want to be included in the research project (none availed themselves of this opportunity). The participants were also asked to read and check the appropriateness of the category system, this assisted in the checking the internal validity of the study (Beeby, 1997). Reading the transcripts of the audiotapes, the participants were confronted with themselves. I had found listening to myself on the audiotapes a learning experience in itself. The students were therefore encouraged to comment on their experience of reading

their own interview transcripts, the result of this will be attended to later on in this chapter.

The data obtained from the ten participants was reduced to one description of their experience. The thematic analysis allowed the search for and identification of common threads that extended throughout an individual interview and the entire set of interviews (Morse and Field, 1996). Consequently the data is condensed in a meaningful way without losing its essence.

- The transcripts were read individually to gain a sense of the whole
- Significant statements and phrases pertaining to the phenomenon under scrutiny were extracted from each transcript
- Meanings were formulated from the significant statements in connection with the original transcripts
- Themes and theme clusters and categories were developed, referring to the original transcripts in order to validate them and note discrepancies
- External validation was sought from 'judges'
- Following an integration of the results obtained a description of the phenomena was arrived at
- Validation was sought from the participants to compare the results with their experience

Figure 5. 1 Colazzi's (1978) method of phenomenological reduction

I chose to structure the description around the thirteen theme clusters using Van Manen's (1990) four existentials of lived space (spatiality), lived time (temporality), lived body (corporeality) and lived human relation (relationality). This framework was chosen as it is congruent with the notion of reflective experience as taking the individual closer to the straightforward experience. Furthermore, Van Manen's (1990) four existentials are based in phenomenology that is context bound utilizing lifeworld existentials, for example Van Manen's method utilizes the understanding that all experience can be seen as temporal in nature. Van Manen (1990) uses these lifeworlds during the discussion of the research findings by way of emphasizing the groundedness of the participants' embodied lived experience. Exemplars and paradigm cases will be used to illuminate the meanings within the themes. Benner (1985) defines an exemplar as:

"a strong instance of a particularly meaningful transcription, intention or capacity" (page 10).

Paradigm cases are vivid and clear and cannot be broken down into smaller units. The process of interpreting the transcripts in this study, was therefore based in hermeneutics, that is, each part of the text was considered in relationship to the whole (Pollio, Henley and Thompson, 1997).

5. 11 Findings

The 13 theme clusters that were developed are depicted in figure 5. 2. The examples of experience that are subsequently described by the participants have been divided into the four meta-themes that were also developed. These are self awareness; locus of control, theory-practice gap and learning.

Category	Theme Cluster (total number of quotes in this cluster in brackets)	Themes (codes in brackets)
Self Awareness	Self Esteem (74)	SA1 Self efficacy
		SA2 Assertiveness
		SA3 Feeling useful
		SA4 Gaining confidence
		SA5 Feeling wanted
		SA6 Taking initiative
		SA7 Feeling valued
	Self in relation to others (66)	SA8 Group participation
		SA9 Therapeutic use of self
		SA10 Communication skills
		SA11 Establishing trust
		SA12 Evaluating interpersonal effectiveness
		SA13 Acceptance/Rejection
	Awareness of needs (29)	SA14 Recognizing and attending to emotions
	Boundaries (31)	SA15 Recognizing limitations
	Handling conflict (36)	SA16 Feeling safe
		SA17 Trusting own ability
Locus of control	Power (40)	LC1 Feeling good
		LC2 Acting as patient advocate
		LC3 Putting the patient first
		LC4 Listening to self
	Self Direction (21)	LC5 Seeking external validation
		LC6 Relying on self
		LC7 Motivation
	Being heard (24)	LC8 Having an opinion and voicing it

Theory-practice	Nursing theory (33)	TP1Putting it into practice
		TP2Critical analysis
	Role of the nurse (46)	TP3Doing versus being
		TP4Completing tasks
		TP5 Doctor's orders
		TP6 Being available
		TP7 Care versus Cure
Learning	Achieving metacognition (27)	L1 Deeper understanding of patients, cultures and systems
	Role of experience (39)	L2 Taking risks
		L3 Tacit knowing/ not knowing
		L4 Knowing that versus knowing how
		L5 Methods of teaching
		L6 Comfort and discomfort
		L7 Group Participation

Figure 5. 2 Findings of data analysis

5. 11. 1 Self Awareness

Each participant provided many instances of the experience of developing an awareness of their self esteem needs and this was often explicitly linked to experiential learning programme, this very often presented itself as feeling useful and valued. Students usually described this experience anecdotally, using their relationships to others as examples, based in practice:

"Following the sessions in college spent exploring ourselves, I was really aware of when I wasn't feeling valued (SA14). Just little things in the way people approached me really made a difference to how I felt about myself

(SA14). I am sure that in the past I would not have noticed, I even notice how my friends and family approach me...the worst thing is that the nurses approached the patients in the same way...I guess that the patients felt pretty devalued also (SA7). I think that the nurses on that ward must feel pretty low about themselves (SA10)" (Sarah).

"The reflective session where we looked at identifying our own needs and those of others–I learnt that I need to be useful to feel valued (SA3, SA7). It was interesting exploring my need to be a nurse, I think this ties in with feeling useful – my own need (SA14)"(Judith).

An interesting aspect of this theme relates to how students were able to identify how having their own needs met improved their mood:

"...it felt so much different when the enrolled nurse said "would you come and help me with..."(SA7) and she always said thank you no matter how small a task we had completed...(SA12) it really made a difference to how I felt for the rest of the day (SA14)" (Siobhan).

resulting in an increased sense of confidence and an enhanced capacity to take the initiative:

"I said to myself – I can actually do this...(SA4, SA1)" (Sharon).

In this category the students demonstrated an ability to discriminate between feeling equal as a person, but not having the same expertise as the qualified staff, indicating her awareness of her own boundaries and subsequent limitations:

"I felt equal to the rest of the staff (SA7), but I noticed and respected that they had much more experience than me, having said that I did feel more useful when I was able to do things (SA15, SA3)"(Louise).

Participants described their growing awareness and experiences of learning through their interpersonal interaction with others. The need to belong was prevalent, manifesting itself as rejection and acceptance:

"when we washed each other in class, I felt really uncomfortable (L6). There were all the usual things about being watched etc. but more importantly for me I had a fear of being rejected (SA13). I suppose I feel it's easier with a patient, it is less likely that they will reject the nurse, they need the nurse (thinks)...which makes us really important to them, in control (L1), I find it's easier when I feel in control...when someone is more vulnerable than me" (Francis).

"...feeling accepted by my peers was really important (SA13), I didn't realize how much I needed other people's approval, I noticed that when I went to the wards I really wanted the patients to like me (LC5), I wasn't always myself

because of this. Sometimes I wanted to say things but I wasn't sure how it would be accepted (SA2)"(Sarah).

Students also commented on improvements in their interpersonal effectiveness:

"Initiating conversations felt really good (SA6, SA12, SA10)" (Jane)

This was related to the experiential learning and highlighted an increased level of assertiveness when handling conflict:

"I needed to ask sister if I could work day time shifts to fit in with my personal situation – I have school age children. I know that I am usually fairly assertive, well actually, I'm usually more assertive when it comes to my children, not always for myself (SA2). I was losing sleep over making this request, my first ward. I was scared of getting myself a reputation. I discussed it in the reflective group work and I was able to role-play the scenario (SA8, L5). It helped to test out the worst case scenario. When I made the request it wasn't half so bad as I thought it was going to be (L2)" (Sarah 2).

Francis' example is representative of how the students viewed the group participation and the relationship of safety to handling conflict:

"I took lots of risks in the group, saying things to people that I knew might cause conflict, this helped me to say things on the ward to staff which I might

not have been able to say before...I noticed that no one really challenged anyone on the ward, but then I wonder if that was to do with safety, I felt safe in the group... (SA12, SA16, SA17, SA11, L2, LC8)".

Overall, the students exemplars indicated a marked ability to critically evaluate their own development through self-awareness:

"I felt really wanted, part of the team (SA5). It was good to feel wanted, I felt more able to do things, I didn't expect to feel so useful. I have gained so much more confidence... (SA1, SA4) this is in comparison to how I viewed myself at the beginning of the course" (Judith).

"I think I got to know people better than I have done before because I was just myself, although I was aware of putting on a professional act at times, I think the patients like to have a bit of both (SA9)" (Louise).

5. 11. 2 Locus of Control

Locus of control was a theme that acted as a common thread through much of the transcribed material and was therefore difficult to discriminate as a distinct category. The experience of locus of control was contextualised and dynamic and very often dependant upon interpersonal relations, hence the examples tended to be implied:

"...the fact that someone believed in me, just that and I felt capable... (LC1, LC5, SA1, SA5" (Serena).

Power and subsequent self-direction were very closely related to the felt experience of locus of control. Louise identified a meta-theme in her own reflection, noting that sometimes one can choose to externalize one's locus of control which paradoxically demonstrates an internal locus of control:

"the learning from experience was fine, the only thing I found difficult was that I felt I needed someone to tell me that I had got it right, that I had understood what we were doing (LC5, LC7). Its quite difficult relying on yourself for that (LC6). What I learnt though, was that asking someone for there reassurance consciously is different to the games I used to play"(LC4, SA1).

Sarah's example also brings together the themes of locus of control and power:

"I went with a doctor to chaperone for a female patient. When we got to the bedside the doctor went straight to the patient and started telling her about the procedure. He just assumed that I would draw the curtains and sort out the bed (LC2, LC3). As I responded by drawing the bedside curtains I realized that this was a subtle power game. Some of the things that doctors do are so subtle that they are almost undetectable, I suppose you just get used to it and fall into a role".

5. 11. 3 Theory-Practice Gap

The theory-practice gap was mostly described in association with the role of the nurse and linked to task oriented versus holistic care:

"I tried to give the impression that I knew what I was doing, this seemed to be the thing to do, all the nurses were going around looking efficient. Actually in the end this was not a good thing because the staff thought I was more competent that I was"(TP1, TP3, TP4) (Sarah).

Sarah explained that appearing to know what you were doing was a trick that seemed to appease the sense of uncertainty and unpredictability that permeated the atmosphere. Siobhans' example illustrates the drive towards control:

"I spent quite a lot of time trying to find something to do so as I wasn't just sitting around (TP3, TP4). I discussed this in the reflective session, I came to see that some of it was my own expectations of myself to be busy, but it was also the expectation of the ward (TP7). The time that could have been for just being with patients was filled with cleaning and drug checking (TP4, TP6). I'm sure these things are important too. This was at odds with the concept of caring that many writers discuss (TP2, TP1). Being with the patient is really important but nurses just don't seem able to do it very easily"(TP6, TP2) (Siobhan).

Another emergent thread in this category was the students' awareness of the gap between their own informal theories and the reality of the situation, highlighting a developing level of consciousness concerning the role of the nurse:

"The nurse in charge spends a lot of time record keeping and she does a lot for the doctors, especially on the days of consultant ward rounds" (TP5, TP7) (Jane).

Serena's reflection demonstrates both single and double loop learning as she not only challenges her chosen ends, but explores alternative ends:

"I honestly thought my role was to cure everyone of their pain, I didn't really think what I would do if I couldn't help (TP7, TP3). I'm starting to think of helping in a different way. I'm learning to recognize that there are some situations that I won't be able to make better...just being there will be hard enough"(TP6, TP3, SA9) (Serena).

Judith was one of several students who were critical of the application of theory to practice:

"When I was on the ward I saw that they used Roper's model of nursing. I looked at the philosophy of care that the ward had... it was up on the wall mounted in a frame. I don't think that the philosophy of care tied in with what happened in practice (TP2, TP1). Roper's model could be really suitable to the client group, they were elderly, but it seems like they felt they had to have a model of nursing so they chose one (L1). It didn't really reflect what they did in practice, but they did approach care with a very task oriented approach and I suppose the activities of daily living model can be interpreted as tasks to be completed (TP2). I don't think that was how it was meant to be used. I didn't

want to criticize unfairly so I asked the sister about it, she looked at me like I had three heads (LC8)".

5. 11. 4 Learning

The reflective sessions were mentioned frequently in the interviews. Jane commented on how they had helped her to learn that she was not alone in her fears:

"I wasn't looking forward to going onto care of the elderly ward, I didn't think that I would be able to talk to the patients. My grandparents died when I was young. Funny, I mentioned these concerns in our reflective group and other people said they had concerns about going to care of the elderly (L5). I thought that these were just my concerns and felt that I would make a fool of myself (L7, L6, L2)"

The subject of conflict and challenge was associated with learning from experience and was mentioned frequently:

"the experiential group was the most useful learning experience for me (L5, L7). The fact that we were all able to air our views and discuss things from a different viewpoint, even if we didn't all agree was great"(L7, L6, SA16) (Sarah 2).

Didactic approaches were not always welcome:

"I don't like teaching that is just like reading from a book, I found the reflective sessions most beneficial, we were all involved (L5, L7), everyone's opinions mattered. If someone wasn't speaking they were challenged, but if they wanted to be quiet, they could say so, it felt really adult"(SA12)(Judith).

References were made explicitly to specific methods of teaching and these were associated with increased performance:

"I enjoy all sorts of teaching really, but you don't benefit if it's the sort of teaching where students don't join in (L5). I think you can really gain a lot from speaking in the group (L7), I really gained more confidence in myself from doing that"(SA4) (Sarah).

and the same student later comments on her ward placement:

"I didn't feel threatened at all in the clinical placement, I felt I could ask questions all the time, if I didn't understand, I just said I don't understand. I wasn't really worried about what people thought about me not knowing... (L3) I'm a student and I'm there to learn"(L1, SA2).

The experiential learning was a recurring theme:

"I really enjoyed the role play and the reflective sessions in the small groups (L5, L7). These helped me to get to know myself and others, also how others saw me. The johari window was good for that" (Francis).

Despite this, not everyone found the experiential group work easy:

"Learning in large groups can be difficult for me, it's not necessarily the people in the group, it's the size (L5, L7, L6). It also helps if I feel good about myself, sometimes the group is what helps me to feel good about myself, so I guess I just have to take the risk of being in the group"(L2, L1)(Serena).

Although students felt able to take risks despite the discomfort:

"Taking risks leads to further development, I'm getting more confident in dong that (L2, SA4), I feel like I'm progressing (SA1, LC6), I feel differently about myself"(L1) (Francis).

Paradoxically, students also commented on how the group work had facilitated a sense of calm in their learning:

"The way we worked together as a group and bringing in personal experience really helped me to feel relaxed (L7, L6), I could get involved and ask questions"(Jane).

This sense of feeling comfortable with discomfort was quite marked:

"The more confident I became, the more I was able to show my weaknesses"(SA4, L6, SA15, SA16) (Sarah 2).

"the group work helped me to feel able to stand back if I felt uncomfortable, but discuss it afterwards, reflect on the discomfort and where it was coming from"(L1, L6, L7) (Judith).

The students translated this learning directly to patient-care:

"I found some of the experiential group work and exercises a bit uncomfortable, but I learned how to respond to a whole mixture of people and situations and I'm sure that this had an impact on the way that I responded to patients (L6, L5, SA12, SA10, TP1). I also felt more confident in my personal relationships"(SA4) (Jane).

The students indicated that they found it difficult to describe their experience of learning and noted the sleeper effect of experiential learning:

"I prefer to learn this way- its more meaningful (L5)" (Sarah).

"I'm not always sure where my confidence comes from – I have a feeling it comes from experience (L3, L4, L5)"(Siobhan).

"I know I've learned things – its difficult to say what it was that did it"(L3, L4, L5) (Francis).

"I sometimes wondered what I was actually learning in the group exercises and the reflective sessions (L5). Afterwards I realized it does have an effect, when I come to do something, it takes time to appreciate the real value of learning by experience"(L4, L3) (Louise).

5. 12 The Experience of Experiential Learning in First Year Student Nurses

From the students description of their own learning experience I could then write a complete description, my own interpretation, in my own words. The description is built around Van Manen's (1990) four existentials previously identified as lived space (spatiality); live time (temporality); lived body (corporeality) and lived human relation (relationality).

Lived Space

The students experienced their lived space as shared and sometimes merged with their colleagues', other nurses' and patients'. Space was either experienced as in the classroom or on the ward. The space within the classroom was experienced as safe, reflective and uncomfortable simultaneously. The ward was not so safe a space, it evoked a stronger desire to be accepted. The role of the student seemed to change dependant upon whether the space was deemed to be professional or personal. Space was also seen as a place to be active in, either in being or doing or both. There was some fear of space in terms of it being invaded or invading others, although the size of the group could have caused some difficulties with shared space, it created a space in which similar experiences could be explored

Lived Time

The students experienced lived time as moving and in short supply. Time was something that busy nurses had too little of and was measured in units related to the classroom and the ward. It was bought and sold like a commodity. In the classroom lived time was experienced as before course and after course and through reflection in diaries and on experience. On the ward, lived time was experienced in terms of shift patterns and as something to fill with things to do. Time was valuable if used effectively, this usually entailed completing tasks. Hence lived time was measured by the significance of the tasks being performed. Time was rarely an 'in the moment' experience, instead the students experienced time as in the past, in terms of what had been achieved, or in the future, in terms of what needed to be done within a certain time frame.

Lived Body

The students experienced their lived body as a tangle of emotions with a heightened sense of attunement to the experience of the lived emotions. In the classroom the lived body contained an inner voice which the student could dialogue with and listen to. The voice was a notable part of the lived body experience and particularly when the students felt able to speak out. The lived body was experienced as both relaxed and uncomfortable in the classroom. On the ward they had an awareness of not being them 'selves' on occasions and seeing them 'selves' differently. The students often referred to themselves in parts in the clinical area, 'a pair of hands' for example. Hence the students

being disembodied experienced alienation from themselves. In the clinical setting the lived body was linked both to usefulness (an extra body) and to vulnerability as the patients were seen to be exposed through their physical dependence.

Lived Human Relation

The focus on lived human relation was heavily weighted. Lived relationships were experienced as intense and the students' sense of self was measured by its relationship with other people. The lived experience of searching for personal relationships in an environment that functions at an impersonal level was felt to be a challenge. Bonding with colleagues led to the development of deeper alliances involving challenge and risk. The lived experience of human relation was measured in terms of giving and receiving. The giving of self was seen to be valued if openly appreciated. In the clinical area relationship was experienced if the student felt she had made a difference. Respect was a crucial factor in the experience of lived human relation, this included respect for differences and respect for self. Conflict was experienced in the area of personal and professional relations, this manifested itself in the tension between the need to belong and the need for recognition. Thus the students experienced a tendency to lose them 'selves' in lived human relation.

5. 13 Discussion on the Meaning of the Findings

Before discussing the meaning of the findings a brief note pertaining to the trustworthiness of the data ensues. In order to establish the trustworthiness of the data the above phenomenological description of the students experience

was validated with the participants. This phenomenological description of the students' description is my reflection on their reflective experience and as such is at least two steps removed from the original straightforward experience (Spinelli, 1989). So, and as is often the case with phenomenological writing, the meaning lies in the data itself rather than the phenomenological writing about the data. With this caveat this section attempts to understand the meaning of the findings in the context of this study. A further discussion ensues pertaining to the validity of this phase of the research before a comment is made regarding the research questions.

The students' narrative indicates that experiential learning allows the tensions and contradictions in nursing and nurse education to surface. Rather than ignoring the gap for the sake of comfort, the process of learning from experience was opening up the chasm for exploration. This unveiling of the inner and outer contradictions is the first step towards critical consciousness (Mezirow, 1981). Of the many tensions that surfaced, those tensions that demanded attention were the tension between the classroom and the clinical situation (lived space); between being busy and idle (lived time); between being and doing (lived body) and between the need for love and the need to be recognized (lived human relation). The students' experience indicates an awareness of living with these bipolar tensions (Hall, 1986), whilst simultaneously trying to find their own rhythm (Chaplin, 1998). With an emerging awareness of the bipolar consciousness the students demonstrated the ability to consciously differentiate the opposites (Hall, 1986) and move towards the dialectical process (Hegel, 1971).

This was manifest in the conflict between relying on external validation for self-esteem but also being aware of knowing self better than others. An increased awareness of how other people's attitude towards them affected the student's emotional well being was highlighted; this seemed to create a conflict between competing needs. In terms of Maslow's hierarchy (1970) these related to the levels of belonging and safety needs. A question could be posed concerning the students' capacity to have more choice over how they are affected by others having developed an increased consciousness.

The other side of this coin pertains to the effect that the student had upon others, namely patients and other staff. This displayed itself as a tension between being and doing. The students appeared to be aware of the pull to act therapeutically in the clinical situation as well as in the classroom setting. What was not so clear, was how to act on this call. The model set in the clinical setting was that of busyness and whilst the students adopted this model of therapeutic use of self, it was, in the main, incongruent with their espoused theories regarding the therapeutic use of self.

These findings infer that the student nurses lived experience of being on the experiential learning programme was one of competing tensions of opposites. These deep conflicts were surfaced and made conscious through the process of learning from experience, whilst the students struggled to find their own self boundary and a rhythm of opening and closing (Figure 5. 3)

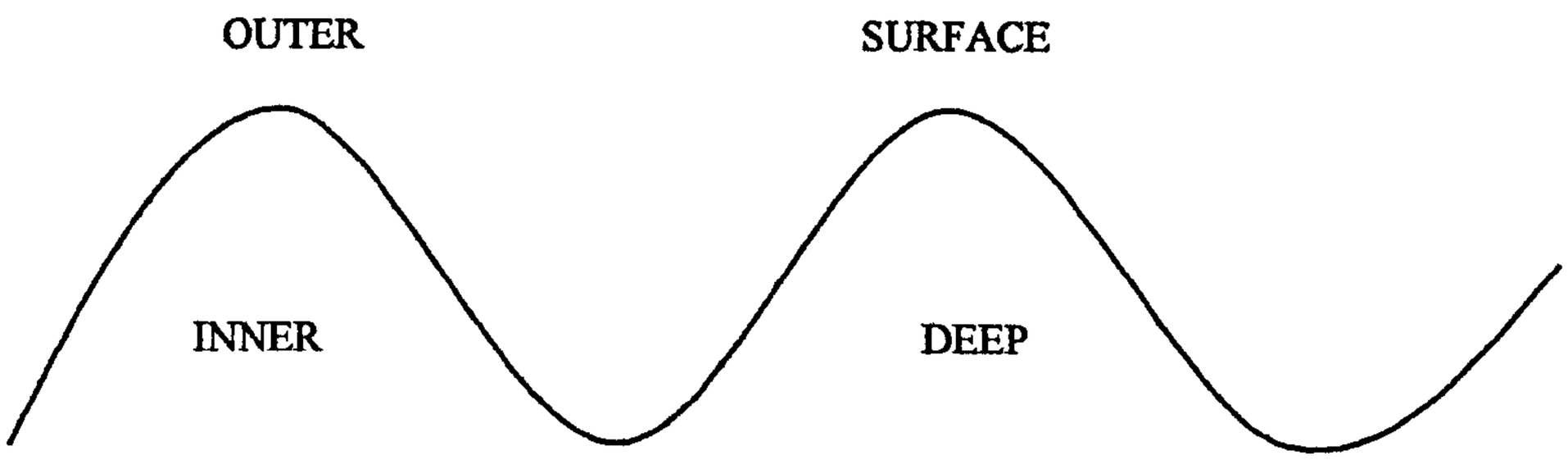

Figure 5. 3 Rhythm of learning

At this point it is appropriate to raise certain points regarding the validity of the level 2 research. Whilst every attempt was made to ensure internal validity at every stage of the interpretative process through member validation (Sandelowski, 1993) I was open to the possibility of the social desirability factor, that is that the students might have felt a need to please me. Although I was not involved as an assessing tutor with any of the participant sample, I noticed that no students opted out of any of the experiential learning sessions, nor the research. And although the students engaged in fruitful discussion having read the interpreted transcripts, no changes were made. On reflection I wondered if I had substituted the tutor-student game for a student-researcher game. Were both the students and I kidding ourselves? Playing the game of traditional research under the guise of collaboration. Of course there was also the possibility that none of the students wanted to opt out, after all they were being given extra attention and to some extent this elevated their status in the student common room.

