THE UNIVERSITY OF CALGARY

An Exploration of Students' Personal Constructs: Implications for Clinical Teaching in Psychiatric Mental Health Nursing

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF DOCTOR OF PHILOSOPHY

GRADUATE DIVISION OF EDUCATIONAL RESEARCH

CALGARY, ALBERTA

WINTER, 1998

ABSTRACT

Despite revolutionary rhetoric in the nursing education literature calling for collaborative student centered learning, few opportunities actually exist, particularly in the psychiatric clinical teaching area, to include the voices of student nurses in the scholarly dialogue surrounding their learning. This thesis was designed to understand students' own ways of knowing during their six-week mental health practicums on acute hospital units. A constructivist conceptual perspective and George Kelly's personal construct psychology are the theoretical bases of the research. Qualitative methodology using the case study approach was used to describe the experiences of six Canadian second year nursing students from their own perspectives. Data sources included before and after repertory grids, a questionnaire and audiotape-recorded transcribed interviews. Content was theme analyzed, Vee Heuristic diagramed and concept mapped. The case studies were written collaboratively with students and member checking by correspondence six months after the practicum ended confirmed that the reports authentically narrated the personal construct changes which occurred, or did not occur, as a result of the course. The study spanned three years, included a pilot project and incorporated the resulting student "stories" into a clinical curriculum. The case reports are snapshot portrayals of how student nurses construed the professional activities they observed on hospital units which recently underwent organizational changes. They reflect human faces behind the paradigm shifts occurring in nursing education and health care. The following four overarching themes represent key findings. The research approach invited constructivist teaching. Students' anxiety related more to feeling unable to help than to mentally ill patients. Students felt a lack of inclusion in staff nurse groups. Non evaluated student-instructor discussion time was vitally important. Suggestions for clinical teaching strategies are made to assist instructors in the selection of experiences which can help link university curricula to hospital practicum sites. The research contributes to the conceptualization of how students learn nursing by re-valuing what they bring to clinical experiences, by increasing understanding of what students find engaging or difficult and by developing a pedagogical mode of inquiry which extends clinical instruction beyond demonstration and evaluation to creating a space for student perceptions.

ACKNOWLEDGMENTS

I extend my heartfelt thanks to my mentor Dr. Bonnie Shapiro, whose caring guidance made writing this thesis possible and to my precious family Ross, Derek, Garth, Lois, Janet, Edith, Cam, Bruce, Sean and Erin. Thank you all!

I very much appreciate the financial support and recognition given by the Alberta Association of Registered Nurses' Educational Trust and The Harshman Foundation.

Finally, I am grateful to the nursing students who I came to know through this study: Sandra, Nathan, Simone, Heather, Beth and Casandra. It was a privilege to share this learning experience with you.

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CHAPTER ONE

INTRODUCTION AND PROBLEM

Purpose, Questions and Significance

This thesis is a naturalistic study which explored students' ideas about mental health nursing. The research emphasized the importance of incorporating students' perceptions into nursing education. The investigation uses a case study design. The main purpose of the research was to investigate how student nurses develop personally meaningful constructs during their psychiatric mental health clinical rotation. A secondary purpose of the study was to examine the role that personal construct theory can play in the learning/development process.

Three questions guide the research. First, how do student nurses construe professional staff activities? Second, what changes, if any, do student nurses perceive in their personal ways of knowing about mental health nursing? Third, does the construction and discussion of a repertory grid help student nurses to articulate what they learn?

A constructivist conceptual perspective undergirds the project. In a constructivist approach to learning, the individual is viewed not as a passive recipient of knowledge, but as an active constructor of meaning (Shapiro, 1994).

Personal construct theory is an outgrowth of a constructivist world view and lends itself to exploration and inquiry in complex interactive situations. The techniques involved in the use of repertory grids or repgrids logically derive from the theory (Costigan, 1985; Pollock, 1986;

Rawlinson, 1995). According to Bannister and Fransella (1971) "personal construct theory is elegant in its formal logic, precise in its methodological implications and rich in its imagination" (p.10).

George Kelly's (1955/1991) theory of personal construct psychology provides a framework for understanding self and the perceptions of others. Costigan (1987) described the essential aspects of the theory as follows.

> The fundamental postulate of Kelly's theory states that "a person's processes are psychologically channelized by the way in which he anticipates events" (Kelly, 1955). This means that individuals choose to interpret or form constructions of events in ways which are most meaningful for them. Personal constructs are "templets of reality" (Kelly, 1955) or categories of thought which determine subsequent expectations and behavior. The meaning of events is ascribed within the context of those events. Constructs form patterns of reality which may be unique according to the *Individuality corollary*; shared by a group according to the *Commonality corollary*; understood by others according to the *Sociality corollary*, or even inconsistent according to the *Fragmentation corollary*. Constructs are chosen because they are the most meaningful in a given situation according to the *Choice corollary*. Once chosen they are tested in the light of experience according the *Experience corollary* and can be consolidated, modified or elaborated in the process of personal development according to the *Modulation corollary*. The individual's idiosyncratic construct system must be seen to be firm to prevent anxiety or chaos. Constructs which are pre-emptive ('nothing but' type construing) or constellatory ('stereotyped or typological thinking') serve to keep the system tight and impermeable (Costigan, 1987).

In the field of nursing education, there is a paucity of current research in the area of psychiatric mental health clinical teaching. This study makes a contribution to this literature and is significant in four ways. First, it provided in-depth insight into the current learning

needs of participating student nurses. Second, it informed practice in terms of recommending collaborative nursing educational experiences from a personal construct theory approach. Third, this research suggested important changes in our understanding of clinical teaching in psychiatric mental health rotations. Fourth, publications extending from this study will contribute a Canadian perspective to the developing body of international literature linking personal construct theory and nursing education.

The project provides a detailed description of learning in one local nursing program. The study emphasized the importance of discovering personal meaning as opposed to an assumption of universal meaning, and therefore limited generalization is warranted.

Finally, two key areas of research in nursing education are pertinent to this study--*clinical teaching* and *personal construct theory*. It was the objective of this investigation to weave a common thread between these two research strands in order to provide students, educators and practitioners with insights into student nurses' ways of knowing in mental health nursing. The heart of the project involved listening to the students themselves and collaborating with them to create a meaningful report of their experiences.

Given the above, in this thesis, I argue for the importance of the inclusion of student voices in the scholarly dialogue surrounding their learning. In order to accomplish this aim, the research is arranged into five chapters. The following section outlines the organization of this project.

The Organization of the Study

The timetable for this case study investigation spanned three years. The research proposal was initiated in September 1995. Following a pilot study conducted from January through April 1996, the present study was implemented from January through April 1997, written up from May through December 1997 and employed as a curricular tool in January 1998.

Six second year students, who were the case study students, were recruited from a local Canadian nursing program where I am a sessional instructor. The case study reports were constructed from three sources of data. First, students were interviewed extensively each week during their six-week mental health clinical placements on psychiatric wards. The final post course interviews were audiotape recorded and transcribed. Second, using personal constructs, students created pre- and post course repertory grids. Third, they completed Perese's (1996) questionnaire on students' positive, negative and helpful experiences during clinical psychiatric rotations. Throughout the project, the data was subjected to Vee Heuristic diagraming, content analysis for themes and concept mapping. Once the case studies were drafted and concept mapped from the data, they were discussed with my supervisor then submitted to the student participants to confirm authenticity. Any necessary revisions were made and the collaborative case study reports and a discussion of their implications for the practice of nursing education was concluded by December 1997.

This first chapter of the thesis has been organized to introduce my work and identify my

personal connections to the research. Chapter One also introduces the conceptual framework of constructivism and George Kelly's (1955) theory of personal construct psychology as an alternative to traditional thinking about knowledge and learning. This personal and theoretical backdrop establishes the kind of thinking which guides the inquiry and initiates a process of viewing clinical learning from a student centered perspective, which continues throughout the writing.

In Chapter Two, to situate the study within the larger context of nursing education, I review the two areas of nursing education literature which are relevant to the project: clinical teaching and personal construct theory. The first section, clinical teaching, locates the unique experience of psychiatric mental health nursing within the larger world of clinical nursing education. I trace the practice of instructing student Registered Nurses on hospital wards from its historical roots with Florence Nightingale to its current place in today's changing health care system. Existing studies of clinical teaching are categorized in relation to whether they are viewed from a faculty perspective or from a student perspective. The second section of the chapter, personal construct theory, organizes and explains published studies which link personal construct theory to the field of nursing. This research is grouped according to participants' practice or educational program.

Chapter Three presents my research design and procedures, spelling out my approach to using repertory grid technique, constructing grids, piloting the study, sample selection, research methodology, data analysis and ethical considerations. In this chapter, I defend the depth and

rigor of my investigation. I emphasize the procedures which I implemented to enhance the authenticity and credibility of the work.

Chapter Four, my research findings, contains six case reports or stories about nursing students as they enter a psychiatric unit for the first time to study mental health nursing. The students' experiences are not simply a chronicle of their progress. The reports identify themes that constitute each individual's own way of knowing and creating meaning in a clinical laboratory. Viewing the experience through the students' eyes invites all those involved with their education to reflect and reconsider how clinical learning could be facilitated differently and more meaningfully.

Chapter Five, the implications of my work, reflects on the research process and the personal learning which occurred or did not occur during students' clinical experiences, summarizes the study and suggests strategies for creating relevant curricula which fit current psychiatric mental health practicum opportunities. In this chapter, I conclude the sketch of clinical learning presented in my constructivist analysis and call for nurse educators to extend the craft of clinical instruction beyond basic demonstration and evaluation and more towards acknowledging and building upon students' own natural ways of knowing and learning.

Personal Connections to the Research

The research problem was formulated directly out of my experience as a nursing instructor.

My practice centers on health care education in hospital settings. As a nurse-educator, I have counseled the mentally ill in psychiatric units, facilitated expectant parent and grandparent classes, and instructed student Registered Nurses both in the classroom and on hospital wards. In my own learning and in the process of sharing the learning journey of clients and students, I have come to value the unique and special ways in which people make sense of their experiences.

Both as a student and as a teacher, I have always treasured learning environments which honor personal ways of knowing. However, in the competency-based world of clinical nursing education, opportunities to articulate personal meaning are conspicuous by their absence. Hospital accreditation boards and professional nursing associations impose rigorous standards of practice on Registered Nurses. Patient safety, the credibility of professional nursing, the employability of graduates and the economics of teacher time all dramatically impact both teaching and learning in the clinical laboratory.

My graduate studies in the field of adult education allowed me to spend some time away from nursing. The opportunity enabled me to take a fresh look at some of the issues underlying problems I had encountered in nursing education generally, and in clinical teaching in the psychiatric mental health area specifically. To my dismay, I recognized Paulo Friere's "banking" model of education (Friere, 1984) in my own practice. Friere (1984) identified a banking concept of traditional education in which teachers would deposit information to students, who in turn would patiently receive, memorize, and repeat this same information.

Friere viewed students' only course of action in this situation as receiving, filing, and storing these deposits. He argued against this banking concept and advocated a need for praxis, or critical reflection in action. He regarded students and teachers as co-investigators and encouraged a more equal problem-solving dialogue in the learning process.

I came to realize that I had been teaching as I had been taught, by attending more to received knowledge than to constructed knowledge. As I learned more about constructivist thinking, and participated in personal construct theory and repertory grid technique experiences as a student, I sensed the relevance to my own practice.

My research plan evolved as I considered how to encourage student nurses to articulate what it's really like for them to complete a mental health rotation on an acute psychiatric ward in a general hospital. Once the required nursing competencies are achieved, and the medically based hospital unit expectations met, what do students as individuals feel they learned? Was anything missing in their learning from their perspective? What did they personally think about professional staff actions? What, if anything, was touching or special about the experience? Would it be useful to provide an opportunity to listen and use students' own words to articulate what the rotation was like for them?

When casting my research problem against a literature review of clinical teaching in nursing education, I discovered a disturbing lack of attention to student perspectives. Despite rhetoric calling for constructed knowledge, most of the resource literature simply addressed

methods instructors could implement to ensure students received the required teacher-imposed knowledge. Existing studies neglected to explore the need in real learning for students to make personal connections to new knowledge. My research plan unfolded in an attempt to address this "gap" in our understanding of clinical nursing education and to create a place for students' own reflections within the curriculum.

Kelly's (1955/1991) theory of personal construct psychology offered direction to my developing research plan. Kelly's ideas were congruent with my own views about teaching as an empathetic process, offered insight into how I might go about answering my research questions, and expressed a constructivist world view. The theory, and the methodology which extends from it — repertory grid technique — suggested a straightforward way to translate my abstract concern with students' perceptions into a concrete method of actually listening to their feelings, values, and understandings.

In my experience with personal construct theory as a learner, I was struck by how effective it was to use my own language instead of the language of a course to clarify my perceptions. I also found the approach effective in stimulating discussion with my fellow students, all of whom came from a variety of different backgrounds and diverse philosophical orientations. In my experience with personal construct theory as a teacher, I felt that the techniques provided a novel way to suspend my own agenda of instruction in order to listen openly and empathetically to what students had to say. The process was an educational tool as well as a research tool. A constructivist perspective guides this thesis, and in the following

discussion, I highlight the aspects of constructivism which influence the design of the project.

A Constructivist Conceptual Perspective

This inquiry is grounded in a constructivist perspective in which observers are included in the domain of the observed, and the focus is on process and pattern. In a constructivist approach to learning, the individual is not a passive recipient of knowledge, but an active constructor of meaning (Shapiro, 1994). Constructivism is a broad philosophy and it is beyond the scope of this thesis to attempt a comprehensive review of all the ideas inherent in its many manifestations. In this section, I will define the perspective, and introduce the major tenets which apply to educational inquiry and to the design of the research project.

Within educational inquiry, constructivist thinking views knowledge as contextual and relative and rejects the notion that knowledge is an innate commodity which can be objectified or discovered. One of the central principles of constructivism is that "individuals try to give meaning to, or construe, the perplexing maelstrom of events and ideas in which they find themselves caught up" (Candy, 1989, p.97). A constructivist orientation to the nature of knowledge espouses that "knowledge is not discovered like gold or oil, but rather is constructed like cars or pyramids" (Novak & Gowin, 1984, p.4). Novak (1993) asserted that constructivist ideas "hold that knowledge is a construction based on previous knowledge and constantly evolving over time" (p.169). Describing George Kelly as a radical constructivist, Novak explained that Kelly "rejected the idea that there was one true way of seeing the world.

He emphasized the salience of idiosyncratic constructions" (p.169).

In teaching and learning experiences, a constructivist framework assumes that teaching is not a process of transmitting intact knowledge to learners. Knowledge cannot be taught or received, but must be actively and meaningfully constructed by learners (Candy, 1989). Constructivism in education is concerned with both how learners construe or interpret events and ideas and how they construct or build and assemble structures of meaning (Candy, 1989). In Candy's (1989) view, "the constant dialectical interplay between construing and constructing is at the heart of a constructivist approach to education, whether it be listening to a lecture, undertaking a laboratory session, attending a workshop, reading a text, or any other learning activity" (p.108).

While many definitions have been attributed to a constructivist conceptual framework in educational research, Shapiro (1994) explains that "its basic premise is that approaches to teaching and learning should begin by understanding what it is that learners bring to learning" (p. xiv). Shapiro (1994) emphasizes the importance of moving beyond the cognitive and considering the personal, social, and cultural influences that impact the learning setting. "The chief participant in the (learning) experience, the novice . . . , should be deeply involved in the discussion that determines the meaning of experience. The meanings attributed to the experience by the person actually having the experience, the novice . . . , are given high status" (Shapiro, 1991, p.121).

In the field of educational research, Shapiro (1994) asserts that the following five epistemological features undergird a constructivist view in education: (1) Reality depends on the observer's frame of reference and interaction with the observed. (2) Knowledge is not merely deduced facts; knowledge involves ongoing interpretation of the meaning of events and phenomena. (3) The purpose of education and knowing is to organize and cope with one's experience successfully. (4) The role of the learner is to participate actively in the construction of new meaning, not passively to receive information. (5) The role of the teacher is to guide the learner to consider new ways of thinking about phenomena and events, not simply to present new information, correct misconceptions, and demonstrate skills.

It is important to acknowledge that a constructivist perspective does not deny the existence of an outside reality which is beyond individual knowing. Candy (1989) notes that constructivism has been criticized for its apparent willingness to accept uncritically any and all interpretations of events. Candy (1989) emphasizes that not all constructions are equally useful or valid and that constructivist education allows people to reconstruct events and ideas in ways that lead to more functional outcomes for them. Thus, a constructivist perspective can incorporate consensually validated knowledge as well as individual knowing. This point is particularly relevant to clinical nursing education, where achieving a recognized standard of competence is essential.

Kelly's (1955/1991) theory of personal constructs was derived from a constructivist conceptual framework as a "constructive alternative" for understanding and monitoring

human behavior. Constructive alternativism emphasizes that alternative choices and changes are always possible, and celebrates personal strengths and abilities. As the following overview of the theory will demonstrate, Kelly's ideas suggest more detailed and specific applications of constructivism.

Overview of Personal Construct Theory

George Kelly

Clinical psychologist, sociologist, engineer, mathematician, and educator, George Kelly (1905 - 1966) offered a practical approach to listening credulously to the voices of others. As a psychologist, George Kelly challenged conventional analytic and behavioral psychotherapy and was identified as one of the originators of cognitive therapy (Fransella, 1995). As an educator, he was credited with challenging the Lockean philosophy of learning which views students as tabula rasa or blank slates that teachers must impose knowledge 'on' (Thomas and Harri-Augstein, 1985). Instead, Kelly's theory assumes the philosophical stance that both therapy and teaching involves the negotiation of significant, viable personal meaning between individuals. George Kelly is best known for his psychotherapeutic work as a clinical psychologist. However, this thesis does not include a discussion of his approach to therapy. Instead, in this writing, I focus on the less developed applications of Kelly's (1955/1991) theory within the field of educational research.

Fundamental Postulate and Corollaries

The fundamental postulate of Kelly's (1955/1991) theory is that "a person's processes are psychologically channelized by the ways in which he [sic] anticipates events" (p.32). In other words, people respond not to the real world (although Kelly acknowledged its existence) but to their constructions of it (Costigan 1985). In Kelly's view:

> Man [sic] looks at his world through transparent patterns or templets which he creates and then attempts to fit over the realities of which the world is composed. The fit is not always very good. Yet without such patterns the world appears to be such an undifferentiated homogeneity that man [sic]is unable to make any sense of it. Even a poor fit is more helpful to him [sic] than nothing at all. (p.7)

Kelly's theory has also been referred to as "man [sic] the scientist." Kelly suggested that, as scientists do, all individuals continually construct hypotheses about the situations, events, and people around them. As the hypotheses are tested, they may be confirmed, modified or disconfirmed. If confirmed, the constructs become more tightly re-construed and anchor one's thinking with a degree of safety and certainty. If modified, the constructs cycle through a process of loosening and then tightening again. If disconfirmed, the constructs must extend to incorporate new ways of thinking.

Eleven corollaries derive from Kelly's fundamental postulate equating the thinking of individuals with that of scientists. Applying the theory to nursing education, Costigan (1985) simplified the corollaries in the following manner.

1. The Construction Corollary: peoples' constructions of previous, repeated, similar experiences of themselves, other people, events and situations, form a basis for their constructions of present similar, although not identical, situations.

2. The Individuality Corollary: people differ in their constructions of similar events, less because of their different experiences than from their unique constructions of them.

3. The Organization Corollary: the form in which a person's constructs relate to each other is highly organized on the basis of frames of reference, e.g., good/bad could be a higher order construct which for one person subsumes constructs in relation to other people like accepting-rejecting, or like me/not like me, and for another subsumes constructs like men/women, doctors/nurses, well/sick, or even labour/liberal, depending on the organization of the construct system.

4. The Dichotomy Corollary: constructs are like coins — two sided, e.g., a construct of accepting implies that while some people are accepting, others are not. For many people, only one side of the coin is consciously used in their constructions of reality, e.g., depressed persons may consistently construe themselves as helpless and hopeless and thus fail to recognize the submerged pole of their strengths.

5. The Choice Corollary: people choose that side of the coin which is most meaningful for them in their anticipations of events, e.g., if nurses construe patients as demanding, they might hesitate to ascertain their needs, but if they construe them as suffering, they might go out of their way to extend empathy.

6. The Range Corollary: some constructs have a broad range of application, e.g., good/bad can be applied to many situations, but a construct like medical/surgical has a limited range of convenience; it could not be applied to pop songs or restaurants.

7. The Experience Corollary: this is the developmental aspect of Kelly's theory which accounts for changes in construct systems; most people change their constructs as a result of their changing experiences, e.g., a student nurse's anticipation of being a graduate would be modified when he/she experiences being a graduate.

8. The Modulation Corollary: people differ in the permeability of their construct systems--some are open to experience while others resist change, e.g., in nursing education.

> **9. The Fragmentation Corollary**: the way a person construes his/her reality may appear inconsistent, e.g., a clinical supervisor who tells students to empathize with patients and at the same time tells them not to waste time talking when there are beds to be made.
>
> **10. The Commonality Corollary**: two or more people may construe a situation similarly, even if they have had different experiences, e.g., a hospital-trained [sic] nurse and a college-trained [sic] nurse would construe a patient having a cardiac arrest similarly--hopefully for the patient.
>
> **11. The Sociality Corollary**: this refers to the ability of an individual to construe how another individual construes his/her reality -- rather like empathy. (Costigan, 1985, p. 19)

Many of the ideas that George Kelly articulated in his theory of personal constructs can be summarized in three basic tenets. First, the meanings attributed to the experience by the person actually having the experience are given high status. Second, we straddle the unknown with what we know. Third, present interpretations of experiences are subject to revision (Shapiro, 1991).

Two criticisms have been directed toward personal construct theory. The first is that the theory does not account for social contexts. The second is that it is a purely cognitive and overly intellectual theory which fails to recognize the importance of human emotions. Fransella (1995) refutes the first criticism by noting that George Kelly was not a sociological innocent; his master's thesis was in sociology. Fransella also emphasizes that his theory was written as a psychology not a sociology. In the second instance, Fransella (1995) refutes the criticism by explaining that Kelly's ideas dispensed with the classical thinking/feeling dichotomy or the trichotomy of intellect, will, and emotion commonly expressed in the field

of psychology. In Kelly's view, thinking, feeling, learning, motivation, emotions, and perceptions were all indivisible.

In terms of research application, the theory of personal constructs is humanistic and embraces both quantitative and qualitative paradigms (Bannister, 1985). Unlike most quantitative methods, Kellian measures (repertory grid techniques) use participants' own language and constructions of personal meaning instead of devising mechanistic questionnaires or tests from the researchers' perspective. However, systems of repertory grid analysis exist which do yield numbers allowing comparisons and hypothesis testing. On the other hand, the approach is phenomenological in that individuals' own subjective experiences and perceptions are central to the theory. Kelly's views about people and his general approach to research is epitomized in what has been referred to as Kelly's first principle. He advised that "if you want to know something about someone why not ask them; they just might tell you" (Morrison, 1990, p.253 citing Kelly).

Personal Construct Theory in Psychotherapy

Personal construct theory has been promoted strongly and successfully as a unique form of psychotherapy within the field of psychology. The following selected studies provide a brief description of the variety of research applications that have evolved from George Kelly's (1955/1991) ideas. Don Bannister showed that those with schizophrenic thought disorder are much more organized (tighter) at construing objects than they are at construing people

(Fransella, 1995). Fay Fransella demonstrated that some individuals who stutter were helped by the use of personal construct therapy (Fransella, 1995). Eric Button shed considerable light on the way individuals struggling with anorexia nervosa construe issues related to food and size (Fransella, 1995). Dorothy Rowe has written extensively to combat the widespread belief that depression is a physical complaint best treated by drugs (Fransella, 1995).