This raises a further point for reflection – the difficulties of unpicking the effect of the learning on the course from the learning gained from being a

research participant. In a sense the students that were interviewed had an opportunity to reflect upon their reflectivity just by being interviewed. They were then given the chance to turn the critical gaze towards themselves in the reading of the interview transcripts. Indeed several students commented that re-reading the transcripts was a learning tool in itself and in the main a therapeutic one. Although students felt embarrassed on occasions, many of them found that the transcripts triggered off a new train of reflection. In Rolfe's (1998) terms the students were reflective observers of their own practice. It is interesting then to note that the research itself may have been the most significant learning tool. This feels like a big EUREKA (accidental) finding within this research project, although I already knew this somewhere, in my own experience. In response to my earlier question as to whether the learning and the effects of the research can be distinguished as separate entities, I would argue that experiential learning is research, research of the self.

One final reflection pertaining to the notion of validity at this level concerns the development of the four meta-categories that emerged from the interview data. These closely matched the themes that emerged in the formal theory exposed in chapter three and whilst I am less concerned about the Husserlian notion of bracketing, I do wonder if I dis-engaged (as opposed to dis-identified or dis-embodied) enough from my research questions to be alert to their limitations thus enhancing reflexivity.

In relation to the research questions the majority of the transcribed material was based in experience and highlighted a parallel process between the learning experience and that which was being transferred to the clinical setting. The data did provide evidence of self-awareness development in the student group, but as already indicated it could be said that this was as much a result of the research as it was the experiential learning interventions. There was little evidence of explicit links between self-awareness and professional competence and the transfer of reflection into practice. Although the data provided some evidence of reflective learning as being meaningful to the students.

In as much as the analysis of the semi structured interviews provided examples of how the experiential learning programme was proving enlightening for the students, the analysis did not really provide adequate information regarding the role of experiential learning in facilitating empowerment and emancipation and therein the development of deeper levels of reflectivity. Furthermore, in as much as it was evident that the experiential learning was creating an awareness of the theory-practice tensions in the students and stimulating the dynamic disequilibrium so to speak (Joyce, 1984), as yet, no sense of how these tensions would be handled was emerging. I was left feeling that I had not gone 'deep' enough into the lived experience. It was with these feelings that I progressed to the next phase of the action research cycle and to level 3 research.

5. 14 Re-visiting the Action Strategy

In order to expose deeper levels of reflectivity I felt that the level 3 research would need to provide a deeper insight into the interaction between the inner world of the student nurse and the external world of formal theory and practice. Reflecting upon the findings based on the action strategy thus far it was judged appropriate to continue with the current programme of learning interventions. Evaluating the experiential learning programme at this stage seemed to show up two main points:

- Nurse education programmes that emphasize self-knowledge, reflection and experiential learning for the purpose of professional growth and improved relationships increase levels of self-awareness by bringing the self into focus.
- Experiential learning programmes brings the theory-practice gap into the foreground

At this stage it would appear that the experiential learning programme (and therein the research) was facilitating transformation of consciousness in the students and was proving enlightening. Still, there was a question mark over the depth of consciousness that was being transformed, especially in the realm of critical consciousness (Mezirow, 1981). I felt that it was important to access an understanding of this within the students' experience as it would help to illuminate the potential of experiential learning for empowerment, emancipation and perspective transformation. It was decided that this could be afforded through focussing the next phase of the action research process on the reflective process groups and the nuances of the reflective process. In

order to do this I took advantage of the forthcoming situation. At the six-month juncture the group of students split into four for the purpose of individual modules. Within the modules the students have a substantial proportion of time in clinical practice. I decided to continue with the reflective process group within each module. This would mean working more intimately with each group whilst they were more intensely engaged in clinical practice. The students would be encouraged to maintain their reflective diaries bringing critical incidents to the reflective process group for exploration within the group. As the group would be smaller more time could be afforded to each individual scenario allowing the potential for deeper exploration. The nature of the course would allow the reflective process groups to run for a period of one year, this was felt to be a substantial period of time over which to evaluate the effectiveness of reflection as a tool for experiential learning and developing critical consciousness. As Louise taught: "*it takes time to appreciate the real value of learning by experience*".

5. 15 Summary

This chapter has explored the findings and implications of an action strategy that was introduced as part of the level 2 research. The level 2 research has facilitated a macro view of the learning situation which was evaluated after an initial period of six months. The action strategy involved the facilitation of experiential learning amounting to a total of 250 hours student contact time. The meanings and experiences of the students in response to the action strategy were explored using semi-structured interviews. Thirteen theme clusters and four themes were derived from the data as a result of

phenomenological reduction. Whilst the analysis illuminated the student nurses' development of self awareness and confidence, consequently raising consciousness of the internal and external conflicts, a revised action strategy has been put forward as a means of achieving greater depth of understanding of the learning experience. Chapter Six indicates how the revised action strategy was operationalised. Moving into level 3 research, the research strategy is congruent with the learning intervention, that is reflection on action. The reflection on action is illustrated through the students critical analysis of practice through reflective episodes. These episodes are described alongside Mezirow's (1981) seven levels of reflectivity.

Chapter Six

Level Three Research

Inner harvesting means that you actually begin to sift the fruits of your experience.

6. 1 Introduction

This chapter is built around the data that emerged from the students' experiences of the reflective process group and as such is aligned with the research at level 3 (Rolfe, 1996) which is operationalised through researching one's own practice and is based on reflection on action (Schon, 1983). Reflection on action is a suitable research method to examine nursing praxis, with its primary aim being to generate informal theory (Rolfe, 1996). As previously indicated it is also a significant part of the action research cycle. In this phase of the research the area of cognitive interest relates to that which Mezirow (1981) describes as power and the state of integrative consciousness in learning (Kolb, 1984). The transition from interpretive consciousness to integrative consciousness is marked by the individuals' personal and existential confrontation of the conflict between social demands and personal fulfillment needs. Rather than being influenced, one sees the opportunity to influence.

Reflective episodes of critical incidents in practice are the methods of data collection in this chapter. These were drawn from written accounts that were kept as part of a reflective journal and reflected upon in the reflective process groups. Given that this chapter is generating and analyzing 'insider knowledge' the context and setting of the reflective process groups is established prior to a brief methodological expose. As the students were actively researching their practice through reflection on action, a paralleled process ensued as I was researching my teaching practice through reflection on action. Hence, this chapter exemplifies the interface between the action research cycle and the experiential learning cycle, that interface is embedded in the process of reflection.

6. 2 Data Collection

Reflective on action was the method of data collection in this chapter. This was felt to be congruent both with action research and experiential learning. Reflective experience requires some sort of communication that relies upon the notion of time and as such can be measured, in this chapter that communication is both written and verbal. Straightforward experience is timeless because it functions in the now of any event (Spinelli, 1989). Reflection on experience may only be an interpretation of straightforward experience but it does take the individual closer to the immediate experience. However, it must be remembered that reflection only allows a minute part of the sum total of experience to be communicated.

6. 2. 1 The Process Groups

The reflective process groups met for two hours weekly for a period of one year. Group contracts were revised in light of the change in group size and ethical issues such as professional accountability and patient confidentiality were discussed. I acted as facilitator for all four groups, I was also joining in, in other words I was a participant observer of my own practice and the students'. As I delved deeper into the facilitation of reflective groups I became more aware of the role of clinical supervision as a framework for reflective practice (Butterworth et al, 1998; Johns and Freshwater, 1998; U.K.C.C., 1996).

The literature and research now available in this area has grown since the current research study was undertaken and I have implemented many changes in light of this work. However, for the purpose of this study I will not be moving into the territory of clinical supervision per se except to comment that my role in the reflective process groups can be understood from both a purely educational perspective as that of facilitator and in the context of clinical supervision as a clinical supervisor. At the time of the research I did not intentionally set myself up in the role of clinical supervisor for this group of students, although there has been progression in this area since that time. This point will be expanded further in chapter six.

Data was generated in several different ways, all students in each of the four groups kept reflective diaries. The reflective process groups were not audiotaped or video-recorded, but the sessions were to be transcribed by

myself. Facilitating four groups meant that time and resources were at a premium, I therefore selected one of the four groups at random to be the main focus of the level three research. I used techniques similar to that of a focus group. Discussion centered on a particular topic (a critical incident) and I made notes about my observations of the group interaction, including my own participation and transcribed the work around the critical incidents. Although the approach may have some similarities with the focus group technique, no interview guide was used as this was not a group interview scenario (Fontana and Frey, 1994). My notes were then matched with the student's reflective diary accounts. Very early on I realized that I was amassing enormous amounts of very rich data and was concerned that I would not be able to do the group process justice. I was enthusiastic about the way the groups were working and the data that was being generated. But it was important to me not to produce a further thematic analysis that would miss the essence of the inner experience of the students. It was at this point that I began to consider the use of a single case study approach. This approach is expanded upon later in this chapter.

The mode of learning used to facilitate reflection on practice within the reflective practice groups was that of Socratic dialogue, developed in Germany in the 1920's by Nelson (1987), and inspired by Socrates. Socrates proposed that important insights are not learnt from other people, rather he espoused that this type of knowledge is carried within and is experienced in everyday life. Socrates would use dialogue to attempt to awaken his scholars up to their tacit knowledge (Polanyi, 1967). Socratic dialogue is suitable as an

experiential learning method as it attempts to impart to reasoning a practical form not by reading about issues that one is concerned with, but by reflecting upon them together with others (Boele, 1997). Boele (1997) suggests that: "Socratic dialogue puts into practice two devices of philosophy: 'know thyself' and 'dare to use your brain' " (page, 49).

6. 2. 2 The Skilled Helper - A model for facilitating Reflective Practice.

A model for facilitating the reflective process group was devised following a synthesis of the wealth of literature available surrounding experiential learning, reflective practice and clinical supervision. The model, presented here, is cyclical and uses the skills of Egan's (1994) three stage model of counselling and acknowledges the benefits of the three main schools of psychological thought (see figure 5. 1).

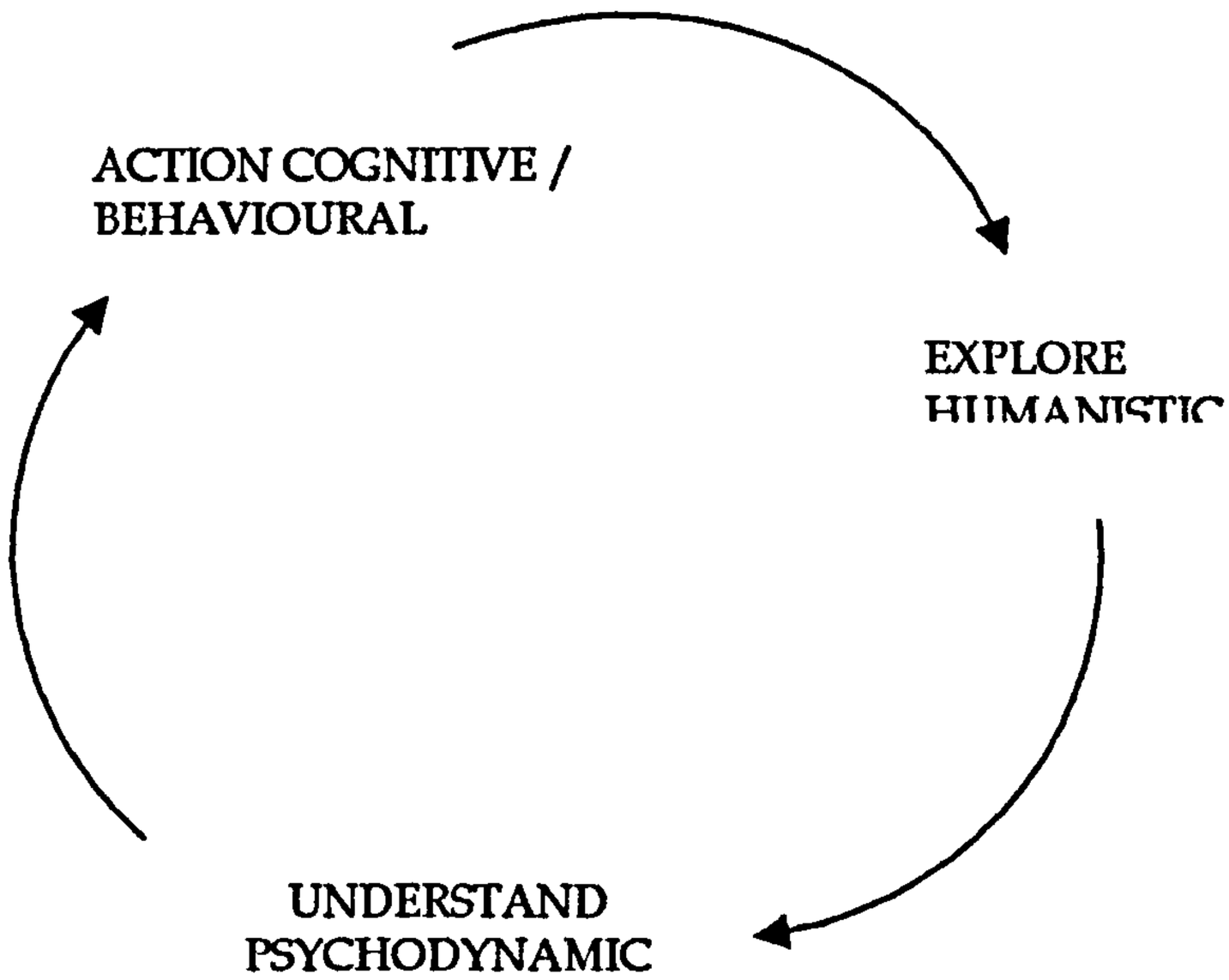

Figure 6. 1 The skilled helper model of reflection

Each session was loosely structured around an opening exploration of the critical incidents which through Socratic dialogue moved to a deeper level of understanding before options for actions/ alternatives were discussed.

6. 2. 3 Reflective Diaries

The benefit of keeping of reflective diaries or journal writing has been debated in the nursing literature. Whilst it is generally seen as an advantageous learning tool, not all students respond positively and in some cases procrastination prevails (Paterson, 1995; Landeen et al, 1995). The reflective diaries that the students were asked to keep were not to be read by myself or any other tutor, as is sometimes the case for example in dialogue journals (Paterson, 1995). Whilst some structured models of reflection had been presented to the students in previous sessions, it was felt that the students should be encouraged to reflect in their diaries in their own style, whether this be semi-structured or unstructured. This is in accord with Shields (1994) who observes that:

"Keeping a reflective journal, regardless of one's personal style, has been shown to be an effective way of evaluating experience and thus promotes learning" (page, 755).

Students were assisted in this process through the exposition of the two models of reflection described in chapter three (figures 3. 3 and 3. 4; Johns, 1998; Smyth, 1989). In addition to this particular attention was given to creative writing on the experiential learning programme, for example students were often asked to write anything that came into their mind non-stop for 6

minutes. The material generated would be used as the starting point for the session.

Other writers assert that the aims of keeping a journal need to be clear so as to clarify the purpose both to the student and to the organization (Lyte and Thompson, 1990). Some of the aims included:

- facilitating reconciliation of theory-practice issues through exploration of applied theory to practice;
- to assist the development of the learner's personal growth through increasing self awareness in relation to patient and colleague interaction;
- to encourage the effective use of independent learning by stimulating motivation to set own learning objectives (Lyte and Thompson, 1990).

These aims were made explicit to the students and incorporated into the discussion around the purpose of the reflective process group. The main purpose of the diary however, was to stimulate learning through analysis, discussion and documentation of critical incidents. The reflective element was confidential, but formed an important part of what might be shared and discussed in the reflective process groups. It was also intended to encourage the students to reflect as a regular activity, rather than something to do for the reflective process sessions.

The integrity and confidentiality of a diary cannot be doubted. The writers can change their minds, state seeming opposites, try things out, express emotions and internal conflicts (Bolton, 1995). Hence reflective writing was viewed as

a valuable tool for the students as it has the potential to stimulate both subjectivity and objectivity, enabling the students to distance themselves from an experience whilst simultaneously reporting a subjective experience (Boud et al, 1993). Not only does reflective writing take the individual deeper, under their own veneer, but it also provides a forum for the individual to step forward and speak their voice. Vezeau (1994) confirms this stating:

"it (writing) is my most political act" (page 175).

Furthermore, the writing and narrating of stories is also closely linked to the development of consciousness through the art of reflection (Van Manen, 1990). Writing helps to capture events that may usually be lost in the mists of time. Reflecting on such events, the individual is able to plot their own developmental processes. In this way Burnard (1988) states the journal can be used as both an assessment and evaluation instrument. This self-assessment and evaluation process is congruent with the concept of adult education and experiential learning. Writing has also been described as a learning activity (Mountford and Rogers, 1996). Callister (1993) also makes this point when she describes writing as means of reading thought and developing thinking, it is a process of becoming.

The students were asked to focus their diary on incidents that were personally meaningful to them, these were termed critical incidents Critical incidents have been widely used as a learning tool in general and more specifically in nurse education (Dunn and Hamilton, 1986; Clamp, 1980; Flanagan, 1954). Critical incidents are snapshot views of the daily work of the nurse. Used in conjunction with reflection they provide a sharply focussed lens through

which opinions, personal actions, judgements and beliefs can be viewed. Students in the reflective process groups were given some brief guidelines for choosing critical incidents for reflection (figure 6. 2).

Rather than each participant of the reflective group read a report of the recorded incidents to be discussed, the groups decided that individual students' would give a verbal account of their story, referring to their diary if they so desired. Hence, the focus of the use of story was not the story itself but the reader (Vezeau, 1994). This felt like a significant decision as nursing historically has an oral tradition (Street, 1991) and relies heavily on the reciting of stories, as can be witnessed each day at ward report. In addition the stories would be based on situational intelligence.

Guidelines for choosing a critical incident

Describe a nursing incident from your clinical practice which has been significant to you because:

- You feel you intervention made a real difference to the outcome
- The incident went unusually well
- The incident captured the essence of nursing
- The incident was particularly demanding
- The incident was particularly satisfying
- You feel the incident could have been handled differently

In your description include details of:

- The context of the incident - where and when it occurred
- What happened
- Why was it significant to you
- What were your concerns at the time
- What were you thinking about and feeling at the time- and afterwards
- What choices you made and why
- Looking back at the incident could you have acted in another way - what might have happened

Figure 6. 2 Guidelines for choosing a critical incident

The emphasis in the reflective diaries and in the subsequent reflective process sessions was on both process and product. Johns (1998a) emphasis-intent grid show how the emphasis of the facilitator's response is linked with the intended outcomes (figure 6. 3).

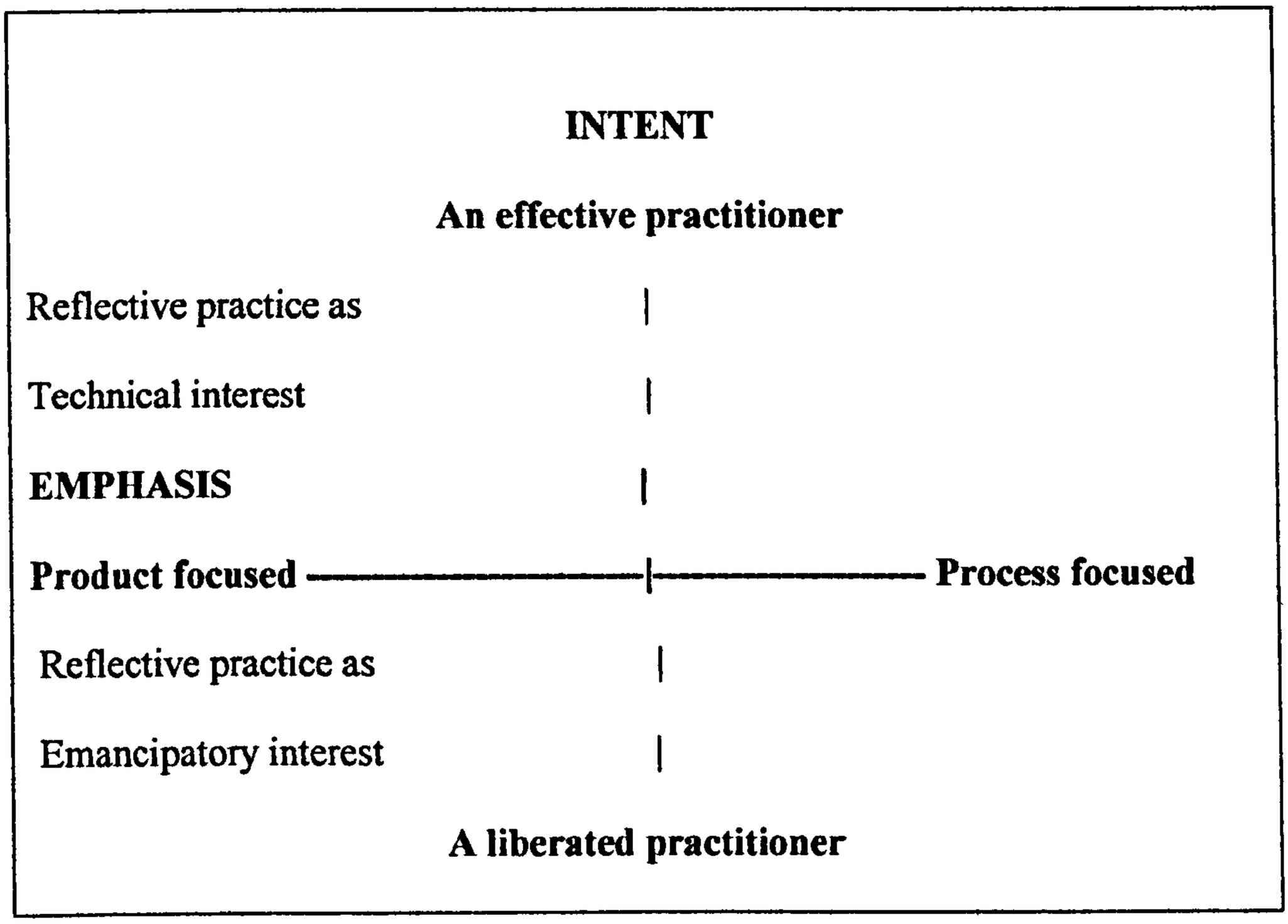

Figure 6. 3 The intent - emphasis grid (Johns, 1998a).

6. 3 Sample

As previously indicated, the students were naturally at a time in the programme that meant separating into four smaller groups, consisting of 2 groups of 10 students and 2 groups of 11 students. Each group formed a reflective process group and each was very individual in working with unique ground rules and boundary dynamics. The reflective sessions provided the overall sense of boundaries in that they were constantly and rigidly maintained, each weekly session lasting for 2 hours beginning and ending on

time. The sessions were concluded at the end of the one-year period when the students were further divided into specific branch programmes.

In order to access features of interest a single case study, Jane, was chosen from a sample of 10 students in the group A (the group in which the interactions were transcribed). This was done to remain true to the level 3 research facilitating a micro understanding through a local narrative or a single case study defined as:

"a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context" (Robson, 1993; page 146).

Returning to my motivation for the research, I was moving into Braud's (1998) third motivation, that of appreciating the world of the student nurse. The intention was to move from qualitative research with a small q to qualitative research with a big Q (Kidder and Fine, 1997). Kidder and Fine (1997) suggest that qualitative research with a small q focuses on consistency in the interview setting and attempts to recruit representative samples. Big Q qualitative research is still unstructured, inductive and grounded in the participants experience, but is less concerned with representative samples and content analysis through valid protocols.

The use of case studies is an important way to focus attention on specific issues that cannot be sufficiently explicated within larger scale research. Data generated from case studies allow for a far more in depth examination and can

have an educational value in calling attention to unusual situations (Wells, 1987). An advantage of the case study method is that different types of information can be used, for example observational material, interview data, and history, the challenge is for authors to integrate this material (Drotar et al, 1995). As mentioned in Chapter Five, I felt it was necessary to ascertain a more in depth examination of the phenomena under investigation and the case study method an seemed appropriate way of focussing on specific issues related to the research questions.

Not only is the case study approach relevant to this study, but case studies are particularly relevant to nursing in the light of evidence based practice (Sharp, 1998). Moreover, case studies can be used as a technique to generate research as a routine part of practice, which implies value in the experience of nursing practice. Hence, the aim is to investigate a phenomenon within its real life context (Yin, 1994). The case study approach to research is heavily criticized for its lack of generalization to the population, although this has been countered by Rolfe (1998a) who contends that research through reflection on action is well suited to nursing praxis as it aims to uncover the uniqueness of the nurse-patient relationship (Koch, 1998; Rolfe, 1996a).

Robson (1993), in response to the aforementioned criticisms, identifies two methods by which (non-statistical) generalizations can be made in the use of case studies. The first of these is 'direct demonstration' the second is 'making a case'. Robson (1993) describes these methods as theoretical generalizations on the basis that the generalizations are not being made on empirical data.

Theoretical generalizations deal with the 'why' questions (as does level 3 of the hierarchy of nursing research, Rolfe, 1996). The notion of 'making a case' and theoretical generalization is congruent within the current research framework and was therefore adopted as a method in this study. In order to 'make a case' and arrive at the theoretical generalization analytical induction was effected (Znaniecki, 1934). Sharp (1998) defines this as the:

"Intensive study of a limited number of cases, or indeed a single case, and its goal is to generate some general theory or model which can explain the relationships between the elements found to be general in that class of phenomenon" (page 787).

Jane was chosen for the case study as a small purposive sample. Where science is interested in general universal laws which should be followed by everyone, the qualitative researcher expects to be able to find indications of such laws in any and all participants (Braud, 1998). Hence a small non-random sample may also yield useful information even for those interested in prediction and control. In selecting a purposive sample it is important to ensure that cases with specific features and characteristics of interest to the research project are included (Braud, 1998). In some ways Jane was an atypical sample, atypical from the traditional view of random or normal distribution, however, she was also a typical sample from the point of representing my research interests at the time (Braud, 1998). Jane was especially interesting as she was 18 years old, had started the course six months previously coming straight from college and a devotee of didactic lectures. She had no previous experience of nursing and as such was the 'type'

of learner that the earlier literature had suggested would not respond to reflective/ experiential learning (see Chapters Three and Four). My experience of Jane in the early stages of the reflective process group contradicted this opinion and as such this made her an interesting candidate for the case study.

A further criticism of the case study approach relates to the subjectivity of the researcher. It is argued that the researcher influences events both directly and indirectly just by being in the research situation (Yin, 1994). In this study, this is exactly what I was hoping to explore, the influence of myself and the experiential learning interventions on the students' learning and the effect of the students' responses on my practice. In this research situation, I was not joining the group, I was already 'in' the group, the college and the classroom was my natural setting. For that reason I include myself in the sample. However, to afford additional internal validity I engaged in research and practice supervision both with a colleague in the college and my research supervisor, allowing me to stand back from my practice, whilst simultaneously being in the process. I continued to use my reflective journal both as a learning and a research tool.

6. 4 Ethical Considerations

In addition to the ethical considerations already outlined in chapters four and five members of all four groups consented to their reflective diaries and critical incident discussions being recorded for the purposes of the research.

Time was also afforded to address issues of accountability and confidentiality in the exposure of individual clinical practice. One example of this related to the keeping of records such as diaries and the legal and ethical stance. Several articles were read by the groups in order to clarify the groups position (for a detailed analysis of these issues see Dimond 1998 and 1998a).

6. 5 Data Analysis

In order to differentiate the levels of reflectivity, and to determine whether or not reflection on and in action was present, the work of Mezirow (1981) was utilized. Levels of consciousness are deemed to be a suitable method of illustrating development of self awareness and ensuing perspective transformation and are closely linked to emancipatory and liberatory education (Askew and Carnell, 1998; Mezirow, 1981; Friere, 1972). As previously identified, Mezirow (1981) classified seven levels of reflectivity, the first four being referred to as consciousness, the last three as critical consciousness. Previous nursing studies have used Mezirow's (1981) work in order to illuminate the practitioner's development of self-consciousness using reflection; these studies have generally been undertaken with post-registration nurses. Powell, (1989), the most often quoted study in the literature, adapted Mezirow's seven levels of reflectivity and reduced them to six as follows:

1. Reflectivity - awareness, observation , description
2. Affective reflectivity - awareness of feelings
3. Discriminant reflectivity - assessment of decision making process, or evaluation of planning or carrying out nursing care

4. Judgmental reflectivity - being aware of value judgements and the subjective nature of these
5. Conceptual framework - assessment of whether further learning is required to assist in decision making
6. Theoretical reflectivity - awareness that routine or taken for granted practice may not be the complete answer, obvious learning from experience or change in perspective

Her rationale for this was that Meirow's approach was highly theoretical and that nursing, being very practical, could encounter difficulties in applying the seven levels. Richardson and Maltby (1995) applied Powell's (1989) work to a group of second year student nurses, further testing its validity and reliability as a research tool. They concluded that the research tool developed by Powell (1989) was sensitive and specific to Mezirow's levels of reflectivity. Both of these studies found that the levels of reflectivity in practitioners hovered around the first four levels. The highest number of reflections amongst the participants was found to be at the lower levels of reflectivity (Richardson and Maltby, 1995; Powell, 1989). However, neither of these studies involved experiential learning processes as part of the classroom learning prior to the testing of levels of reflection in practitioners and whilst Richardson and Maltby's (1995) study analyzed reflective diaries, this was not in relation to the implementation of reflective process groups.

It is interesting to note that the level of reflectivity that Powell (1989) omits from her research tool is that of psychic reflection which in the way that Mezirow (1981) describes it, appears closely relevant to nursing practice:

"Psychic reflectivity leads one to recognize in oneself the habit of making judgments about people on the basis of limited information about them" (page 13).

Nurses are often in the position of not only having to make but also to act on such judgments in caring; it could be argued that this is often unconscious and may even be similar to intuition. Bringing this sort of consciousness into awareness and making it critical seems to be a crucial aspect of developing reflectivity in nursing. This study therefore includes Mezirow's (1981) psychic level of reflectivity as part of the research tool.

6. 6 Findings - Jane: A Story of Presence

The following exemplar is taken from the reflective journal of Jane. These are incidents that she brought to the reflective practice sessions. The incidents are supported by documentary evidence taken from Jane's reflective diary and my own observational records of the sessions.

This first reflective episode was related in session 10 of 40. Each session lasted two hours amounting to a total of 80 hours with each of the four groups; this was in addition to other exercises carried out as part of the experiential learning programme. Jane had loosely based her journal reflections around Johns' (1998) model of structured reflection. These episodes have been

reproduced with Jane's consent and have been validated by her as a true account of the events. To assist the reader I have noted the emergence of the themes developed in Chapter Four in Jane's narrative.

Jane had never found the reflective process groups easy, in one of her early journal entries she expressed some of her fears clearly demonstrating her ability to reflect at the affective level:

"Being in the group does cause me concern, it is not the group size or the other people in the group, although I now know that one of the reasons that I preferred lectures was because I could remain invisible (SA8). The thing that bothers me most about the groups is that I don't know what I am going to find out about myself, I have already had a few surprises. I am worried about what other people will think about me. I don't like the thought that my friends can see things about me that I can't (L6). I guess I am afraid of how they will let me know these things (SA11, SA13, SA14)".

When the group were organising who would be presenting their reflections first I observed that Jane made a deliberate choice to go last. She was also aware of how this had given her a feeling of being in control as reflected in her diary:

"Today went OK, I told myself I am not going to be pushed into doing something I don't feel ready to do. I am going to be last presenting my critical incident, I wanted to go last so I said so"... (SA2, SA4, SA6, SA14, L7)

I found this comment interesting and I noted in my research diary that:

"I wonder if Jane felt able to opt out of this research group, she is obviously concerned about what others think, I include myself as one of the others. Did she feel pushed into doing something that she did not want to do here?" (LC7)

I believe that I felt pushed into the level of theoretical reflectivity by Jane's statement.

In the following session I noted that Jane made her contributions 'cautiously' but was very often very astute and incisive in her observations. I wrote:

"I suspect that this is the very thing that Jane herself is afraid of... her own acute and incisive observer... I get the sense that she is afraid of her own potential to be powerful... "(LC8)

This statement appears to contain elements of both judgmental and psychic reflectivity. I also noted that other members of the group seemed to be developing a lot of respect for Jane and the 'acuteness' of her observations. In one session Siobhan (who was presenting her scenario) expressed her envy of Jane:

"You're like one of those people who just sits there saying nothing, you think they're not even listening... and then they come out with something that

absolutely floors you...I've always wished I could be more quiet and listen more... " (SA9, SA15, L7).

I made a note in my own diary that went along the lines of fear of the envious attack:

"Not everyone feels good about standing out, it is just as difficult to be admired as it is to be hated... "

This set me on a train of thought regarding the need for nurses to be submissive, I engaged in a Socratic dialogued with myself:

"Do people find some reward from maintaining a low self-esteem, what would be the benefits of doing this?

Staying small.

So what is the problem with being big?

You can be seen.

(This is what Jane had written in her diary about being in large group situations)

And if you can be seen?

The people approach you... "

This dialogue continued for three pages bringing in issues of power and responsibility, belonging and betraying self. Jane's first critical incident presented in session 10 brought up similar issues:

Jane began: *"I was discussing placements with Helen. She was telling me about her placement and how she was getting on. She was working with babies and young children with learning disabilities, and some physical handicaps. She was finding it hard to accept the disabilities of some of the children. I asked her if they were ill, they were not. She went on to say that although they were not suffering through illness she felt that they had no quality of life and should not be kept alive. She suggested we were being unkind by caring for them (TP7). I said nothing and she went on to tell me about other aspects of her placement. I did not feel able to say anything because I was shocked by Helen's attitude, she is doing the child branch. I was surprised that Helen found these children difficult to come to terms with. Her reaction was unexpected, her point of view was not one I had considered, I was shocked at the idea of allowing these children to die"(L1, LC2).*

Jane's initial description is rich with affective and judgmental reflectivity as Jane expresses her feelings about the interaction with Helen. The issue of whether or not the children should be allowed to die links closely to judgmental reflectivity although it is not necessarily a conscious judgment at this point.

Siobhan said, *"So perhaps talking to Helen confronted you with your own beliefs?"*

Jane remained thoughtful. Judith's curiosity intervened:

"So what happened?"

"Well Helen was obviously upset by these children and I did not really feel that I could take the discussion any further, I did not want to upset her further. It was easier to hide my feelings by being quiet" (SA2, LC8) Jane replied.

I write a note to myself that this was a recurring theme in Jane's work with herself, keeping things to herself. In my diary I commented:

"Perhaps this is the other side of the acute listening... "

After a short silence Jane continued:

"I felt I ought to do something, say something to make Helen feel better or let her know that I did not agree. When I reflected in my diary I found that I didn't know to tell Helen that I disagreed with her without sounding like I was criticizing her point of view. I also wondered if I would feel different if I met these children" (SA9, SA17).

Jane makes a statement that demonstrates the subjective and dynamic nature of judgmental reflectivity.

At this point the group dived into a free for all debate about the quality of life. Students were bringing in personal examples to illustrate ideas that they felt passionate about. Judith asked Jane a very challenging question:

"How would you feel if you found out that you were pregnant and that the baby was going to be permanently brain damaged. Would you continue with the pregnancy?"

I saw Jane smart, I wondered if she would feel criticized.

"I don't know how I would feel, there are so many other factors to consider, the support network, the father, lots of social influences..." Jane was interrupted... *"Maybe that's what you could have said to Helen"* Judith responded. Jane smiled.

"I survived!" (SA4) was the first entry in Jane's diary following this session.

This next episode is taken from session 21 of 40 and sees the whole group functioning at higher levels of reflectivity. Jane started the session by stating what had prompted her to bring this particular incident. She said:

"This is still causing me some discomfort and is interfering with the relationships I have on the ward, both staff and patients" (SA1, SA9, SA12, SA14, TP6, L6)

This statement clearly demonstrates Jane's ability to reflect in that she becomes aware of a specific phenomena that does not sit right with her; some unfinished business (Boyd and Fales, 1983; Mezirow, 1981). The incident or rather Jane's perception of the incident was causing some discomfort. This is often what prompts the individual into reflection (Boyd and Fales, 1983). In this statement Jane is aware that this dissonance is actually preventing her being with her patients in the way that she would like to be, she is not present.

This signifies not only reflection in action but reflection on action, as Jane was conscious of being distracted from the here and now by the inner conflict. This statement also indicates some discriminant reflectivity, as Jane is making an evaluation of her nursing care. The incident is 'interfering' with the nurse-patient relationship.

Jane went on to describe the phenomenon:

"As I was walking out from handover I saw Brenda in the patients' dining room. She had put her blouse on back to front and her trousers were undone and therefore falling down. She was struggling to keep them up, she was wearing no underwear. I started to walk over to her and when she saw me she rushed over and put her arms around me. She looked so pleased to see me, tears came to her eyes. She said that she couldn't get her blouse off and none of the other nurses would help her. She said that she had asked for help from the night staff before they went home and had been ignored".

Jane continued as the group remained in silence, I was aware of the atmosphere in the room, I had become aware of the subtle differences between tense silences, poignant silences and anticipatory silences. There were some non-verbal encouragers, Jane outlined the context in more detail before going on to relate her own mini-reflection:

"We were in the dining room with other patients looking on and there was a staff nurse sitting at the table. It was 07.45 am and the night staff had just handed over and gone home.

This is my own reflection on the situation, based on what I experienced and what I subsequently wrote in my diary. I was very angry that no one had helped Brenda, but I managed to stay calm (SA14). I took Brenda to her room and helped her to get dressed. All the time she was thanking me for helping her, I was aware of experiencing two emotions. Anger that one of the night staff had ignored Brenda's call for help, this related to Brenda's dignity (SA14, TP2). But I was also feeling humility and some embarrassment as I realized that my presence meant so much to her (SA9, TP7, TP6). My knowledge of Brenda's illness caused me to feel distress as I knew that she was going downhill fast and this was not the right way to treat her"(LC2, LC3, TP7).

In this statement Jane is indicating her ability to reflect at the affective level (Mezirow, 1981). Jane is clearly identifying and expressing her feelings through a piece of discriminant reflectivity.

"When I returned from Brenda's room I saw the staff nurse who had been sitting at the dinner table, she said "you don't believe what these patients tell you, they can be really manipulative, she probably has just got out of bed and not even seen a nurse yet this morning. I bet the night staff let her have a sleep in, she's confused. She knows you're a new nurse and she's trying it on". I didn't say anything in response, I just smiled. I did not know what to say. I was left wondering if this kind, loving elderly lady had pulled the wool over my eyes and I even started to feel angry at her myself. She must have known that I was a new nurse on the ward. I am so naïve".

Jane seemed to be getting angry with herself as she was speaking. Jane was feeling that she had been tricked by Brenda. Siobhan commented on this, remarking:

"Sounds like the feelings are still alive in you, was there any way you could have dealt with your emotions at the time, rather than beat yourself up with them afterwards?"(SA9, SA14).

In her response to Jane, Siobhan moves across a range of the levels of reflectivity. Most noticeable was the level of conceptual reflectivity. Siobhan, recognizing that further learning needed to take place, prompted Jane to explore other alternatives.

Jane: *"I know I could have challenged the staff nurse and talked about the lack of caring that I felt I had witnessed. This would have given me an*

opportunity to discuss the contradictions between my beliefs about care and the actual care that takes place. It would also have given me a chance to express my feelings but I felt so unsure about my experience once the staff nurse had spoken (LC4, LC6, LC8). I started to believe that Brenda had manipulated the situation and so my initial feeling that Brenda had been treated badly was put to one side".

Judith interrupted: *"So you were put to one side and put yourself to one side, what was it that made you dismiss yourself?"*

This exemplar reinforces Jane's ability to confront and recognize the reality contexts. Identifying her relationship to the situation she goes on to demonstrate discriminant reflectivity through the recognition of her mind game:

"I preferred to believe that I had been manipulated by the patient, than to have to confront the fact that maybe staff are not always caring in the moment. I did not feel I could allow this thought as I felt that I would be criticizing the trained members of staff which I did not feel qualified to do (SA2). Instead I kept my feelings and beliefs to myself (LC4). This is more to do with my feelings about being inexperienced and needing to get along with people (SA5, SA7, LC5). I suppose one of my beliefs is that I do not know enough about caring to challenge the experts (LC8). They know about caring, they have been doing it for years. It's almost as if I am saying that you only know how to care if you are an expert... (TP2) I think I also wanted to care for the staff or

maybe protect them, they all seem so tired. But you are right Judith, I guess in caring for the patient and protecting the staff, I did not care for myself" (SA12, LC2, LC3).

The level of judgmental reflectivity is reached as Jane becomes aware of value judgments based upon her own notion of what is and is not caring (Mezirow, 1981).

Being careful not to get drawn into making a judgement I challenged Jane:

"Perhaps it is hard to believe that alongside the caring part in us, there may also be the opposite, a neglectful part, just like it would be difficult to imagine that Brenda could be kind and responsive as well as perhaps needy and manipulative" (L6).

Jane agreed and we spent some time exploring these issues as a group. Theoretical references were made to the definition of caring and the role of the nurse. At an appropriate point, I picked out a related issue, that of Jane's embarrassment at being seen to be caring and asked her what she made of this. Jane said:

"I felt aware of being seen to be special by Brenda in front of the staff nurse in the dining room, I felt I was being judged".

This seemed to be a move towards a deeper level of self-awareness, that of critical consciousness. Jane becomes aware of her awareness. This was confirmed in the group as we examined what the judgement could be about.

Siobhan suggested that it seemed 'unprofessional' to have this sort of interaction with a client, one in which the touch-feelly stuff was around so openly. *"Perhaps"* she said, *" it was an ethical judgement that you made on yourself"(TP2).* Jane was able to identify with this:

"I think that there is a belief that nurses do not get involved with their patients and looking back I think I felt a bit embarrassed about Brenda being so pleased to see me. I sort of felt it wasn't entirely appropriate, although no one has taught me that"(L1, L3, L6).

At this point Jane is evidencing the psychic level of reflectivity as she indicates that she has made an assumption based on her own beliefs. This awareness is crucial as it acts as a precursor to theoretical reflectivity and holds the potential for perspective transformation. Jane was exploring her informal theory; the group examined it in relation to formal theory, based on the professional code of conduct and coping mechanisms, Menzies' (1970) work and the reality of having to work so intensely with so many unwell people.

After a brief sojourn into the territory of emotional involvement with patients in which I was able to integrate some theoretical concepts, I asked Jane to summarize and close the session for us:

" I still feel concerned about the situation and it stopped me being present with the patients and staff during subsequent shifts. I realize that I needed to talk to someone about this in order to actualize my caring beliefs. Doing this may have helped me to understand the situation from the staff nurse's point of view and would certainly have lessened my feelings (SA14). I have also become aware of the emotional attachment that I form with patients and in such a short space of time, I now wonder if this was why some of the nurses seem to be so detached from the situation (TP2, TP6, L1). Perhaps it is too much to cope with long term without the support"(SA9).

The group nodded in agreement and I maximized on the situation and the student's interest by making reference to the work of Burridge (1996) and Bartol (1989), pointing them in the direction of further information on the topic.