According to Costigan (1985), interest in applications of personal construct theory within health care was further stimulated by psychology professor Linda Viney with her prolific research in crisis counseling and the ways critically ill patients construe their situations. Robert Neimeyer has carried out extensive research on depression within a personal construct framework. His work offers insight into how death is construed by suicidal clients and also among the elderly (as represented in Fransella, 1995). Greg Neimeyer's work with constructivist psychotherapy has been significant. Robert and Greg Neimeyer edit the *Journal of Constructivist Psychology* which provides a professional forum for discussing expressions of constructivism such as personal construct theory.

Personal Construct Theory in Higher Education

As mentioned previously, and as the examples in the preceding section indicated, most applications of personal construct theory are in the area of psychotherapy. However, as Shaw (1980) asserted, "the boundaries between learning and psychotherapy, between learning and training, and between training and psychotherapy seem to move so frequently as to be

totally fluid" (p.8). Shaw (1980) described how Kelly, both a psychotherapist and a supervisor of research students, came to the following conclusion after spending an afternoon alternating between students and clients:

> I must say that this sort of thing went on for a long time before it ever occurred to me that I was doing the same sort of thing all afternoon long (Kelly, 1963, p.61 in Shaw, 1980, p.8)

In the field of education, Laurie Thomas's and Sheila Hari-Augstein's work has spawned a variety of practical applications for repertory grid techniques as educational tools (Beail, 1985). The two subsequent studies are particularly relevant to the present research and illustrate how the approach holds considerable promise within the field of higher education research as well.

First, Shapiro (1991) used a narrative approach of reflecting upon personal construct changes to explore the ways in which student teachers learned and developed as a result of their practicum experiences in school settings. According to Shapiro (1991):

> Personal construct theory provided a framework for helping the student teachers themselves analyze the meaning of changes in novice teacher thoughts about their own growth and development. The approach taken in the research permitted involvement of the student teacher in systematic discussion about changes in their own development that they might not otherwise be able to see (p.121).

Second, in Germany, psychologist Martin Fromm (1993)evaluated what university students

"learn(ed) (in a seminar on mental illness) besides or even instead of what was planned for them" (Fromm, 1993, p.195). The seminar was entitled: Concepts for the Explanation of Psychic (Psychotic) Disorders. After viewing and discussing films about psychiatric mental health clinic patients, particularly schizophrenic clients, Fromm (1993) elicited students' own constructions about what they had learned in the seminar. He found that, when given the choice, students did not use professional and academically accepted constructs but instead relied on their personal constructs. His findings indicated that students

> were talking in terms of personal not professional development. The seminar may not have helped the students construe the learning items in a professional way, it seems that this seminar provided a pleasant and sometimes touching experience.
>
> On the other hand, the reminder that learning items even at a university may be constructed in a very personal way is valuable. This specific seminar illustrates the real possibility that the personal construction of learning items may be quite **disturbing** (emphasis mine). Construing in a very personal way makes some professional knowledge a potential threat to the psychological stability of the students, a possibility that is totally ignored by professional curricula and strategies for the evaluation of learning results. (Fromm, 1993, p.206)

Shapiro's (1991) research with student teachers and Fromm's (1993) work with psychology students inspired the present study and is closely related to the 13 personal construct theory-based investigations of nurses and student nurses which will be described in Chapter Two. As in this thesis, these investigations all integrated personal construct theory and repertory grid techniques to explore how learners construct personal meaning and change (or do not change) within their formal educational experiences.

A common thread linking the variety of personal construct theory research applications in both psychotherapy and education is the consistent attention these researchers paid to participants' own frames of reference. The psychology of personal constructs honors people as knowing individuals, self-inventors, and interpreters of their world — the antithesis to Friere's (1984) "banking" education.

Summary

In summary, this naturalistic case study research looks at learning in the psychiatric mental health clinical area of Registered Nurses' education from the students' point of view. The research problem, questions, and plan evolved from both my professional experience as a hospital-based nursing instructor and my personal experience as a lifelong learner committed to personally meaningful education.

The investigation is guided by constructivist thinking and George Kelly's (1955/1991) theory of personal constructs. The work is unique in that students' own language and ways of categorizing information framed and directed the research interaction with them. A pilot study, ready access to nursing students enroled in their psychiatric mental health rotation and actual implementation of the results in a curriculum indicated that the project was feasible. Finally, the investigation is timely in that a deficit of nursing education literature exists in both strands of research under investigation — clinical teaching and personal construct theory application.

CHAPTER TWO

REVIEW OF RELEVANT NURSING EDUCATION LITERATURE

SECTION ONE: CLINICAL TEACHING

Since the time of Florence Nightingale, an apprenticeship model of "training" has been applied to the nursing education process. Recent advances in education generally and in clinical nursing education specifically indicate a need to expand beyond traditional didactic "training" to include active, involved, and meaningful pedagogical practices.

Registered Nurses no longer learn their profession exclusively in hospital-based schools. Nurses are also educated in university programs of study and may attend hospital sites only for their clinical practicums. Upon graduation, Registered Nursing practitioners can offer significant savings to healthcare systems. The cost-effectiveness of improved learning outcomes resulting from educational interventions during Registered Nurses' clinical experiences is a motivating force behind further research in this area. And yet, a surprising dearth of published scholarly works addressing clinical teaching in nursing education exists (Lindeman, 1989; Shoffner, Davis, & Bowen, 1994; Tanner, 1994; VanArsdale & Hammons, 1995;Wood, 1992). "In the last decade, fewer than 10% of the articles published in the *Journal of Nursing Education* have explicitly focused on clinical teaching" (Tanner, 1994, p.387).

Traditionally, the process of investigating nursing students' experiences during clinical

placements centered on measuring characteristics and behaviors of faculty, or on describing students' responses to questions which faculty felt were important. Students were only rarely invited to articulate their own perceptions. How student nurses constructed knowledge and what they found personally meaningful about their clinical experiences was neglected.

Understanding the process of teaching and learning in the nursing clinical laboratory is not easy. In psychiatric mental health hospital wards designated as practicum sites, the process involves other unique challenges. The present research questioned how student nurses construe professional staff activities, and what changes, if any, they perceived in their personal ways of knowing during their mental health rotations. In order to begin to understand how student nurses view the world of clinical nursing in hospital settings, this section will first provide a sociohistoric perspective highlighting the association which the clinical component of nursing education has had with hospitals in the past. Second, the section comments on the nature of psychiatric nursing. Third, the section describes the role of the psychiatric nurse. Finally, the section critically reviews existing research addressing clinical teaching in nursing education from the perspective of faculty and from the perspective of the student.

Sociohistorical Perspective

Nursing education's past is very much also its present. While a practice component has always been a part of nursing education, the role has experienced varied interpretations (Christy, 1980). In the mid-19th century, Florence Nightingale emphasized the educational

value of clinical teaching and learning in her reformed British school of nursing. Her emphasis on autonomy for the school from the hospital demanded that the school was both independently governed and independently funded (Nightingale, 1859/1969). Practice in the wards was conducted in an apprenticeship mode under the tutelage of ward sisters and clinical sites were selected on the basis of their relevance to the educational program, not in terms of patient care needs (Reilly & Oermann, 1992).

Although the Nightingale system of nursing education was adopted by some hospitals in North America, Reilly and Oermann (1992) note how the educational value inherent in the system was soon diminished as hospitals realized the potential for nursing schools to provide pupils to meet the need for care of the sick. By the end of the first decade in the twentieth century, nursing schools existed for economic, not educational, reasons and the primary mode of education was trial-and-error in the ward setting (Reilly & Oermann, 1992).

By the early twentieth century in both Canada and the United States, the technological advances of the Industrial Revolution were matched by profound social changes, including hospital sites as the chief providers of health care (Coburn, 1974). With the rapid transition to industrial mass production, new and unregulated hospitals materialized under the industrial prototype (Donner, Semogas, & Blythe, 1994). In 1910, the Flexner report (Doering, 1992) revealed the existence of substandard schools of medicine associated with those hospitals and this resulted in the closing of inferior schools.

While medical education moved rapidly into university settings in response to the Flexner report, nursing depended upon the unpaid labor of nursing schools. Thus, closing inferior schools would have meant closing hospitals. Nursing leaders proposed a similar study of nursing schools. The result was the Goldmark report (1926-1934); however, the Goldmark report never achieved the "cleansing" effect that the Flexner report had on medical education (Doering, 1992).

As a result of nursing education remaining in hospital settings and medical education becoming established within the scientific milieu of universities, nurses "viewed the patient through the physician's eyes for he/she possessed the scientific knowledge" (Reilly & Oerman, 1992, p. 17). The consequence was that nursing gradually became redefined as filling out physician's orders and performing housework on the wards (Vicinus, 1985). For nursing students, services to patients superseded learning needs, and the notion of time in the clinical setting as constituting "work" (Reilly & Oerman, 1992, p.17) persisted long after nursing education became more structured (Reilly & Oerman, 1992, p.17).

In Canada, the 1932 Weir report (Weir, 1932), the first comprehensive Canadian nursing student survey, revealed that only 8 percent of the 1,368 students surveyed came from professional family backgrounds. By contrast, Stuart (1993) noted that during that same time period, more than half of an interdisciplinary group of women students studying at Queen's University, Kingston came from business families. Stuart (1993) concluded that nursing had become the acceptable career for the daughters of people who had moderate means and who

could give their daughters few advantages. Nursing students, almost exclusively women, were provided with lodging in residences or nurses' homes adjacent to hospital sites and took their meals from the same kitchens which fed patients. Students' "work" in the clinical area constituted their tuition and instruction occurred only after patient demands were met (Reilly & Oerman, 1992).

A Curriculum Guide for Schools of Nursing, published in 1937 by the Committee on Curriculum of the National League of Nursing education, was one of the first important documents directing and regulating nursing education (Lindeman, 1989). The authors of the guide compiled lists of detailed nursing activities totaling about 800 tasks and noted that the goal of nursing education was to produce a professional nurse competent to provide those services to patients (Lindeman, 1989). According to Lindeman (1989), the guide emphasized that the clinical component of nursing education was significant, that it must reflect the real world of nursing, that the instructor was also the student's supervisor, and that the classroom provides the knowledge base applied in the clinical setting.

With the advent of World War II, "trained" nurses experienced considerable autonomy when their practice extended away from physician organized hospitals and onto the battlefield. Postwar governmental assistance allowed many nurses to attend institutions of higher learning for advanced study and degrees. Reilly and Oerman (1992) posit that this exposure to the world of ideas and research enabled nurses to begin to see their discipline in a new light and to view patients "through their own eyes" (p.17). Nursing education began to find its own

theoretical base and accredited universities and colleges assumed control of some hospital schools of nursing, a significant paradigm shift within nursing education.

Within this climate of **educating** rather than "training" nurses, the role of the clinical component within nursing education moved closer to the Nightingale model where practice sites were chosen in accordance with learner needs and instruction was provided by prepared nurses designated as faculty. In 1948, E. L. Brown's seminal report commissioned by the National Nursing Council, *Nursing for the Future*, asserted that all registered nurses were expected to obtain their baccalaureate degree. Hospital programs were to be allowed to remain open only for a brief time as an interim solution to a nursing shortage that existed at that time (Brown, 1948).

In the 1950's and 1960's, however, a division between the nursing practice and education emerged. Financial constraints in hospital settings, the introduction of para-professional nurses into the hospital industry, and graduate programs focusing on administrative rather than clinical skills all contributed to this division (Yonge, 1985). Despite Brown's (1948) recommendations, hospital schools of nursing continued to exist and to provide a supply of "trained" student labor through their clinical practicums. Unlike university programs, hospital programs also continued to offer accommodations and educational opportunities to young women of limited means. The rift between practice and education widened as graduate prepared nurses chose academic rather than clinical practice as their career routes. As Yonge (1985) explains:

> Academia offered status, normal working hours, increased decision-making opportunities and overall greater freedom. Faculty members directed energy toward curriculum development, review and adoption of nursing frameworks, examination of teaching and learning methods, development of research projects and publication. At the same time these nurses recognized the need to be accepted by other disciplines in academia, and consequently put a great deal of energy into university committees and establishing collegial relationships with other disciplines in an attempt to be accepted and respected in the university community. (p.4)

In universities, nursing faculty continued to carve out their academic roles, while at the same time losing credibility and respect from nurses working on hospital units (Kellmer, 1982). More and more faculty members from university programs were seen as guests, and too frequently as unwelcome ones, when they taught nursing students in hospital clinical areas (Christy, 1980). According to Myrick (1991), "It is no secret that clinical teaching is deemed as low status and even punitive within the modus operandi of the university setting" (p.44). Carlisle, Kirk and Luker (1996) found that clinical teachers did not have the same academic status as other higher education teachers, and that, to some nursing professors, the role of clinical instructor presented nursing as more of a practice discipline than a professional one. Thus, the role of clinical teaching became relegated to sessionally employed clinical teachers and practitioners who were often unfamiliar with the school curriculum and clinical perspective (Karahije, 1986; Myrick, 1988). Clinical teachers became isolated from both faculty and staff nurse groups. Patterson (1997) described clinical teachers as "temporary systems" (p.197) struggling to maintain an identity within the permanent culture of hospital units.

In 1975, Mary Sue Infante introduced the concept of the laboratory into clinical nursing education in response to "apprenticeship or worker-oriented programs (being) transplanted to the college or university campus (from diploma programs)" (Infante, 1975, p.7). Infante's controversial model of the clinical area as a laboratory challenged many commonly held assumptions about the clinical experience (1975; Infante, Forbes, Houldin, & Naylor, 1989). Infante (1975) insisted that nonjudgmental formative evaluation should occur throughout students' clinical experiences, and summative evaluation and grading "should be reserved until the end of the course of study. There should be enough time allowed to freely learn to explore without the constraints of being evaluated" (p.161). Clearly, transforming hospital settings which provide care to acutely ill individuals into university laboratories was and still is an obvious challenge. Distinguishing time for instruction from time for evaluation remains an issue for nursing faculty (Mulder, 1992), but Infante's (1975; Infante et al. 1989) process of naming the clinical area as a laboratory opened the issue to new discussions and possibilities.

In the Canadian marketplace of the 1980's, social policy and technological advances combined to generate a high demand for nurses (Donner et al., 1994). Government capital supported the medical advances associated with hospital institutions and nurses were needed to staff the facilities.

With nurses valued because of their work in hospitals, nursing leaders seized the opportunity to revolutionize nursing education. In 1988, over 400 nurse educators gathered in

Philadelphia for the first of a series of conferences which proclaimed a "Curriculum Revolution" (Tanner, 1996, p. 387). Speakers argued for transformations away from behavioral models, taken-for-granted practices, teaching as instructors themselves had been taught, requiring students to practice in oppressive, patriarchal systems of medical care and a system which failed to be responsive to the health care needs of vulnerable populations (National League for Nursing, 1988, 1989, 1991; Tanner, 1996).

In the seminal *Curriculum Revolution: Mandate for Change*, Bevis (1988) called for a revolution that once again focused on educating rather than training nurses. Bevis urged a dissolution of the incongruity between a humanistic philosophy promoted in educational settings and the behavioristic practices often experienced in clinical practice. From a feminist perspective, Wheeler and Chinn (1989) challenged the traditional power relationship between teachers and students and advocated a transformed egalitarian relationship within which nursing students and their instructors shared the responsibility for learning. Similarly, Diekelmann (1988) encouraged a phenomenologically based model of dialogue and meaning to guide the new curriculum. In her view, the curriculum should be a dialogue among teachers, practitioners, and students on what will constitute the knowledge in the nursing curriculum and what role experience will play in the curriculum. Diekelmann (1988) promoted a pedagogy of empowerment, in which the students' powers of inquiry, self-knowledge, and critical thinking are both exercised and increased.

By the middle of the 1980's, however, the rising costs of health care and the desire of the

Canadian federal government to reduce spending brought an end to hospital expansion (Donner et al., 1994). The recession of the late 1980's and early 1990's, along with increasing government deficits, stimulated a belief that institutional care had become too costly and that reform of the health care system was overdue (Manga, 1992).

By the 1990's, the institution of the hospital was undergoing reorganization as a result of rising costs for publically funded health care, a previous overemphasis on institutional services, and a depressed national economy that could no longer sustain increasing health care demands on traditional service structures (Roch, 1992). As a result, in Canada, a surplus rather than a shortage of nurses developed.

In Alberta, by 1996, all hospital-based diploma schools of nursing in the province had closed (Elabdi, 1996). Programs of nursing education are currently offered almost exclusively from universities and community colleges. However, Canadian Nurses' Association figures show that 76% of practicing nurses have a diploma education, while only 17% are prepared at the baccalaureate level and only 1% at a graduate degree level (Elabdi, 1996). Thus, on many hospital units, distanced from the university faculty who designed their curriculum, students learn from nurses who lived right in the hospital setting, "worked" for their tuition in their own clinical practicums, and were not privy to academic ideas of revolutionary education.

The current trend in clinical teaching is toward the use of these established and skilled nurses in preceptor roles in the clinical setting (Craddock, 1993; Nehls, Rather & Guyette, 1997;

Reilly & Oerman, 1992). However, as Donner et al., (1994) articulate, the "short-term survival goal to remain employed occupies center stage" (p.8) for many hospital nurses today. The challenge of incorporating hospital nurses' rich potential into student learning experiences remains complicated by the longstanding rift between practice and education and the resulting isolation of clinical teachers which was described earlier and by the overwhelming demands on staff time created by hospital downsizing.

The history of the clinical component in nursing education has come full circle. In the 19th century, Florence Nightingale established an independently governed and funded school of nursing. After a period in which student nurses' learning was almost exclusively tied to "working" in institutional hospital settings, clinical practice is independent once again. However, while it is now generally accepted that student nurses are learners rather than service providers, no universally agreed upon definition of the activity of clinical teaching exists (McCabe, 1985). Infante (1975) commented that "for whatever reason, nursing education has had historical difficulty in identifying what clinical teaching consists of" (p.17). In McCabe's (1985) view "clinical instruction is the process of providing students with the opportunity to put theory into practice" (p.255). Clearly, the aforementioned changes in both hospital institutions and nursing education itself underscore the need to know more about the reality of students' clinical experiences on all hospital units. Clinical components within nursing education programs span a broad range of practice sites, and this thesis examines only one particular setting in which the education of nurses occurs — the psychiatric mental health area.

The Nature of Psychiatric Nursing

Controversy surrounds the issue of whether or not psychiatric nursing is distinct and separate from other areas of nursing. Reynolds and Cormack (1987) argue that psychiatric nursing is not separate from general nursing. Reynolds and Cormack (1987) cited the classic Nightingale (1859/1969) and Henderson and Nite (1978) definitions of nursing and suggested that these definitions apply "equally to a patient who is recovering from an appendectomy, to a depressed person, to an individual suffering from schizophrenia, and to an elderly person with a broken neck or femur" (p. 123). According to Nightingale, nursing puts patients in the best position for nature to act upon them (Nightingale, 1859/1969). Similarly, Henderson and Nite (1978), in their watershed statement seeking to define the nature of nursing, made no real distinction between psychiatric, medical, surgical, or other forms of nursing. They defined the unique role of the nurse as being:

> To help people, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will or knowledge. It is likewise the function of nurses to help people gain independence as rapidly as possible. (p.34)

An alternative view of psychiatric nursing is that it is fundamentally different, and distinct from, other forms of nursing (Barker, 1990: Powell, 1982). Powell conducted a study which was designed to gain some understanding of how students in a three-year British diploma program of psychiatric nursing viewed their clinical practicums. In particular, he questioned

the way in which these students saw "training" [sic] as contributing to students' ability to relate or communicate with patients. Powell (1982) concluded that an overall picture of limited appreciation of psychiatric nursing existed and that psychiatric nursing was "not just another speciality but the 'other half of nursing'" (p.85). In his view, the role of the psychiatric nurse is quite different from that of the general nurse and there is no real similarity between the two except that both types of nurses are responsible for the care of patients. Powell (1982) suggested that "the care that the psychiatric patient requires is fundamentally different from that required by a patient with a physical illness. The systems of care that have developed and evolved are not the same" (p.85). While Powell's research was carried out in 1977 (p. 13) in a 434 bed rural mental institution only recently amalgamated with a general hospital, it is significant that he differentiated different systems of care in relation to the two types of nursing.

More recently, in his historical account tracing the roots of psychiatric nursing, Barker (1990) also emphasized how systems of care in psychiatric mental health nursing evolved differently from those in general nursing. Care for people with mental disorders has clearly not been the same as care for people with physical disorders throughout the ages; the mentally ill were often housed in lunatic asylums even well into the 17th century. Priorities for those who care for people with mental disorders historically centered on providing humane living conditions and making care-givers accountable (Barker, 1990). In Barker's (1990) opinion, as physicians developed their psychiatric speciality and incorporated care of the mentally ill into their evolving medical model, psychiatric nursing emerged from the patronage of the medical

profession. "It is clear that most of the nursing developments of the past century have continued to depend upon the beneficence of psychiatrists and the development of psychiatric medicine" (Barker, 1990, p.342).

In keeping with a view of psychiatric nursing as the separate 'other half' of nursing, Fagin (1981) documented the resentment some mainstream nurses felt toward psychiatric nurses. Mainstream nurses resented psychiatric nurses aligning with psychiatrists in the use of the medical model to practice psychotherapy (Fagin, 1981). By establishing themselves as psychotherapists, psychiatric nurses contributed only minimally to emerging nursing conceptual frameworks and decreased their identification with the nursing profession (Fagin, 1981). As well, many staff nurses in the psychiatric area developed liaison roles within the general hospital setting where they functioned as consultants to other nurses. Fagin (1981) asserted that when psychiatric nurses failed to seek the consultive services of other nursing specialities, the lack of mutuality created resentment.

A further consideration in situating psychiatric nursing within the context of general nursing is that hospital psychiatric mental health units may be staffed differently than other hospital units. While Registered Nurses are prepared to practice in psychiatric clinical areas, Registered Psychiatric Nurses, accountable to a separate professional association (Forde, 1996), are also qualified to practice in the field.

Registered Psychiatric Nurses have not always been accorded the same recognition in general

hospitals as Registered Nurses. For example, in the 1990's, Registered Psychiatric Nurses were not offered charge duty on some psychiatric units of Canadian general hospitals and were not allowed to hold office in professional organizations such as the Alberta Mental Health Nurses' Interest group (Forde, 1996).

Registered Psychiatric Nurses traditionally "trained" in state or provincial hospital programs and like Registered Nurses are now expected to obtain their baccalaureate degrees (Forde, 1996). Canadian diploma programs of psychiatric nursing, once located in the isolated provincial mental institutions, were closed in 1996 and are now offered exclusively through community colleges with baccalaureate transfer options (Forde, 1996). Provincial mental institution diploma programs, like their counterparts in general hospital diploma programs, historically offered tuition as well as room and board in adjacent residences in return for students' "work" during clinical practicums. The mental institutions provided both men and women, often of limited means, and often from the surrounding rural community, with a well-regarded and specialized educational opportunity. Thus, once again, in the psychiatric mental health clinical laboratory, students may be learning from a second group of nurses who "worked" during their clinical rotations and who experienced an entirely different kind of clinical learning in their own educational programs.

In addition to being staffed differently, psychiatric clinical settings look different from hospital units providing physical care. In the late 1950's and early 1960's, physicians were introduced to ways in which psychotropic drugs and electroconvulsive therapy could reduce some of the

symptoms associated with mental disorders (Barker, 1990). While psychiatric nurses assisted with these medical procedures, they also introduced social, behavioral, and interpersonal models of care which centered on nursing rather than medical actions. These three models continue to influence the way hospital psychiatric units look today. The social model of psychiatry was based on Maxwell Jones' (1968) ideas of a therapeutic milieu where physicians, nursing staff, and patients all dressed in a similar manner and worked together to plan treatment activities to benefit the unit community as a whole. The behavioral model was based on B.F. Skinner's (1938/1984) belief that human behavior can be shaped and controlled by the environment. The interpersonal model of care was based on Hildegard Peplau's (1952/1988) view of nurses engaging in helping relationships with their patients. Therefore, unlike general hospital units where uniformed nurses administer care to bedridden patients, many of the psychiatric staff are indistinguishable by dress from their clients. Further, if a behavior modification program is being implemented in a psychiatric unit, the environment may not seem as accommodating as, for example, a post-surgical environment. Finally, a psychiatric nurse sitting down in a hospital dining area to engage a suspicious, withdrawn, or antisocial client in a helping relationship, clearly projects a different picture than that of a medical nurse administering an analgesic injection.