Jane's summary dialogue demonstrates an integrated conscious and critical consciousness, conceptual reflectivity is inherent in the statement *"I realize that I needed to talk to someone"* and *"I have become aware of the emotional attachment that I form with patients"*. The final sentence *"Perhaps it is too much to cope with long term without the support"*, could be described as a perspective transformation. Perspective transformation is not only the

development of a critical awareness of thoughts, habits and actions, it is also the awareness of cultural assumptions that govern the rules, roles and conventions (Mezirow, 1981). Although the perspective transformation had not changed the original incident, the reflection on action had changed the way that Jane viewed the situation and had made her more aware of the unspoken rules and roles of the nursing culture.

"I was excited to read Jane's diary excerpt this week following the group session, I wondered what she would focus on. I think the excitement was partly related to the research, but it was more related to the way the group was working. I was almost redundant in the last session. I feel that the group is really benefiting from the reflective process and I feel the same with all the groups. How will I capture this and bottle it for someone else to see?"

The feeling of my own journal entry contrasted with Jane's poignant reflections:

"...the emotional labour of caring I think it's called. I have noticed how snappy my ward colleagues are getting with each other. I realize that this is their defence mechanism, but they moan at each other. They moan about doctors and managers, instead of speaking directly the person concerned they seem to take it out on each other and the patients. Today I saw myself starting to fall into this trap"(SA12, SA14, LC8, TP5, L1).

Jane's reflection is edging towards the level of theoretical reflectivity as she starts to challenge established patterns of practice.

The next piece of reflection comes five weeks later in Jane's session 26; she raised the incident at the reflective practice group and seemed excited and keen to get started:

"I have been working on this ward for some time now and becoming increasingly uncomfortable with the way that the clients are being cared for (L6). There is nothing for them to do, it's as if their growth has been stunted, and their world stopped the day they came into hospital. The strange thing was that the same thing seems to have happened to the staff (L1). It's like being in suspended animation, the scene remains unchanged from day to day, it all feels a bit surreal, freeze frame. You'll remember the first episode on the ward, that caused me quite a lot of challenges, but as time has passed I think I too have become complacent (SA1, LC7)). It's been so important for me to fit in with the staff (SA5, SA7). Last week I realized that since I have been on this placement I have not been feeling too well, nor have I been sleeping that well. I considered going off sick for the final week" (SA1).

In this initial introduction into the critical incident Jane immediately moves into the domains of affective reflectivity *"... becoming increasingly uncomfortable... "*; discriminant reflectivity *"... the same thing seems to have happened to the staff... "*, this is particularly evident in the notion of suspended animation and surrealness, in which Jane is attempting to decipher reality from illusion and judgmental reflectivity *"... there is nothing for them to do... "*.

Sarah came in: "*Its like waiting for a photo to develop, freeze frame...*

Jane continued: "*One morning I was giving out breakfasts as usual, I was in the dining room. Gwen, a lady who occasionally became confused but also had some very lucid moments, kept insisting that she must pay for her breakfasts and refused to eat until we accepted payment. The staff nurse in charge spoke up saying 'Oh, here she goes again'. It was true Gwen had done this before, I had not really taken much notice" (TP4, TP6).*

This statement provides an example of psychic reflectivity as Jane recognizing her own 'not noticing', identifies routine and habit.

*"This particular day Gwen came right up to me, looked me in the eye and said "I can't possibly take this without paying for it". As she spoke to me, it was as if she was trying to tell me something else (L3). From a distance I heard the staff nurse say "Gwen just sit down and eat your breakfast, the nurse is going on her break now, off you go". Normally I would be desperate to get off the ward for my break, but I knew that I would stay with Gwen at the breakfast table. I might miss my break, but I felt it was more important to stay (L3, LC4, LC3). I sat down next to Gwen and said, "It seems important for you to pay your way" (SA6). Gwen did appear confused and I did not know how or if she would respond to me at all, I'm no counsellor (*Jane smiled) *but at least she would have the opportunity to be heard".*

In this exemplar Jane demonstrates theoretical reflectivity in action, being aware of her usual routine of wanting to escape from the ward. Jane also discovers an awareness that this usual behaviour may not be the complete answer. It could be surmised from this change in routine that theoretical reflexivity had taken place creating the potential for perspective transformation. Jane continued:

"Gwen became tearful and she took a mouthful of that horrible watery scrambled egg and she spoke, I nearly cried when she told me her story. She used to be a carer herself, she was married but never had children, her and her husband looked after foster children. Then when she got too old for that, she worked in old people's homes. Her husband got ill and she left the nursing home to look after him, she said "I always made sure he was clean and dry, he never got any sores you know, I would read to him and cook him his favourite meals". She never had any help. I was feeling very aware of how many patients suffered from sores on the ward and the only time they got read to was if a relative felt the urge. Anyway, Gwen said she kept forgetting where she was, she would go to do something and come back wondering where she had been. They had to get help in, a nurse and meals on wheels. Gwen emphasized "we paid for it all of course, it was only right, we worked for everything all our lives. My husband found it so hard being cared for by me, it was even worse when we had to get someone in. He's been dead eight months now". Things were starting to make sense now and I realized that Gwen was eating her breakfast. I said to Gwen that it must be hard having been so independent having to be cared for, I remembered what it felt like for me when

I broke my leg. Gwen said' if only I could help in some way, that's what keeps me going'. I thought God, you sound just like me. I looked at Gwen, she had beautiful green eyes. I asked her if she would like to help me clear the breakfast dishes, she nodded and we cleared the table in silence Later, I went to the nurse in charge and reported our interaction, I made some changes to Gwen's care plan in light of our conversation and I went to my break. I felt so good (TP1, TP2, TP3, TP6, L1, SA4, SA9, LC4, LC6).

At this point Jane reflects on her reflections:

When I wrote up my diary I realized that I had ignored what the staff nurse had said and found my own voice (LC8). This is what we were talking about before, I did not dismiss myself. I feel like I have stepped out of the picture and something has changed, Gwen reminded me of myself in some ways. She was stereotyped and labeled and nurses are also stereotyped and labeled". (SA12).

Jane related this to the reading she had been doing around nurses coping and being seen to be nice since our last session. She concluded:

"I have woken up, I remembered what nursing meant to me. I feel so much stronger in myself and guess what ...I am less tired and I did not go off sick!"

Here, Jane illustrates perspective development, stepping out of the picture she feels empowered and liberated from previous beliefs and behaviours. This is

linked to her experience of her lived body. It is as if she has been in a world of her own and has developed a deeper understanding of herself.

Further detailed reflections on critical incidents taken from Jane's reflective diaries can be found in appendix nine.

6. 7 Discussion - Experiential Learning and the Role of Reflection on Action in Jane's story

The discussion of the meaning of Jane's story and its relevance for this study is again structured around Van Manen's (1990) four existentials, the themes and theme clusters generated in the semi-structured interviews in chapter five and Mezirow's (1981) levels of reflectivity.

Lived Space

Jane experienced lived space as either belonging to her or belonging to the other. In this way space was territorial, marked out by rooms on the ward (dining room, bedrooms) or space away from the ward (breaks). Hence, the space was either personal or professional. Jane's first narration related to life space and autonomy of choice to exist in the life space. In Jane's second narration space was filled primarily with patients and staff and lastly herself, in other words the space in the ward was for taking care of others. Space was also something that Jane could step out of and into. Jane's third reflective episode challenged this; space was not so clearly delineated by experiences of distance and proximity. Being with Gwen had coaxed Jane to bring some of herself into the professional space. The reflective process group provided space for Jane to explore herself and her practice and a parallel process

occurred, as Jane was given space, she was more able to make space for her patient.

Lived Time

Jane described her experience of time in the ward in relation to day staff and night staff; work time and break time. In Jane's third reflection time had stopped and scenes remained the same. With the passing of time and the situation remaining unchanged, Jane experienced a sense of timelessness and meaninglessness. Thus Jane's experience of lived time was that it was either dynamic or static. Jane also used her attachment and detachment from patients as a measure of the passing of time. Time in the reflective process groups was retrospective and introspective, based on the notions of straightforward experience and reflective experience (Spinelli, 1989). Time was therefore measured in units of before the course and after the course and the previous reflective process groups.

Lived Body

Jane experienced her lived body as having an inner and an outer boundary; feelings could either be experienced on the inside of her lived body in that they were contained, or both inside and outside in that they were felt and seen. Jane's first narration saw her keeping herself contained. The lived body contained conflicting emotions simultaneously. Jane's lived body felt unwell in the clinical situation when it was not listened to, that is she was disembodied. As Jane was able to experience her voice she became more embodied. Patients were also viewed as either 'sore' bodies or 'not sore bodies'. In the

reflective process group Jane experienced herself as 'in' her lived body as she listened to and responded authentically to her feelings.

Lived Human Relation

As in chapter four, Jane's focus was heavily weighted in the domain of human relation. Jane experienced herself as uncomfortable with relationships that might be deemed to close, trying to maintain professional distance. Paradoxically, Jane also witnessed herself as needing to belong and to be close, particularly in terms of the staff group. Many tensions in the experienced of lived human relation, for example, caring *or* not caring; superior *or* inferior; novice *or* expert; words *or* no words; dependence *or* independence and conflict *or* peace. The experience of human relation in the reflective process group was one of support *and* challenge and distance *and* proximity, engaged *or* detached. This is something that Jane demonstrated in all of the reflective episodes.

Reflection on the meaning of Jane's Story

Using Van Manen's (1990) four existentials to illuminate Jane's experience highlights the split between the personal and professional persona that Jane attempts to maintain at a cost to her lived body and lived relation. Whilst this is true of many of the students (as shown in Chapter Five), Jane's story has focussed the lens more sharply. The developing levels of consciousness through reflection increased Jane's awareness of her inner conflict and contradictions, having held the tension Jane deliberately opted for congruence and authenticity (Burns, 1982; Festinger, 1957).

Jane made herself available to Gwen and through creating space she was able to co-create meaning. Jane was aware of being available for Gwen in the moment, as opposed to her previous example, in which on reflection she realized that the conflict that she was experiencing prevented her from being there (Heidegger, 1972). The struggle to maintain or deny the inner contradictions faced in everyday practice is energy sapping and takes up psychic space. As the contradictions were made conscious and confronted energy was liberated and space was made (Freshwater, 1998). It could be argued that it was these previous learning experiences that both facilitated a self-awareness in Jane and helped her to deal with the inner contradictions. This resulted in her having more of herself available not only to be with her clients but also to learn about herself.

The findings infer that as a result of the reflection on experience Jane was able to act as a therapeutic tool and in doing so brought about a therapeutic change in Gwen. In fact, Gwen was involved not only in the process of experiential learning but was also somehow involved in the research process, both mine and Jane's.

Jane's second experience seems to support the humanistic definition of caring; this perspective contributes to a more personal connection with the patient. Appleton (1994) for example states that:

"Nursing originates within the patient, who is the primary focus of the nurse...the nurse perceives the patient as unique, a person of dignity and

worth". Further: "the nurse practices from a humanistic perspective of the patient as a whole person, feels compassion for the person in need and becomes personally involved through caring"(page 97).

From this perspective nurse care giving is an end in itself and becomes a significant moment of living as opposed to nursing that is directed towards an end that is different from the process of doing.

It is argued here that Jane's initial response to Brenda came from this place of caring, and that the awareness of this was facilitated through a parallel process in the learning milieu. That is, that the provision of a humanistic learning environment which focused on and valued the uniqueness of Jane and in turn the patient. Thus Appleton's (1994) words could be re conceptualized as:

> "*Learning* originates with the *student*, who is the primary focus of the *facilitator*... the *facilitator* perceives the *student* as unique, a person of dignity and worth. The *facilitator* practices from a humanistic perspective of the *student* as a whole person, feels compassion for the person in need and becomes personally involved through caring".

In the clinical situation Jane felt she had to hide her realness. Her humanness was something to be afraid of, ashamed of even. When confronted with actual practice she acted on her beliefs about desirable practice, but did not allow these to be uncovered because of the conflict she feared this might cause. Jane did not feel free to be authentic, instead she experience dissonance between

her self-concept and her organismic self (Rogers, 1991); this continued to distract her from her lived temporality, the here and now. Although she had not been able to be authentic at the time of the incident, on reflection, she was able to shift her awareness and level of consciousness to a deeper more congruent level, through the development of critical consciousness. This led to perspective transformation (Mezirow, 1981).

Jane's reflection highlights that becoming personally involved enables the nurse to come to know both themselves and the patient (Watson, 1998; Appleton, 1994). This, however, is not easily done and as was discussed in the reflective group several writers have noted this. Burridge's (1996) work with psychiatric nurses concluded that nurses fear reflecting too deeply about their responses to patients which he linked to a fear of vulnerability. He proposed that nurses survive on the whole by not, allowing themselves to be deeply touched by patients. This vulnerability is linked to not coping. Jane was able to recognize this phenomena through the experience of reflection, having become aware of it she was able to allow herself to acknowledge her own feelings about Gwen. This, it could be argued, is what Menzies-Lyth (1988; 1970) has been seeking to reveal in her work.

Drawing parallels with the process of teaching nurses, it could be inferred that if nurse truly are to nurse holistically then the nature of the teacher-student relationship has to mirror this process back to the student. This means becoming involved and revealing oneself as human. Like the nurses in

Menzies-Lyth's (1988; 1970) studies, nurses who are teachers may feel afraid of this connection so perhaps it is easier to stick to didactic models of teaching in which each person feels protected by their clearly defined roles and boundaries. Consequently, roles and boundaries are also tightly controlled as a way of maintaining a sense power and locus of control (Rotter, 1966).

Jane's example illustrates that experiential learning does lead to boundaries between subject and object, the learner and the learned, the wounded and the well, being more blurred (as does action research). It is proposed that this is one of the reasons for such defensiveness in nursing, when boundaries are clear and detachment is maintained, then control is felt to be internal. Hence, detachment is used as a defence against vulnerability and subsequent loss of control, the very thing that carers witness in their work day in and day out (Burridge, 1996; Menzies-Lyth, 1988). Jane was able to reclaim her power by reflecting on, becoming aware of and remaining engaged with such issues in theory and practice. In reclaiming her own power, she was able to empower the patient. For it could be said that in order to empower another person, one must firstly feel empowered and secondly be prepared to be the powerful influence in the other person's life.

The literature previously reviewed indicates that nurses do not necessarily find it easy to stand in their own power, although they may often use this when acting as patient advocate (Stein et al, 1990; Roberts, 1983). Again, drawing parallels with the teaching process, it could be argued that Jane was empowered by both the facilitator of the reflective process, that is myself, and

her peers. It would seem reasonable to assume that if teachers of nursing are not able to stand in their own power, then it is highly unlikely that they will emanate a sense of internalized locus of control. Thus, one could question the underlying message being transmitted to students by nurse teachers who experience themselves as having no voice. The current system of nurse education is in danger of reinforcing the submissive position if the teachers do not find a forum to be heard (Johns, 1998a; Roberts, 1983; Jersild, 1955).

Reflecting on experience expanded the meaning of what was previously though to be understood and as such Jane's consciousness was expanded (Newman, 1994; Mezirow, 1981). Jane's development of self-awareness and levels of consciousness were apparent within the two stories, it could be said that she was in the process of developing an internal supervisor (Casement, 1985). The reflective episodes clearly illustrate a developing critical consciousness and ensuing perspective transformation. Self awareness and perspective transformation does not mean leaving oneself, it is an outgrowing of ones old self and expanding the limits of consciousness to include the new transcendence of a previous state of being, thinking, and doing (Newman, 1994; Mezirow, 1981). The familiar is seen in a new light, the ordinary becomes extraordinary and the profane becomes the sacred.

Jane's expanded consciousness illuminates the two phases of the liberation process (Friere, 1970), firstly the unveiling of the world of oppression, making it conscious and secondly the expulsion of the old order. The first and second reflective episodes illustrates the process of unveiling, it is an uncomfortable

process of conscientization in which Jane becomes aware of her own incongruence and in doing so was also able to identify her own need to belong (Friere, 1972; Maslow, 1970). The second phase of the liberation process, expulsion of the old order, is demonstrated in Jane's third reflective episode in which Jane was able to reflect in action and in so doing remained congruent to herself, using herself as a therapeutic tool.

The third reflective example is evidence of perspective transformation in action through the development of critical consciousness. Jane responds to the situation as an adult (Berne, 1991), using discriminant reflectivity to identify her game playing (Mezirow, 1981). The critical awareness of self leads Jane to a change in routine which in turn influenced the patient outcomes and empowered Jane through a process of emancipatory consciousness (Fay, 1987; Habermas, 1972). Habermas (1972) characterizes emancipatory consciousness as involving self knowledge and knowledge of self-reflection. The emancipation, says Mezirow (1981) is from:

"libidinal, institutional or environmental forces which limit our options and rational control over our lives but have been taken for granted as beyond human control"(page, 5).

The insights gained from reflection on action were emancipatory in that they transformed consciousness and subsequent action. Jane moved from conformist to conscientious in the process of conscientization (Friere, 1972). As a result of transformed consciousness, Jane is freed from self-deception and coercion in this particular instance. Hence, emancipation incorporates a

shift in the locus of control which in this case facilitated an act of integrity and selfhood (Van Hooft, 1995). It might be suggested that Jane, in acting with integrity, acted at a level of 'ethical' reflectivity. Meaning that once one is morally aware of something, then one is compelled to act on it, out of moral obligation (Van Hooft, 1995). Jane's exemplar provides an example of how that shift can be made through experiential learning, reflection on and in experience and the subsequent impact of that shift on patient care.

Jane's experience of learning was transformatory (Askew and Carnell, 1998). The reflection on action taken from Jane's journal notes and her participation in the reflective group demonstrates that higher levels of reflection and critical inquiry were attained than in previous studies (Richardson and Maltby, 1995; Powell, 1989) indicating that experiential learning can lead to the awareness of critical consciousness in student nurses. The sense of discomfort which triggered the reflective process and the subsequent learning that took place confirms the idea that dynamic disequilibrium, that is discomfort, can motivate and liberate the energy required for perspective transformation to occur (Joyce, 1984). This, it seems, is best afforded in an environment that paradoxically affords security and discomfort for the individual to explore their actions. Clarke (1986) phrases this thus:

"In acting people can monitor their actions, monitor their self-monitoring and criticize the account they give of themselves. In general the human must act before he can think in order to later think before he acts, and therefore there must be safe areas in which he can play" (page 6).

Experiential learning is based in action, but nevertheless does reduce the theory-practice gap. As Jane's example clearly teaches practical activity is primary to learning, however theoretical activity arises from practice and serves to modify it (Hughes, 1985). Reflective writing enable Jane to clarify her ideas and theories and her stance towards them. Whilst in the reflective process group theory and practice were related in a paradigm dialectic, each defining the other (Vezeau, 1994). As an experiential learning method the reflective process group thoroughly engaged Jane with her own and other people's lives. In contrast scientific education often leads to the opposite, that is disengagement and disembodiment (Vezeau, 1994; Bartol, 1989).

Reflection on my own participation

What follows is an attempt to acknowledge myself as a participant in the level 3 research. Not only is this congruent with the philosophy of this research project but it also enables me to make some of the decision processes visible, thus addressing some of the questions pertaining to methodological rigour.

I joked with myself that this would not be my lived experience of the research, I lived breathed, ate, slept and drank the experience of the reflective process groups. In this sense the research was not experienced as something separate to me, rather one that was embodied. Braud (1998) comments that research that is a lived experience is an aesthetic experience manifest as ones action and interaction in the world and one which is always lived by the author. In the process of this inquiry I polled all aspects of myself, my body, feelings, relations, intuitions and cognition's.

I was aware of my own developing consciousness as I became more cognizant of the games that I was playing in the research. At one point I asked myself if I was playing the game of giving the students a choice, this was particularly foreground in regard of consent to the research at level 3. There is no doubt that peer pressure does play an important part in this game and I wonder to what extent individual students felt able to 'standout', that is to opt out of the research.

I noticed that it was difficult for me to detach from the levels of reflectivity and when writing my own journal I was being involved in critical subjectivity. I would dialogue with myself about the levels of reflectivity that I was demonstrating, but then I would argue that I knew what I was looking for! This is quite a significant issue when linked to the data analysis. Any number of theories could be constructed around the data and each would hold some meaning. I have attempted to signpost how I came to construct the theories around the data, but would ask the reader to consider these as one approach of many.

The act of writing up the stories became a dialectic tension of both distance and intimacy, this paralleled the process that I underwent in the reflective practice groups. Often I would catch myself engrossed in the story and in catching myself realized that I was also standing back and monitoring the group process and myself. I found each group and each session unique and to some extent unpredictable. This was both exciting and anxiety provoking. The experience of the reflective process groups was for me immensely

satisfying, in that the students taught me so much about myself and aspects of my practice by revealing themselves and their practice. The students brought along a rich tapestry of stories which they explored with openness, honesty, creativity and imagination. Paradoxically, my own interventions, although creative, often brought in the balance of propositional knowledge. However, this did not feel to be a 'contradiction' on my part. I engaged in this as a deliberate conscious act, intuiting that this was grounding for the students. Thus I used experiential knowledge to guide the appropriate use propositional knowledge and practical knowledge. The skill seemed to be in feeling safe enough to allow the space for experience, creativity and imagination and trusting in my own ability to have the resources to 'ground' the learning.

6. 6 Summary

Chapter Six aimed to generate informal theory and aligned with level 3 research used reflection on action as a method for exploring and evaluating experiential learning. A single case study has been used to illustrate one student's experience of being in a reflective process group. Relating this to Mezirow's (1981) levels of reflectivity, some tentative suggestions have been made and discussed in relation to the process of nursing, teaching and learning. Chapter Seven takes these suggestions further and discusses the implications of the findings as a whole. A critical analysis of the research is undertaken. The research questions generated in chapter four re-visited. Conclusions and recommendations will be drawn from the critical analysis.

Chapter Seven

Discussion and Implication of Findings.

But the unnameable was not in the wind. And after the wind,

An earthquake; but the unnameable was not in the earthquake.

And after the earthquake, a fire; but the unnameable was not in the fire.

And after the fire, a still, small voice.

(Lao Tse)

7. 1 Introduction

This chapter pulls together the themes explored throughout this thesis. There will undoubtedly be some loose ends which will remain despite the tidying up (Rolfe, 1998b) and in a sense this is absolutely appropriate for a study concerned with systems that are forever open and in process (Chaplin, 1998). With this caveat, Chapter Seven firstly evaluates the findings as a whole, that is the research at level 1, 2 and 3. Inferences are drawn from the formal theory and the level 2 and 3 research findings forming the main part of the discussion which is evaluative in nature remaining congruent to the process of reflexive action research (Rolfe, 1998b). Drawing upon the work of Gallego (1983) the tenets of illuminative evaluation have been considered in the writing of the discussion. Specific attention has been given to the learning milieu; the views and the experiences of the students involved in the research and the

relationship that exists between my own beliefs and practices and those of the students and the organizations. Anecdotal evidence taken from informal ongoing evaluation of sessions has also informed the discussion.

The process of reflexive research, that is level 4 research is also evaluated in relation to the current study. The critical analysis of the research addresses issues of validity and reliability both in the methods chosen for the research at levels 1, 2 and 3 and for the research framework as a whole. Chapter Seven concludes by examining the significance of this study for nurse education, nursing practice and my professional own practice. Several changes have been implemented since the completion of this study; these are outlined in the final summary.

7. 2 Returning to the Research Aims

In Chapter Three I attempted to translate a research problem into a series of research questions:

Does an experiential learning ethos in the Project 2000 programme enhance self-awareness in student nurses. If this is the case, how is the professional competence of the student nurse influenced, if at all.

What level of reflectivity can the student nurse achieve through experiential learning and personal development and are they able to transfer this learning into nursing practice.

What are the students nurses experience of power in the learning situation

Can reflective practice assist the student nurse in integrating theory and practice through practical reasoning.

How meaningful are reflective learning interactions both for the student and the facilitator.

As a way of evaluating the experiential learning programme and to provide a framework for discussion, each question will be addressed in the subsequent discussion. However I wish to make it clear at this point that there are multiple realities and as such no 'true' interpretation of the findings will exist. The theme throughout this research has been that of reflexivity. How the researcher makes sense of data and the meaning that he/she extracts from it depends upon their own experiences and location (Shotter, 1993). As the researcher I have been guided by the stories of the participants and from those have begun to construct a new story, one which is acceptable not only to myself and the participants, but also to my audience (Murray, 1997). For that reason the aim of this discussion to make sense of the experience of 'our' research project and to have the many voices of the research endeavour, heard. Shortly after the introduction of the experiential learning programme, level 2 research was conducted. A total of 250 hours of formal timetabled teaching time had taken place prior to the exploration of the students' experience of their learning through semi-structured interviews.

Does an experiential learning ethos in the project 2000 programme enhance self-awareness in student nurses. If this is the case, how is the professional competence of the student nurse influenced, if at all.

The extent to which self-awareness was enhanced in the student group was, to some extent, evident in the findings of the semi-structured interviews, although this was not easy to make explicit. The change in self-awareness is a perceived change and as such can only be measured by the self. Many of the students did perceive a change in their self-awareness, which seemed to be linked to and referred to through the medium of self-esteem and self in relation to others. Judith outlined this in Chapter Four as she reflected:

"I learnt that I need to be useful to feel valued"

She then goes on to link this with her own needs. Other participants described their growing awareness of the need to belong and the fear of rejection demonstrating their emerging awareness of self in relation to others:

"I didn't realize how much I needed other people's approval"... (Sarah).

Whilst it remains difficult to ascribe how much, if any, of this perceived change in self-awareness was due to the experiential learning programme (and/or the research), the students did clearly and explicitly refer back to specific learning sessions in their dialogue about themselves. Francis, when speaking about role-play and reflection stated:

"These helped me to get to know myself and others, also how others saw me...".

These findings compare with Burnard's (1992), who discovered that the outcomes of the experiential learning process included increased self-awareness and development of interpersonal skills. In the themes that emerged in Chapter Five, the students' perceived awareness of self-developed both intrapersonally and interpersonally. In the initial stages of the experiential learning programme students experienced an increased level of tension, as they became aware of both internal and external conflicts in their work:

"I wasn't looking forward to going onto care of the elderly ward, I didn't think that I would be able to talk to the patients. My grandparents died when I was young..." (Jane)

and *"I'm learning to recognize that there are some situations that I won't be able to make better...just being there will be hard enough"* (Serena).

This confirmed that the notion of dynamic disequilibrium in learning challenges the previously established patterns of learners (Joyce, 1984). The development of self-awareness did not happen in isolation. Although students spent some time reflecting on their learning, a significant amount of the learning took place in the presence of another.

"I took lots of risks in the group, saying things to people that I knew might cause conflict"... (Francis)

and *"the experiential group was the most useful learning experience for me"* (Sarah).

This would seem to confirm Spinelli's (1989) view that the individual's perception of others is so tied up with intersubjective factors that perceptually, the very existence of others depends upon the self-awareness of the perceiver. In other words the 'not 'I' can only exist in the perception of the 'I' once the 'I' has constructed a limit to itself. It could be argued that the experiential learning challenged the learners perceived limits, which in turn impacted self and other relations. So, it could be stated that in experiential learning the 'I' is viewed as impermanent and the interpretation of past events change as the individual changes and the meaning that is bestowed upon experience alters (Wollheim 1984).

Other students often acted as witness to their colleagues' emerging self-awareness; this was particularly noticeable in the small group work and the reflective process groups. It was almost as if the other students were a projection of the individual's own witness consciousness. So far two tentative findings have been inferred in relation to the first research question; that an expansion of self-awareness stimulates the students into recognizing the contradictions between their espoused theories and their theories in action (Arygris and Schon, 1974); that awareness of self is *created* in relation to another person. One could question the pre-requisite role and qualities of the 'other person', is this necessarily someone in a designated role (that is a teacher).

Moving onto the level 3 research, this appeared to bring to her an awareness of the dialectic between her need to belong (manifest in being useful, busy, completing tasks and trying to say the right thing) and the need to be recognized, valued and respected (Maslow, 1970; see figure 7.1). That Jane's attention became focussed on these conflicting aspects of herself seems to suggest that Jane's self-awareness had been enhanced. However, from a Heideggarian (1962) perspective, it could be argued that Jane already knew these aspects of herself and was just given the opportunity to bring them to the surface through exploration of the everyday.

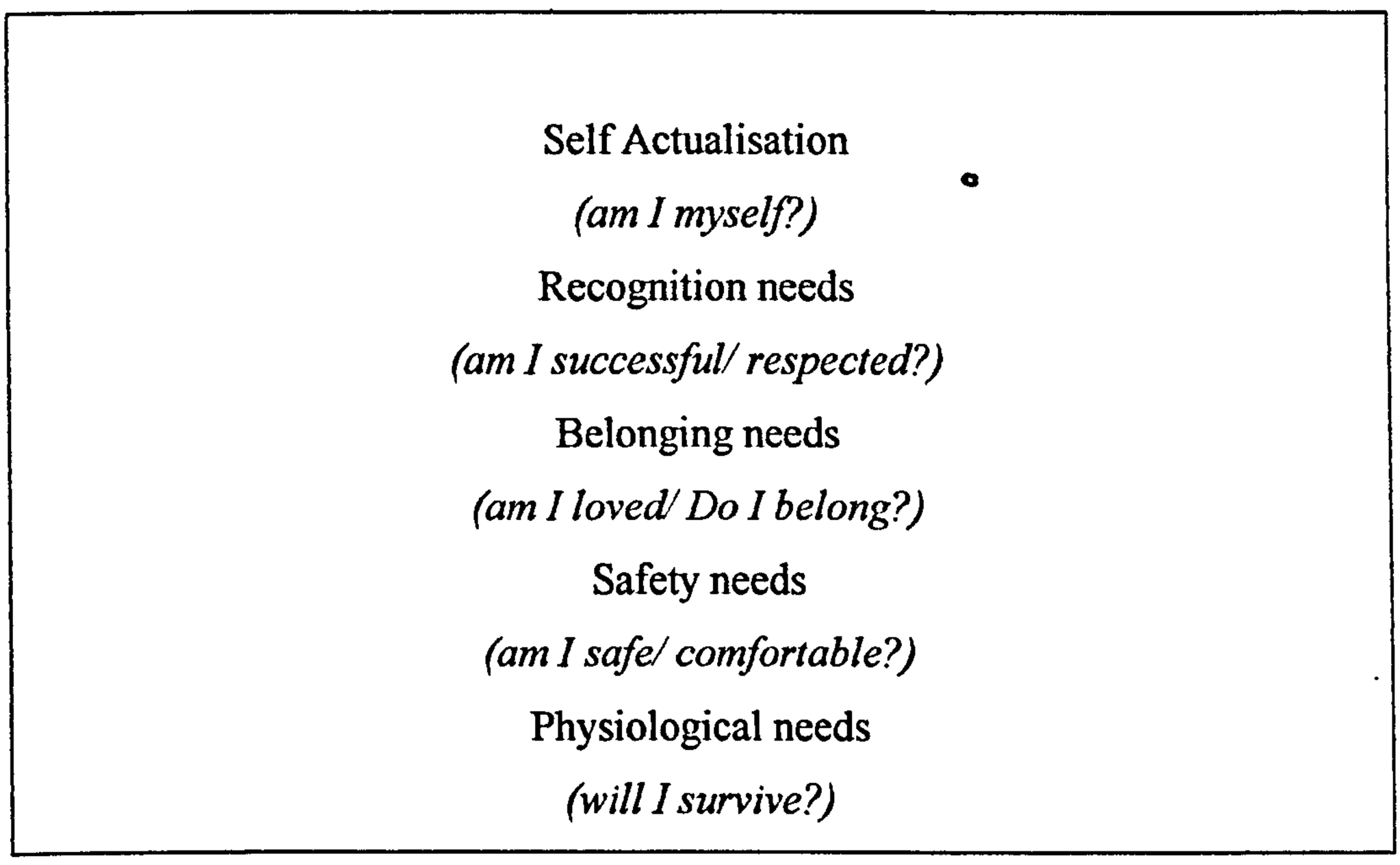

Figure 7. 1 Maslow's (1970) Hierarchy of Needs.

Consequently Jane's dialectic can be conceptualized in terms of *particularity* and *universality* (Sarup, 1993). Particularity refers to the individual agent whilst universality refers to the social aspect of man's existence. The conflict

between the two is not new; Sarup (1993) contends that everyone on the one hand would like to be different from all others and on the other hand would like to be recognized in his/her uniqueness by as many people as possible. Hence, it is only through the universal recognition of human particularity that individuality realizes and manifests itself. It could be said that the process of individuation is a synthesis of the particular and the universal.

This has some parallels with the idea of holistic and humanistic nursing in which each patient is viewed as individual and unique whilst concurrently enjoying universal experiences which when responded too empathetically give the feeling of both individuality and universality.

Reflecting on the experiential learning programme (a major component of which was the reflective process groups), I would argue that this particular approach to learning could facilitate students to become increasingly sensitive to their dynamic selves. Nevertheless, whilst it has the potential to result in a more deliberate and responsible use of self as a therapeutic tool, it is only one of many approaches to learning which also produce meaningful learning and assists the growth of the student.

The growth of the student is essential to nursing as it encourages them to accept responsibility for themselves and their actions and as such knowing self needs to be a significant focus in the nursing curricula. Experiential learning is grounded in who the person is, it is embodied learning not learning that is disengaged from the self. For this reason, experiential learning encourages

involvement with others. Experiential learning is dynamic and in a constant process of becoming, as is the 'I' (Parse, 1987). Self-awareness development therefore is not only important in the initial stages of nurse education, it is a lifelong process and has to be addressed throughout professional practice. For this to become a reality, health care organizations would have to foster a more receptive 'open' environment in which personal learning is viewed as part of the nurse's professional development. This is a challenge that is currently being addressed through the implementation of the clinical supervision initiative (UKCC, 1996).

Evaluating the second part of the first research question has been challenging as the notion of professional competence is complex and subjective. On reflection, it may have been useful to have been more specific in describing my own definition of professional competence. It is perhaps easier to be guided by the professional code of conduct (UKCC, 1992) which is already provided than struggle to clarify one's own understanding of professional competence.

The findings of the semi-structured interviews indicated a developing awareness of situations in which the students were inclined to disempower themselves. For example Sarah explains how she responds to the doctor-nurse game on page 194), something that she was becoming more aware of in her professional practice. The case study with Jane explored in Chapter Six highlighted the shift to an internal locus of control in one student which directly affected patient care and professional competence. Consequently

consciousness and professional competence were linked in this case as a result of cognitive dissonance. In other words, it became uncomfortable to repeat old patterns of practice and the ensuing self-deception once Jane was aware of her responsibilities.

Overall it seems that learning from experience, especially by reflection on action, is a 'potent' method of facilitating the knowing of self within the context of professional practice. Through reflection, the students became active interpreters of their experience rather than passive reactors to it (Rotter, 1966), which it could be argued led to an increase in perceived self-esteem which in turn can influence professional competence. I would concur with other writers on this topic who suggest that reflection on and critical debate about practical activity is a means to professional development (Butterworth and Faugier 1992). And that learning from experience is a way of developing the advanced practitioner (Johns, 1998).

What level of reflectivity can the student nurse achieve through experiential learning and personal development and are they able to transfer this learning into nursing practice.

The discussion will now turn to the question of developing levels of reflectivity through experiential learning. In examining the data generated from the case study in the level 3 research it could be argued that Jane's development of reflectivity occurred not only at the level of consciousness but also at deeper levels of critical consciousness (Mezirow, 1981). Jane' story

shows how these skills were transferred into a patient situation illustrating some transferability of learning.

With the help of critical consciousness, Jane was not only able to identify her thoughts, feelings and actions, but was also able to comment critically on the origin of the same. Shotter (1975) argues that critical consciousness leads to responsible actions. What makes an action responsible is that it is chosen from amongst other actions, it is an intended action. Responsible actions are expected in nursing practice and as such nurses are required to be critically aware of their intentions in order to make deliberate and therefore responsible choices. Placing this in the context of adult learning and levels of maturity, Jane could be considered a mature responsible adult as she demonstrated the ability to critically contexualise past and present experience (Goulbourne, 1997, Knowles, 1990).

Transferability of learning is also an important concept in qualitative research. The extent to which a similar construction would be formed in a different context is discussed in relation to the trustworthiness of the data towards the end of the current chapter (Denzin and Lincoln, 1994). Still, it is perhaps worth reiterating here that as qualitative research concerns itself with meaning and as meaning in human experience is not generally likely to be universal, it is not relevant to attempt to generalize from Jane's experience (Zyanski et al, 1992). Nevertheless other student participants made contributions in response to Jane (as indicated in the case study in Chapter Six) which also indicated

high levels of reflectivity and to a small degree, transformation of consciousness.

The extent to which individual transformation was experienced is difficult to assess, as transformation is not necessarily manifest externally, in altered behaviour for example. Transformation may be a change in perception or experience of self that creates an altered inner state in the individual. A specific example of this referred to the issue of emotional engagement with patients. Nursing is difficult work technically and emotionally and can lead to the nurse disengaging, learning purely from a scientific standpoint can perpetuate this disengagement. The experience of learning was transformative for the students in this study not only because it facilitated engagement with self and others but it also enabled them and Jane in particular to undergo perspective transformation regarding the issue of emotional engagement. This perspective transformation was witnessed, facilitated and experienced by myself and Jane's colleagues and stimulated further discussion on this matter. It could be argued that Jane's perspective transformation was a shared experience that belonged to the group and as such provided vicarious learning.

In Jane's case perspective transformation lead to the therapeutic use of self. It is argued that self-experiences can only occur if appropriate regard is given to the environment in which nursing activity takes place, this refers to the psychological environment as well as the physical space. Woods (1998), for example, comments that personal psychological space is needed:

"to explore the internal feelings and anxieties that are created by being vulnerable and ill" and that this "is as important as technical and practical procedures" (page 44).

Nurses need to be able to learn not only to 'hold' the situation (the patient) but also themselves (Casement, 1985; Winnicott, 1971; Menzies-Lyth, 1970). In this way anxiety has the potential to be contained and transformed. This study demonstrates that reflective process groups may be one method of facilitating a 'holding' environment in which the students can experience feeling 'held'. In being held the students were able to allow their discomfort and anxieties to be seen and felt and 'held'. For one student learning how to be 'held' was transferred into practice as learning how to 'hold' the patient. Learning has the potential to be transformatory and transferable in nurse education providing adequate attention is given to the facilitating environment.

What is the student nurses experience of power in the learning situation.

Turning my attention to the student nurses' experience of power in the learning situation I found that this was closely linked to the locus of control. The case study presented in Chapter Six best authenticates the personal development and expansion of consciousness generated from the learning interventions, although there are further exemplars in Chapter Five:

"I felt I needed someone to tell me that I had got it right... it's quite difficult relying on yourself for that... what I learnt though, was that asking someone

for their reassurance consciously is different to the games I used to play"(Louise).

As already mentioned Jane's narrative clearly highlights a shift in consciousness, this resulted in 'experiential freedom' or autonomy in practice.

Sartre (1956) coined the term experiential freedom and defined it as the right to interpret the stimulus events in life as you chose to. Being free to interpret experience as one chooses leads to the understanding that there is no definite interpretation and therefore no definite certainty. Individuals who do not act upon their situational freedom, that is they deny freedom of choice, are inclined to see themselves as passive reactors to external influences. Locating their locus of control as external, they are the slave to a master.

Sarup (1993), referring to Heidegger, describes the events leading to experiential freedom quite succinctly:

"To satisfy the desire of the master the slave has to repress his own instincts, to negate or 'overcome' himself. The slave transcends himself by working, that is, he educates himself. In his work he transforms things and he transforms himself at the same time." (Sarup, 1993; page 18).

Jane transformed herself and her practice through the experience of work and education and in this instance became her own guide. It could be said that Jane experienced personal empowerment and emancipatory change as a consequence of the attention given to her personal development. There is a certain paradox herein that Jane may have been free to choose her response to

the clinical situations as a result of her emerging consciousness, but I am left with the question of whether or not Jane felt free to be involved in the research. Was Jane a slave to the 'research master'? Jane's early diary entry was full of ambivalence about 'being seen' in the reflective process groups. How much choice did she experience in her transformation of self in a situation in which self-awareness has the potential to become the normative discourse? Whilst the reflective process groups facilitated an open forum for the participants to recognize sources of their oppression, did I allow myself to be recognized as one of these potential sources? What sort of power relationship did I create within the research itself?

In any research encounter the research findings become a commodity which can be exchanged with publishers, universities and others (Richer, 1988). What is not always made clear to the participants is how they will benefit. Initially I was not able to be clear about the indirect benefits of the research project as I was unsure myself, but I did discuss the direct benefits having one to one work in addition to the other routine support. I was not a disinterested observer in the reflective practice groups and the students would often ask me questions, our relationship was such that they would approach me for any number of things. This caused me some concern as I constantly asked myself 'what kind of researcher involvement is acceptable?' (Anderson, 1991). But, as I was an insider I had access to insider knowledge and felt that it would be mis-use of power to withhold information that I would normally give out freely to other students. I include these deliberations to demonstrate that the research itself could have acted as a form of oppression if the voices of the

participants (including myself) were stifled and edited out so as to conform to the scientific discourse (Belenky et al, 1986).

The use of emancipatory change strategies within nursing however has and still does stimulate critical debate. Many authors question the ethical underpinnings of such change strategies that seek to empower nurses who may in reality find their autonomy to act limited (Sparrow and Robinson, 1994; Webb, 1990). Before addressing this point, it is important to note than many of these criticisms are based on the assumption that all empowerment has an external behaviour attached to it. Having worked intensely with the students in this study, I would argue that for the most part liberation that does occur is from internal barriers that are self-imposed (Okri, 1997). Sparrow and Robinson (1994) however do have a substantial point and suggest that changes brought about by educational programmes are often nullified by the students' re-entry into the organizational culture. Going against the cultural narration is a not a battle that is entered into lightly, practitioners often opt for the alternative of collusion and acquiescence (something that research participants may also find themselves doing). Paradoxically, it is education that may help to address the issue of autonomy in practice. McCall (1996) in her study of horizontal violence in nursing found that "nurse education was a significant factor in righting the injustices in the nursing profession" (page 31). McCall's (1996) findings were also linked to self-esteem and the experiential knowledge of the practitioner:

"whilst acknowledging the necessity of education, the participants did not believe that they were valued despite their education and wealth of experience" (page 31).

Education that is based in context of practice and the culture of practice is in itself a method of accomplishing widespread change. Johns (1998a) recommends that education for clinical effectiveness would need "to focus on deconstructing the norms of practice" (page 346) and it could be added, the norms of the context of practice. Working with the students in this study I believe that particular reference should be made to the issues of power distance and the ability to tolerate uncertainty. The dimension of power distance indicates the extent to which a society (organization) accepts the fact that power in institutions is distributed unequally.

The context within which nursing and nurse education practices could be said to that of a high power distance society. This manifest itself in the way in which other people are perceived as a threat to the individual's power, with those who hold the power being entitled to privileges (Farrell, 1997). Experiential learning is best nurtured in a society which functions with small power distances, advocating the reduction of inequality and legitimate use of power (Askew and Carnell, 1998).

The ability to tolerate uncertainty may indicate the extent to which a culture feels threatened by uncertain situations and tries hard to avoid these by establishing greater stability, formal rules and not tolerating

difference/diversity. Uncertainty is experienced as a threat resulting in a great concern for security (Maslow, 1970) and the search for absolute truths and answers. In an organization that tolerates uncertainty, risks can be taken and existing rules can be challenged. The evaluation of the experiential learning through the semi-structured interviews illustrated that a notable number of students felt comfortable enough to take risks within the group. It could be argued that experiential learning is potentially a tool for reducing the power distance and encouraging tolerance of uncertainty in nursing, which may eventually lead to a more widespread change in the organizational culture.

It is also proposed that feminist theory could be helpfully incorporated into nurse education, making nurse education a political education in the sense that it would help focus on the power dynamics with the health care system. Only when these power dynamics are understood can they be changed (Millar and Biley, 1992; Hagell, 1989).

In Chapter One it was proposed that the theory practice gap in nursing was due to a variety of complex reasons including the fact that nurses feel undervalued, oppressed and powerless, which all lead to a sense of meaninglessness and disillusionment (Scott, 1998; Johns, 1995a; Roberts, 1983). The writing around Van Manen's (1990) four existentials demonstrates the schism that was apparent within the dialectic tension. Bringing the tension to the surface enabled a deeper view of the students' experience of the theory-practice gap. The findings would seem to suggest that the theory-practice split is experienced as an inner split as well as an external one (Menzies-Lyth, 1970).