Psychiatric mental health clinical areas have not escaped the hospital downsizing crisis described earlier. However, compounding the problem of organizational restructuring is a critical declining interest in the speciality (Arnswald, 1987; Perese, 1996). In 1983, Dumas reported that publications of psychiatric nurses outnumbered any other speciality area, faculty

from the psychiatric departments of nursing schools were strong and highly admired and professional organizations and agencies searched for psychiatric nurses to fill high-ranking positions (Dumas, 1983). In 1987, Arnswald described how fewer and fewer nurses were choosing psychiatric nursing for both employment and graduate study. From her literature review, she suggested that both integrating psychiatric nursing into general nursing curricula and a negative undergraduate experience in the psychiatric clinical area were responsible for the decline. In 1996, Perese questioned 38 student nurses about their psychiatric undergraduate experience. Their contemporary comments reflect a continued disenchantment with the psychiatric mental health undergraduate experience.

> The students described the adult inpatient nursing staff as "uncaring" in their interactions with patients and "unprofessional" with one another. The students commented that there seemed to be very little interaction between clinical nurses and patients. This was previously cited as a concern by Lowery (1992). The students also noticed that the units seemed to be understaffed and lacked support services such as those usually provided by ward clerks. Thus, a great deal of clinical nursing time was consumed in answering the telephone and delivering messages. Most distressing to the students was the limited participation of the head nurse in treatment review and planning conferences where she often was asked to confirm whether a patient had received a medication or treatment but seldom asked to share her clinical expertise. (Perese, 1996, p.283)

As the preceding discussion demonstrated, the issue of whether or not psychiatric nursing is distinct and separate from other areas of nursing is by no means resolved. Systems of care for the mentally ill developed differently than those which evolved to care for the physically ill. The nurses who care for clients on psychiatric mental health hospital units come from different backgrounds and continue to disagree about issues related to their status. With few

patients resting in beds, staff members wearing street clothes, and nurses sitting and talking with clients, psychiatric nursing units look different from other hospital units. Psychiatric nurses come from different nursing education backgrounds and direct their practice from both non-medical and non-nursing theoretical frameworks. Finally, the current nature of psychiatric nursing is poignantly reflected in a critical decline in interest in the area at the undergraduate, graduate, and employment level.

The Role of the Psychiatric Nurse

Given the nature of psychiatric nursing, defining the role of the psychiatric nurse is not straightforward. According to Reynolds and Cormack (1987), the role of the psychiatric mental health nurse has three major components. First, psychiatric nurses offer custodial care, second, they support other staff groups, and third, they personally influence the mental health status of the patient. Custodial care, also referred to as basic care, involves providing food, fluids, warmth, clothing, a safe physical environment, exercise, and the means by which the individual will physically survive (Reynolds & Cormack, 1987). Support of other staff groups involves implementing medical prescriptions, (in some cases persuading the client to accept these), and collecting data which are subsequently passed on to other members of the health care team (Reynolds & Cormack, 1987). Finally, the third component of the psychiatric nurses's role relates to the manner in which the nurse personally influences the mental status of the patient: the counseling or therapeutic approach (Reynolds & Cormack, 1987).

The third area of care, where the nurse personally influences the mental health status of the patient, frequently involves one or more models of intervention. Houseman (1994) identified current examples: the medical model, theories of group therapy (Yalom), theories of family therapy (Bowen and Minuchin), theories of nursing (Peplau, Orem, King, Martha Rogers, Roy, and Leininger), object relations personality theories (Freud, Jung, Adler, and Horney), theories of growth and development (Erickson, Piaget, and Kohlberg), social personality theories (Sullivan), humanistic personality theories (Carl Rogers, Perls, Maslow, and Ellis), behavioral personality theories (Skinner and Glasser), cognitive theories (Beck and Bandura), and theories of communication (Bandler & Grinder, and Berne).

Clearly, the scope of current models of psychiatric nursing interventions now extends well beyond the established medical, social, behavioral, and interpersonal models of the 1950's and 1960's described earlier. However, as the psychiatric nursing conceptual base expands, practitioners subsequently require additional specialized knowledge and skills. The role of the Clinical Nurse Specialist evolved in response to this need for advanced knowledge. Houseman (1994) distinguished the role of the hospital nurse from that of the Clinical Nurse Specialist. She defined the role of the hospital nurse: "establishes and maintains milieu, responsible for 24-hour care, activities of daily living and safety" (p.35), while Clinical Nurse Specialists "may perform individual, family or group psychotherapy" (p.35).

Thus, while all hospital psychiatric nurses, despite their varied educational backgrounds, once shared equally in implementing the three components of their role, now only specialists may

be in a position to personally impact the mental health status of the patient through therapy. Amid the turbulent climate of hospital downsizing and brief admissions of acutely ill patients, the role of the hospital psychiatric nurse today may, of necessity, center on custodial care and supporting other staff, generally physicians. Within this evolving system and as a consequence of their diminished resources, hospital psychiatric nurses, therefore, have less opportunities to interact in meaningful and personally rewarding ways with their patients. Their everyday activities often revolve around basic institutional and custodial tasks. While student nurses once accepted the actions of their role models on hospital units without question, for indeed their food and lodging often depended upon it, today's student nurses, as Chapter Four of this thesis illustrates, are not as forgiving as they form their constructions about what being a psychiatric nurse means. As the preceding discussion demonstrated, neither the nature of hospital psychiatric nursing nor the role of the hospital psychiatric nurse are simplistic concepts. It seems likely that, despite the curricular revolution of the 1980's, the practice component of nursing education in hospital settings continues to be influenced in multiple ways by the culture of the hospital. Indeed, given the historic themes of isolating and neglecting clinical teaching inherent in nursing education history, it would be astonishing if student centered hospital practicum experiences could be so readily redesigned. It would be easy to assume that, as nursing education moves out of traditional hospital settings and into universities, that attention to students' own narratives and ways of constructing knowledge would increase. This would be consistent with recent reforms in education generally and in the field of clinical nursing education specifically. However, as the following critical review of clinical teaching research reveals, student voices continue to have little

presence in academic discourse.

The View of Clinical Teaching From the Perspective of Faculty

The process of reviewing the existing research which does focus on the importance of clinical teaching to the nursing students' total educational experience revealed a striking paradox. On the one hand, students' clinical experiences are hailed as "the heart" (McCabe, 1985, p.255) of their nursing education, while on the other, there is a paucity of research actually reflecting students' own views about their practicum experiences. Contemporary clinical teaching research in nursing education is dominated by faculty dialogue.

Fundamentally, studies of clinical teaching done in nursing education have predominantly been descriptive, generally surveying students and faculty for their opinion of characteristics of effective teachers. Using a quantitative approach, Morgan and Knox (1987), Nehring (1990), and Sieh and Bell (1994) measured effective instructor characteristics using the Nursing Clinical Teacher Effectiveness Inventory (NCTEI). In these studies, students and faculty perceptions differed markedly. The only general similarity was that both students and teachers perceived that being a good role model was the highest rated characteristic for the best teachers and the lowest rated characteristic for the worst teachers.

Similarly, Brown (1981) and Bergman and Gaitskill (1990) used the Clinical Teacher Characteristics Instrument (CTCI) to measure student and faculty perceptions of effective

teacher characteristics. Despite being a decade apart, again student and faculty responses to this instrument differed. In 1990, faculty ranked relationships with students as more important than the faculty had a decade before, yet in both studies, students were more concerned with communication-related attributes than were faculty.

Additional tools to describe teaching actions have recently been developed. For example, Theis (1988) developed a structured, scaled, free response instrument to identify the types and frequency of unethical teaching behaviors that nursing students encounter and the degree to which students find these behaviors problematic. Morgan and Warbinek's (1994) work shadowing twelve clinical instructors resulted in the production of the Observations of Nursing Teachers in Clinical Settings (ONTICS) instrument to measure desirable and undesirable clinical teaching behaviors. Catalano (1994) created the Status and Promotion of Professional Nursing Practice Questionnaire (SPPNPQ) to determine the extent of instructors' use of empowering activities. Another questionnaire, devised by Clifford (1992), gathers base line data to explore teachers' views about their role.

Significantly, in her comprehensive quantitative study, Krichbaum (1994) related students' achievement of learning outcomes to the measurement of teaching behaviors. Directing two different questionnaires to students, and another two to faculty, she concluded:

> Empirical evidence from this study points to the need for further investigation of teacher behaviors that relate to different types of learning outcomes ... **perhaps what we need is to learn to ask better questions and to talk with students in more meaningful ways about their learning** (emphasis mine). (p.314)

An overall trend to study clinical teaching exclusively from the instructor's perspective also persists in current qualitative as well as quantitative nursing education research. Crotty (1993), de Sales Ferguson (1996), Owen (1993) and Forrest, Brown and Pollock (1996) all interviewed instructors to explore the nature of the clinical teaching role. Crotty (1993) in her Delphi study of 201 nurse educators from 25 colleges in the United Kingdom found that limited ongoing professional development was offered to clinical nurse educators. De Sales Ferguson (1996) echoed this finding that limited preparation or ongoing support was available to clinical instructors in her phenomenological study of four Australian clinical educators. Owen (1993) in her action research on a British psychiatric unit found that teachers had difficulty maintaining the research, teaching, and change catalyst demands of their role. Forrest, Brown and Pollock (1996) in Scotland, through interviewing and focus group conversations, found that while the role lacked clarity, clear criteria emerged which stipulated that clinical teachers were expected to assure the quality of the learning environment.

In their comment articles discussing the nature of the clinical teaching role from the perspective of the instructor, both Lee (1996) and Myrick (1991) emphasized the complexities inherent within the role of clinical educator. Lee (1996) from Hong Kong, used a literature review to summarize how the role of the clinical nurse teacher "appears to be implicit and 'hidden', resulting in a wide difference in interpretation . . . of that role" (p.1127). Commenting on the multidimensional role expected of Canadian nurse educators, Myrick (1991) indicated that expectations within the role include demands that the nurse educator teach in the classroom, instruct and facilitate in the clinical setting, publish on a

prolific basis, do clinical research, participate in and chair numerous committees, act as student advisor, and demonstrate involvement in the community-at-large, as well as possessing the ability to be on the leading edge of nursing knowledge.

On different hospital units, other qualitative studies also revealed that student and staff perceptions of clinical teachers may differ from the way in which teachers' perceive their own actions. In an employers' evaluation of clinical instructor's performance during direct client care and in small group conferences, Wellard and Rolls (1995) described 40 Australian instructors and the kinds of instructional design activities they implemented. Findings indicated that "educators relied heavily on their clinical skills and used a limited range of teaching strategies" (p.737). In the United States, Morgan (1991) explored how nine clinical faculty members said they implemented teaching activities. Morgan (1991) discovered that while faculty noted role modeling as a teaching activity the greatest number of times, they actually implemented it less frequently. In South Africa, Uys (1992) explored the focus of 26 clinical teachers' interactions with their students during unit visits and "found that students interpret the clinical visits of tutors as (being) aimed at evaluation even when the educators themselves saw themselves as having taught [sic]" (p.23). Finally, Paterson (1994a) provided an in-depth look at six Canadian clinical teachers' values and knowledge claims and highlighted the need to explore the possible consequences of clinical teachers' (particularly novices) value and knowledge claims. Paterson (1994a) called for assistance for faculty to "recognize the intended and unintended consequences of their perspectives on student learning" (p.359).

Thus, viewing clinical teaching from a faculty perspective, research exists which offers ways to critically examine and to improve practice. A plethora of survey instruments are available from the authors mentioned above to measure the characteristics and behaviors of nurse educators. The multidimensional and isolated nature of the clinical faculty role has been explored and articulated. Nurse researchers have risked describing situations where their intentions did not translate into effective actions.

The View of Clinical Teaching From the Perspective of Students

A constructivist approach to understanding the nature of clinical teaching extends research beyond what teachers appear to be and do and asks those who are primarily involved, the students themselves, to elaborate about the process of teaching and learning in the clinical area. The following studies investigate students' ways of learning and reflect rich insights surrounding the themes of anxiety, evaluation, and unacknowledged learning which are made visible through this avenue of inquiry.

Anxiety

Student nurses, particularly novices, have consistently viewed the clinical area as a frightening learning environment. In their classic ethnographic study of the professional socialization of nursing students, Olesen and Whittaker (1968) in *The Silent Dialogue* found that the reality of nurse education was often far different than the prospective student's image of it. These

researchers found that students exhibited sleepless and anxiety-ridden nights before their first appearance on the ward because they were fearful of their initial encounter with a patient. Later, they were burdened with the sense of their own inadequacy. Wong (1978) used a critical incident technique and compared the perceptions of eight first year students with those of six second year students. Wong (1978) found that students in their first year were anxious and particularly sensitive to how the teacher made them feel, whereas students in their second year were more concerned with the teachers' competency in teaching. Windsor (1987) categorized data from taped, transcribed interviews with nine students into three stages of student development. The first stage was permeated with anxiety and obsession with the rules of task performance. The second stage was a difficult transition period where students struggled with identifying the roles of nurses. During the final stage, the students became more comfortable with performing nursing tasks and became interested in expanding their role and becoming more independent. Kleehammer, Hart and Fogel Keck (1990) analyzed the content of situations that both junior and senior students felt were anxiety-producing in the clinical area. They concluded once again that initial clinical experiences on a unit and the fear of making mistakes were anxiety-provoking for students, and that juniors were significantly higher in their expression of anxiety than seniors.

Evaluation

Research examining clinical teaching from the student's frame of reference reveals important considerations surrounding the concept of evaluation. In their social psychology class, 28

second year nursing students at the Hebrew University of Jerusalem were asked to write about an encounter which they found stressful and which involved themselves and a person of higher status (Kushnir, 1986). Twenty out of the twenty eight referred to encounters with their instructors. Analyzing these encounters from a social facilitation and stress theory conceptual framework, Kushnir, a social psychologist, concluded that the aim of teaching is to reduce errors, especially in critical tasks involving people's lives. Yet, much of the learning in clinical nursing is carried out in the presence of instructors. According to Kushnir (1986), "in theory, the presence of significant others during learning increases the error rate due to fear of failure or of embarrassment" (p.19). Kushnir (1986) suggested that a possible solution to this problem is that "instructors should emphasize less [sic] their evaluative role (thus reducing evaluation apprehension and anxiety), and help create a more supportive learning atmosphere in which errors are treated as opportunities for learning rather than as occasions for criticism and punishment" (p.19).

Viewing the concept of evaluation through the students' eyes is further illustrated in the research of Pagana (1988), Flagler, Loper-Powers, and Spritzer (1988), and Wilson (1994). Pagana (1988), again from a stress theory conceptual perspective, initially intended to describe aspects of an introductory medical surgical experience which were both challenging and threatening. However, her results suggested that "the qualitative data largely reflected the threatening, rather than the challenging, aspects of the experience" (p.418). Predominant themes of threat included personal inadequacy, fear of making errors, uncertainty, the clinical instructor, and fear of failure (Pagana, 1988). Flagler et al., (1988) explored instructional

behaviors which promoted student self-confidence in the maternity clinical area. Like Pagana (1988), their results, showed that it was instructional behaviors "other than evaluation" (p. 342) which promoted self-confidence, and led them to emphasize that "focusing on evaluation to the exclusion of other aspects of clinical teaching may impede students' professional development" (p.342). Finally, in an extensive ethnographic study of how students caring for acutely ill infants constructed meaning from the social context around them, Wilson (1994) also underscored the pervasive influence evaluation continues to have on students' views of their clinical learning. Wilson (1994) found that students identified six goals: to do no harm to a patient, to help patients, to integrate theory-based knowledge into clinical practice, to learn clinical practice skills, to look good as a student, and to look good as a nurse. Clearly, the question of whether clinical practice is a time for teaching or a time for evaluating remains an issue for student nurses.

Unacknowledged Learning

Learning in the clinical area may well occur, but go unacknowledged by instructors. Bewley (1995), Diekelmann (1993), and Davies (1993) looked beyond what students were required to know for the purposes of instructional evaluation and explored the meaning of the experience from the students' point of view. Bewley (1995), from a phenomenological perspective, used transcribed interviews to explore both student midwives' and practicing midwives' experiences of clinical teaching. Her findings suggested that clinical teaching was perceived as a didactic, teacher-led activity which occurred in the clinical area but away from

women and their babies. "Other significant learning in the clinical area arises almost by accident as students go about their work. This learning is viewed negatively, and not always capitalized upon" (Bewley, 1995, p.129).

Diekelmann (1993) used Heideggerian phenomenology as a philosophical background and explored the day-to-day lives of both students and teachers. She focused on how technology dominates many clinical settings and how nursing education has "moved from hospitals to almost every major university in the last 25 years . . . utilizing predominantly behavioral approaches" (Diekelmann, 1993, p.245). In unstructured 90 minute interviews, she transcribed responses to the question: "Tell me a story about a time, one you'll never forget, that stands out for you because it taught you what it means to be a student or teacher in nursing" (p.246). A central theme which emerged from Diekelmann's (1993) analysis of everyday life in the clinical area for both students and teachers was that views of "successful learning--learning as cognitive gain, have come to dominate nursing education" (p.246). Diekelmann (1993) suggested that this unidimensional view of what constituted 'successful' learning in the clinical area evolved from a "legacy of behavioral pedagogy . . . in concert with [a] technological epoch . . . (and urged clinical educations to) explore alternative approaches" (p. 246).

Davies (1993), using a grounded theory approach, questioned whether the observation of clinical role models led to knowledge discovery. Through coding, memo-writing, and concept mapping, Davies (1993) uncovered how clinical role modeling relates to the artistic

rather than the scientific aspect of nursing knowledge. The nature of the nursing knowledge surrounding their new role, discovered by her students, clearly broadened in scope as her research progressed.

The research described above was constructivist in nature and geared to listening to students' concerns. Students raised issues of feeling anxious, being overwhelmed by evaluation, and having important learning go unacknowledged when they were invited to share their perceptions. Beck (1991) analyzed 47 students' descriptions of caring student-faculty experiences and concluded that "attentive listening to what the student says, or in some cases, does not say, makes students feel they are being cared for" (p.22). While studies which approach clinical teaching from the students' point of view, such as those described above, are limited, within the psychiatric area the deficit is even more pronounced.

Research in the Psychiatric Mental Health Clinical Area

As mentioned previously, a critical disinterest in the psychiatric clinical area currently exists at the undergraduate, graduate, and employment level (Arnswald, 1987; Perese, 1996). Davidhizar and McBride (1985) questioned 191 students in seven courses about their feelings of success or failure in the clinical area. While these students "generally felt successful both in their nursing care and in mastery of theory, the lowest feelings of success were indicated in the Psychiatric and Community Mental Health Nursing course" (p.288). Melia (1982), in an early qualitative study exploring 40 student nurses' constructions of their nursing world

concluded that for these students, 'real nursing' was technical work, and 'not real nursing' was 'just basic care'. Given the paucity of current nursing education literature addressing teaching and learning in the psychiatric clinical area, the questions of whether students continue to feel unsuccessful and prefer more technical areas remain unanswered.

Perese (1996) recently queried 38 baccalaureate students about the positive, negative, and potentially helpful factors which they experienced in their psychiatric mental health practicums. Perese (1996) found that positive factors included staff's professionalism and enthusiasm, acceptance of students, diversity of learning opportunities, and direct involvement with patients. Negative factors generally related to nursing staff performance. Potentially helpful factors were those promoting goodness of fit between program expectations for students, characteristics of the clinical setting, and modeling of psychiatric nursing.

Previous research offers clinical psychiatric mental health educators little guidance in resolving the current crisis of disinterest within the field. Previous studies centered on measuring students' attitudes towards psychiatric patients. For example, Bairan & Farnsworth (1989) measured the effectiveness of their own clinical teaching by using the Opinions About Mental Illness (OMI) scale with 185 students. The findings were similar to five previous investigations using the OMI (Creech, 1977; Gelfand & Ulman, 1961; Lewis & Cleveland, 1966; Morris, 1964; Smith, 1969) in that psychiatric courses reduced attitudes which stigmatized the mentally ill. Again however, the pre- and post-test format measured only what was of interest to the course instructors and did not invite any personal constructions

of meaning from students' points of view. In the 1980's, Schoffstall (1981), Krikorian and Pavlanka (1984), and Yonge and Hurtig (1987) invited students to discuss their perceptions of their psychiatric clinical experiences through open-ended questionnaires. Their findings revealed that at that time, when the role of psychiatric nursing revolved around Maxwell Jones' (1968) therapeutic community milieu, students generally entered their practicums with trepidation, but emerged with a sense of recognition that the experience had provided an opportunity to develop both personally and professionally. Schoffstall (1981) stated that students were initially concerned about their own ability to cope and contribute, physical danger or fear, being similar to psychiatric clients, psychiatric clients being stereotyped as 'different', and the experience being emotionally painful. Krikoran and Pavlanka (1984) found that students' "overwhelmingly identified clinical experience and self-awareness as the primary change-producing factors, and lectures / readings / assignments, teachers and peers as secondary" (p.124). Yonge and Hurtig's (1987) findings differed slightly in that the teacher was identified as the most influential change agent, with patients rated second. However, while students may continue to experience the kinds of concerns Schloffstall (1981) identified, educators may no longer presume that today's hospital psychiatric unit continues to stimulate positive change-producing experiences for students. Slimmer, Wendt, and Martinkus (1990) found that different clinical sites did not account for any significant variance in students' negative attitudes towards psychiatric nursing. Insights and possibilities for improving the image and desirability of the psychiatric mental health clinical area remain elusive.

In summary, while a paucity of published research addressing clinical teaching in general

exists, specific contributions have been initiated, but from the perspective of instructor knowledge more than student knowledge. The psychiatric mental health area, however, is profoundly under-represented in the nursing education literature. In order to respond pro-actively to the sweeping changes in hospital environments, researchers must consider how students themselves make sense of their practicums. A constructivist view of research, based on participants' deep and active involvement in the construction of knowledge is particularly congruent with the collaborative egalitarian process of learning which nurse educators called for in the curriculum revolution of the 1980's. Expanding nursing education's world view to incorporate a constructivist perspective may generate more meaningful pedagogical practices than revolutionary rhetoric alone was able to do. Kelly's extension of a constructivist world view to his personal construct theory, as explained in Chapter One, provides the techniques with which to do so. In Section Two of this chapter, I illustrate applications of the approach within nursing literature.

SECTION TWO: PERSONAL CONSTRUCT THEORY

Although personal construct theory and its associated methodology, repertory grid technique, is grounded in the clinical arena, there have been surprisingly few research studies using the approach in the field of nursing. However, one psychiatric nurse clinician (Pollock, 1986, 1988, 1989) and 12 educators or groups of educators involved with student nurses, have reported their research applications of the theory in the nursing literature (Bell, 1990; Burnard & Morrison, 1989; Costigan, 1985; Costigan, Humphrey & Murphy, 1987; Davis,

1985; Diamond & Thompson, 1985; Franks, Watts, & Fabricus, 1994; Heyman, Shaw, & Harding, 1983; Morrison, 1990, 1991; Rawlinson, 1995; White, 1996; Wilkinson, 1982).

The reports reflected a broad variety of practice settings, participants, and insights. However, all of the investigators described the approach with enthusiasm and found that it fit with their research interests. Promoting personal construct psychology as a theoretical and methodological framework for nursing research, Costigan (1995) applauded its' "potential for a rigorous, humanistic approach" (p.17). As the following discussion illustrates, the approach was effective in framing research with community psychiatric nurses, nursing administrators, nurses and social workers, novice nurses and nursing students in both post-basic and basic educational settings.

Community Psychiatric Nurses

Psychiatric nurse clinician Linda Pollock (1986, 1988, 1989) used personal construct theory and repertory grid techniques to describe and compare perceptions about the work of community psychiatric nurses in two separate rural psychiatric hospitals near Edinburgh. In an extensive two-year project, she sampled 18 community psychiatric nurses and, for each of these nurses, seven patients and their families. She described what the nurses did, and what the patients and their families thought of the services that the nurses provided. Pollock completed a pilot study with colleagues to elicit elements which described different types of patients. She elicited participants' constructs by triadic comparison, taped and transcribed her

structured, laddered interviews, and then categorized her findings. She also analyzed a one-to-six rating scale grid with Ingrid computer software and incorporated a questionnaire to measure outcomes of patient care. She found the repertory grid technique:

> of value to psychiatric nurses, at the therapeutic level (where the bread and butter work is assessment and treatment by interview). It is also of value to psychiatric nurses both clinically and as a means of making their work research based and open to scientific manipulation. (Pollock, 1986, p.439)

Pollock's (1988) findings highlighted how these community psychiatric nurses continually sought to legitimize their work and how they juggled resources.

Nursing Administrators

Nursing lecturer Paul Morrison (1989, 1990, 1991), at the University of Wales School of Nursing Studies in Cardiff, explored perceptions about caring with 25 charge nurses who occupied leadership roles within their workplaces. Eight elements were used, some of which contrasted by being uncaring. Eight bipolar constructs were elicited and respondents entered checkmarks between the construct poles. Later, numerical values from one to seven were assigned by the researcher and measured with simple difference scores. From this structural analysis, Morrison (1989) concluded that few constructs related to physical aspects of care, that all informants perceived shortfalls in their own performance as carers, and that "a most interesting finding that emerged almost by accident . . . was the personal cost of caring" (Morrison, 1989, p. 424). In addition, Morrison devised a method of content analysis where

200 constructs on index cards were sorted and categorized. This content analysis revealed that personal qualities occupied the main (39%) category of constructs. Morrison's (1989) findings are intriguing in that his research process provided an important opportunity for the nursing leaders in his study to discuss issues which were of concern to them and one which might not otherwise have been available.

Nurses and Social Workers

John Rawlinson (1991, 1995), a Lecturer at the University of Wales School of Nursing Studies was supervised by Bryn Davis and Paul Morrison during his graduate study. In his Master of Nursing thesis, he looked for similarities and differences among the role construct systems of eight psychiatric nurses, eight general nurses, and eight mental health social workers. His 12 supplied elements elicited 416 (triadic) constructs from the 24 participants. Twenty identical sorts were undertaken for each subject. Rating was used to score each element for each construct. He used Bell's G pack computer and content analysis to refine categories of content. Significantly, he found "more variation within groups than among them" (Rawlinson, 1995, p. 338). However, he clearly came to know more about how each of his subjects perceived their roles within mental health. He cautioned fellow researchers to recognize the importance of discovering the personal meanings held by individuals as opposed to seeking universal meaning. He advised against using a personal construct framework to generalize findings or to draw conclusions about outcomes, program effectiveness, or group roles.

Novice Nurses

Alan White, Senior Lecturer in Nursing at Leeds University in England, created a theoretical framework from a repertory grid analysis of six novice nurses in their first year of hospital employment after graduation. As he was interested in the feelings neophyte nurses have towards clinical practice, he used a triadic card sort to elicit and then cluster 66 bipolar construct pairs from supplied elements. Elements in his study were actual clinical situations the new nurses would be expected to face. Participants rated their bipolar constructs against all the elements or situations on a seven-point scale to form the repertory grid. The grids were analyzed with the Grid Analysis for Beginners (GAB) computer software, clustered for themes and the findings were developed into collaborative case studies. Together, the researcher and the research participants discussed the case studies and the theoretical framework which emerged. White (1996) suggested that novice nurses experienced feelings related to connectedness, job satisfaction, effectiveness, ability, threat to self and pressure of work. Emphasizing the pressure of working on contemporary hospital units, White (1996) noted that novice nurses "are quite fragile and the difficult situations tend to knock them quite badly" (p.149). White's (1996) work sheds considerable light on the experience of nursing on hospital units today. Calling for educators to prepare students for the transition from student to practitioner, he pointed out that: "The hospital setting (in 1996) appears to require a bureaucratic nurse who is able to function in an unquestioning manner and accept the stress of the workplace as a normal and therefore acceptable scenario" (p.149).

Nursing Students

Post-basic Programs

Philip Burnard at the University of Wales School of Nursing Studies worked with Paul Morrison (Burnard & Morrison, 1989) to explore 21 postgraduate students' perceptions of what constitutes an interpersonally skilled person. Using six elements, eight bipolar constructs were elicited and ranked from one to five. Respondents rated themselves against an ideal image that they had constructed. Structural analysis of the resulting matrix revealed discrepancies between self and ideal self elements. The nurses identified themselves as deficient in many of the qualities that they elicited. As in Morrison's (1989, 1990, 1991) study, the content of the 168 constructs was sorted and categorized on index cards. This content analysis, checked by colleagues and confirmed by respondents, again revealed that more than half (57%) of the constructs fell into the category of personal qualities. The researchers, who were both involved in the preparation of learner nurses [sic] for psychiatry and general nursing, found the process of identifying "what an interpersonally competent person 'looks like' . . . (useful in understanding) . . . how to teach such skills" (Burnard & Morrison, 1989, p. 384).

In another study, in Melbourne, nursing lecturer Jacqueline Costigan and home care nurses Joan Humphrey and Clare Murphy (1987) explored seven post RN community health students' constructions of people who had attempted suicide. Repgrids representing both

elicited (triadic) and supplied constructs were subjected to factor analysis and multidimensional scaling with Bell's G pack computer programme. A questionnaire, containing items related to experience and demographic data, was also incorporated. The findings reflected that all respondents held pejorative attitudes, in varying degrees, toward individuals who attempt suicide. Costigan et al. (1987) linked their findings to a literature review of how responses of rejection and hostility can prompt further suicidal behavior. It was their intention to "alert respondents and readers to the importance of an awareness of their personal constructions" (p.40).

A research project by educational psychologist Patrick Diamond and nursing educator Maureen Thompson (1985), in Brisbane, assessed how nine registered midwives' perceptions of themselves as midwives changed and evolved over a four-week refresher course. A shortened, modified group version of repgrids with both supplied and elicited constructs was analyzed with Shaw's Multivariate Focus and Sociogrid computer programmes. Instead of being fed ready-made facts and concepts, students were able to compare the group's image of midwifery with their own and those presented in the course objectives. In this situation, knowledge was construed as a shared endeavor involving both the learner and the educator.

Basic Programs

Professor Bryn Davis (1985) from the University of Nursing Studies in Cardiff Wales described how 21 student nurses coped, or did not cope, with various situational problems

that they identified. She explored how these students construed their own dependencies and their relationships with the resource people who were available to help them. Potential resource people such as tutors or ward sisters were the elicited elements. The elicited constructs were the problems of death, old people, unsocial hours, people in pain, acquiring knowledge, difficult patients, fear of inflicting pain, battered babies, bedpans, being in charge, discipline, and fatigue. Graphing the elements or resource people on the top, and the problem situations down the left side, the repertory grid technique was adapted to a situational grid or 'sitsgrid' and analyzed with the INGRID computer program. The study, a part of the author's PhD thesis, was conducted over a nine-month period and also incorporated two repertory grids. The sitsgrids revealed striking differences in students' dependency upon others. For example, one student graph had check marks for different resource people for each of the situational problems. However, another student simply had one line of checks which revealed how she viewed the ward sister as her only resource. Davis (1985) emphasized that "if the application of repgrids or sitsgrids is used to type or categorize those who complete them, then the essence of the Theory of Personal Constructs would be lost" (p. 331). Rather, she called for the use of grids as a way to reveal dependencies and to guide participants towards scientifically manipulating their available resources.

Nursing instructor Patricia Bell, from the University of Wollongong, was supervised during her PhD dissertation by psychology professor Linda Viney who was mentioned on page 18 of this thesis. Over a three-year period, Bell (1990) explored the transitions women experienced throughout the process of becoming nurses. She identified differences of

construct invalidation between university student nurses who were older and had been hospital employees and those who were younger students. Of the participants, 72 were in their late adolescence and 72 were adults. Five interviews with each of the participants yielded 626 constructs. When students regrouped prior to clinical placements, researchers conducted interviews which included a five-minute period of open verbalization. The interviews and verbalizations were analyzed with 14 scales and sub scales devised mainly by Linda Viney. The Statistical Programme for the Social Sciences (SPSS) computer software was also used in the analysis. Bell's (1990) findings revealed higher than normal levels of construct invalidation in the form of anxiety and depression for all the student nurses. In addition, she concluded that the older women experienced significantly higher levels of construct invalidation than the younger women. She recommended that people experiencing transition might be assisted with counseling directed to loosening tight constructs.

Psychologists Vicky Franks, Mary Watts, and Julia Fabricus (1994) at North London College of Health Studies studied how nine undergraduate nursing students in their first and second clinical experiences construed small group instruction and reflection as a means of teaching communication skills. The group met once weekly for six months. Triadic elicitation with the same eight elements produced 19 constructs each with its bipolar opposite. Two repgrids were developed. One examined processes and change in intrapersonal construing and the other examined interpersonal processes and construing about patients. The Grid Analysis for Beginners (GAB) computer programme analyzed the two grids and calculated the constructs which were considered the most important. The hypothesis which emerged was that "group

work appears to be dependent on the provision of a balance between structure and space for personal reflection" (Franks, Watts, & Fabricus 1994, p. 1168). Students in the study experienced a loss of self-identity and expressed a need for guidance and structure as they shared their responses to learning about nursing and the psychological defense mechanisms which they employed during the process. Franks et al. (1994) concluded that "this project supports the contention that in order to be truly effective those who come in contact with the emotional needs of patients need some support and reflection for themselves" (p. 1169).

Social psychology lecturer R. Heyman, sociology lecturer M. Shaw and research assistant J. Harding (1983) from Newcastle-upon-Tyne in rural England, conducted a longitudinal investigation of changes in perceptions about professional role with 64 nursing trainees [sic] in two hospitals. They explored how student nurses from a rural hospital-based program perceived the process of socialization into the role of nurse. Interviews took place on the students' first day of training [sic] and again at four and 18 months. Investigators used 15 elements to elicit up to 10 constructs during each of the three interviews. Each element was rated on a five- point scale and individual subjects' distance scores were determined with the SPSS Aggregate computer programme. These researchers found that students became progressively more identified with high-tech medical roles during socialization and progressively less identified with low-status non-medical alternatives. They stressed that learning involves more than just the formal knowledge encoded in the curriculum and endorsed the use of personal constructs within nursing.

Finally, clinical psychologist D. Wilkinson's (1982) study in Cumbria, another rural area in England, provides disturbing insights. He compared the before and after personal constructions of six students assigned to a psychiatric clinical area with those assigned to a geriatric clinical area. He supplied constructs in the form of six matched pairs of medical or psychiatric case studies so the data could be collated in a standard form for intergroup comparisons. The rating measure consisted of two pages with 10 items per page, each arranged as an 11-point bipolar scale, ranging from the positive pole of a construct on one end to the negative pole of the same construct at the other end. Students rated the constructs with a cross and the grids were analyzed with the Grid Analysis for Beginners (GAB) computer program. The findings were alarming in that, after a nine-week practicum, the students in the study had not altered their stereotypical constructions of psychiatric patients as "frightening, less likely to cooperate, more likely to be violent and dangerous and to need strict control" (p.239). He concluded that "psychiatric training [sic] did not eliminate students' distrust of psychiatric patients" (p.239). He emphasized the importance of attending to issues of fear and prejudice during psychiatric nursing placements. This study was conducted over 15 years ago, in an isolated rural hospital-based school of nursing, and the constructs were supplied rather than elicited. However, a common thread woven throughout all of the above studies is that the personal construct framework clearly elucidated the meaning of the learning experience from the students' perspectives.

Summary

A "gap" in our understanding of clinical teaching in nursing education exists. As Section One of this chapter indicated, clinical teaching, particularly in the psychiatric mental health area, is not adequately represented in nursing education literature. Questionnaires are available to mine quantitative data about nursing instructors' characteristics (the NCTEI and the CTCI), behaviors (the ONTICS), use of empowering activities (the SPPNPQ), and views about their role (Clifford, 1992). As well, instruments like the OMI are available to measure whether students' attitudes towards the mentally ill have changed. Existing qualitative studies reflect nursing instructors' ideas about their role, their values, and their knowledge claims. Ways of evaluating instructors' performance during small group conferences, the kinds of instructional designs they use, and what they focus on during unit interactions with students have all been documented. However, to date, few investigations actually explored the nature of the nursing knowledge which students themselves acquired during their learning experiences.

Research guided by personal construct theory and repertory grid techniques, as demonstrated in Section Two by 13 investigations of nurses and nursing students, offers important insights. In the practice area, the framework provided a forum for community psychiatric nurses and their patients' and families to collaborate on nursing care and for the nurses to voice their concerns about juggling resources and legitimizing their work (Pollock, 1986, 1988, 1989). With nurse administrators, the approach facilitated an opportunity to discuss ideal performance as well as perceived shortfalls in self-performance (Burnard & Morrison, 1989;

Morrison, 1989, 1990, 1991). With psychiatric nurses, general nurses, and mental health social workers, Kelly's (1955) theory and methods offered a way for each of these professional groups, as individuals, to discuss their perceptions of their roles (Rawlinson, 1991, 1995). With novice nurses, Kellian inspired techniques shed light on the feelings of pressure associated with the transition from the role of student to that of new graduate nurse (White, 1996). In nursing education, personal construct theory and repertory grid techniques served as educational tools as well as research methodology. The approach was useful for learners to compare their own conceptualizations with fellow students' ideas and the course objectives (Diamond & Thompson, 1985). The thinking was effective in stimulating personal awareness of pejorative attitudes towards people who attempt suicide (Costigan, 1987) and ways of using available resource people in the clinical laboratory (Davis, 1985). The approach further alerts nurse educators to the possibilities of emerging anxiety and depression (Bell, 1990), loss of self-identity, the need for opportunities to reflect and share personal defenses (Franks et al., 1994), and inclinations to identify with high-tech medical roles (Heyman et al., 1983) in their students. Finally, the research framework does not necessarily dictate self-congratulatory findings. Wilkinson's (1982) investigation of student nurses enroled in their psychiatric rotation revealed that participants' stereotypical constructions of psychiatric patients as frightening and dangerous people were not altered as a result of a nursing course. Of note is the fact that at this point in time, no Canadian contributions exist in the literature linking personal construct theory and repertory grid techniques to the field of nursing.

CHAPTER THREE

RESEARCH DESIGN AND PROCEDURES

Introduction

The design and procedures framing this naturalistic study were geared towards developing six collaborative case study reports. Each report is a snapshot picture of students' experiences as they completed a clinical practicum on a psychiatric hospital unit. The case studies reflect the human faces behind the shifting paradigms in both nursing education and the hospital institution as described in Section One of the preceding chapter.

In order to ensure that the final case study reports are contextually grounded, jointly constructed and authentic, the research methodology, data analysis and ethical considerations are explained in detail in this chapter. I begin by describing Kelly's (1955) repertory grid technique — the cornerstone of the investigation. Next, I outline a pilot study I implemented previously and which indicated that the present project was feasible and worthwhile. Then I discuss my sample selection for the study. These explanations establish a preliminary understanding of the research methodology, data analysis and ethical considerations of the study.

The research methodology of the study centered on my interviews and correspondence with students. In this section, I clarify the structure of my personal and written communication

with students. I introduce the explanation of my data analysis procedures by defining my naturalistic case study design and then I emphasize the rigor of my work by elaborating on the procedures I implemented to enhance the authenticity and credibility of the work. At this point, I present the study with a diagram — the Vee Heuristic. From there, I detail the sources of data which I used and how I ordered and made sense of the wealth of information I collected. For each student report, I collected data from personal construct changes illustrated on before and after repertory grids, a questionnaire, and repeated interviews (one of which was audiotape recorded and transcribed). Throughout the process of collecting the data and organizing the information in relation to similarities and patterns, three or four consistent themes emerged for each student and I created files to record the process of delineating these themes. I used colored pens to index the categories of information which, to me, repeated in a patterned fashion and constituted themes. I displayed my thinking on concept maps, which I shared with the students and their comments confirmed that the themes were accurate. Following the creation and re-creation of the graphic concept maps in response to student feedback, I drafted the text of the case studies and shared the work with participants once again. In the section entitled: Constructing Collaborative Case Study Reports, I elaborate on this process of analyzing content and using concept maps as a tool to link the data which I collected to the final case reports and continuously exchanging the information with participants. In the final section of the chapter, I outline the ethical considerations of the study and I conclude with a summarizing diagram of the design and procedures implemented in the research.

The Repertory Grid Technique

The repertory grid technique has been compared to a view or window on the world which invites clients to describe the scenery (Davis, 1985). A variety of adaptations have evolved from Kelly's original reptest (Bannister, 1985), but the essence of the method is that "a grid is a way of getting individuals to tell you, in mathematical terms, the coherent picture that they have of . . . (whatever subject is under investigation)" (Bannister & Fransella, 1987). Describing the repertory grid as a conversational tool, Shaw (1980) stated, "not only can the grid map out an individual's personal space to assist him [sic] in looking at his [sic] own perceptual and conceptual styles, but it can also help to map out shared space and enable him [sic] to relate his [sic] individual perceptions to the styles of communication of others" (p. 15).

Repertory grid techniques are objective in that scientific systems of analysis do exist. However, they are not standardized, mechanically scored questionnaires which yield numerical scores on prescribed traits. They are subjective as forms of the grid permit participants to work with material drawn from their own experience and to comment on such material in their own personal terms. Yet, they do not allow free-ranging, projective responses and interpretations. Pope and Shaw (1981) asserted that grids potentially provide both the researcher and the participants with a means of explaining, monitoring, and reflecting on idiosyncratic (individual) and shared (common) frames of reference that evolve. Shaw (1980) explained that "the repertory grid exhibits a 'scientific' tool with which to structure

a conversation (and) has come to be known as 'a hard tool for soft psychologists'" (p.9).

Devising a repertory grid or repgrid is a unique way of guiding and documenting a conversation. The format should not be seen as a standardized test, but rather as a type of reflective, collaborative interview structure (Pollock, 1989). Hermans (1997) described the narrative aspect inherent within the process of constructing and reflecting upon repertory grids as a way of equalizing the playing field between researcher and participant, a way of building a bridge between the expertise of both and a way of valuing the multiplicity of stories which emerge. Discussions which evolve throughout the task do not objectify the participant and they are keenly sensitive to exception. Further, Hermans (1997) emphasized that change, growth and active self reflection is expected as grids are created and re-created. He asserted that the experience can stimulate powerful emotions. In this Dutch psychotherapist's words: "Sometimes we find a drop of tears on the matrix" (H. J. Hermans, personal communication, July 8, 1997).

The blueprint to develop a repertory grid involves three distinct stages. The first stage is construction of the grid (that is, creating both elements and personal constructs). The second stage is using the personal constructs to rate, rank, or dichotomize the elements. The third stage is analysis. The section which follows details these three stages.

Stage One: Construction of Grids

A repertory grid consists of a matrix with elements on the top and constructs down the side of a graph. The elements are relevant people, objects, activities, or concepts (Pollock, 1985) in the subject's experience. The constructs are personal bipolar descriptive dimensions which can be applied to each element. In one common form of the grid, and in this study, the elements are supplied by the investigator and the constructs are elicited from the subject.

Elements

Elements can either be supplied by the researcher or elicited with participants. Beail (1985) stresses two important points when selecting elements to be used in grids. First, the elements should be representative of the area to be investigated. For example, in this study, the area under investigation was mental health nursing activities in the psychiatric clinical area of a general hospital where second year student nurses are required to attend two days each week for a six-week practicum. Secondly, the elements should be within a particular range as constructs apply to only a limited number of people, events, or things. In this case, the range spans common, every day nursing activities. Students see staff nurses doing these activities and are expected to engage in these same activities themselves. Beail (1985) emphasized that some elements can be outside of one's existing construct system and therefore cannot be included in the grid. He underscores the importance of giving participants the opportunity to say that they cannot construe a particular element.

The elements in this study fit the above criteria, were supplied and were developed in collaboration with a psychiatric nurse colleague. The Element List is included as Appendix 1. Examples from the Element List include "contracting with a suicidal patient to be kept informed," and "denying a noncompliant anorexia nervosa patient's request to spend time together." The elements or nursing activities all have unique meanings. Eliciting nursing students' personal constructs, before and after their clinical practicums, provides an opportunity to listen credulously, and from another perspective, to determine just what kind of learning transformations, if any, are actually occurring during this period of clinical teaching. The elements are non evaluative and constitute the defining content or structure of the interview (Pollock, 1989).

Personal Constructs

Fransella (1997, July) described a personal construct as the "unit" (p.1) of Kelly's (1955) theory and explained that it is "a porthole through which we peer to make sense of events swirling around us" (p.1). She emphasized that a construct is not a concept or a rule. According to Fransella (1997, July), a construct has 10 main features. They are as follows: it is an abstraction, bipolar, linked to fellow constructs, used at different levels of awareness, the basis of anticipation and prediction and constructs are ways of controlling our world, inseparable from behavior, inseparable from feelings, form the basis of choice and they can be used effectively within counseling. Fransella summarized personal constructs:

> The ways in which we experience the world relate to the system of personal

> constructs we have created to make sense of that world. They are an integral part of the ways in which we behave and feel. Our personal constructs are the ways in which we experience our being. (Fransella, 1997, July, p.6)

Methods for eliciting constructs (Rawlinson, 1991) include dyadic, full, and triadic. Simple dyadic comparison of one element with another can be used, however, this method is likely to generate constructs which are idiosyncratic rather than generally applicable to other elements. On the other hand, full context elicitation can be undertaken, in which all the elements are used at once and are sorted by the subject into groups. Most commonly used, however, is triadic elicitation which was used in this study.

In triadic elicitation, the participant is asked to look at three specified elements (a triad) at a time, and to say how two of the elements are alike in a way which distinguishes them from the third. The way in which the two are alike defines the emergent pole of the construct and the way in which the other is different is the contrast, or implicit pole (Rawlinson, 1991).

A more concrete explanation of eliciting personal constructs, using the elements of hockey, baseball, and football, would be simply to ask one individual: "Which two do you think are the same and different from the third?". A response might be: "Hockey and baseball are the same because they both use sticks as equipment. Football is different because players don't have anything in their hands." Thus, the two constructs elicited are "using sticks as equipment" and "not having anything in their hands." In this example, the emergent pole (or

the two constructs which were categorized as the same) is "using sticks as equipment." The implicit pole (or the construct which was different or contrasting) is "not having anything in their hands." Other sports (or elements) could subsequently be discussed in relation to whether they use sticks as equipment or do not have anything in their hands.

Asking the same sport-related question to a second individual would elicit entirely different constructs. For example: "Football and hockey are the same because they're more violent; baseball seems calmer." In this example, "violent" is the emergent pole and "calmer" is the implicit pole. Thus, by using individuals' own words to record collaboratively how they organize and make sense of information in their world, those same words can be charted and then revisited after a learning experience has occurred.

Stage Two: Dichotomizing, Rating, or Ranking the Elements

Once two columns of constructs, with the emergent pole on the left and the implicit pole on the right have been formed, elements are considered individually in relation to each of these pairs of personal constructs. When Kelly first developed the method, this was completed by a simple binary or dichotomous consideration of whether a construct pole does or does not apply (i.e., with check marks and crosses, or zero and 1) (Rawlinson, 1991). Most grids now either rank or rate. Rawlinson (1991) summarized that ranking involves placing all the elements in the order in which the construct applies to them. Where rating is used, a three- (trichotomous), five- (as in this study), or seven-point scale is used to indicate the degree to

which the relevant construct applies to each element. With some scales, no numbers are apparent to the participants, but numerical values are added by the researcher later. The rating scales, between the columns of constructs, form the rows of the grids. In this study, all numbers were apparent to participants.