(Examples of this can be seen in Chapter Five). To some extent this endorses the need for an education that places as much emphasis on knowing self as it does on teaching clinical skills. The students in the reflective practice groups seemed able to use the time and space to facilitate an awareness of the inner contradictions that they were living out in their everyday practice. These groups were based in practical activity which is primary to learning, however theoretical activity arose from practice and served to modify it.

It is debatable how much of the students awareness of their inner tensions was drawn from the experiential learning programme and how much was due to the research itself (and indeed other factors not accounted for). For example it could be argued that the students became aware of their temporal existence (and its tensions) just by reading the research narratives and the interpretations of the same. Ricoeur (1984) posits that one of the defining characteristics of life is that we exist in chronological time and that narrative provides one means of overcoming this position. Narrative is the process by which we organize our experience of time, writing this thesis is an example of organizing an experience of time. Time was just one example of how the theory-practice was lived by the participants. The reflective process groups and to a similar degree the reflective diaries can be seen as opportunities to integrate the experience of time through narrative, whether verbally or in writing.

With reflection, and having acknowledged the work of Sparrow and Robinson (1994) at an earlier juncture, the research itself may have perpetuated the

theory-practice gap. The space that was created for reflection within the research project is not always available in practice, or rather time for reflection is not always made available. This is apparent in the current struggle to implement clinical supervision into nursing practice. Reflection and clinical supervision are often viewed as time wasted when there is so much to 'do'. So, the students may have been exposed to something that they will not experience in the reality of practice. However, whilst it may not have been possible to address this issue within this small scale research, the students are perhaps able to take with them their internal supervisor and the awareness of reflection in action.

Can reflective practice assist the student nurse in integrating theory and practice through practical reasoning.

This study may provide only a partial answer to this important question. As discussed in Chapter Two theory and practice can be linked through the notion of praxis – a doing action (Rolfe, 1996). The facilitation of reflective practice in this study was grounded in doing actions and seemed to inspire critical consciousness and research mindedness in the participants (Mezirow, 1981). Judith was able to be critical of the application of theory to practice (Chapter Five) and as such was actively researching her own practice through practical reasoning. It could be suggested that the students were engaged in evidence based practice (Department of Health, 1989) when involved in the reflective process groups as they were approaching their practice with a critical gaze and exploring principles that underpinned their work. 'Research mindedness'

(Committee on Nursing 1972) can be achieved not by superimposing research findings onto situations but by enabling the practitioner to become aware that all of her practice is research when examined through the lens of reflexivity.

What I believe I can say in response to this research question is that the reflective practitioner is one that is able to spell out the principles on which her practice is based. Distilled from observations of the craft in practice, the principles can be articulated in clear terms and validated against formal knowledge. To illustrate how this happens I will turn to my final research question concerning the meaningfulness of the reflective learning interaction.

How meaningful are reflective learning interactions both for the student and the facilitator.

In this study reflection was structured by the provision of a regular and consistent space with negotiated contracts and boundaries. In addition the skilled helper model adopted as a model of reflection proved a valuable framework around which to structure the reflective session (Egan, 1994). The students made a commitment to maintain reflective diaries and prepare for the reflective group sessions. The reflective diaries proved a useful learning tool and acted as an aide memoir for the students. Several of the students claimed that they would continue to keep their diaries at the end of the research stating that it had become "their friend and ally". Although models of reflection were discussed in the group most students preferred to adopt their own style of reflective writing and narrating.

Reflections were all facilitated by an experienced tutor, myself. Whilst it is contended here that the students were able to use reflection effectively which is in conflict with some of the literature (Burrows, 1995; Schank, 1990; Miller and Malcolm, 1990). The students did need help in identifying learning opportunities, for as Powell suggests there are many learning opportunities in everyday practice that not always seen by the nurse (Powell, 1989). In this respect, Johns (1998a) reasons that reflection always needs to be guided by another person, someone who has 'super -vision' or the ability to see beyond the students' own horizon (Freshwater, 1998).

The patterns of reflection identified within level 2 and level 3 research confirmed the three stage process previously outlined (see figure 3.7). The external world acted as the stimulus to experience, whilst the awareness of experience was the result of interpretation through critical self-analysis. Writing the reflective diaries and deconstructing the critical incidents appeared to move the students through three levels of interpretation, beginning with factual descriptions through to the social and finally deeper into the personal level. Although these levels are implied within current models of reflection, these levels of processing are not always made evident to the reflective practitioner. This can also be contextualised as moving between the universal and the particular (Sarup 1993).

The experience of power within the reflective process groups has briefly been touched upon. As the teacher/researcher/practitioner I also had to surrender to

uncertainty and be willing to let go of power and control over the students. In letting go of being the teacher I opened myself to the teachings of the students and the patients. Meaning was therefore created in taking risks and being open to conflict. This, as Chapter Five reveals, was also the experience of the students in the study. It is proposed therefore that meaning is created not wholly by support, but also by challenge. Jane's story of her interaction with Gwen exemplifies the meaning that can be created once one is open to being taught.

I intended that the process in my teaching and learning moved from surface to deep, superficial events were deepened into experience (Hillman, 1994). The thesis itself follows this pattern of reflection identified earlier –from the context of the formal learning environment, to the social (interpersonal) and to the personal (intrapersonal). This, for me, is how meaning was intended to be created but in order to be truly meaningful research it has to make a difference to the lives of the participants (Rowan, 1981). It needs to make a difference to those involved in the research, to those who come to know about the research and importantly to what is being studied. This thesis is a chronicle to the difference that reflective learning has made to both the research participants and to myself. How has it made a difference to what it being studied? Guba and Lincoln (1994) pinpoint this criteria, that is the extent to which the findings stimulate action and challenge to existing structures, as one which has bearing on the authenticity of the research project.

The research presented within this study has attempted to develop a body of evidence that emerges from knowledge generated by those experiencing the phenomena of experiential learning. It has also attempted to challenge accepted ways of thinking about teaching and learning. As a result of the research endeavour and out of the stories that have been told a new metaphor (story) for nurse education has been constructed, one which has evolved with the participants and that captures the essence of the experiential learning programme. This metaphor provides a further way of conceptualising the data and describes the additional meaning in of nurse education that I as facilitator have derived from reflective learning as a result of the study.

An Archetypal Journey into Nurse Education: Knowing, Teaching and Learning.

Education, by definition of its origins means either the filling of an empty vessel (educare) or to lead out (educere, Hillman, 1994; Moore, 1996). An archetypal metaphor is constructed to develop an in depth understanding of how these two differing perspectives on education have developed and are practiced. Archetypes are anthropological constants; they are motifs that run through all human experience, expression, work and behaviour. They give form and shape to the heart of human experience (Fontana, 1993) and are therefore seen as useful symbols to illustrate the differing perspectives. Furthermore, the use of archetypal symbols to illustrate educational concepts is congruent with the approach to learning which has been espoused in this study.

Apollo – Propositional Knowledge.

Traditional approaches to teaching and learning are derived from the mechanistic worldview and emphasize cognitive and behavioural aspects of development (Reese and Overton, 1970; Watson and Rayner, 1920). The god Apollo is closely aligned to the mechanistic worldview and it is suggested that Apollonian logic has and continues to dominate the philosophy and psychology of teaching and learning (Paris, 1995; Neville, 1989). The Apollonian myth is the myth of logic, rationality, distance and scientific enquiry. From an epistemological basis Apollonian logic can be viewed as propositional knowledge (Burnard, 1987; Heron, 1981) Propositional knowledge can be described as textbook knowledge in which a person builds up a bank of facts or theories about a subject without necessarily having direct experience of the subject (Burnard, 1987). Students in this study challenged the appropriateness of textbook knowledge in relation to nurse education:

"I don't like teaching that is just like reading from a book... " (Judith, Chapter Five)

and *"I enjoy all sorts of teaching really, but you don't benefit if it's the sort of teaching where students don't join in... " (Sarah, Chapter Five).*

Pring (1976) and Benner (1984) have referred to this way of knowing as 'know that'. From a nursing perspective, this equates with the well known and oft quoted Barbara Carper's (1978) scientific way of knowing. In critical theory it is referred to as scientific or technical knowledge (Fay, 1987; Habermas, 1972). Apollonian communication is straight and clear like an

arrow carrying with it single meaning. Apollonian logic sheds light on subjects, celebrating the clear light of the sun. The prime source of light and heat, the sun, has been regarded as all seeing and was worshipped in a number of civilizations as a masculine god (Fontana, 1993). It would appear that this masculine god manifest in Apollo is a god that is still worshipped in many universities and schools and I would argue in departments of nurse education (Neville, 1989). Durand (1981) reports that the Apollonian myth took hold and he argues has maintained a grip in Europe ever since the seventeenth century. Apollo style teaching is linked to direct teaching in which the teacher is seen as having the information and the student is the empty vessel.

Neville (1989) argues that the intellect of Apollo is one sided and when applied to teaching makes it narrow and ineffective. He does not disagree that Apollo's style of teaching can be clear and intellectually rigorous, indeed he commends Apollo on having inspired great philosophical and scientific achievements. Neville (1989) reminds us that Apollo has found a number of valuable and fashionable robes to wear, Dawinist, structuralist, constructivist amongst them. Nevertheless, he complains that Apollo is also guilty of rigid and dogmatic fundamentalism. Paris (1995) adds that Apollo does not realize at which point his sophisticated jargon becomes an obstacle to intellectual clarity. Neville (1989) observes that Apollo can only provide intellect on manifested reality, that is, empirical science. As a nurse teacher it is quite easy to become seduced by the clear vision of Apollo (as I found for myself in the development of the action strategy – see Chapter Four) and as a learner one might feel more comfortable having questions answered, this is particularly so

in the case of essentialist education. Sarah voiced a clear example of this in Chapter Five:

"...I felt I needed someone to tell me that I had got it right, that I had understood what we were doing. It is quite difficult relying on yourself for that."

Nurse education has often been viewed as an essentialist education with the emphasis on producing an individual that is fit for practice. Essentialist education by its very nature tends to make everyone the same. In this sense, one could argue that nurse education with its statutory competencies to meet is a training rather than an education. Prior to project 2000 courses, nurse education was largely an apprenticeship model of training, akin to the pre-technocratic model described by Bines and Watson (1992). This model comprises the acquisition of skills through on the job training with theoretical components taught block or day release. The goal of traditional nurse education has been to teach specific skills and knowledge in order that students can reach a certain standard of behaviour, attitude and work as defined by the educational establishment and in the case of nursing the United Kingdom Central Council for Nurses, Midwives and Health Visitors (1992). However, this study has argued that there is no such thing as the 'typical' nurse, nor for that matter the 'typical student', Apollonian knowledge does not allow for difference or diversity, an issue that caused the students in this study some discomfort. Furthermore it could be argued that the Apollonian approach to nurse education attempts to narrow the consciousness of the student nurse as opposed to expanding it (Newman, 1994).

Prometheus - Practical knowledge

The theory-practice gap in nursing has highlighted that Apollo has been the god of the classroom and that practical knowledge was gained in the clinical environment. The god of practical knowledge is embodied in Prometheus. The skills and knowledge acquired by nurses in practice have been increasingly influenced by technological advances. These have signaled the introduction of a new breed of nurse, the engineer or the technocrat, inspired by the industrial age. Neville (1989) refers to this way of knowing as Promethean. Promethean knowledge can be likened to practical knowledge (Burnard, 1987; Fay, 1987; Heron, 1981; Carper, 1978; Habermas; 1972), that is knowledge that is gained through the acquisition of skills, sometimes referred to as 'know how' (Benner, 1984; Pring, 1976). Prometheus, the technologist, is now clearly in evidence within universities, schools and hospitals alike. With its focus on product this model of knowledge justifies itself through meeting the requirements of industry and economic development. The pursuit of manifesting reality by throwing light upon it becomes subversive. As Neville (1989) states:

"The Apollonian pursuit of knowledge for its own sake is now apparently a luxury which even the richest societies cannot afford" (page 14).

The introduction of Project 2000 programmes presented the opportunity to challenge traditional nurse training and the split of theory (Apollo) and practice (Prometheus). However, the models of education have shifted from the pre-technocratic to the technocratic (Bines and Watson 1992). Both the

pre-technocratic and technocratic approaches to nurse education and nursing practice are firmly based in Promethean and Apollonian logic. Hence the curriculum development models used have been closely aligned to the instrumentalist ideology, liberal humanism (Pendleton, 1991) and the functionalist model of education (Criticos, 1993). The student is the inheritor of society's wisdom and the manifestation of society's values. Anyone who has been a patient in hospital or has had a sick relative will be grateful for the instrumentalist ideology that has driven nurse curricula, for it is the teaching of a safe and competent performance of practical nursing skills that serves to protect the general public. Patients also have the right to assume that the type of care they receive is based upon sound evidence. However, it could be argued that there is more to high quality patient care than the safe and adequate completion of tasks as Siobhan noted in Chapter Five:

"I spent quite a lot of time trying to find something to do... the time that could have been for just being with patients was filled with cleaning and checking drugs... "

Making informed decisions in clinical practice means re-evaluating the relevance of a particular intervention for a patient and learning from experience. And as Burnard (1987) observes a person may develop practical knowledge without developing the appropriate propositional knowledge, for example in the giving of an injection, and conversely a person may develop propositional knowledge without ever having developed the practical knowledge, an example of this is often seen in the administration of cardio-

pulmonary resuscitation. Neither of these ways of learning feel particularly holistic, rather, the split remains. Burnard (1987) argues that the bulk of nurse education has concerned itself with propositional and practical knowledge. Unfortunately this has not usually been used simultaneously as Judith reflected:

"When I was on the ward I saw that they used Roper's model of nursing...I don't think that the philosophy of care tied in with what happened in practice...It didn't really reflect what they did in practice..." (Chapter Five).

Whilst there is no doubt that the curriculum benefits from the explicit inclusion of propositional knowledge, the lived experience of the student nurses in this study seems to confirm the existence of the theory-practice gap. Propositional knowledge being the concern of the college and practical knowledge coming from the clinical or ward area. Thus not only the students but also the patients are seen as split entities, (affirming the findings of Menzies-Lyth (1970). The functionalist model of education, intstrumentalism and Apollonian logic have all been criticized for being too mechanistic and failing to take a holistic approach to the educational requirements of students and in this case the nurse and patient (Askew and Carnell, 1998; Paris, 1995; Pendleton, 1991; Neville, 1989). Whilst the above approaches to teaching and learning may appear to be relatively uncluttered, they are incomplete. Learning is surface rather than deep (Entwistle and Ramsden, 1993), there is little, if any room for imagination, the focus is on the parts rather than the whole. The role of the teacher when adopting this approach to teaching is that of the expert, transmitting knowledge and in the case of student nurses,

training students in social and psychomotor skills (Askew and Carnell, 1998; Pendelton, 1991). It is assumed that the student needs, and will respond to, plenty of explanations of concepts and principles and demonstrations of practical skills.

These models were perhaps appropriate for the traditional nurse syllabus conceived of by the General Nursing Council (GNC, 1969), although the lack of emphasis on the experience of the student could be contested as being one sided. Current thinking in the advancement of nursing curricula is influenced by critical social theory and feminist epistemology. Such theories are critical of behaviourist approaches to teaching and the hierarchical organization of educational institutions (Osbourne, 1996), espousing a more holistic and mutual approach to teaching. This approach is embodied in the image of Psyche.

Psyche - Experiential Knowledge

Whether education is dominated by Apollo or Prometheus is of little consequence to this narrative, as this not only buys into the either/or debate, but in addition they both foster teaching methods that come out of masculine consciousness. These methods are not dismissed, rather they are seen as one end of a polarity which has excluded teaching methods that emanate from a feminine consciousness. What is required is a pontifax- a bridge built between the two- similar to that of the corpus collosum between the left and the right brain. In referring to masculine and feminine consciousness, It is clear that this does not refer simplistically to men and women, it is unfortunate that

masculine and feminine have gender connotations which are not neutral. Here, I am using Carl Jung's (1960) notion of the amima and animus, the masculine and feminine, that is present in each individual consciousness. Teaching that emerges from a feminine consciousness has suffered at the hands of the Apollo and Prometheus. Indeed, one aspect of the myth of Apollo which is seldom referred to is that Apollo stole the oracle from the female goddess Delphyne. It could be said that teachers who make Apollo their God in their classroom are silent thieves, stealing from their students the capacity to come to their own answers.

Feminine consciousness is concerned with dissolving hierarchical thinking and relating, and like some postmodernisms, it attempts to replace them with more fluid equalizing forms (Chaplin, 1998). This may seem paradoxical, as levels of consciousness are often viewed from a hierarchical vantagepoint (see Powell, 1989; Mezirow, 1981) such as surface and deep and have been to some extent in this study. It is important however to recognize the value of all levels of consciousness, for paradoxically, deep levels of consciousness can only be known by becoming surface.

Both the Apollonian and Promethean approaches to education make no reference to the process and experience of the student, the student is seen as a 'closed system', that is an empty vessel. A more recent and progressive approach to teaching and education views teaching and learning with a different lens (Askew and Carnell, 1998; Boud et al, 1993). This approach places the self in the centre of the learning process and contends that in the

right environment learners will become increasingly responsible for their own learning and strive towards self actualization through transformation (Maslow, 1970; Rogers, 1969). Transformatory learning sees learning as originating in the actions of the learner and teaching is not deemed as the imparting of knowledge but the facilitation of learning (Askew and Carnell, 1998; Neville, 1989; Grundy, 1987; Rogers, 1969).

The function of transformatory education is to support the individual's growth through self-reflection and analysis of individual experiences. Hence the self and the learner are seen as an 'open' system. From an epistemological standpoint this type of knowing is in the domain of experiential knowledge, that is knowledge gained through direct personal encounter with a person or subject, it is knowledge gained through relationship (Burnard, 1987; Heron, 1981). In relation to Carper's (1978) framework it is the domain of personal knowledge, what Polanyi (1967) termed 'tacit knowledge' and what critical theorists refer to as critical or emancipatory knowledge (Fay, 1987; Habermas, 1972).

Chapter five provided rich examples of how experiential knowledge deeply embedded in personal learning and is essentially a relational experience and as such informs patient care:

"I really enjoyed the role play and the reflective sessions in the small groups. These helped me to get to know myself and others, also how others saw me..."(Frances)

and Jane discussing reflecting on the experiential group work stated:

"...I learned how to respond to a whole mixture of people and situations and I'm sure that this had an impact on the way that I responded to patients".

Experience is the domain of the archetype Psyche. Psyche is representative of the feminine consciousness, characterized by receptivity, intuition, relationship and a sensitivity to the aesthetic. Psyche logic informs us that reality is not simple, nor is it just manifested so clearly and directly as Apollo would have us believe. Psyche is closely aligned to the organismic worldview which stresses holism and interaction (Reese and Overton, 1970). Reality is not just under the guise of Apollo, it is also found in the shadows and subtle intuitions, in imagination and experience. Psyche teaching uses indirect methods of facilitation such as some of the experiential learning interventions that were utilized in this study. It is posited here that Psyche, that is experiential personal knowing, can provide the bridge between which Apollo and Prometheus, propositional and practical knowledge, can flow. Psyche provides the tools for building a bridge between theory and practice, that of experiential knowledge.

This study suggests that experiential knowledge is an appropriate way of preparing nurse practitioners for and supporting them in their practice (Bines and Watson, 1992). Other writers concur with this sentiment, Burnard (1986) demonstrated how clinical experience could be used as a basis for planning theoretical study, combining experiential knowledge with propositional knowledge and practical knowledge. Murphy and Atkins (1994) argue that it

is essential that approaches to nurse education which facilitate learning through practice are considered, recommending a post technocratic model of education (Bines and Watson 1992). This approach features reflection on practice as a key component of learning and a student (practitioner) centred, facilitative, non-directive approach to teaching is adopted. Neville (1989) notes that indirect teaching methods call on capacities of the brain that are only marginally used in direct teaching, this includes the unconscious. Thus the movement of Psyche is not upward and outward, rather it is downward and inward.

The learning that takes place in the deep approach is one in which formal learning is integrated with personal experience to develop an understanding of meaning. Motivation for deep learning is essentially intrinsic, although learning is made concrete though the interplay of the inner and the outer. Deep learning is however, associated with challenging the familiar and is often accompanied or impelled by discomfort (Joyce, 1984; Thelen, 1960). This may account for some of the resistance to experiential learning that is documented (see Burnard, 1989) and some of the discomfort that the participants encountered in this study:

"...when we washed each other in class, I felt really uncomfortable...I had a fear of being rejected..."(Francis)

and *"I found some of the experiential group work and exercises a bit uncomfortable..." (Jane).*

Neville (1989) argues that indirect 'unconscious' learnings are more permanent learnings than direct verbal instruction. Hillman (1994) categorically states that:

"Any education that in any way neglects imagination is an education that results in a sociopathic society of manipulators. We learn how to deal with others and become a society of dealers" (page 171).

Whilst Neville's (1989) work is useful in informing the philosophy and history of education, it does not go far enough for the findings of this study (and therein nurse education). Neville (1989) makes reference to Hestia and this is relevant and can be built upon in relation to reflective practice - Hestia will be revisited later. More pertinent to nurse education and nursing are Hermes (Hermetic intellect and the personification of communication) and his female counterpart, Metis the healer.

The God's in Nurse Education and Nursing

Hermes - The Trickster

When wearing Hermes' hat, the individual goes unnoticed. When unnoticed you are truly invisible and are never openly opposed to authority, as Jane demonstrated in her second reflective episode (Chapter Six). Hermes' intellect is often criticized as being too simple, but as Paris (1995) recognizes, Hermes is an archetype to stand up to the champions of Logos. According to Paris (1995), Apollonian logic is more vulnerable to the cleverness and astuteness of Hermes than to the perceived threat of the uprising of the oppressed.

"Winning while appearing to lose is a strategy that a hermetic person knows how to play to advantage" (Paris, 1995 page 61).

Hence, although Hermes is the god of communication, he is also known as the patron saint of liars! Where the communication of Apollo carries a single meaning, clear and straight like and arrow, Hermes communication follows twisted pathways, shortcuts and multiple paths allowing for loopholes, distortions, double binds and half-truths.