Stage Three: Analysis

It is important to acknowledge that many forms of complex mathematical and computer analysis of Kelly's (1955/1991) original reptest now exist. Rawlinson (1991) identified 38 different computer programs. It is beyond the scope of this thesis to enter into a discussion of how correlations within the matrix can be analyzed statistically. In this case study research, the pre- and post-course repertory grids were treated as educational tools to stimulate discussion between the researcher and participants. As in Shapiro's (1991) work with student teachers, the personal constructs and resulting grids in this study were used as "collaborative tools for reflection" (Shapiro, 1991, p. 123). Because the constructs and grids were developed from participants own terms or language, it was the process of discussing and reflecting upon changes in the grids and then searching for themes within the narrative which constituted the analysis.

Another way of looking at the repertory grid data is to look at the constructs themselves. The type of constructs elicited can be looked at in terms of their content and a content analysis can be undertaken. Pollock (1989), Morrison (1989), and Burnard and Morrison (1989)

separated the constructs they elicited into categories and then counted the number and frequency of occurrence of constructs in each category in their analysis.

Simple difference scores can also be worked out by hand. Commonly used is the difference in scores between self and ideal self. This is illustrated by Morrison's study (1990) examining nurses' perceptions of themselves as carers and Burnard & Morrison's (1989) investigation of nurses' perceptions of interpersonally skilled people. In the present study, modeled on Shapiro's (1987, 1991, 1994) work, differences between how students rated the element list of nurses' activities before the course and then again after the course was an important data source and the differences were used to stimulate discussion between the researcher and the participants.

The Pilot Study

I conducted a pilot study during the 1996 winter term at a local university nursing program (which operated conjointly with a community college) using a sample of three Registered Nursing students who were enroled in their psychiatric mental health rotation. No specific criterion for selection of the pilot subjects was stipulated and all three students who volunteered for the project were accepted. There were several purposes for the pilot study: They were:

1. to determine whether the research questions could be answered by the use of a repertory grid technique;

2. to test the appropriateness of the selection of elements;

3. to identify and overcome any problems which might be encountered with the procedure, such as recruiting and sustaining subjects; providing a distraction-free physical environment in which to conduct the interviews; and explaining the technique, interviewing style, and technical operation of audio equipment;

4. to determine whether the techniques and approaches would provide significant and useful information.

The three student nurses' personal constructs were elicited at the beginning of the second six-week practicum offered during the course. The students were interviewed as a group and expressed interest in hearing their peers' ways of categorizing the element list of nurses' activities. During the group interview, each student developed an individual repertory grid with two columns of constructs on either side. Before meeting with the students, I had cut the element list into strips and randomly placed the strips into an envelope. Each pair of constructs was elicited when students took turns pulling out three elements from the envelope and responded to my question: "Which two do you think are the same and different from the third?".

Once the students had formed the columns of their grid with the elicited personal constructs, they added the rows. As I read each of the nurses' activities on the elements list out loud, the students rated the activity from one to five on their own charts.

At the end of the practicum, I met with each student individually and audiotape recorded and transcribed the interviews. I had recopied each chart of students' personal constructs onto a second grid, but I did not include how each element had been rated. After we took a few minutes to discuss the rotation generally, each individual student and I repeated the rating procedure. Together, we looked at how the elements had been rated at the beginning of the course on the initial grid, and then how they had been rated at the end of the course on the second grid.

For the most part, the students' ratings on their grids reflected that their perceptions had not shifted, or had shifted only one or two increments. The first student grid was virtually the same at both the beginning and the end of the course. However, the process of suspending my own agenda of instruction and listening credulously to students' own explanations of their learning revealed intriguing insights about how novices view the world of clinical psychiatric nursing. This first student found it particularly valuable to discuss how she had not really understood many of the nursing activities she observed, and our time together provided a non evaluated opportunity for her to ask questions.

The second student initially categorized Element Five: "Contracting with a suicidal patient to be kept informed," in the middle (#3) of her personal constructions of "Formal (nurse-client)" and "Informal (same-level)." At the end of the course, however, she rated the activity very close (#5) to her category of Formal (nurse-client). She commented on how her thinking about what nurses do to help clients with suicidal ideation had changed. In her view, "it's not

just talking, there actually **is** a nursing action involved."

The third student's grid reflected a fairly dramatic shift in thinking. At the beginning of the course, she ranked Element Six: "Denying a noncompliant anorexia nervosa patient's request to spend time together" closest (#1) to her category of "Working with patients directly" as opposed to her category "Working with patients indirectly." At the end of the course, however, the numbers were completely reversed; she ranked the same nursing activity as a (#5), closest to "Working with patients indirectly." She explained that "working indirectly is working against the patient to do something for their benefit. I didn't really see how **serious** it was before."

As a result of the pilot study, the following three factors were identified for consideration:

1. Recruiting and sustaining subjects is problematic. During the first six-week practicum, I distributed 60 Letters of Introduction to a class in which I was not a lecturer, but no students responded. When a fellow nursing instructor explained my project to her clinical group of eight, three students from the group did volunteer. The students required reminding to attend the second interview, did not seem fully engaged in the project, and the data collected was insufficient to develop in-depth case study reports.

2. Physical space for interviews at both the college and hospital sites is limited. At the college, one office was allocated to all sessional instructors, and the room was needed for coats and personal belongings. The pilot study interviews were conducted

on the hospital unit during the day shift and coincided with students' lunch breaks or times they were not implementing patient care. Due to the acuity of the unit, our conversations were repeatedly interrupted by patients entering the room and requiring assistance, physicians requesting the room to interview patients privately, and loud noise from construction workers renovating the building.

3. Creating an atmosphere of fun and support with the students and emphasizing the potential within the research methodology to create an educational tool was not achieved. Students had difficulty seeing the elements (which I had typed and cut into strips) and one student suggested developing the element list into a deck of cards. The forms I supplied for students to write their grids on did not allow the numbers to be seen readily. A more "learning-centered grid" (Shaw, 1980) form would include larger squares for numbers. Although my voice was clear on the audio tapes, the students' voices were often inaudible. Taking more time to reflect on each of the pairs of constructs, how they had changed or stayed the same, and role modeling how to frame clear statements around the experiences would produce more animation and involvement.

Two observations which provided encouragement and support for the continuation of the research were made during the pilot study. One was the confirmation that, despite intentions to the contrary, clinical teaching can focus so extensively on measuring the knowledge students receive from the curriculum that the knowledge which they construct themselves is neglected. The other observation was the affirmation that, for these three students, the ten

selected elements were appropriate and that acknowledging and honoring their personal learning with a repertory grid was a valuable and positive experience.

After weighing the above factors, four decisions were reached with regard to the main study. First, to heighten the visibility of the project, an in-progress report of the investigation (Melrose & Shapiro, 1996) was published in *The Canadian Nurse*. Second, the study was extended to weekly interviews instead of a basic two in order to develop more in-depth case study reports. Third, Perese's (1996) questionnaire was incorporated into the study. Fourth, concept maps were used to confirm and synthesize data with students.

Sample Selection

As I did in the pilot study, I selected student volunteers from the second year nursing course I am involved in as a sessional lecturer. The first six students who volunteered were accepted and their reasons for participating are noted in the case study reports. The participants varied in age, gender and culture. Two of the students, Sandra and Heather, were adult students in their late twenties. Sandra was the only married student, Nathan was the only male participant and Simone was the only non-Caucasian student who represented a different culture. None of the students had children or were responsible for caring for dependents. All of the students except Casandra had completed several courses before enrolling in the nursing program and none of the students disclosed any academic difficulties at the time of the study.

The course integrated both mental health and medical surgical content. Over a 12-week period, students attended weekly three-hour lectures and two-hour tutorials which combined the two subjects. Concurrently, students spent six weeks in the medical surgical practice area and six weeks in the psychiatric practice area, with a break of one week in the middle. Therefore, within this curriculum, two groups of students each completed a six-week practicum of two eight-hour shifts on an inpatient psychiatric mental health unit. In this study, three of the six participants in the sample were drawn from the group of students assigned to psychiatric hospital units during January and February, and the remaining three participants in the sample were selected from the March through April group. Four of the students were assigned to a day shift rotation and two were assigned to an evening shift rotation. None of the participants were evaluated, or taught in any way, either in class or in the clinical area, by the researcher.

Research Methodology

The Interviews

I engaged in weekly in-depth interviews with the six second-year nursing student participants. Only the post-course interview was audiotape recorded and transcribed. In most cases, our conversations lasted at least one hour and on some occasions, the interviews were two hours long.

The first interview was scheduled as soon as possible after classes began and the process of constructing a pre-course repertory grid by eliciting six personal constructs from 10 elements or nurses' activities was initiated. As previously mentioned, the ten elements are included as Appendix 1.

To construct the first stage of the grid, participants randomly pulled out three of the element cards and answered the question: "Which two do you think are the same and different from the third?" On the Personal Constructs form, developed from Shapiro's (1991) work with student teachers and included as Appendix 2, the element numbers were entered in the left Code column. On the left side, the participants' own words describing what is the same about the two elements were entered as the emergent pole. On the corresponding right side, the participants' own words describing what is different about the third element was entered as the implicit pole. The form was labeled (A) and printed on green paper to distinguish this pr-course grid from the second grid, which was created when the course was over.

Once six descriptive words or phrases were personally constructed on opposite sides of the green Personal Constructs (A) form, participants created the second stage of the grid. Each element from the sheet of nurses' activities was reviewed in relation to the constructs and rated 1 2 3 4 5.

While this first interview was structured around constructing repertory grids and engaging students in the project, the remaining interviews were unstructured and took place weekly.

I joined five of the participants on their clinical units each week. The remaining student completed her practicum at an out of town site and while one interview with her occurred in her hospital unit, our weekly meetings were held after her lectures at her community college site.

These conversations with students provided an opportunity for me to repeatedly touch base with each of the participants, to maintain their engagement in the project and to discuss how the experience was affecting them. Students were invited to articulate how they would like to introduce themselves in the collaborative case study reports, to choose their own pseudonyms and to put forward any issues which they felt warranted attention. I urged them to ask me any questions about the course or the research process, and I made a point of getting back to them with any answers which I was not yet able to provide at the time of the interview. I often asked students questions like: "What was that like for you? Can you talk a bit more about that? What made that possible? How does that make you feel? What stands out for you?"

The students particularly liked my business cards, which I handed to them when they volunteered to participate in my research. On my third hospital unit visit with each student, I brought him or her a similar set of business cards and explained how I made them on my computer. This gesture was useful in maintaining student engagement in the study and it was an opportunity to discuss issues of personal boundaries within hospital psychiatric nursing. We talked about how it would be inappropriate to distribute the cards to inpatients, but we

also discussed situations where they could be very effectively used in outpatient psychiatric nursing. As a result of these discussions, I came to realize that the students, particularly those on the evening shift, were missing information about patient's experiences before they were admitted to hospital and what services were available to patients after discharge. Stake (1995) wrote that in addition to collecting and analyzing data, the role of the case study researcher includes being a teacher, an advocate, an evaluator, a biographer, and an interpreter. Throughout the interviews and correspondence process of this investigation, due consideration was given to these additional roles.

Because I joined students right in their clinical units, I was, to a certain extent, present and involved with the ward milieu. As well as listening and talking with each student individually, I was invited to clinical group conferences on several occasions. I also held group discussions with the first three participating students, who were assigned to the same shift on adjoining hospital units. Before each meeting with students, I telephoned ahead to make appointments with them, book an interview room and to alert their instructors that I would be on the unit. Attending to nursing unit protocol in this manner enhanced the professional dimension of the project and allowed me to role model the process of integrating research activities into everyday nursing practice.

The final post-course interview took place once the students completed their rotation and was somewhat longer. This interview was audiotape recorded and transcribed and conducted in a small interview room at the community college. Each student completed Perese's (1996)

questionnaire on positive, negative and helpful aspects of psychiatric practicums and finished his or her repertory grid at this time. Before meeting with the students, I copied their repertory grid — without the numbered ratings — onto a yellow copy of the personal constructs form. I labeled this yellow form Personal Constructs (B). During the interview, each element, or nurses' activity was reviewed once again in relation to the constructs and rated 1 2 3 4 5.

When all the elements were rated, I showed the students their green (A) pre-course grid form and we compared the two grids. As we looked at the grid together, we discussed the changes in students' ways of rating the elements which had occurred, or, in many cases, the changes which had not occurred. Students used pencils to mark horizontal arrows on their grids to illustrate where their ratings changed. I later employed a secretarial service to transcribe these hand printed grids with arrows emphasizing change and I include them in the case study reports in Chapter Four. As each student and I talked, I sketched preliminary concept maps and questions and comments evolved as students described the kind of knowledge they had acquired or rejected. It was an opportunity for students themselves to share their feelings about their ways of knowing and growing in their roles as novice nurses.

Thus, in this post-course interview, the personal constructs were revisited, reviewed, and reconsidered collaboratively. Any significant changes in student nurses' views of their original categories of nurses' activities were pointed out. Recognition for meaningful personal learning that may not otherwise be apparent was extended. Once the study was completed,

and all our six-month post course correspondence developing the final case study reports ended, I met with each of the students one last time to thank them in person for their participation and to provide closure to a project in which they had been so actively involved.

Member Checking by Correspondence

Once I had constructed written case study drafts and typed concept maps from my handwritten notes and sketches of data from the interviews, grids and questionnaires, I reviewed the drafts with my supervisor. To continue including the students' voices in the final reports, I mailed these drafts and maps to the students and included a stamped self-addressed envelope for them to return the reports to me. I posed questions in the margins of my writing and left spaces in areas where further information was needed.

I included the interview transcripts, grids and questionnaires in the packages I sent to the students. Using three or four different colored markers, I marked each of the students' comments on these pages of text to link the point to a corresponding section of their concept map diagram. This color coding demystified the process I used to examine the descriptions of learning which students shared with me and illustrated how I arrived at the patterns of meaning I incorporated into the final text of the case study reports. Themes emerged as, time and time again, the students and I saw how their individual ways of knowing actually formed unique and important patterns. I summarized the colored sections of the concept map into three or four main themes. These themes were labeled in bold typeface in the upper left hand

corner of the concept map and, in turn, most of these same themes were then used as headings in the text of the students' "stories."

While I spoke on the telephone to all of the students to clarify points, confirm address changes or prompt them to return their case reports, most of our post-course communication was written. At the time of the study, the Canadian postal service warned that a postal strike was imminent, so I also dropped off and picked up our correspondence at students' homes. Since our correspondence occurred six months after their course ended, the study offered ample time to reflect upon their psychiatric clinical learning both during and after the course. To maintain engagement, I chose to give the gift of a membership to the provincial professional association and a subscription to the association's newsletter at this six-month post-course correspondence interval as well.

Thus, the students had an opportunity to peruse and correct my writing and to become keenly involved in the analysis of the research data they generated. Together, we ensured that the case studies reported in Chapter Four are accurate. In case of disagreement, I was prepared to present both versions of the experience.

Data Analysis

A Naturalistic Case Study Design

The research is a naturalistic case study design. Information from repeated interviews, students' personal constructs, rating and plotting of those personal constructs on repertory grids, and questionnaire responses were used to create concept maps and, ultimately, case study reports. Arguing that inquiry is not and cannot be value free and that multiple realities exist, Lincoln and Guba (1985) explained that naturalistic investigation is based upon two important tenets: no manipulation and no a priori units of the outcome occur. This non-experimental, exploratory, descriptive, or illustrative work is grounded in a qualitative rather than quantitative paradigm. Merriam (1988) characterizes qualitative inquiry as inductive — focusing on process, understanding, and interpretation — rather than deductive and experimental.

Merriam (1988) defines a qualitative case study as an intensive, holistic description and analysis of a single entity, phenomenon, or social unit. In her view, case studies are particularistic in that they focus on a specific situation or phenomenon, they are descriptive, and they are heuristic and offer insights into the phenomenon under study. A desire to understand how parts work together to form a whole underpins qualitative research. Naturalistic inquiry observes, intuits, and senses what is occurring in a natural setting. The researcher is the primary instrument and the researcher responds and adapts to the context.

Commenting on the limited generalizability inherent in constructivist case study research, Stake (1995) notes that "a constructivist view encourages providing readers with good raw material for their own generalizing" (p.102). Thus, the present research, questioning what it's like for student nurses during their mental health clinical practicums, meets the above criteria for qualitative case study research.

The naturalistic research design is most usefully viewed as a starting point rather than as a final blueprint for action: a path toward achieving a goal that links the discovery of truth — the traditional objective of science, with the creation of meaning — the traditional goal of art (Eisner, 1981). The general design of case study research is best represented by a funnel. Good questions that organize qualitative studies are, at least in the beginning stages of a project, not too specific. From broad exploratory beginnings, they move to more directed data collection and analysis (Bogdan & Biklen, 1992). This investigation began with a broad inquiry into the way student nurses construe professional staff activities and became more narrow and specific as issues which impacted individual participants unfolded. The work fits with Yin's (1994) position that case studies need not take a long time, are the preferred strategy when **how** or **why** questions are being posed, suit investigators who have little control over events, and focus on a contemporary phenomenon within some real-life context.

Rigor: Procedures which Enhance the Authenticity and Credibility of the Work

Truth Value, Applicability, Consistency and Neutrality

As qualitative methods of inquiry have increasingly been endorsed as relevant for nursing education's focus and goals, the need for appropriate tests of rigor has been cited by nurse researchers (Beck, 1994; Hall & Stevens, 1991; Munhall, 1988; Paterson, 1994b; Sandelowski, 1986). Lincoln and Guba (1985) suggest the basic issue in assessing rigor is trustworthiness or "how a researcher can persuade his [sic] audience that the research findings are worthy of attention" (p.290). In this study, the research was guided by the framework suggested by Sandelowski (1986) based on the four factors relating to tests of rigor as discussed by Lincoln and Guba (1985). They were: **truth value, applicability, consistency, and neutrality.**

According to Sandelowski (1986), truth value "resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects rather than in the verification of a prior conception of those experiences" (p.30). The **truth value** is assessed by the study's credibility, or by the descriptions or interpretations of a human experience that is immediately recognized by people who have had the experience (Lincoln & Guba, 1985). The experience, when it occurs, can be also recognized by others based on their reading of the study. The truth value of a qualitative study can be affected by the closeness of the researcher-participant relationship. Description and interpretation of the researcher's responses and feelings in

relation to the research process is considered a strategy helpful in maintaining credibility.

In this study, credibility is addressed through an ongoing journal of personal feelings and responses kept by the researcher, repeated interviews, continued communication with a fellow mental health nursing educator as well as the researcher's dissertation committee, and comprehensive member checks. In order to provide accurate descriptions of the interactions, the interviews where participants tabulate any changes in their personal constructs were audiotape recorded and transcribed verbatim. Once the questionnaire and repertory grid data were collected, the researcher developed concept maps and case study reports which were shared with the participants. In the event of disagreement, both the researcher's and the participant's constructions of the experience were invited. The researcher, in each interaction with participants, consciously tried to convey an approach where the students were considered experts in the knowledge of their own learning, and the focus was on attentive listening rather than interpretive comments. Munhall (1988) emphasized that rigor in qualitative research is founded on a profound respect for human beings and their experiences. Thus, each of the aforementioned strategies were utilized to increase the credibility of this study.

The study must be **applicable** and fitting in representing the context of the real world (Sandelowski, 1986). Participants were not selected for the purpose of generalizability as is customary in quantitative research, but the six participants did differ in terms of their gender, age, and cultural background. The contact with participants was intense and was maintained

throughout the duration of their six-week course and through written correspondence six months after the course ended. The use of three data collection methods, before and after repertory grids, taped and transcribed interviews, and a contemporary questionnaire provided evidence of the real world complexity of the phenomena of study.

The third characteristic towards assessing rigor is **consistency** of the study. Auditability--or the ability of another researcher to follow the thinking, decisions, and methods used by the original researcher — is the criterion suggested to measure consistency (Sandelowski, 1998). This criterion was achieved through Vee Diagraming, my own reflective journal and continued review of the process by the researcher's dissertation supervisor. To further assist in meeting this criterion, I kept a file for each participant which included all the data collected and each aspect of the data analysis. Each student participant's file documented how critical words and phrases were transferred from interview notes, the repertory grids, transcribed interviews and questionnaire responses to the concept maps through color-coding. The themes which emerged were labeled in bold typeface in the upper left corner of the concept map, and these themes were then used as headings in the text of the "story" sections of the case reports. Thus, by using colors in the graphic concept map and headings in the written text to link students' own words to the final case study reports, the case studies are organized and categorized so that another researcher could follow the coding procedure. This documentation, and the further records or sources of evidence which emerged during the study (for example, some of the students shared their clinical journals and I spoke at length to all of the students' clinical instructors) provides the necessary information for an audit

decision-making trail, thereby strengthening the construct validity of the research.

The final test of rigor in qualitative research described by Sandelowski (1986, p.33) is that of **neutrality**, or the freedom from bias in the research process. Neutrality is measured with the criterion of confirmability or when truth value, applicability, and auditability are established (Sandelowski, 1986). This study addressed the criterion of confirmability through the aforementioned strategies for credibility, applicability, and auditability.

Validity and Reliability

As with any research, Merriam (1988) noted that concerns of validity and reliability must also be addressed when considering the rigor of any qualitative research project. In case study research specifically, Merriam (1988) summarized that validity and reliability can be assessed with the following criteria:

> The question of **internal validity** — the extent to which one's findings are congruent with reality — is addressed by using triangulation, checking observations with individuals interviewed or observed, staying on-site over a periods of time, asking peers to comment on emerging findings, involving participants in all phases of the research, and clarifying researcher bias and assumptions. **Reliability** — the extent to which there is consistency in one's findings — is enhanced by the investigator explaining the assumptions and theory underlying the study, by triangulating data, and by leaving an audit trail, that is, by describing in detail how the study was constructed and how the findings were derived from the data. Finally, the extent to which the findings of a case study can be generalized to other situations — **external validity** — continues to be the object of much debate. Working hypothesis, concrete universals, naturalistic generalizations, and user or reader generalizability have been discussed as alternatives to the statistical notion of

> external validity, which involves generalizing from a sample to the population from which it was drawn. (Merriam, 1988, p.184-184)

In this study, the six procedures Merriam (1988) identified to ensure **internal validity** were: implemented. They were:

1. Triangulation, which is where multiple investigators, multiple sources of data or multiple methods are used to confirm emerging findings. I used three different data sources and treated the data with five different analytic methods.

2. Member checks, which is taking data and interpretations back to the people from whom they were derived and asking them if the results are plausible. Throughout the study, I continuously shared my work with participating students, from inviting them to identify how they would like to be introduced and choosing their own pseudonyms to confirming that the final case reports were authentic.

3. Long-term observation at the research site or repeated observations of the same phenomena. I followed the students throughout their six-week course and for an additional six month post-course period. Also, I joined students weekly at their learning site and, during these visits, I often stayed on the units for several hours. While I did not assume any patient care duties on the units, I generally chatted with patients, staff, other students and teachers in order to become aware of the broader

context of the hospital wards.

4. Peer examination, which is asking colleagues to comment on the findings as they emerged. I shared my observations with my supervisory committee, fellow psychiatric nursing instructors and a psychologist in my PhD cohort group.

5. Participatory modes of research, which is involving participants in all phases of the research. I involved students in the data collection, analysis and the write-up phases of the project. Due to time limitations with the short six week course, I did not involve students in the process of developing the element list. I did, however, incorporate comments from students in the pilot study when a colleague and I generated the element list.

6. Researcher's bias, which is clarifying the researchers's assumptions, world view and theoretical orientation at the outset of the study. In Chapter One, I elaborated upon my personal connections to the research and my commitment to both a constructivist world view and a personal construct theory approach.