The semi-structured interviews generated data which was full of Hermetic communication:

"I tried to give the impression that I knew what I was doing, this seemed to be the thing to do, all the nurses were going around looking efficient" (Sarah)

and the same student later in discussing her interaction with a doctor"*...I realized that this was a subtle power game. Some of the things that doctors do are so subtle that they are almost undetectable".*

Hermes' domain is that of speech with all its accents and nuances in tone manner and gesture and he is also present in the doctor/ nurse game that was previously discussed (Stein et al, 1990) in which the nurse learns to get what she wants by tricking the doctor into thinking that it is what he wants. It could be argued that the nurse has been forced into this position by medicine, the embodied archetype of Apollo. as was Cassandra, the woman who always told the truth but was never believed nor taken seriously. Tschudin (1997) argues that this image fits nursing well. Stating that nurses are often listened to but never heard, Tschudin (1997) notes:

"Their (nurses) words are heard, but the persons behind the words are not acknowledged" (Page 70).

In this study, the findings indicated that the participant had difficulty in finding their voice in clinical practice (Chapter Six) which points to several areas of rhetorical deliberation, for example does the nurse know her own voice/person and is the nurse able to hear herself without fear of rejection, loss of confidence and esteem? Perhaps it is easier to fall back on Hermes, the storyteller, to become alienated from the self, than it is to tackle such personal and often painful issues of self-awareness without **the appropriate learning environment.** But as Dawson (1998) warns with such alienation:

"the subject is no longer the author of the ongoing narrative of his self" (page 164).

In simple terms the locus of control remains external and from a humanistic perspective this could be seen as a matter of choice rather than one of learned helplessness (Bandura, 1977). Perhaps Hermes' way of knowing should be linked with Carper's (1978) notion of ethical knowledge, that is, the knowledge of morality, a pattern of knowing essential to nurses who are required to make decisions about how to act with each individual patient. Since the nurse is acting in the best interests of the patient, that is as the patients advocate, is it then ethical to use trickery in order to care? It could be argues that the nurse needs some hermetic qualities, ethical questions surrounding truth telling and honesty frequently arise in nursing and it is often not deemed appropriate to make the truth available. It would seem from this that Hermetic knowledge is linked with integrity.

Van Hooft (1995) describes integrity as: "the aim of striving for our selfhood" (page, 9).

Taylor (1991) expands upon this explaining that integrity speaks of the persons' need to hold all of the aspects of their personalities or characters together in a coherently lived life. He argues that if a carer is faced with a plurality of identity conferring commitments, then the carer will carry out the actions which are either congruent with their commitments or the actions which are not, but the carer will strive to maintain integrity by ordering or integrating these actions in some way. I am left wondering how the participants and Jane in particular would have maintained their integrity during their clinical placements if they were not in reflective practice groups, perhaps, like Hermes they take liberties with the truth of clinical practice. For just as the inspired storyteller adds and leaves out, Hermes, adjusts the facts and takes liberties with the truth, because as Paris (1995) states:

"it is not enough to have something to talk about, the words must make a connection between the inner world of the listener and the "elsewhere" of the teller" (page 83). I interpret this to also mean the espoused theory of the nurse (inner world) and the theory in action (outer world).

Metis the Healer

Metis, was the Greek name for intuitive intellect, and was often attributed to women. Metis is the antipathy of deductive knowledge and runs contrary to the linear logic of Apollo. Metis' intelligence, or what may be called 'situational intelligence' is rooted in an inner knowledge. Benner (1984) has done much to raise awareness of intuitive intellect in nursing practice. In order

to contextualise this type of intellect it is necessary to reveal some of the details of the archetypal myth itself.

The first wife of Zeus, Metis (Goddess of Wisdom) was purported by Hesiod to know more than all gods and men put together. Zeus became fearful that his wife's intelligence might be passed on to his offspring. He could not allow his children to be superior to him lest he was dethroned. So he swallowed Metis before she could give birth to her daughter Athena, so that the power of Metis would never belong to anyone else other than himself. Feminine intelligence from then on is imprisoned in the belly of Zeus - as 'gut' intelligence, the patriarchal mind swallows and imprisons the wisdom of the feminine intellect. Examples of this sort of intellect can be seen in the data generated in this study:

"...As she spoke to me it was as if she was trying to tell me something else... I felt it was important to stay" (Jane, Chapter Six).

But, it appears that Jane only started to pay attention to her 'gut' intellect after recognizing that she had been ignoring something central to her caring self. Her 'gut' intellect had been swallowed up by tradition and routine (see reflective episode two). This story can be aligned to the doctor-nurse relationship. In which the nurse intellect has been swallowed by the medical model, however literature surrounding the doctor-nurse relationship and the games that are played reveals that the nurse turns to her male counterpart -

Hermes - in order to trick her way out of her prison. The nurse wins whilst appearing to lose (Stein et al, 1990).

So, it could be argued that whilst Hermetic intellect offers a great deal to nursing through the skill of verbal communication, and storytelling, like Hermes this ensures that the nurses remains invisible and do not have to confront their oppression. Perhaps as Hillman (1994) suggests nurse education helps to create a society of manipulators, people who deal with others.

Hestia

Whilst Hermes and Metis may be vital to the process of change, transformation and healing, Mercury, the metal associated with Hermes, is quite a volatile element and a second element is required in order to fix the change. The principle of change is not enough for change to take place. If efforts to change end with a visit from Hermes, the change will not be effected, one of two things can happen. Either the person is back at square one or else there is constant change manifesting in disruption and disorder. In alchemical terms the second principle of change is fixation. Hestia is the archetype who offers focus and is the opposite of Hermes representing fixedness, but she does not equate with stubbornness or rigidity (Paris, 1995).

Where Apollo persuades us to search for truth in the clear light of intellect and Prometheus concerns himself with knowing how things work, Hestia invites us to look within, the truth she says is in stillness (Neville, 1989). Hestia brings with her the image of circularity and rhythm everything begins and

ends with her quietly gathering in the threads which she will weave into a pattern. Hestia is the god of 'just sitting' in stillness and centredness and as such is associated with reflection. Within this stillness, there is a detachment, but not a cold objective stance, rather a 'disidentification' (Assagioli, 1970). Hestia is therefore the 'patron saint' of the reflective practice groups in this study and indeed of reflexive research. Hestia offers us the gift of in-sight, which brings together the work of Apollo, Prometheus and Psyche to create meaning out of the whole of an experience. When sitting with Hestia, the individual is allowing their experience, the prima materia, to transform, as if a caterpillar waiting to emerge from its cocoon as a butterfly. Like the butterfly, the process of transformation is both an inner and an outer experience. The experience of inner and outer transformation was the intention of this research study for both the participants and the researcher. I believe that the data provides evidence of transformative processes occurring within the personal and professional lives of the individuals involved in this work.

Education as Alchemy -Transformational learning

Alchemy refers to the process of transformation, namely that of turning lead into gold. Alchemists, who thought of themselves as artists and scientists, performed elaborate operations in order to bring about this transformation known as the 'great work'. Much of the great work was done in the dark, meditating underground, before the ascent could begin (Fontana, 1993; Hall, 1986). Despite working in the dark and in secret, alchemy was not a process of hiding, but revealing. A critical stage of the process was that of uniting the opposites of male and female in the alchemical marriage. With Apollonian

logic, it would seem ludicrous to suggest that lead could be turned into gold by meditation in the dark. However, writers springing from the domain of Psyche and Metis interpreted the great work in a symbolic rather than a literal way. Hence the base metal becomes symbolic of the unredeemed self, while the gold becomes symbolic of the transformed self. Alchemy is therefore about the transformation of human consciousness. Alchemical text is more than just a symbol of inner transformation, as Fontana (1993) muses:

"it provides the means by which this can be achieved" (Page 146).

The practice of alchemy is laid out in medieval texts so obscure that they are almost incomprehensible. What is clear is that the alchemist begins with the prima materia which contains two principles, these are usually referred to symbolically as sulphur (male, solar, hot energy) and mercury (female, lunar, cold energy).

Poincare (1952) and Wallas (1926) describe their own process of transformation which followed four distinct stages similar to those of alchemy:

1. An initial investigation termed the *preparation*
2. A period of rest known as the *incubation*
3. The occurrence of a sudden and *illuminatory* solution
4. Finally conscious rational development of understanding to validate the insight-*verification*

(Cited in Neville, 1989).

The first two stages usually take place in the dark and are deep processes, while the latter two stages are more surface and therefore in the light. The practice of transformation through alchemy is similar to that of experiential

learning or transformational learning (Askew and Carnell, 1998), as one of the goals of experiential learning is that of self actualization, that is transforming the base metal into gold (Maslow, 1970). And in this sense, as Paris (1995) comments, the teacher employs the role of the alchemist:

"A very good teacher, one who has the ability to help us understand complex matters, is more of an alchemist than an esoteric freak knowledgeable in the history of alchemical symbols" (page 114).

What are these complex matters that Paris alludes to? In the realm of transformational learning, it is asserted that these are andragogy, student-centred learning, the self and reflection.

Alchemy recognizes the need for including all ingredients in the alchemical vessel, in the same way this study is not espousing that nurse education bases all its educational input on Psyche intellect, this would perpetuate the split further. Apollo, Prometheus and Psyche all have a place in the classroom. Psyche education does not mean to temper Apollonian or Promethean intellect, rather she demands to be on an equal footing with science and technology in a dialectical relationship, in a process of individuation (Jung, 1971). In response to my research question regarding the meaningfulness of reflective learning interactions, I believe that the research study and the learning interventions have played an important part in my own individuation process.

7. 3 Further Findings

One remarkable (and accidental) finding was the difference in attrition rates in the research groups in question. At then end of the period of training the cohort on Site C suffered a loss of nine students (20.93%; n=34), whilst the cohort on site P experienced a loss of only one student (2.38%; n=41), which was due to personal difficulties. This was the lowest attrition rate for a considerable number of years. This was a significant finding in relation to the current recruitment and retention difficulties and one that was not expected (Scott, 1998; RCN, 1998). These results have been discussed at length with interested parties in the host college. It cannot be known for sure whether this was a direct result of the experiential learning programme, although there were no other changes the curriculum implemented during that time. However, it is difficult to determine the effect being a research participant had on the student group on site P. The one to one attention I am sure pays dividends in terms of valuing the student and their contributions, nevertheless I would add that it needs to one to one attention of a certain quality (whether this is in the role of research or teacher).

The information regarding the teaching strategies in site C when collated demonstrated that 74% of the classroom sessions were taught in what the tutor described as didactic methods, although nearly all of the tutors' involved the students' in some degree of discussion. Twelve percent of the sessions involved some student led activity for example, guided study or seminar work. Fourteen percent of tutors described their sessions as interactive, this included the use of resources other than the tutor themselves, such as videotapes,

models and music. No one described their sessions as experiential, although this may have just have been down to the choice of terminology and the tutor's personal understanding of differing teaching methods. As a result of conducting the research project a series of in service training programmes have been developed – at the request of the staff- these have focussed on reflective practice, journalling and more recently clinical supervision. The college now has a team of tutor's dedicated to the advancement of reflective practice in nurse education.

7. 4 A Critical Analysis of the Research

Thus far Chapter Seven has addressed the research questions with a critical gaze. The subsequent discussion explores issues of validity and reliability pertaining to the choice of data collection methods and the research methodology as a whole. The theoretical framework is examined for its methodological fit and its success as a strategy for research in nursing.

In quantitative research a well-defined set of criteria is applied to the research findings to evaluate the goodness of the study and its results. Concepts such as reliability, validity and generalizability are utilized (Burns and Grove, 1987). Validity refers to the ability of the research instrument to measure what it set out to measure, thus ensuring authenticity of the content. Reliability on the other hand pertains to whether or not the research instruments would continually produce the same result when applied in identical situations on different occasions. Thus reliability ensures that the research would be consistent when applied to others (Burns and Grove, 1987).

These concepts are often seen as irrelevant in the legitimization of qualitative research, instead researchers talk of credibility, dependability and transferability (Denzin and Lincoln, 1984). The methods of data collection utilized within this study were drawn from qualitative approaches, ranging from semi-structured interviews to reflective diaries and critical incidents to case study, all broadly in the realms of narrative.

Narratives are classified by the scientist as belonging to a different mentality: savage, primitive and underdeveloped (Sarup, 1993). Lyotard (1984) however, argues that narrative knowledge certifies itself without recourse to argumentation and proof. He presents an interesting twist when he argues that scientific knowledge cannot know and make known, without resorting to the other narrative kind of knowledge, which from its point of view is no knowledge at all. Whilst both scientific and narrative knowledge are equally necessary, it is impossible to judge the existence or validity of narrative knowledge on the basis of scientific knowledge or vice versa, the relevant criteria are different.

The involvement of the researcher may result in data control and manipulation during the data collection and analysis. In this study techniques were used that aimed to stay as close to the students' narrative as possible. These included Colaizzi's (1978) framework for phenomenological data analysis and Van Manen's (1990) four existentials. In addition Sandelowski's (1993) indices were taken into consideration and as she suggests a decision trail was left to

indicate the development of the data analysis. Furthermore, the students were asked to act as internal verifiers of their own narrative, confirming the adequacy of the transcribed content.

Several frameworks are available for subjective validity of research such as that carried out in this study. One such framework is offered by Bruyn (1966) who highlights six areas of measurement, these being time; place; circumstance; language; intimacy and social consensus. These six indices were enhanced due to my being an 'insider' in the college within which the research took place. Using these indices as a way of examining the validity of the research at level 2 and level 3, it could be argued that the validity of the research is high due to the nature of my relationship with the research setting (Rolfe, 1998b).

Returning to the evaluation criterion previously mentioned (Altrichter et al, 1993) which asks:

- has the research resulted in an improvement of the situation
- has it caused any unintended negative effects
- is the improvement short term or long term

In responding to these questions, the study evaluates favourably in all three criteria, although it is difficult to be precise about the long-term effects of the study. The changes that have been outlined as a result of this project are minimal and yet as chaos theory teaches a small change can have a disproportionately enormous effect (Gleick, 1997).

The decisive test of validity however, is left to the reader and the extent to which the reader can relate to the text. I have relayed my interpretation of the narratives and placed them within a larger narrative. Whilst the reader may not always agree with my interpretations, it is anticipated that they will be able to make enough sense of the process in order to formulate their own interpretations. This is congruent with the philosophical underpinnings of experiential learning, in that whilst the readers may identify with some of the common themes throughout the thesis, the experience of this narrative will of course differ from person to person (Hall, 1986). In a sense we are all on the same journey yet we each have our own personal signatures, this is my personal signature. The chosen theoretical framework of andragogy, humanism and transformatory learning has take into account these individual differences whilst at the same time places them in the context of a universal journey of discovery.

As part of this journey the modernist view of a 'grand narrative' is losing its charm as the postmodernists make the case for 'local narratives', big stories are bad, little stories are good (Lyotard, 1984). Little narratives are associated with local creativity; grand theories are philosophies of history. Whilst this radical shift may actually be beneficial to nursing research and nursing practice, it too is in danger of becoming the grand narrative.

7. 5 Evaluating the Design - Action Research and Hierarchy of Nursing Research

Returning to Hart and Bond's typology of action research (1995) this research project has followed a developmental process which spans the whole spectrum of action research typologies. The level 1 research was more at the experimental and organizational end of the spectrum; the theory was used to generate research questions and infer relationship; the pre-tests were used to identify causal processes that could be generalized. Level 2 research links to the professionalizing aspect of the typology. At this level the research was practitioner focussed and process led, using experience and reflection as a way of enhancing the individual's self awareness and professional practice. Level 3 research demonstrates elements of the empowering typology of action research in that it focussed on consciousness raising and shifting the balance of power, empowering the individual. This remains open-ended and was explored as part of the process of change.

The research was structured using propositional knowledge and beliefs to generate the research aims and conclusions. Practical knowledge helped me to make the leap to translate the idea of action research into practice and experiential knowledge was fundamental to the understanding of the phenomenological discrimination of the students in relation to their world (Rowan, 1981). Conducting research is an emotional business, the process of transforming a research problem into a series of questions and those questions into a method poses a serious challenge. To some extent this has been a large part of my learning. I have certainly challenged myself and others to think

differently about teaching and learning and, for that matter, research, in nursing.

The whole of the project reflects action research as a distinct process in itself through the constant reflection in action that led the process. This is akin to the level 4 research which recognizes that the action components are dominant. Hence, the project as a whole is an example of reflexive research, that is level 4 research. Action research is reflexive in that it changes practice as a direct result of the research. As one of the aims of the research was directly related to the theory-practice gap it is suggested that the use of Rolfe's (1996) hierarchical model of nursing research and the action research design were appropriate and congruent frameworks for the purpose of this study.

On a larger scale it is proposed that action research is a suitable method for nurse education which is as much a social practice as nursing. Reflection on experience used as a part of the education and the research process offers nursing a way of working with others which not only has the potential to be non-hierarchical and non-exploitative but in contrast holds the possibility of empowerment and emancipation. In addition it may be used to implement changes and narrows the theory-practice gap. Its widespread use in nursing, however, does beg some ethical considerations. One that surfaces with increasing frequency in the literature has already been highlighted and pertains to the implications of using emancipatory change strategies with nurses who may find their autonomy to act limited (Sparrow and Robinson, 1994; Webb, 1990). Action research, as a member of the new paradigm collaborative

research group, has been criticized by Meyer (1992) as potentially being a more subtle form of exploitation of the research participants, using friendship to mask the true nature of the relationship. Thus we come full circle; the nurse (researcher) is required to reflect upon and monitor her actions in order to become conscious of the trickster, who is always looking for a 'good' home. The researched are at risk of being normalized by the research process (Fahy, 1997). Students are at risk of being standardized by their education and patients are at risk of being routinised by their care.

The research could be criticized for being predominantly based on self-report measures. Researchers from a traditional scientific background would undoubtedly question the validity and reliability and indeed the generalizability of such a study. Based in pragmatic action research, this study relies heavily on the judgement that the results appear to bear out reality. As Walker (1980) remarks, educational researchers generally bring news of two kinds: one is the seeking of truth through explanation, the other; to seek the truth through portrayal of reality. As this study demonstrates, when the portrayal of reality is reflected upon it may lead to some explanations which may be found to be of relevance to a wider audience.

The research strategy has aimed to address the theory-practice gap at two levels. Firstly and more specifically, it has explored the role of experiential learning in narrowing the theory-practice gap in nurse education. Secondly, it has provided an example of the struggles of carrying out research which in itself does not perpetuate the theory-practice gap. Like experiential learning,

which espouses that significant learning takes place when the subject matter is perceived by the learner as having relevance for her purposes, research is significant when it is of relevance to the individual practitioner. Hence, it could be argued that all nursing research should be particular rather than general (Rolfe, 1998b).

Evaluating the role of the researcher in action research and of the facilitator in education, I would draw on the analogy of the midwife. The midwife is there to support the mother in labour and to witness the new delivery. She does not however give birth for the patient, she witnesses the birth. Zuber-Skerritt (1992) describes the role of the researcher in action research as revolving around an in depth dialogue or learning conversations with participants about their experience. Action research therefore encourages the development of subjective and objective consciousness. Parse (1987) implies that the presence of others may help persons move beyond the perceived limits of the present, but the person must do the moving themselves, I would add in the presence of another. Action research and education are collaborative processes in which each individual has their own unique part to play.

7. 6 Conclusions and Implications

Several tentative conclusions can be drawn as a result of this study:

- that a climate of transformatory learning in which the student is valued and an ethos of adult learning is created facilitates the development of a reflective and an effective practitioner

- that experiential learning leads to an increased self-awareness and subsequently deeper levels of reflectivity in student nurses
- that a learning ethos which values the students individual experience and focuses on the needs of the learner improves the attrition rate in student nurses
- that experiential learning facilitates the development of practical reasoning and therefore praxis
- that student nurses do have the capacity to utilize reflection despite a lack of paradigm cases
- that experiential learning and self-awareness facilitates a shift in locus of control to a more internal position, which subsequently enhances the students ability to make deliberate and intended choice over actions
- that transformatory learning and self-awareness leads to emancipation in student nurses

These conclusions have certain implications for teachers of nursing which I have outlined earlier in the study. Facilitating self-awareness in others is a demanding task, not least because it demands a high level of self-awareness in the facilitator.

Nursing is not a conglomeration of care-giving events; each care-giving situation is connected to and is part of the larger whole of professional activity. Teaching must respect this and address it in the nurse education curriculum. Teaching, like nursing, is not a conglomeration of teaching events. Teaching, like nursing is a moral activity and as such teachers have a professional obligation to develop and review their practical knowledge and

explore the effectiveness of their practice (Eraut, 1993). Teachers like nurses want to make a difference to other people's lives and like practitioners, teachers require professional development for the purpose of self-renewal. This could take the shape of reflection on action and the process of deconstructing and reconstructing practice.

This study, like experiential learning has its limitations, for example there are occasions when teachers of nursing are required to teach certain aspects of the curricula and self-assessment does not lend itself to all areas of nurse education. There are many aspects of nurse education which have not been addressed within this study. However, it is suggested that the teaching and learning ethos is fundamental to all aspects of the nurse education curricula and that if this is attended to all learning and teaching will be meaningful.

Recommendations for further exploration include;

- exploring the use of storytelling and narrative as a method of oral assessment in nurse education
- a longitudinal study examining the 'sleeper effect' in experiential learning in student nurses
- exploring the use of experiential learning in the differing branch programmes in nurse education
- exploring the use of Mezirow's (1981) levels of reflectivity in relation to ethical and moral dilemmas in nursing (ethical reflectivity)
- further exploring reflection and reflective groups as a research method

A Final note...

As befitting an action research study the strategies commenced during this study are ongoing and in a process of continual development. As a result of this work several in service training days in reflective practice have been provided for the teaching staff at the college and reflective practice now has a much higher profile across the whole spectrum of courses. The most recent development is in the area of clinical supervision and I am currently in the process of setting up an action research strategy implementing clinical supervision for teachers of nursing.

This study has been pregnant with paradox and I would like to end with another. For Day (1993) comments that the post modern 1990's:

"is not a decade of 'either or' but one of multiple solutions to problems" (page 36).

Novice nurses are potentially the most receptive to learning from experience and developing the skills of multivalance in critical debate on their practice. It is because they come to nurse education as beginners that they are able to function as an open system and as the Zen koan reminds us:

In the beginner's mind there are many possibilities.

In the expert's mind there are few.

Perhaps the strongest recommendation to be taken from this study is for nurse teachers, that of being willing to approach each learning situation with a beginner's mind and marvel at the possibilities that manifest.

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APPENDIX 1

Dear Student,

I am writing to ask for your assistance in a research project that I am carrying out as part of my PhD studies.

I should like to work with students in the October 1994 cohort based at Peterborough, selecting a random sample to participate in the study. All students have the choice to opt out of the study if desired.

The research will involve:

1) an analysis of a reflective dairy
2) interviews relating to your development in practice
3) an analysis of data collection from questionnaire

My aim is to identify if there is any link between teaching methods, learning styles and development in practice. All information gathered will be treated as confidential and names will not be used within the completed study.

The study will take place over approximately 18 months but may continue for a further period if necessary. I would be pleased to inform you of the results at the completion of the study.

Please do not hesitate to contact me if you have any questions regarding your participation in the study.

Thank you

Please indicate your response by returning the attached slip.

I do/ do not wish to be included in the research project.

Name:

Signature:

Dawn Freshwater

Senior Lecturer

APPENDIX 2

Dear

Thank you for agreeing to take part in the research study. I hope it will prove a mutually satisfying and interesting experience.

It would be useful to meet with you soon to discuss dates and times for meetings. I would also like to visit you in your placement area to offer support to both you and your clinical practice supervisor.

Please could you call in to see me at your own convenience so that we can make some arrangements.

Hope the course is going well.

Dawn Freshwater

Senior Lecturer.

APPENDIX 3

Dear

Re:

The above named has agreed to take part in research being carried out as part of my research studies.

I will be following the students through practice and looking at the theoretical components which have influenced practice. Some of my work will involve interviews, reflection and working closely with the participants and their clinical practice supervisor.

I hope that you will find this a help rather than a hindrance in your relationship with this student.

I will be happy to answers any questions you have regarding the research project.

Yours sincerely,

Dawn Freshwater

Senior Lecturer.

APPENDIX 4

Dear Student

As part of my research project I am collecting information relating to the different learning styles of student nurses within your group. It is useful to see how these learning styles match the various personality types. To this end I would ask you for your help and cooperation in completing the attached questionnaires.

The information collected will remain confidential and students will not be identified within the analysis.

A follow up test will be carried out after 18 months and compared to the initial results.

I will be pleased to inform you of your results on completion of the study and to discuss this individually.

Thank you

Yours sincerely,

Dawn Freshwater.

Senior Lecturer.

APPENDIX 5

October 1994 Cohort

Personality test instructions:

The questions inside this booklet are to give you a chance to say what sort of person you are and to state your attitudes.

Since each person is different there are no right or wrong answers, only what is true for you.

Answer the questions as frankly and truthfully as possible, since there is no advantage in giving the wrong impression.

Answer the questions as quickly as you can - you will be shown how to interpret your profile.

Your answer will be kept confidential and discussed with you individually if you wish.

Dawn Freshwater

Senior Lecturer.

Practical 1: Fibel's Generalised Expectancy for Success Scale

Directions: Please indicate the degree to which you believe each statement would apply to you personally by circling the appropriate number, according to the following key:-

1 - highly improbable

2 - improbable

3 - equally improbable and probable,

4 - probable

5 - highly probable

Please do not omit any questions.

In the future I expect that I will:	Number
1. find that people don't seem to understand what I am trying to say	1 2 3 4 5
2. be discouraged about my ability to gain the respect of others	1 2 3 4 5
3. be a good parent	1 2 3 4 5
4. be unable to accomplish my goals	1 2 3 4 5
5. have a successful marital relationship	1 2 3 4 5
6. deal poorly with emergency situations	1 2 3 4 5
7. find my efforts to change situations I don't like are ineffective	1 2 3 4 5
8. not be very good at learning new skills	1 2 3 4 5
9. carry through my responsibilities successfully	1 2 3 4 5
10. discover that the good in life outweighs the bad	1 2 3 4 5
11. handle unexpected problems successfully	1 2 3 4 5

12. get the promotions I deserve 1 2 3 4 5

13. succeed in the projects I undertake 1 2 3 4 5

14. not make any significant contributions to society 1 2 3 4 5

15. discover that my life is not getting much better 1 2 3 4 5

16. be listened to when I speak 1 2 3 4 5

17. discover that my plans don't work out too well 1 2 3 4 5

18. find that no matter how hard I try, things just don't work out the way I would like 1 2 3 4 5

19. handle myself in whatever situation I am in 1 2 3 4 5

20. be able to solve my own problems 1 2 3 4 5

21. succeed at most things I try 1 2 3 4 5

22. be successful in my endeavours in the long run 1 2 3 4 5

23. be very successful working out my personal life 1 2 3 4 5

24. experience many failures in my life 1 2 3 4 5

25. make a good first impression on people I meet for the first time 1 2 3 4 5

26. attain the career goals I have set for myself 1 2 3 4 5

27. have difficulty dealing with my superiors 1 2 3 4 5

28. have problems working with others 1 2 3 4 5

29. be a good judge of what it takes to get ahead 1 2 3 4 5

30. achieve recognition in my profession 1 2 3 4 5

Practical 2: scale measuring degree of Extroversion- Introversion

Directions: Try to decide whether 'yes' or 'no' represents your usual way of acting or feeling. Then put a cross under the heading 'yes' or 'no'. Work quickly and don't spend too much time over any of the questions. It is best to give your first reaction, not a long drawn out thought process.. Please do not omit any questions.

Question	**Yes**	**No**
1. Do you often long for excitement?		
2. Are you usually carefree?		
3. Do you stop and think things over before doing them?		
4. Do you generally do and say things quickly without Stopping to think?		
5. Would you do almost anything for a dare?		
6. Do you often do things on the spur of the moment?		
7. Generally, do you prefer reading to meeting people?		
8. Do you like going out a lot?		
9. Do you prefer to have few but special friends?		
10. When people shout at you do you shout back?		
11. Can you usually let yourself go and enjoy youself at a party		
12. Do other people think of you as being very lively?		
13. Are you mostly quiet when you are with other people?		
14. If there is something you want to know about, would you Rather look it up in a book then speak to someone about it?		
15. Do you like the kind of work that you need to pay		

Close attention to?

16. Do you hate being in a crowd who play jokes on one another?

17. Do you like doing things in which you have to act quickly?

18. Are you slow and unhurried in the way you move?

19. Do you like talking to people so much that you never

Miss a chance of talking to a stranger?

20. Would you be very unhappy if you could not see lots of

People most of the time?

21. Would you say that you are fairly self-confident?

22. Do you find it hard to really enjoy yourself at a lively party?

23. Can you easily get some life into a rather dull party?

24. Do you like playing pranks on others?

Practical 3 : Scale measuring degree of internal-external locus of control.

Directions: Tick the statement that you feel most applies to you.

I More Strongly believe that	Or
Promotions are earned through hard work	Making a lot of money is
And persistence	largely a matter of getting the
	Right breaks
In my experience I have noticed that there	Many times the reactions of
Is usually a direct connection between how	teachers seem haphazard to
Hard I study and the grades I get	me
The number of divorces indicates that more and	Marriage is largely a gamble
More people are not trying to make their	
Marriages work	
When I am right I can convince others	It is silly to think that one
	Can really change another
	Person's attitudes
In our society a man's future earning power	Getting promoted is really a
Is dependant upon his ability	matter of being a little
	Luckier than the next guy
If one knows how to deal with people they	I have little influence over

Are really quite easily led	the way other people behave
In my case the grades I make are the results of my efforts; luck has little or nothing to do with it	Sometimes I feel that I have little to do with the grades I get
People like me can change the course of world Affairs if we makes ourselves heard	It is only wishful thinking to believe that one can Really influence what Happens in society large
I am the master of my fate	A great deal that happens To me is probably a Matter of chance
Getting along with people is a skill that must be Practised	It is almost impossible to figure out how to please Some people

Practical 4: Assertion Inventory

Many people experience difficulty in handling interpersonal situations requiring them to assert themselves in some way, for example, turning down a request, asking a favour, giving someone a compliment, expressing disapproval or approval etc. Please indicate your degree of discomfort or anxiety in the space provided before each situation listed below. Utilize the following scale to indicate degree of discomfort:

1. none
2. a little
3. a fair amount
4. much
5. very much

Then go over the list a second time and indicate after each item the probability or likelihood of your displaying the behaviour if actually presented with the situation. For example, if you rarely apologise when you are at fault, you would mark a four after that item. Utilize the following scale to indicate response probability:

1. always do it
2. usually do it
3. do it about half the time
4. rarely do it
5. never do it

Note: It is important to cover your discomfort rating (located in front of the items) while indicating response probability. Otherwise, one rating may

contaminate the other and a realistic assessment of your behaviour is unlikely. To correct for this, place a piece of paper over your discomfort ratings while responding to the situations a second time for response probability.

Discomfort probability	Situation	Degree of response
	1.Turn down a request to borrow your car	
	2.Compliment a friend	
	3.Ask a favour of someone	
	4.Resist sales pressure	
	5.Apologise when you are at fault	
	6.Turn down a request for a meeting or date	
	7.Admit fear and request consideration	
	8.Tell a person whom you are intimately involved with that they have said something to upset you	
	9.Ask for a raise	
	10.Amit ignorance in some area	
	11.Turn down a request to borrow money	
	12.Ask personal questions	
	13.Turn off a talkative friend	
	14.Ask for constructive criticism	
	15.Initiate a conversation with a stranger	
	16.Compliment a person you are romantically interested in	
	17. Request a meeting or date with a person	

18. Ask the person again when your initial request is turned down

19.Admit confusion about a point under discussion and ask for clarification

20.Apply for a job

21.Ask whether you have offended someone

22.Tell someone that you like them

23.Request expected service when such is not forthcoming.

24.Discuss openly with one person their criticism of your behaviour

25.Return defective items

26.Express an opinion that differs from that of the person you are talking to

27.Resist sexual overtures when you are not interested

28.Tell the person when you feel they have been unfair to you

29.Accept a date

30.Tell someone good news about yourself

31.Resist pressure to drink

32.Resist a significant person's unfair demand

33.Quit a job

34.Resist pressure to take drugs

35.Discuss openly with another person criticisms of your work

36.Request the return of borrowed items

37.Receive compliments

38.Continue to converse with someone who disagrees with you

39.Tell a friend the thing they do which annoys you

40.Ask a person who is annoying you in a public situation to stop.

THE EXERCISE - THE LEARNING STYLE INVENTORY

This survey is designed to explore the way you prefer to learn.

(a) Look at the four statements in each row, and decide how they refer to you. Give four marks for the statement nearest to you, three to the second, two for the third and one for the statement least appropriate to you. There are no right or wrong answers.

	a	b	c	d
1	I like to get involved	I like to take my time before acting	I am particular about what I like	I like things to be useful
2	I like to try things out	I like to analyse things and break them into parts	I am open to new experiences	I like to look at all sides of issues
3	I like to watch	I like to follow my feelings	I like to be doing things	I like to think about things
4	I accept people and situations the way they are	I like to be aware of what is around me	I like to evaluate	I like to take risks
5	I have gut feelings and hunches	I have a lot of questions	I am logical	I am hard working and get things done
6	I like concrete things, things I can see, feel, touch or smell	I like to be active	I like to observe	I like ideas and theories
7	I prefer learning in the here and now	I like to consider and reflect about them	I tend to think about the future	I like to see the results of my work
8	I have to try things out for myself	I rely on my own ideas	I rely on my own observations	I rely on my feelings
9	I am quiet and reserved	I am energetic and enthusiastic	I tend to reason things out	I am responsible about things

(Adapted from Kolb and McCarthy 1980)

Example:

	a	b	c	d
1	I like to get involved 2	I like to take my time before acting 4	I am particular about what I like 1	I like things to be useful 3
2	I like to try things out 1	I like to analyse things and break them into parts 4	I am open to new experiences 2	I like to look at all sides of issues 3
3	I like to watch 1	I like to follow my feelings 2	I like to be doing things 3	I like to think about things 4

... and so on

(b) Use the grid below to summarise your score on the Learning Style Inventory and fill in your total score for each column in the spaces below.

CE	RO	AC	AE
_____	_____	_____	_____
1a	1b	2b	2a
_____	_____	_____	_____
2c	2d	3d	3c
_____	_____	_____	_____
3b	3a	4c	6b
_____	_____	_____	_____
4a	6c	6d	7d
_____	_____	_____	_____
8d	8c	8b	8a
_____	_____	_____	_____
9b	9a	9c	9d

TOTALS

CE = _____ RO = _____ AC = _____ AE = _____

Here is an example using the scores from a previously completed Learning Style Inventory.

CE	RO	AC	AE
1a 2	1b 4	2b 4	2a 1
2c 2	2d 3	3d 4	3c 3
3b 2	3a 1	4c 4	6b 1
4a 1	6c 3	6d 4	7d 3
8d 1	8c 2	8b 4	8a 3
9b 3	9a 1	9c 4	9d 2

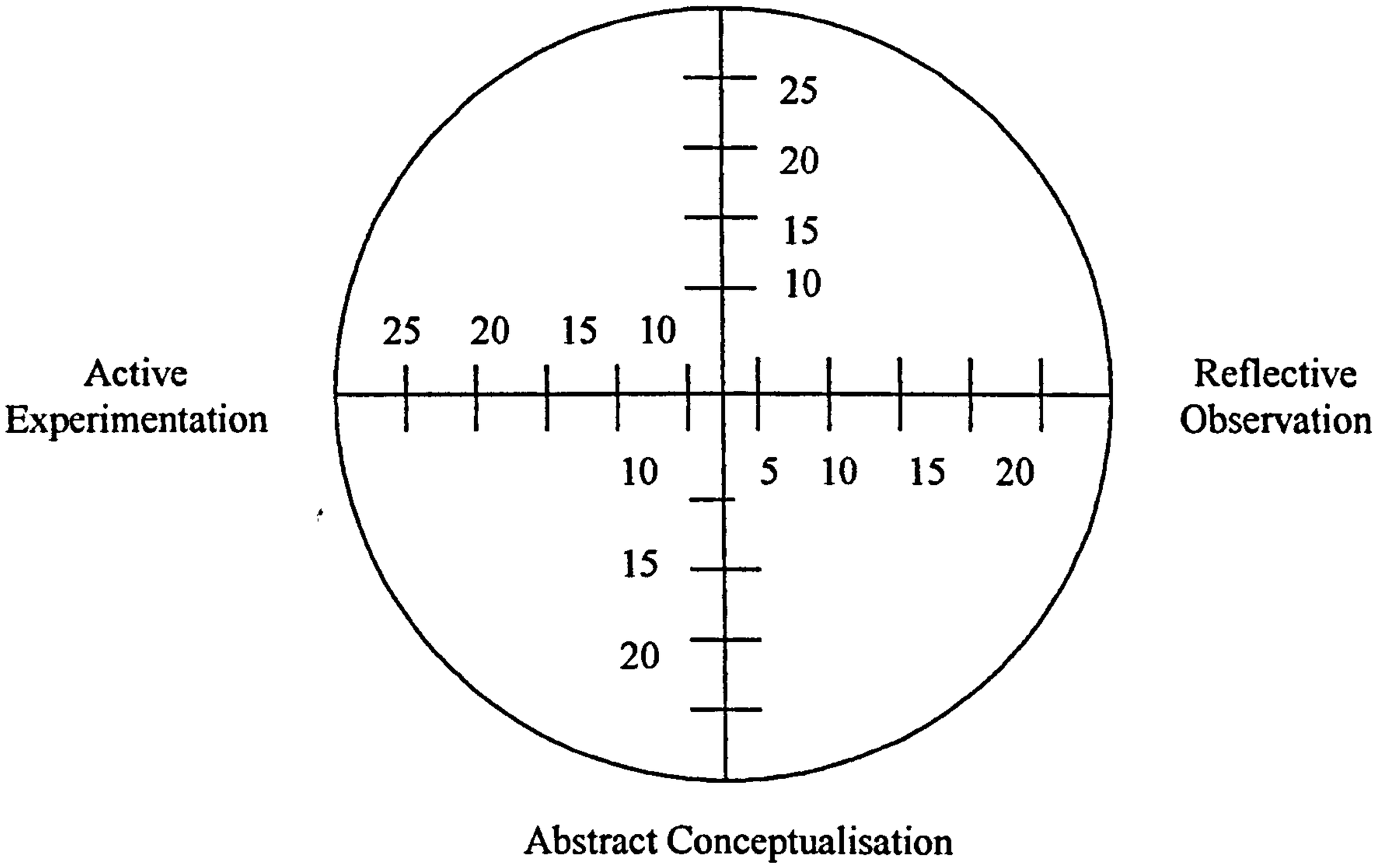
TOTALS

CE = 11 RO = 14 AC = 24 AE = 13

N.B. Only put down the 'marks' asked for. You will notice for instance that the mark for 1c and 1d are not asked for. This is intended to stop "patterning" and is not a mistake.

(c) The scores you have now arrived at can be now plotted on to the diagram below to produce your "kite".

CE = _____ RO = _____AC = _____AE = _____



KOLB'S LEARNING ORIENTATIONS

An orientation toward *concrete experience* focuses on being involved in experiences and dealing with immediate human situations in a personal way. It emphasizes feeling as opposed to thinking; a concern with the uniqueness and complexity of present reality as opposed to theories and generalizations; an intuitive, "artistic" approach as opposed to the systematic, scientific approach to problems. People with concrete-experience orientation enjoy and are good at relating to others. They are often good intuitive decision makers and function well in unstructured situations. The person with this orientation values relating to people and being involved in real situations, and has an open-minded approach to life.

An orientation toward *reflective observation* focuses on understanding the meaning of ideas and situations by carefully observing and impartially describing them. It emphasizes understanding as opposed to practice application; a concern with what is true or how things happen as opposed to what will work; an emphasis on reflection as opposed to action. People with a reflective orientation enjoy intuiting the meaning of situations and ideas and are good at seeing their implications. They are good at looking at things from different perspectives and at appreciating different points of view. They like to rely on their own thoughts and feelings to form opinions. People with this orientation value patience, impartiality, and considered, thoughtful judgement.

An orientation toward *abstract conceptualization* focuses on using logic, ideas, and concepts. It emphasizes thinking as opposed to feeling; a concern with building general theories as opposed to intuitively understanding unique, specific areas; a scientific as opposed to an artistic approach to problems. A person with an abstract-conceptual orientation enjoys and is good at systematic planning; manipulation of abstract symbols, and quantitative analysis. People with this orientation value precision, the rigor and discipline of analysing ideas, and the aesthetic quality of a neat conceptual system.

An orientation toward *active experimentation* focuses on actively influencing people and changing situations. It emphasizes practical applications as opposed to reflective understanding; a pragmatic concern with what works as opposed to observing. People with an active-experimentation orientation enjoy and are good at getting things accomplished. They are willing to take some risk in order to achieve their objectives. They also value having an influence on the environment around them and like to see results.

LEARNING STYLES AND PEOPLE AT WORK

Given below are descriptions of the four basic learning styles together with comments which link these styles to typical work environments and activities.

> *The* convergent *learning style relies primarily on the dominant learning abilities of* abstract conceptualisation *and active experimentation. The greatest strength of this approach lies in problem-solving, decision-making, and the practical application of ideas. People with this learning style are referred to as* convergers *since they seem at their best in such situations as conventional intelligence tests where there is a single correct answer or solution to a question or problem. They prefer dealing with technical tasks and problems rather than with social and interpersonal issues. Convergers often have specialised in the* physical sciences. *This learning style is characteristic of many* engineers *and* technical specialists.

The divergent *learning style has the opposite strengths of the convergent*

style, emphasising concrete experience *and* reflective observation. *The greatest strength of this orientation lies in imaginative ability and awareness of meaning and values. The prime ability of this type is to view concrete situations from many perspectives and the emphasis is on adaption by observation rather than by action. People with this style are called* divergers *because they perform better in situations that call for generation of alternative ideas and interpretations. Those oriented towards divergence are interested in people and tend to be imaginative and feelings-oriented. This style is characteristic of individuals from* humanities *and* liberal arts *backgrounds. People involved in* caring *and* welfare *activities, the* arts, *and* personnel management *are examples of people at work who tend to be characterised by this style.*

In the assimilative *style the dominant learning abilities are* abstract conceptualisation *and* reflective observation. *The greatest strength of this orientation lies in inductive reasoning in the ability to create theoretical models, and in assimilating disparate observations into an integrated explanation. As in convergence, this orientation is less focused on people and more concerned with ideas and abstract concepts. Ideas, however, are judged less in this orientation by their practical value. Here it is more important that the theory be logically sound and precise. This learning style is more characteristic of individuals in the 'pure'* sciences *and* mathematics *rather than the 'applied' sciences. In organisations, people with this learning style are often found in the* research *and* planning *departments.*

The accommodative *learning style has the opposite strengths of the assimilative, emphasising* concrete experience *and* active experimentation. *The greatest strength of this orientation lies in doing things, in carrying out plans and tasks, and in getting involved in new experiences. The emphasis is on opportunity-seeking, risk-taking and 'getting in on the action'. The style is called* accommodative *because it is best suited for those situations in which one must adapt oneself to changing immediate circumstances. In situations where the theory or plans do not fit the facts, those with an accommodative style will most likely discard the plan or theory. (With the opposite learning style, assimilation, one would be more likely to disregard or re-examine the facts). People with an accommodative-orientation tend to solve problems in an intuitive trial-and-error manner, relying on other people for information, rather than on their own analytic ability. Individuals with accommodative learning styles are at ease with people but are sometimes seen as impatient and pushy. Their educational background is often in technical or practical fields such as* business. *In organisations, people with this learning style are often found in* action-oriented *jobs such as* marketing *or* sales.

APPENDIX SIX

Site	Test	Mean	Sdev.
P	Intro/Extroversion	12.07	3.67
C	Intro/Extroversion	12.98	4.65
P	Locus of control	-3.31	3.60
C	Locus of control	-1.77	3.58
P	Assertiveness 1	94.36	18.98
C	Assertiveness 1	99.93	27.18
P	Assertiveness 2	99.45	14.41
C	Assertiveness 2	98.49	22.09
P	Expectancy for Success	110. 79	12.80
C	Expectancy for Success	106.27	14.22
P	Concrete Experience	15.98	3.39
C	Concrete Experience	16.70	3.30
P	Abstract Conceptualisation	12.86	2.85
C	Abstract Conceptualisation	13.14	3.53
P	Reflective Observation	13.76	3.66
C	Reflective Observation	13.95	3.57
P	Active Experimentation	19.05	3.72
C	Active Experimentation	17.86	3.51

Table 3 Findings of Pre-test questionnaires.

APPENDIX SEVEN

INTERVIEW SCHEDULE

What has been your experience of learning on the course so far?

What has been your experience of learning in the clinical environment?

What was your preferred method of learning?