Additionally, in this study, further procedures to ensure **reliability** or dependent consistent results, involved explaining the investigator's position. The preceding section addressed consistency in qualitative research generally and the aforementioned comments on triangulation of data collection, triangulation of analytic methods and

leaving a clear audit trail, all of which also foster reliability, address case study research specifically. With regard to explaining the investigator's position, ethnographers Goetz and Le Compte (1984), elaborate that the procedure of explaining the investigators' position also involves clarifying the assumptions and theory behind the study, his or her own position vis-`a vis the group being studied, the basis for selecting informants and a description of them, and the social context from which data were collected. In Chapter Two, by developing a critical literature review which incorporated a sociohistoric perspective of clinical teaching in nursing generally and then specifically explaining the unique experience of hospital psychiatric nursing within today's changing health care system, I presented a broad picture of the group being studied. In the case reports, particularly the first one — Sandra, I explain the social context of the curriculum and the hospital learning site in detail. I introduce the thesis with my position that student nurses' voices must be included in the scholarly dialogue surrounding their learning, and throughout the project, I was empathetic towards students' perception of their experiences. In both the pilot and the study project, all students who volunteered to participate were accepted.

Finally, in this study, the four procedures Merriam (1988) identified to ensure **external validity** were implemented. They were:

1. Working hypothesis, a term which is used to replace the notion of generalization with a perspective of local conditions. According to Cronbach, (1975, pp. 124-125,

cited in Merriam, 1988) "When we give proper weight to local conditions, any generalization is a working hypothesis, not a conclusion" (Merriam, 1988, p.175). In this study, I do not claim to generalize my findings; instead, I follow my broad working hypothesis that a personal construct theory approach is an effective method of listening to and reporting student experiences and the narrow working hypotheses which emerged with each of the students as we discussed their personal ways of knowing and learning.

2. Concrete universals, which involves attending to particular concrete details in a specific case rather than arriving at abstract universals from a sample population which would then be generalized to a larger population. As Merriam clarifies: "The general can be found in the particular" (Merriam, 1988, p.176). In this study, while each report of a student's clinical learning experience on a psychiatric unit is presented as a unique entity, each report also displays universal properties of teaching and learning mental health nursing. However, in this writing, these properties are reflected in the concrete rather than the abstract.

3. Naturalistic generalization, which is drawing on tacit knowledge, intuition and personal experience to identify patterns within experiences. In this study, as I listened intensely to each of the students and carefully reviewed all the verbal and written information they shared with me, I identified similarities within their individual experiences. As consistent patterns and ways of making sense of their learning

emerged, I clarified my perceptions with them in our interviews and in our correspondence. As well as verbalizing my perceptions, I was also able to articulate my own sense of the student experience graphically on the concept maps and then with written text in the "story" section of the case reports.

4. Reader or user generalizability, which is the extent to which a study's findings can be applied to other situations. In this study, clinical teachers, particularly in the psychiatric mental health area, students, and practitioners can all benefit from these reports which view learning through the eyes of the individual actually immersed in the learning experience — the student nurse. For clinical teachers, the six case reports are a guide to viewing practicums from a different perspective and an invitation to extend instruction beyond basic demonstration and evaluation. For students, reading "stories" about their peers also acts as a guide and could foster their engagement within the area. Clinical learning in a hospital psychiatric unit is a powerfully complex and emotionally draining experience, especially at the beginning of the rotation. As Chapter Two emphasized, existing literature has neglected students' perspectives of clinical teaching generally, and in the psychiatric area in particular, little direction exists as to what the experience is really like. Both Section One of the literature review in Chapter Two and the case study reports in Chapter Four of this thesis would be useful orientation tools for students as they begin their mental health rotation. As students who are new to the area read about the concerns and experiences of those who have completed the course, questions, difficulties and

concerns can be raised and discussed promptly. For practitioners, the case study reports are a mirror image, — and not always a flattering one — of the way their actions appear to guests on the unit.

In essence, the design and rigor of this case study research sought to enhance the possibility that the collaborative case reports are externally valid. To improve the possibility of readers generalizing the findings to their own situation, I have provided rich thick description "so that anyone else interested in transferability has a base of information appropriate to the judgement" (Lincoln and Guba, 1985, pp.124-125). Lastly, I have established the typicality of the students' experiences. That is, based on nearly twenty years of nursing practice and instruction, I have sketched reports of the students in relation to how they compare to other second year nursing students. Goetz and LeCompte (1984) suggest that describing how typical the individual depicted in the case study is in relation to others is effective in encouraging readers to make comparisons with their own situations. In the section which follows, I use the Vee Heuristic to graphically introduce the substance of my research project.

Diagraming a Vee Heuristic

Vee analysis or the Vee heuristic is "an efficient way to see the substance of an inquiry. A whole thesis study can be summarized diagrammatically on one page" (Novak & Gowan, 1984, p. 155). The Vee, a visual prop, helps to conceptualize how the focus questions of a study relate to the events which seek to answer those questions, and how the theoretical and

practical perspectives frame the investigation. The particular "V" shape of the heuristic represents the coming together of theory and practice in a research study.

Laying the Vee on an event is a way of analyzing previous knowledge, understanding the theory and practice of an event, and constructing new knowledge (Novak & Gowin, 1984; Smith, 1992). Vees are "read" by first reading the focus questions, which are fundamental questions about what is to be learned in the research (i.e., How do student nurses construe professional staff activities?). Since the focus question is answered by the research event (i.e., interviewing six student nurses before, during, and after their clinical practicum), the event is read next.

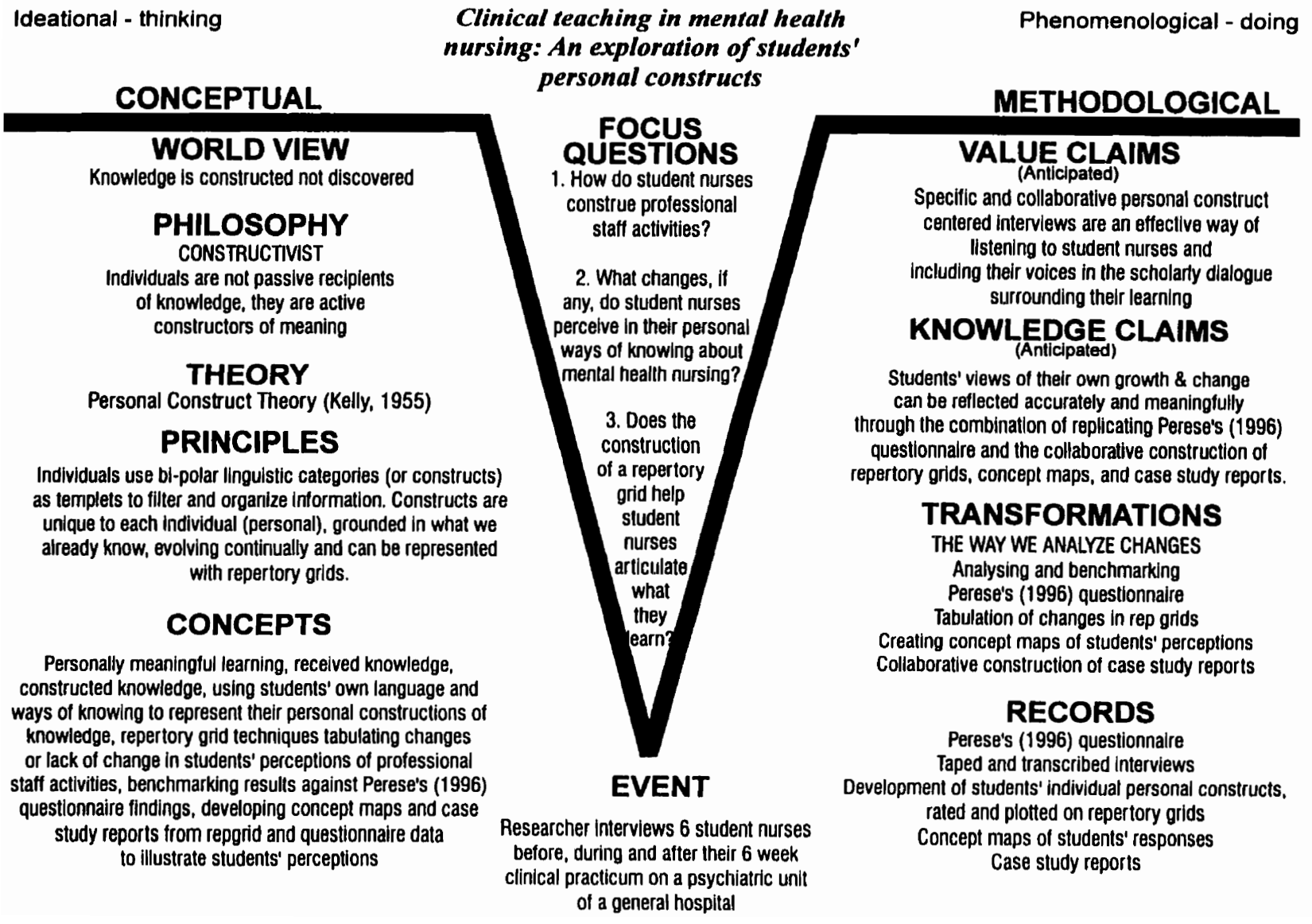
In order for a research event to be theory-driven, the left side of the Vee is used to analyze the theoretical domain of the event. By listing all relevant concepts, one is forced to analyze what is being studied at a finite and definitional level. Next, principles are stated that reflect relationships among concepts to identify knowledge. Principles tell how events or objects appear or behave, whereas theories tell why they do so (Novak & Gowin, 1984). Theories are collections of principles organized into broad and inclusive systems of beliefs (i.e., personal construct theory). Philosophy is even broader in interpretation in that it expresses the overriding value of the entire theoretical domain. When the left side of the Vee is well developed, a research event has a valuable theory base (Novak & Gowin, 1984; Smith, 1992).

Once concepts, principles, theories, and philosophies are clarified, that understanding is used

to underpin research on the practice side of the Vee. Moving up the right side of a Vee heuristic from the event, the practice domain is addressed first by making records of the event (i.e., Perese's questionnaire, interviews, development of students' personal constructs and repertory grids, concept maps, and case study reports). These records are transformed into useful, "workable" (Smith, 1992) data such as analyzing and benchmarking the questionnaire, tabulating changes in rep grids, and ultimately using that data to create concept maps and collaborative case study reports of the students' perceptions of their experience. Knowledge claims are the new pieces of information guided by theory and used in the practice of the event (i.e., the students' own views). Finally, value claims reflect the inherent worth and usefulness of the practice domains.

Thus, the right side of a Vee addresses practice aspects of a research event within the framework of the theoretical left side (Smith, 1992). In the following Vee heuristic, included on the next page as Figure 1, I summarize my research approach. The interplay between the left and right sides of the Vee emphasizes how the inquiry within this thesis is theory-driven and how prior knowledge guides the understanding of constructing new knowledge.

Figure 1. Vee Heuristic Diagram



Data Sources used in the Construction of the Case Study Reports

As the **TRANSFORMATION S** section of the Vee Heuristic illustrated diagrammatically, three sources of data were used to develop the concept maps and ultimately the collaborative case study reports. In the following section, I comment on each of these data sources in relation to this study.

Comparing Before and After Repertory Grids

The three stages involved in repertory grid technique — first: constructing grids, second: dichotomizing, rating or ranking elements, and third: analysis — were described in detail at the beginning of this chapter. In this study, personal constructs elicited in conversation with participants were developed into repertory grids and rated both at the beginning and at the end of the course. The grids were developed by participants and used their own language. Together, the researcher and the participants reflected upon any changes which occurred and there was an opportunity to discuss students' own perceptions of their clinical learning. In this study, available statistical computer analysis of the repertory grids was not applied and the constructs were not laddered or clustered. The narrative process of reflecting upon and comparing the changes, or lack of changes, on students' before and after course repertory grids, constituted the analysis.

Analyzing and Benchmarking Perese's (1996)

Questionnaire Responses

As noted in Chapter Two of this thesis, little is currently known about student nurses' perceptions of their mental health clinical experiences. Erese Perese recently posed eight open-ended questions to her own psychiatric nursing students at the University of Buffalo in New York and reported her findings in the *Journal of Nursing Education* (Perese, 1996). Her findings are described on page 52 of this thesis. This questionnaire (obtained through personal correspondence and included as Appendix 3) included questions such as: What did you expect, what did you find most difficult, what did you like the most, what did you like the least and what was helpful?

Encouraging nurse researchers to benchmark, or "compare results against those found in previous research" (p.193), Beck (1994) advocates replication strategies as a method of stimulating dialogue between nurse researchers. The format of this pre-tested instrument met Berdie, Anderson & Niebuhr's (1986) criteria of formulating effective questions on questionnaires. According to Berdie et al., (1986), survey questions should ask for only one piece of information, assume no previous state of affairs, imply no desired answers, contain no emotionally loaded, poorly defined or overly general words, or contain any unfamiliar abbreviations which could cause misunderstanding.

Applying Perese's (1996) recent questionnaire from the literature to the present study also

provided an opportunity to demonstrate research-based practice to students. Tanner (1992) commented on the potential of engaging in small studies in order to stimulate an attitude of inquiry about practice with student nurses. Tanner (1992) writes: "What better way to model this attitude than by engaging in inquiry about our own practice of teaching?" (p.148).

Similar to the New York students, the Canadian students in this project found hospital psychiatric nurses uncaring and un-welcoming, and students in both geographic locations felt that hospital psychiatric nurses performed more custodial tasks than professional ones. Students in the present study were intrigued with how I implemented a research tool developed by a psychiatric nursing instructor in New York simply by writing to her after reading about her study in a nursing journal. They were struck by how their own responses to what was positive, negative and helpful in their mental health practicum were similar to students in a different geographic location. The tool served as an opportunity to share information as well as to engage students in the research process.

Audiotape-Recorded and Transcribed Interviews

The post-course interview with each student, where repertory grids and questionnaire responses were discussed, was audiotape recorded and transcribed verbatim by the secretarial service I employed. The structure of these interviews was described in detail on pages 85 and 86. The process of having the interviews audiotape recorded and transcribed by a third party was useful. I was able to look at the information from a fresh perspective and I could

simply listen to the tapes without attending to the task of typing.

An interesting and unexpected affirmation of the worth of the study occurred from one of the typists who assisted me with this aspect of the data collection. As described in the section on ethical considerations, all secretarial assistants involved in the project signed a confidentiality pledge and agreed not to discuss any of the information shared by participants. However, when I came to pick up my work one morning, a young woman who had worked on the transcribing asked to speak to me privately. When we were alone, she inquired: "I know it's confidential, but what can you do about this situation on the psychiatric ward?"

I replied that I hoped to publish the students' accounts of their clinical experiences in nursing journals and that, if I could tell the stories effectively enough, nurses reading them might be inspired to look at instructing students from a different perspective.

When I asked the young woman about her interest in my work, her eyes filled with tears and she replied:

> I was a patient on the psych ward a while back. This brought it all back. It's the same for the patients. It's not that I was mistreated or anything there, it's just that I wasn't part of things either. I hated to go up to the desk to ask for my crochet hook. They kept it there because it was sharp and I might kill myself with it or something. All day I would sit in the solarium and watch the nurses and doctors at the desk. They never seemed to leave that desk and come and talk to us. I don't know what I got out of the whole experience except that the pills the doctor prescribed for me did seem to help my depression. I don't know what the nurses were supposed to do. I hope what you do can help!

In the process of analyzing the content of the audiotape recorded interviews and the transcripts, I often thought of the young woman who was, as a patient on the psychiatric ward, very much an authentic authority on the experience of learning about mental health. Her interest encouraged and inspired me to continue wrestling with the important insights students were so willing to share with me and to organize those insights in meaningful ways so that indeed, what I do could "help." In the following section, I discuss how concept mapping effectively imposed order on the information I collected from the data sources just described and ultimately linked that information to the final case study reports.

Developing Concept Maps

In this study, I created concept maps from my communication with students and used these maps to illustrate my perceptions. The concept maps epitomized the themes which emerged from the data by organizing and summarizing the information. I used the maps as a communication strategy with students to check the truth of my perceptions and to see if I was on the right track as I attempted to view the experience from a student perspective rather than an instructor perspective. The concept maps provided an explicit and visual link between students' verbal and written comments and the final case study reports.

Concept maps are graphic organizers. Ideas can be visually arranged on concept maps to show the connections between and among concepts as they are being studied. Concept maps allow researchers and participants to exchange views, or to recognize the missing linkages

between concepts that suggest a need for new information (Novak & Gowin, 1984).

A concept map is a tool to negotiate meaning. It is a schematic hierarchal summary of key ideas (concepts) and the pathways linking them (propositions) that an individual holds at a particular point in time. In general, more inclusive, superordinate concepts are represented at the top of the map, with more specific, less inclusive concepts arranged subordinately. Specific events or objects can be included at the base or elsewhere on the map (Colling, 1984). Like road maps, concept maps represent a larger entity, lend themselves to frequent revision, and may be enhanced with illustrations, magnification and color (as in this study).

As a communication strategy built into the research process, concept mapping invites both researchers and participants to enter into a lively involved conversation where personal interpretations of events are valued. Once I sketched the concept maps to organize information from the interviews, repertory grids and questionnaire responses, I shared them with participants. Any misinterpretations were clarified and corrected and the students confirmed that the themes which I identified were accurate before I undertook the final stage of the data analysis, the collaborative construction of case study reports. At a later date, I employed the secretarial service once again to transform the graphic map sketches into typewritten documents, and I include these typed concept maps as a link between students' repertory grid and the "story" of their hospital unit experience when I present the student cases in Chapter Four.

The Emergence of Themes

Developing the collaborative case study reports in this thesis was neither an easy task nor a linear one. While I have presented my results in an orderly and systematic manner, the process itself was a circular one which moved in different directions at different times. I began my approach to creating collaborative case study reports based on a previous case study research project I conducted with unemployed Registered Nurses (Melrose and Kirby, 1994). In this 1994 study, I used a color coding scheme to link comments participants made during audiotape recorded interviews to "stories" of their experiences. My intent in both projects was to present brief vignettes of human experience which alert busy practitioners to problematic situations and illustrate possibilities for change.

Recording the active involvement of six different students following different schedules in the collection, analysis and write-up of the project was a challenge. For example, as I came to know the students in the present study, I began the cursory process of interpreting the information I gathered from them. Comments students made during our meetings informed the direction our conversations took and often led to new questions and issues to explore. In the pilot study, as these issues unfolded, I successfully documented them on "sticky" notes and tucked them into the files I made for each participant. Once I dealt with the point, I would discard the "sticky." However, in applying the same tactic in the larger study, I realized I wasn't preserving the information adequately, so I established a more permanent system with foolscap to make interview notes and sketches. The six files were different

colors and students soon came to recognize their own folders and used them as clipboards during our discussions. Students would often comment: "This is important; put it in my story."

While this shared ownership of the process lent itself to different organizational strategies within the files themselves, it fit with the constructivist world view undergirding the research. Throughout the study, in addition to listening to the voices of the students, I consistently turned to the literature, mentors and colleagues as I began to search for meaningful themes within the data.

Initially, I found the experience extremely distressing. It was difficult to see the perceived unprofessional and custodial oriented actions of the nursing staff through the students' eyes. In my own experience as a student nurse and then as a practicing hospital staff nurse, the role of the hospital psychiatric nurse had, until recently, seemed dynamic and autonomous. As I listened to students and continued reading, I wondered about how staff hospital psychiatric nurses came to assume so many custodial oriented functions. I questioned why so few nurses seemed interested in the speciality and I was struck by the impact which hospital downsizing and cutbacks had on nursing activities. I developed these insights in Chapter Two in my discussion of the nature of psychiatric nursing and the role of the hospital psychiatric nurse.

As the course and my data collection both progressed, and the students remained alarmingly unengaged in the unit milieu, I was once again reminded of my own "training" where I lived

in a nurses' residence adjacent to the hospital and "worked" on hospital units during my clinical practicums. At that time, the process of engaging students in any hospital unit milieu required little curricular attention because the hospital administration depended upon student nurses to staff the units. I applied my reading to this insight and developed the section explaining a sociohistoric perspective of the clinical component of nursing education which introduces the literature review of this thesis.

Additionally, various mentors offered their expertise as I searched for themes within my research data. I met regularly with my advisor and, mid way through my data collection, I met formally with my supervisory committee. In July 1997, I co-presented one of the student case reports with my supervisor when we attended the Twelfth International Conference on Personal Constructs in Seattle, Washington. I also met regularly with a classmate, who is a practicing psychologist, to discuss our work and exchange ideas. While I gleaned considerable guidance from both the nursing literature and these mentors who were all truly generous with their time and ideas, actually finding and articulating the themes embedded within the data was a rather solitary task.

The process of interpreting the data deepened as the study progressed and I devised different ways of sorting the variety of information into similar groupings. Intense analysis of all the information occurred during a six-month period of reflection immediately after I had collected all the data. I constructed each case study report one at a time, alternating between creating the text of the story and the final diagram of the concept map. For each report I read and

reread the personal constructs, the before and after repertory grids, questionnaire responses, the transcriptions and interview notes and passages from my reflective journal. I made copies of the transcriptions in order to keep a "clean" record and I wrote notes and underlined words and phrases throughout my working pages of transcriptions. I cut up some of the transcripts and arranged them in different ways on the floor. As I read the transcripts, I listened carefully to the voices of the students on my tape recorder to attend to the nuances of tone of voice, laughter and points of emphasis. As I listened to recordings of the students' voices, I remembered how I felt as I searched for the time and energy to attend appointments with them to collect data. At first, the task seemed an impossible one, and yet, I inevitably left each of the interviews with students feeling wonderfully energized and excited. I remembered how all of the students seemed engaged in the project and when I rescheduled an appointment with one student, she commented: "I wish that you'd come last time — I had some things to tell you!"

Gradually, as I continued to read, listen and sort each student's comments into sections, key points seemed to stand out so I underlined them with different colored markers. For example, I started with a red marker to distinguish points related to anger or frustration. These points seemed to stand out and, in most cases, the students had emphasized them fairly clearly as aspects of the course which had been missing for them. With these similarities and patterns related to the kind of student knowledge which had not changed beginning to take form, I went on to look at the situations where changes had occurred and marked these in purple. I found most of the points in this category of learning changes on the post-course repertory

grid. This observation lent support to my growing respect for the personal construct theory approach which directed my research. The repertory grid had clearly helped students articulate their personal learning. I created the last grouping with information related to the background and personality of the student and marked these with green.

Establishing this broad system of categorizing provided a framework to present the final reports consistently. With this organization in place, I was able to return to each student file individually and search for themes which captured the essence of that student's personal experience.

I would leave the work for a few hours or days and then check the pages again to see if the points consistently "fit" the categories which had emerged and did actually form a pattern or theme. For example, with Sandra, during our weekly interviews, she made several references to evaluation requirements, but her verbal emphasis at that time seemed to center on how she did not choose to accept some of the nursing actions she saw being implemented on the ward. During our mid-course discussions, I did not sense that "evaluation" was a dominant theme in her learning experience. Later, during our post-course correspondence, she used underlining and large print to emphasize that she did not feel she had been evaluated fairly by her instructor. This written emphasis, completed after the course was over, led me back to my interview notes and, at that point, I noticed how Sandra had indeed been very concerned with how her instructor would evaluate her. This cyclic process of reviewing different kinds of information in different ways and at different times continued as I prepared to transform

my data into case reports.

In my work, I turned to a format suggested by Berg (1995) for a systematic method of content analysis to supplement the intuitive process I initiated. According to Berg (1995), first the transcriptions are read thoroughly and systematically for naturally occurring patterns. Second, the major topics of interest which emerge are coded and indexed. Finally, Berg suggested creating thematic topic sheets which can be readily located or cross-referenced. In this study, naturally occurring patterns from the different sources of data were coded with different colored marking pens rather than numbers. I expanded Berg's (1995) idea of indexed columns of themes on a thematic topic sheet to a different visual arrangement — the concept map described in the preceding section. I found the colors and maps more pleasing to work with than numbers and students seemed to enjoy the playful aspect of the colors. Despite this slight variation in recording, patterns in the data which led to themes are clearly located and cross-referenced. Through color-coding, students' comments link directly to a section on their concept map. The concept map organizes and groups the information further and a summary of the three or four individual themes which emerged for each student is presented in bold typeface in the upper left corner of his or her concept map. Most of the themes are again referenced as headings in the collaborative case reports which concluded the process. In the following section, I explain the final phase of my research, constructing the case study "stories" of student experiences in psychiatric mental health nursing.

Constructing Collaborative Case Study Reports

This naturalistic study questioned how student nurses construed the professional staff activities they observed on hospital units which have recently undergone radical organizational changes. Using a personal construct theory approach, an adaptation of Kelly's (1955) repertory grid technique, interview and questionnaire data, students were invited to articulate the changes they perceived in their personal ways of knowing about mental health nursing and their responses were developed into concept maps and case study drafts.

Guided by the Vee Heuristic, data from the personal constructs, before and after repertory grids, questionnaire responses, audiotape recorded and transcribed interviews, handwritten interview notes of meetings with participating students, their peers and their teachers, the researcher's journal, and some of the students' journals were all filed in individual folders and read systematically to detect similarities and patterns which were then subjectively color coded and charted on concept maps. Patterns and relationships that ultimately led to themes were established, noted on the concept maps and confirmed with participants. Successive drafts of the written case study reports, with the themes used as headings, were shared with participants and any necessary revisions or inclusions were made. The students were invited to pick their own pseudonyms and remained actively involved throughout the project. The reports were written during the six-month period immediately following the data collection.

Ethical Considerations

Type of Participants and Age Range

Participants were second-year university students enroled in an integrated medical surgical and psychiatric mental health nursing course required by a mid-sized western Canadian nursing program. While nursing students range in age from young adults through early middle adults, age was not a consideration in this study.

Specifics of the Group

The researcher's experience facilitating clinical group learning on acute psychiatric units in general hospitals suggests that student nurses engage in a plethora of unacknowledged learning discoveries throughout their rotations. Students are often confused when asked to wear appropriate street clothes, set professional boundaries with profoundly disturbed patients, and implement nursing theoretical frameworks on units oriented to a medical model. Current hospital reorganization and cutbacks can limit clinical placements and novice nursing students often find themselves joining staff nurses in caring for acutely ill patients. Many nursing students have not visited a mental health facility previously. Other students have had personal involvement with psychiatric care themselves or through friends or family members. Reflecting on the emotionally charged experiences that mental health treatments can provoke is an established aspect of clinical learning and daily group conferences are generally well used

by students. Both Perese's (1996) questionnaire and the repertory grid technique are activities which could be adapted to a post-conference discussion.

Recruitment of Participants

A letter of introduction, included as Appendix 4, was sent to all students in the nursing class who were not in the researchers' lecture section group. The first six students who volunteered were selected. Students were not paid to participate in the research; however, I was able to offer them two small gifts, a set of business cards and a membership in the provincial professional association. The opportunity to conduct my research full time was made possible through grants from the Alberta Association of Registered Nurses Educational Trust and the Harshman Foundation. I received these awards once my project was underway and, although I had not informed students at the beginning of the study that I was able to offer them any gifts, I was able to do so with monies from these grants.

Informed Consent

All participants were informed both verbally and in written form of the methods of research and the nature of their involvement in the study. Participants who agreed to participate in the study all signed consent forms (included as Appendix 5) prior to recording their personal constructs or completing the questionnaire. Each participant retained a copy of the consent form with telephone numbers of the researcher, the researcher's supervisor, the college

research officer, the faculty of education ethics committee chair, and the vice-president (Research) at the university.

Risks to Participants

None of the information gathered during the research was used for clinical evaluation unless the students so requested. Other than the inconvenience of donating their valuable time, there was no known likelihood of any discomfort or inconvenience associated with participation in this study. Neither was there any known nor are there any suspected short- or long-term risks for any of the participants. Ethical approval was obtained from both the college and the university before conducting the study.

Anonymity of Participants

All participants in the study were guaranteed anonymity. When transcribing and reporting the results in the thesis or any subsequent research publications, pseudonyms were used. A Pledge of Confidentiality, included as Appendix 6, was signed by all the typists from the secretarial service I employed who were involved in the project.

Ultimate Disposal of Records

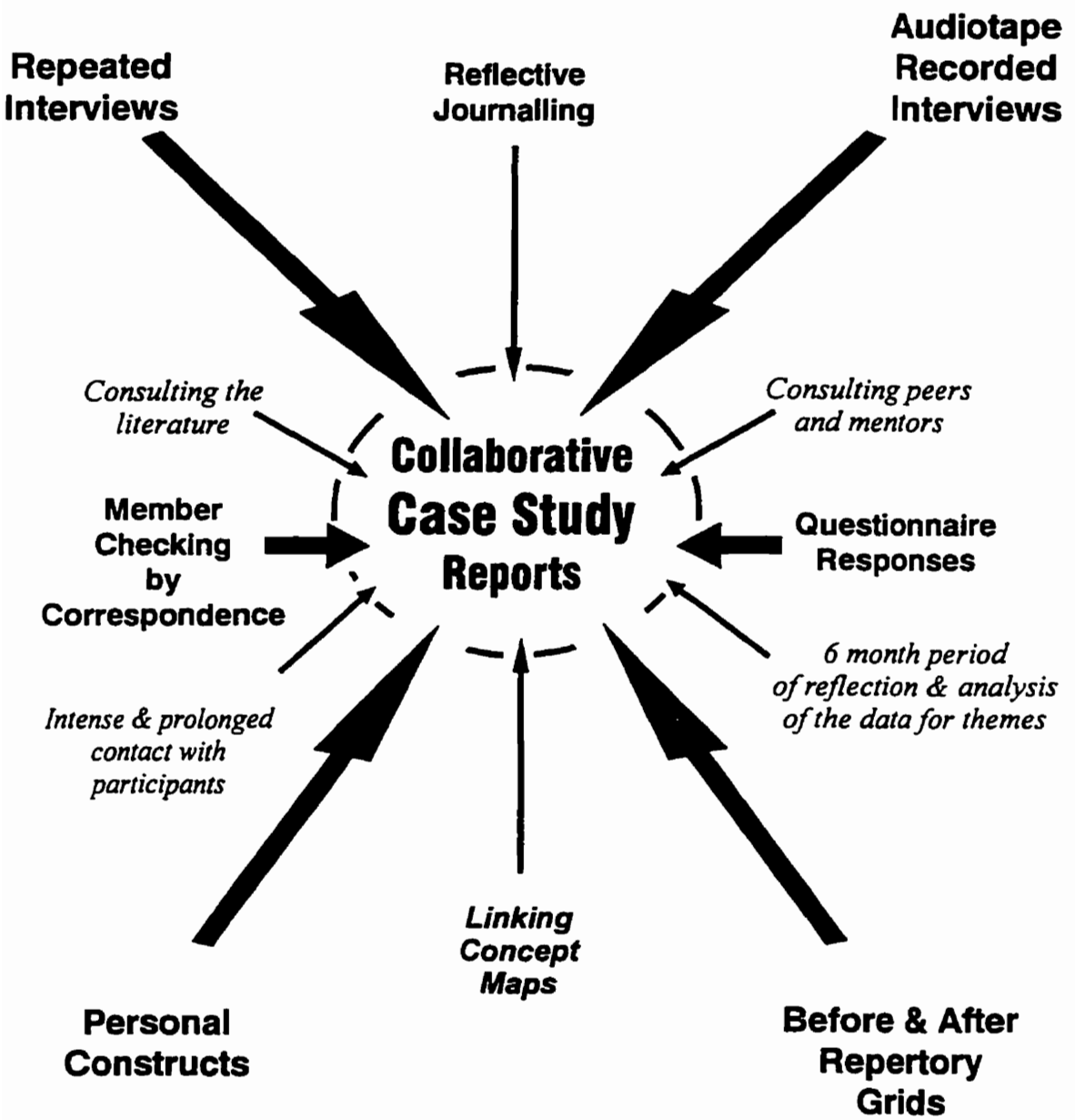
During the study and upon completion of the study, files were kept in a secure place

accessible only to the researcher. All records were filed by pseudonym. After completion of the study, all tapes were erased, but some transcriptions were preserved for future comparative studies. Participants were informed of this and acknowledged permission to preserve these transcripts on their consent forms. Only pseudonyms were used on these transcriptions to protect participants' identity.

On the next page, in Figure 2, I summarize my research design and procedures with a diagram. This diagram illustrates features in the process of constructing the case study reports. The open lines which form a circle around the final case study reports represent the flexible nature of the writing and the arrows show how a variety of data sources were used throughout the research process.

Summary Diagram

Features in the Process of Constructing the Case Study Reports



CHAPTER FOUR: THE SIX COLLABORATIVE CASE STUDY REPORTS

Linking Analysis, Interpretation and the Assessment of Authenticity with the Epistemological Stance of the Research

This chapter links the philosophical commitment of the research approach, which applied a constructivist conceptual framework, and Kelly's (1955) theory of personal construct psychology to the collection and analysis of the stories of six student nurses as they completed their psychiatric mental health clinical practicum. The stories which are presented following this introduction were co-created by the students and the researcher and are intended to stimulate new ways of looking at clinical teaching.

In this study, working with what Kelly (1955) described as "templets of reality," or the way individuals personally construct meaning from the events around them, involved sketching the case study reports from students' own perspective and articulating what was meaningful to the students themselves. The study delved into what it's like for students to learn about the distinctive nature of psychiatric nursing from a revolutionary curriculum implemented in a health care delivery system undergoing sweeping change. For each student, patterns emerged from our conversations and correspondence which reflected how they construed what was happening around them and how they anticipated what might happen next. Kelly (1955) referred to individuals' categories of thinking as "personal constructs" and described how constructs form patterns of reality which are unique according to the "individuality corollary," shared by a group according to the "commonality corollary" and understood by others

according to the "sociality corollary." In this study, an adaption of an approach developed by Shapiro (1987, 1991, 1994) employing narrative inquiry and reflection on construct changes guided the research. In keeping with the constructivist world view espoused throughout this project, the process of listening to students and recording their personal constructs on repertory grids and then rating those constructs both before and after the course was considered a pedagogical intervention as well as a research methodology. It is the intent of the final reports to provide a brief snapshot view of students' experiences in relation to the shifting paradigms impacting both health care and nursing education which were discussed in Chapter Two. Thus, while the students' stories are uniquely individual, their thoughts, feelings and expectations may be recognizable to nurse educators who seek to create meaningful clinical curricula to meet the needs of today's university educated student nurses. It is my hope that both the research approach and the stories themselves will stimulate readers to create further dialogue between students and instructors. Each report raises unique points and issues and contains an important message about the process of learning mental health nursing. In the previous chapter, I explained the research method in detail. In this chapter, I present the final collaborative case study reports. To introduce the reports, I note how the cases were organized.

The Organization of the Case Study Reports

The case reports are organized according to four main sections. The first section of the reports, the heart of cases, is the "story" of the student experience. Here, I present a fresh

and thought-provoking perspective of learning in the psychiatric clinical area which differs from existing nursing education literature. As I asserted in Chapter Two, previous studies in clinical teaching have approached student learning from a perspective of instructor knowledge more than from a perspective of student knowledge. The student "stories" in this thesis view the experience through the eyes of the students themselves and voice their own ways of knowing and constructing knowledge, a timely contribution to current nursing education literature.

The second section, the post course repertory grid diagram, illustrates the personal constructs students developed and the changes which occurred as a result of their practicum. In these figures, dominant horizontal arrows pointing to an element number show how students rated the element at the beginning of the course and then again at the end of the course. The length of the arrow emphasizes the increments of change which occurred. In some cases, the arrows reveal a complete reversal in thinking. A student may have rated an element with the number five at the beginning of the course and with a number one at the end of the course. By contrast, the rows on grids which have no arrows illustrate how students rated the nursing activity element in exactly the same way at the end of the course as they did at the beginning. Students grids vary markedly; for example, the arrows on Casandra's grid covers only one increment rating change. Heather's grid, however, depicts dramatic five point reversals in thinking for five different elements.

The third section of the reports provide a discussion of the repertory grid diagram. The

discussion fleshes out students' ideas about their learning and illustrates the unique language and creative ways of expressing insight which students shared when they were given the opportunity to do so.

The fourth and final section of the reports present a figure diagram once again, a concept map which organizes and summarizes information sifted and grouped from the variety of data sources used. Due to printing limitations, the colors I used in my analytic process are not present on this illustration, but the groupings are clearly linked with vertical lines. In the upper left corner of the map, the overriding themes which emerged are identified in bold typeface. In most of the reports, these summarizing words are used as headings in the written text of the reports. The concept map provides a graphic link between the repertory grid discussions and the "story" section of the report.

The student "stories" begin by introducing the participants in the way they stipulated that they would like to be introduced and by the observations which led me to connect a title to their story. Background information, reasons for entering nursing, interest in the study, personal goals and academic grades in the course are examples of information which was included in these opening passages. The concluding segment of the "story" is unique for each student and highlights the personal themes of learning which emerged throughout the research.

The word "patient" rather than "client" is used throughout the reports. This word was chosen because any of the patients who students refer to were actively admitted on a hospital

ward at the time of the study. The first case study, Sandra — The Independent Learner provides more details about the climate of the psychiatric ward and my process of communicating verbally and through written correspondence than the remaining reports.

The case reports are presented in the order that the students came forward to participate. It is interesting to note that as the project progressed, I became more comfortable with the research approach and, in turn, my conversations with students became more detailed and personal. Sandra, who shared the least amount of information about herself, is presented first and Casandra, who shared very personal information about her experience, is presented last. The possibilities inherent in the research approach are illustrated in this progression and once again, the reader is invited to speculate on further applications of the techniques in the study as tools to promote constructivist teaching and learning in clinical nursing education.

Case Report I: Sandra

Sandra — The Independent Learner

Sandra is a 27-year-old married fitness instructor who entered nursing as an adult student after taking several previous university courses. Sandra's work as a fitness instructor and her time with her husband are important to her and she is proud of her ability to "balance" her activities. She chose the faculty of nursing because "it seemed a logical stepping stone to medicine." Sandra volunteered to participate in the study because she was interested in

learning more about the research process and she hoped to gather additional information about psychiatric mental nursing through her involvement with the project. Sandra earned a grade of B+ in the course. Sandra believed that her clinical experience "will help me in whatever I do," but at the end of the course, she concluded: "I don't think that I would do this for a lifetime career, I don't think it is my cup of tea."

Sandra, looking ahead to a career in medicine, had clear scholastic goals. When I asked Sandra how she structured her time on the unit when her patients were unavailable, she replied: "I look around to see if there's anyone I can help — if not — **I study!**" In my conversations with Sandra, I noticed that she described several situations where she pieced information together herself "rather than ask." Sandra seemed self-sufficient and independent in her approach to her studies and when I shared my observations with her, Sandra smiled. She agreed and added that "other instructors also described (her) as an independent learner."

Sandra's only previous knowledge of psychiatric mental health nursing was from "movies" or from her father who worked briefly "as a carpenter in a mental institution." Sandra's father described "crazy" people, and she initially felt "a lot scared" about the experience generally and about "aggressive" patients specifically. Sandra was assigned to a psychiatric unit on a general hospital for her first clinical placement in her integrated medical-surgical and mental health nursing course.

"Completely unprepared."

While Sandra had consistently been introduced to medical-surgical nursing knowledge both theoretically and practically in the first year and a half of her program, she had no previous exposure to the unique and separate nature of psychiatric nursing. None of the faculty she had been involved with during her earlier nursing courses had ever worked in the area and none of her previous nursing textbooks discussed treatment of the mentally ill. Sandra felt "completely unprepared" for her practicum. She emphasized that "completing the theory course "PRIOR" to entering the clinical setting" and "a longer time there" would have been helpful to her. Sandra valued her clinical experience on the psychiatric hospital unit, commenting: "Everybody should try this (the clinical practicum) and everyone would learn something . . . it has been a very valuable experience." However, a persistent lack of orientation to psychiatric nursing knowledge within her curriculum left Sandra poorly prepared to implement nursing care to patients hospitalized for medical management of an acute psychiatric crisis. In Sandra's words: "I wish that I had this experience earlier."

Transferring knowledge from theory to practice was not a straightforward process for Sandra. Neither her background in fitness training nor her introductory nursing courses could be expected to equip her with the skills necessary to nurse psychotic, suicidal or aggressive patients. Available faculty resources to help her were limited. None of the full time faculty who facilitated the combined medical-surgical and mental health tutorial components of the curriculum had ever worked in the mental health area. While the lecturers and the psychiatric

clinical instructors did have experience in the field, the clinical instructors were all sessionally hired. Their employment was only for two days a week for one thirteen-week term during the year, and their services were not needed at any other time, so these instructors had limited contact with the full time faculty and had no voice in curriculum planning decisions. Like their students, clinical instructors bought their own textbooks and sought out any supplemental course literature on their own.

At the time Sandra completed her clinical course, the hospital unit she was assigned to was in a state of turmoil itself. Three hospitals in the city were in the process of closing and staff from those hospitals were placed in the two remaining city hospitals. Seniority within hospital unions allows nurses to "bump" those with less seniority and assume their positions. Due to hospital closures as well as province wide health care restructuring and downsizing, several of the nurses employed on Sandra's unit, therefore, had no background in psychiatric mental health nursing and were not sure when they might be "bumped" into another position. Many were hired on a contract basis and classified as "casual" staff.

Further, budgetary cuts which forced reclassification and de-skilling of the employee title "mental health worker" on this unit were an important consideration in situating Sandra's learning experience within the context of the hospital unit. Previously, any staff members employed on this unit were required to be registered with either the Psychiatric or Registered Nurses Professional Association, or possess an undergraduate degree in psychology or a related field. All staff members completed extensive orientation and through a process of

certification, earned the title "mental health worker." Most mental health workers were also certified in group and family therapy assessment skills. Prior to employment reclassification, physicians and mental health workers alike implemented a medical model of assessment and treatment of psychiatric disorders and sought to create a non-hierarchical therapeutic milieu. However, when Sandra came to this unit for her clinical practicum, due to employment reclassification and "bumping," the role models she sought to learn psychiatric nursing from were not all mental health workers. The staff Sandra met included a surgical nurse, a lactation consultant and two former kitchen workers who had recently been employed as "unit aids." While Sandra "did not agree" with some of the nursing care she saw implemented, she empathized with hospital nurses new to the area. Sandra appreciated how one nurse "invited me to do things. I felt comfortable to ask to join her on an admission." Sandra also noticed a nurse who "encouraged an agoraphobic patient who couldn't take a bath to try just sitting at the sink to wash." However, for the most part, Sandra viewed the eclectic staff mix as more preoccupied with their own concerns than with those of students. Sandra noted with disappointment that "these hospital nurses don't even think to ask us to do something with them." Sandra suggested that staff be provided with "a clear orientation to the context of our course and where we're going with it."

In addition, at this same time, unit staff occasionally found themselves in the position of accepting patients who would otherwise be expected to be admitted to a forensic facility. For example, one male patient had been admitted in order to manage his ruminations about stalking and hurting young women.

It is not surprising that at the end of her course, Sandra's initial concerns about "aggressive" patients were not fully resolved. In her response to Perese's (1996) post course questionnaire item: What did you like least about your experience, Sandra wrote: "Sense of fear because some patients were aggressive. Seeing how some nurses talked about the patients in private."

Thus, at first glance it could appear that in addition to lecture content, Sandra's university curriculum provided her with tutorial opportunities to talk about nursing mentally ill patients and with clinical opportunities to participate in the actual nursing care of those patients. However, for Sandra, the reality of her experience was that the intentions of her curriculum were eclipsed by the dramatic paradigm shifts occurring in the health care system all around her, leaving her "completely unprepared" for her clinical practicum.

The many sides of evaluation.

The lack of preparedness which Sandra felt at the beginning of her rotation colored her entire experience. In the first year of her program, Sandra's two clinical courses were graded "pass or fail." These courses introduced medical-surgical nursing concepts and provided students with skills such as recording vital signs, administering topical, oral, rectal and intra muscular medication and even inserting urinary catheters. As noted previously, Sandra had no such introduction to psychiatric nursing. By her second year, Sandra was awarded letter grades for her clinical courses and these grades were recorded on her permanent academic transcript. During one of our mid-course conversations, Sandra explained that she could not follow up

on a topic that interested her because: "I'm not graded on that. I have to focus on what I'm graded on." Sandra accepted that academic grades were required for university courses and commented: "I wouldn't have it any other way." However, during this mid-course discussion, she also remarked:

> There is so much information we don't know. We weren't graded before. This is an introductory course. Here (unlike medical-surgical nursing), we work on the patients' schedule, not ours. It's not fair to give us a letter grade. (Grading) is too subjective in mental health.

When the course was over, during our written follow up correspondence, Sandra wrote: "My grade did not reflect the amount of progress I made. Also, the instructor could not view me all the time. Therefore, I don't think she could evaluate me fairly."

Questions

In relation to the level of knowledge she entered the course with, Sandra progressed in her ability to "question and engage" others in a way which was important to her, but which she did not feel was adequately reflected in her final course grade. During our first interview, Sandra expressed her concern that she "didn't know what to say" to patients hospitalized for treatment of a psychiatric crisis. Then, in one of our mid course interviews, she commented on the "frustration" she experienced "trying to direct a conversation with a (patient diagnosed with hypo mania)." She identified that "formulating purposeful questions and eliciting conversations from patients who did not wish to interact" was the most difficult aspect of the

course for her. By the end of the course, it was this area of questioning and engagement where Sandra felt she had made the most progress. Reflecting on her own growth, Sandra concluded: "I learned excellent questioning techniques" and she "gained confidence" in her ability to "engage withdrawn individuals." However, there seemed to be no place within the course evaluation to acknowledge this personal progress. In turn, this lack of acknowledgment served to erode Sandra's developing sense of herself as an independent learner. This omission, in concert with feeling "completely unprepared" for the clinical experience initially, did little to stimulate her interest in the field of mental health nursing.

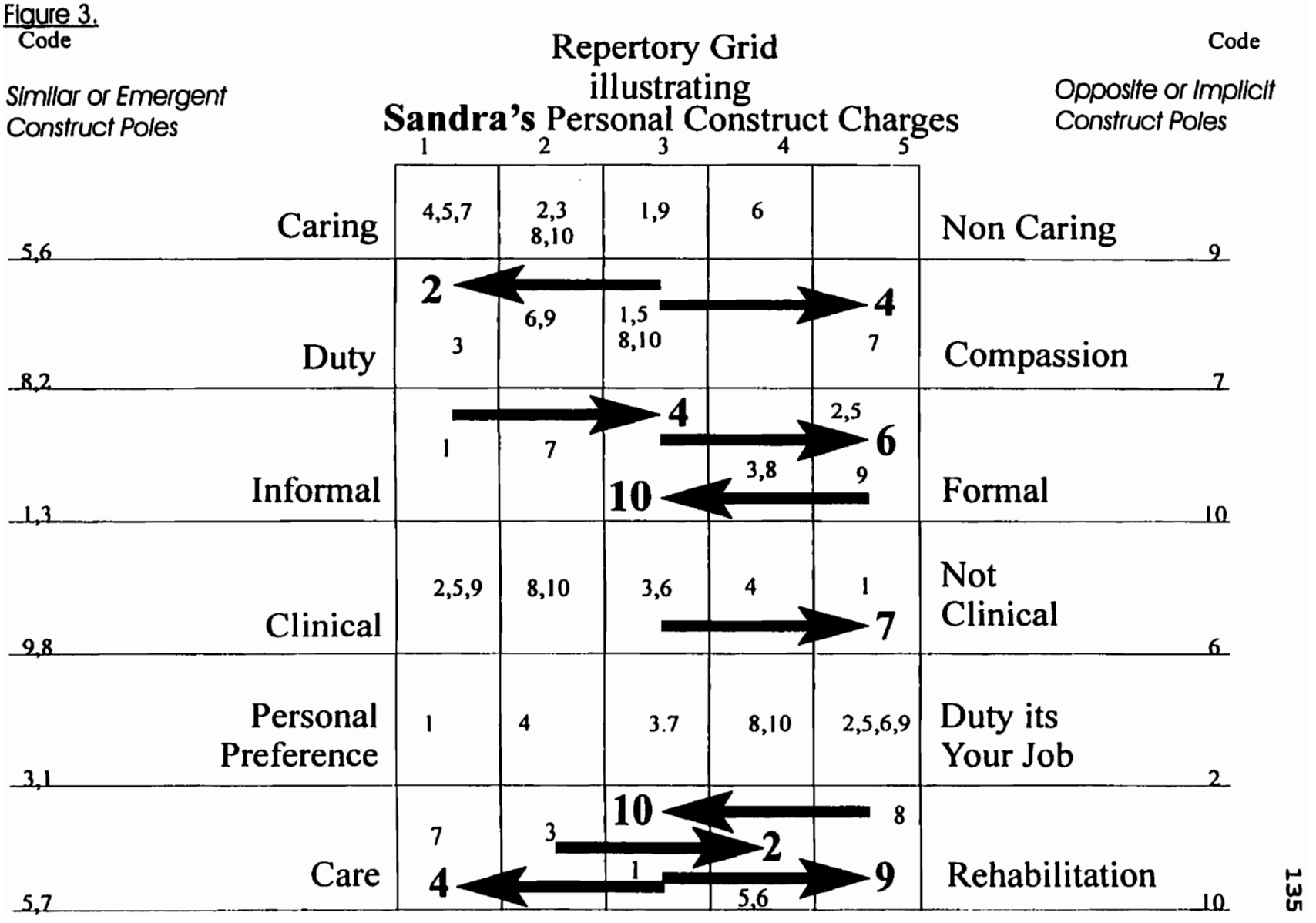
When I asked Sandra to consider what it was within the learning environment which did encourage her to grow and develop in areas which were personally meaningful to her, Sandra discussed "viewed interactions." In this clinical experience, students observed their instructor interview patients from behind a two-way mirror, and, in turn, were observed conducting their own interviews with their patients. It is interesting to note that while viewed interactions were expected to occur within the design of the course, the course outline stipulated that students would not be formally evaluated for their course grade with this learning activity. For Sandra, this non evaluative component of the course was the most valuable to her. She used her "new found skills with (her) husband."

In Chapter Two, this thesis discussed how international nursing education research reflected that themes of feeling anxious, being overwhelmed by evaluation and having personal learning go unacknowledged dominated many nursing students' clinical experiences. For Sandra, this

was the case. The anxiety she initially felt was not fully alleviated, she did not feel she was evaluated fairly and her personal learning accomplishments remained unacknowledged.

In conclusion, Sandra is a student who was identified by her nursing instructors as an independent learner, and who found herself in a clinical placement which she felt "completely unprepared" for. Sandra had neither prior personal nor academic knowledge of psychiatric mental health nursing and the hospital unit which she attended was in the throes of intense institutional change itself. While her curriculum endeavored to provide Sandra with adequate resources, commitment to academic evaluation within the course dominated students' own ways of knowing and integrating new constructions of knowledge. Consequently, Sandra left her mental health practicum without resolving her initial fear of aggressive patients, feeling she hadn't been evaluated fairly and wondering about nursing actions such as administering PRN medications to agitated patients and denying noncompliant anorexia nervosa patients' requests to spend time together. Sandra did value her experience and she clearly viewed the nursing action of sitting down for a cup of coffee with a patient differently after her time on the unit. Sandra gained confidence in her ability to question and engage others. However, Sandra's experience underscores the indisputable need for nurse educators involved in clinical curriculum planning to continue to provide students with adequate basic knowledge and current theoretical concepts being implemented in both the medical and nursing management of psychiatric disorders before placing students on today's acute hospital units. Failing to do so disadvantages not only students, but the clinical instructors and hospital staff nurses who are expected to mentor their progress.

Figure 3.


Repertory Grid
illustrating
Sandra's Personal Construct Charges
Code
Similar or Emergent Construct Poles
Code
Opposite or Implicit Construct Poles
1
2
3
4
5
Caring
4,5,7
2,3 8,10
1,9
6
Non Caring
5,6
9
Duty
2
6,9
3
1,5 8,10
4
7
Compassion
8,2
7
Informal
1
7
4
10
2,5
6
3,8
9
Formal
1,3
10
Clinical
2,5,9
8,10
3,6
4
1
7
Not Clinical
9,8
6
Personal Preference
1
4
3.7
8,10
2,5,6,9
Duty its Your Job
3,1
2
Care
7
4
3
10
1
2
8
9
5,6
Rehabilitation
5,7
10

Personal Construct Changes and Reflections — Discussion

Overall, the personal constructs Sandra initially used to describe her way of looking at the ten elements or nurses' activities studied remained effective as she described her views at the end of the course. As Sandra commented when she explained her first set of personal constructs: "I think all the time that things are either caring or not caring when it comes to nursing." In fact, on eight occasions, Sandra emphasized how her ways of looking at the elements at the end of the course had "not changed" since the beginning of the course. In Sandra's words:

... Nothing of mine really changed.
... I don't know if (the element) is really important.
... That's what inhibited my change here.
... My attitudes haven't changed.
... Just because I have a little more knowledge about why it's done, I (still)don't agree with it.
... It's not what I would want to do.
... The same essentially. Nothing changed.
... Everything else was within one (increment).

Feeling "completely unprepared" and concerned with attending to course evaluation requirements prohibited Sandra from exploring the nursing activities she saw role modeled in relation to her own constructions of knowledge. With the exception of the present study, how Sandra's personal constructions of knowledge changed or did not change during her clinical experience was not acknowledged.

Sandra viewed the elements or nurses' activities studied as "caring or not caring," "duty or

compassion," " informal or formal," "clinical or not clinical," "personal preference or duty — it's your job," and "care or rehabilitation." In ten instances, Sandra rated elements differently by three increments on her post course repertory grid. Three of those instances involved element number four, sitting down and drinking a cup of coffee with a patient in the hospital dining room. Three involved element number two, administering a PRN medication to an agitated patient. One involved element number six, denying an anorexia nervosa patient's request to spend time together. One involved element number seven, holding a crying patient's hand. The last one involved element number nine, presenting a patient to the health care team during unit rounds.

Regarding element number four, sitting down and drinking a cup of coffee with a patient in the hospital dining room, Sandra initially rated this action right in the middle between "duty and compassion." However, at the end of the course, she clearly rated it "compassion." Sandra explained:

> I think now that I've worked in mental health a little more, (it is necessary to) engage your patients. That's part of being a mental health nurse. Therefore, it's sort of your duty, but it also engages the person. It says: "I'm a human being too and I'm here to help you. Let's sit down and talk. I'm real. I'm a person too and I can talk to you." I've learned that!

Sandra rated element number four as "informal" at the beginning of the course, but in the middle, three increments closer to "formal" at the end of the course, commenting: "it has therapeutic value."

Further, Sandra initially rated element number four in the middle between "care and rehabilitation," but later rated it directly beside "care" on her post course grid. During our discussion, Sandra thought further about the nursing action and "how you're rehabilitating" in the process of having coffee with a patient and added: "I've changed my answer: Yes it's caring but I think you're being therapeutic while you're caring, so therefore you're rehabilitating."

When I asked Sandra to talk more about how her thinking changed about sitting down and drinking a cup of coffee with a patient, she replied:

> I have a different slant on it. Originally, when we did this sheet, I said it was right in the middle. I think, now that I really think about it, I think about it more articulately. More in a global sense of what I've learned. I think you can be therapeutic. You are being personal with another person, but you are the professional, so you can glean information by doing this.

I was interested in this "different slant" Sandra felt towards sitting down for coffee with a patient and, a month after the course ended, I asked her to comment again on this element during our correspondence. Sandra wrote:

> At first, this kind of interaction seemed too casual for the "nurse/patient" relationship. Now I realize that sometimes more information can be gleaned in a less formal setting where the focus is not strictly "the patient."

Regarding element number two, administering a PRN medication to an agitated patient, Sandra initially rated this activity in the middle between "duty and compassion." After her

clinical experience, Sandra rated it three increments over, directly beside "duty." She explained:

> What I was thinking when I first did this was that because the person is agitated — you want to help them, so I put it in the middle. But (after the course), it's all duty. Strictly duty.

Sandra identified that with an agitated patient — "Oh, they're agitated, gotta give them their meds," but her reluctance to accept the practice is apparent in the following except from our conversation:

> We had an experience with a gentleman who is mentally retarded and he's quite aggressive. The first thing they did, as the lady or the nurse said, was stick him with a butt full of Haldol. I asked my instructor about that. I said: "Just because he's a little agitated, why should you do that?" She said: "Because, a lot of times it will only get worse." So, in order to preserve the environment, we have to take the bull by the horns and deal with it now before it gets out of hand. So really, I guess that's why I went from being in the middle of the road of duty and compassion to strictly duty.

When I asked Sandra if she viewed administering PRN medication to agitated patients as important, she continued:

> I don't know if it's really important. I think I've learned that's the way they do it here. If it were me, mind you I'm just a student nurse, if it were me, I probably would have let it go a little longer. That's because the patient knew he had done something wrong and he ran into his bed and covered his head. So — he knew he was a bad boy really, because he had the brain of a six-year-old. I think really that's all he needed. Anyway, I think that's what inhibited my change here.

Using her personal constructs of "care and rehabilitation," Sandra rated the nursing action of administering a PRN medication to an agitated patient one increment away from "care" at the beginning of the course but three increments farther away from "care" and closer to "rehabilitation" by the end of the course. Sandra commented that "once you have calmed an agitated person, you can work with them a little better," but after her hospital experience, she clearly viewed the nursing action as one which is less caring than rehabilitative. Looking at the practice through Sandra's eyes, with so little background in the pharmacological treatment of mental illness and the hospital staff's non professional discussion of the practice, Sandra's observations serve as a mirror inviting continued examination to explain why psychiatric mental health nurses administer PRN medications to agitated patients.

Regarding element number six, denying a non compliant anorexia nervosa patient's request to spend time together, both at the beginning and at the end of the course, Sandra emphasized that she did "not" think this activity "is therapeutic." Sandra originally rated the nursing action in the middle of "formal and informal." By the end of the course, Sandra rated it three increments over and explained that she viewed this activity as "strictly formal now." Again, without extensive background information on the role of behavior modification as a treatment plan for acutely ill and critically emaciated patients, some of whom weigh less than 70 pounds and have been admitted for immediate medical management of anorexia nervosa, Sandra wondered about this nursing action and compared the practice to one implemented by a psychologist she had heard of. Sandra elaborated:

> Just because I have a little more knowledge now about why it's done — I

> don't agree with it. Originally, I put that it was in the middle of formal and informal. Now I understand it so I think it's strictly formal. So that's the way they do it, that's the way it's supposed to be done, that's protocol. However, personally, that's not what I would do. Therefore, I go by the book — so it's formal . . . It's not what I would want to do. I don't know if I could get around it in any way. I don't really have that much experience. I just know what I've seen about this woman in Victoria (Peggy St Pierre), and she has miraculous success. She's a wonderful woman and it's all based on love. This particular scenario (the behavior modification treatment plan) is not caring to me, it's not a loving situation. It's denial of both those things. To me anyway, that's my personal opinion.

Regarding element number ten, facilitating a group therapy session, Sandra rated this nursing activity three increments closer to both her categories of "informal rather than formal" and "care rather than rehabilitation." Thus, on her post course repertory grid, Sandra's thinking about facilitating a group therapy session was right in the middle of her personal constructs. At the beginning of the course, she had clearly rated this element right beside two of her implicit construct poles.

Sandra had the opportunity during her rotation to observe a certified nurse group therapist conduct inpatient therapy sessions. Unlike hospital staff nurses, who implemented mainly basic or custodial care, this nurse specialist worked only with therapy groups and was not responsible for any patient care assignments on the unit. Sandra's developing understanding and respect for this practice is apparent in the following explanation of how she views this element as more "informal and both caring and rehabilitative" after the course:

> At first I thought it was formal but now I changed it right in the middle of formal and informal. I think that after watching a couple of sessions — as a

> facilitator you're not necessarily there to run the group. You're there to facilitate, to help people get things going and let them do the talking. Therefore, you are there as a catalyst for everybody else to get what they need, to say what they want to say. So therefore it's in the middle. You're there, but you're not the focus. So — therefore it's not as formal . . . Originally I said it was just rehab, but now I think that it's rehab as well as caring. That's because, by facilitating this group, you are showing that you are using your professionalism so that as a patient, you see this person trying to help you bring out your issues.

Regarding element number seven, holding a crying patient's hand, Sandra commented: "Originally, I said that was right in the middle, clinical versus not clinical. Today I said it's not clinical. I believe that now." In Sandra's view:

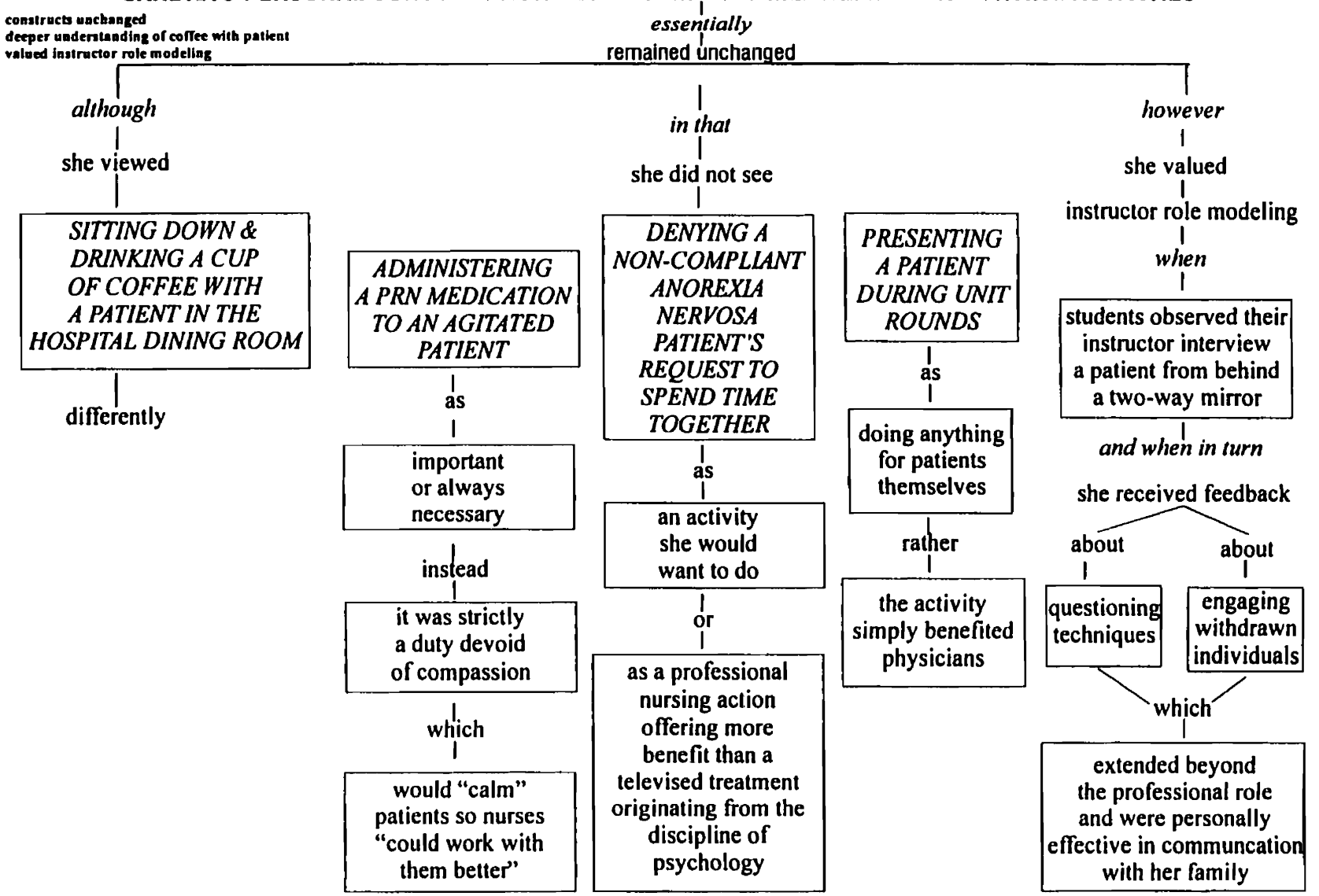
> I think that holding a crying patient's hand shows that you have compassion, that you're a person and you're there to help. I don't necessarily think that helping is clinical, caring is just being a person . . . Holding a person's hand isn't clinical, you don't have to do that, it's just a personal touch.

Finally, with regard to element number nine, presenting a patient to the health care team during unit rounds, discussing Sandra's perceptions of this nursing activity shed further light on how the practice can appear to a student visitor to the unit. Sandra summarized her perceptions with these comments:

> Presenting a patient to the health care team. Originally I said that was right in the middle between patient care and rehabilitation and now I think that it is strictly rehabilitation. I really don't think personally that I would want a bunch of people standing over top of me. That really isn't for the patient's benefit. It is in the sense that maybe somebody might come up with something but really the doctors or nurses or whoever is doing the presenting is just presenting. They are not doing anything for that patient. So — therefore it might be rehab for the doctors but it's not rehab for the patients!

Figure 4.

SANDRA'S PERSONAL CONSTRUCTIONS OF PSYCHIATRIC MENTAL HEALTH NURSING ACTIVITIES



Case Report II: Nathan

Nathan — The Team Player

Nathan is a 21-year-old former science student from the North West Territories. At home in the Canadian north, he felt close to his neighbors. Moving to a larger urban center was a striking change. Initially he found the city "interesting" although "it's still too big." After attending university for a year, he chose the faculty of nursing because he enjoyed being with nursing students and "did not find satisfaction or see a future with science education."

Nathan felt he had "something to say" and participated in the present study as one way of entering the scholariy community within nursing and sharing his views about nursing "for some type of purpose greater than me just talking about it saying: "I don't like this and I don't like that." In his view, practicing nurses all too often seemed "apathetic" and lacked the "passion and enthusiasm" for the profession that he and some of his fellow students felt. He saw himself as a confident team player who enjoyed working in groups. Throughout this investigation Nathan was careful to attend interviews promptly and not to jeopardize his clinical commitments because of his participation. He made a point of sharing a relevant research article with me to strengthen my project.

Except for what he had seen and heard in the media, Nathan had no previous knowledge of what psychiatric mental health nursing involved. At the beginning of the rotation, he felt

apprehensive, expressed little interest in the field and believed that the clinical experience "had nothing to give me." He expected mentally ill patients to present with "acutely psychotic, vegetative or extreme symptoms" and wondered if he could "do" anything to help them.

By the end of the clinical experience, he was more open to the possibility of working in the area and had rated two nursing activities differently according to his own personal constructions of meaning. Nathan held his instructor in high regard, felt closer to students in his clinical group and had been genuinely touched by his patients. However, he remained profoundly disturbed by hospital nurse role models who often lacked a professional presentation and who seemed to implement little other than basic or custodial nursing care.

The value of his instructor, peers and patients

Nathan's clinical instructor, his peers and his patients were all positive influences as he constructed his own knowledge about psychiatric mental health nursing. He appreciated his clinical instructor's modeling of interviewing strategies with patients, her instructions prior to the clinical experience and her willingness to listen to his ideas and frustrations throughout the course. He commented that "she's good at what she does." He valued the verbal feedback she offered while students were on the hospital unit and the ongoing comments she wrote in his journal each week. Reflecting on his developing interviewing skills, Nathan expressed that he "would have liked more specific feedback from my instructor and on a more frequent basis."

"Support from other students" was also important to Nathan. During his clinical experience, he "became very good friends with (his fellow students) in this setting." In fact, it was his peers who were his main source of "suggestions, guidance and feedback." Nathan did not believe that the course had been designed to facilitate the clinical group process. "Sometimes, our instructor would (confront) us if we were talking amongst ourselves when we were all together in a group...it would make others feel excluded ... she wanted us to be a group as students and not to be paired off." Overall, however, Nathan believed that it was the students themselves who "formed good group dynamics" and "if the dynamics of this group hadn't been good, I think it would really have affected how I felt about this rotation, not having the support of the other students. My peers were my life support!"

By the end of his clinical experience, Nathan felt he had engaged several "remarkable" patients. He spoke of an older man who was "so charismatic ... one of the most interesting people I have ever met in my life." Additionally, Nathan described an eighteen-year-old who had been admitted for depression and suicide attempts as "a person who is so intelligent and articulate ... the type of person I would be friends with outside the hospital setting." Clearly, as in previous studies (Bairan & Farnsworth, 1989; Creech, 1977; Gelfand & Ulman, 1961; Lewis & Cleveland, 1966; Morris, 1964; Smith, 1969), Nathan's stereotypical views of patients were altered as a result of his clinical experience.

Disturbing staff role models

On the other hand, consistent with Perese's (1996) findings, the Registered Nurses and Registered Psychiatric Nurses who Nathan met on the hospital unit, projected a strikingly negative image. At the beginning of the course, Nathan did not view the professional staff as a "team," saw no evidence of the "therapeutic milieu" he had been introduced to in class and felt actively "rejected" by the unit group. As the course progressed, he was "impressed" by one nurse's charting but he never really came to know any of the nurses. For Nathan, "an inquiry or even a smile" from staff nurses was consistently missing from his clinical experience. During other clinical experiences, unit staff often included students during procedures or lunch breaks, but during Nathan's psychiatric mental health experience, this was not the case. Nathan explained:

> the only time my nurse and I communicate is when I approach her or him (to say that) "I'm going on break now, my patient did this, or I'm leaving for the day, this is what I did today." Very little "How is your patient doing, or do you need anything from staff?" So that type of comradery or team is missing from this rotation for me.

By the end of the course, Nathan had not seen any nurses actually "sit down half an hour with a patient." He thought that "granted they probably can't," but he wondered why they couldn't "sit down today for half an hour with three patients and then for half an hour tomorrow with three other patients ... even for ten minutes ... I just don't see it being done."

The professional staff's personal presentation and language exchange was disturbing to

Nathan. He felt uncomfortable around one staff member and noted that "I wouldn't want him for my nurse." Fellow students recounted an incident to him where a patient described a staff nurse who entered the patient's room and mimicked the patient's tremors. The students all viewed the action as belittling and unkind and were offered no further clarification or explanation. In another situation, when a patient remained in the bathroom for an extended period of time, a nurse remarked to Nathan: "He's probably masturbating in there." Nathan left the experience convinced that "some nurses could be doing things differently" and his initial negative perceptions of professional staff, particulary the male nurses, remained completely unchanged.

Nathan's perceptions reflect an important aspect of learning which was missing for him. As a novice male nurse, Nathan valued experiences where he could observe positive role models. In 1995, only 4 per cent of Canada's Registered Nurses were men (Trudeau, 1996). According to Trudeau (1996), close to 16 per cent of male nurses worked in the psychiatric mental health area in 1995, compared with fewer than 5 per cent of female nurses. Reflecting on historical patterns, Trudeau (1996) noted that traditionally, most schools of nursing that accepted men were connected with mental institutions (believing men were better able to deal with the physical demands of psychiatric patients) and that when males were accepted into mainstream nursing schools, they met with resistence in areas such as obstetrics and gynecology, resulting in a tendency for male nurses to specialize in psychiatry or critical care. While male nurses are well represented in psychiatric nursing, unfortunately during Nathan's practicum, few opportunities existed for him to even meet potential mentors.

Figure 5.

Repertory Grid illustrating Nathan's Personal Construct Charges

Code: Similar or Emergent Construct Poles	1	2	3	4	5	Code: Opposite or Implicit Construct Poles
Easy to Violate Ethics 9,6	9	6,10,2,5	8,1,3,4		7	Not Easy to Violate Ethics 5
Cognitive 8,7	6,7, 8,9, 10,5	4,2,3		1		Psychomotor 2
Duty 10,12	7	5,8,10,2	4,3	1,6,9		Policy 1
Patient oriented 8,6	5,7	4,6,8, 2,3	10	1,9		Hospital or Community Oriented 9
Unit Judgement 2,3	4,7,8	5,6,2,3	9	10	1	Unity Policy 1
Sequential/Concrete (an action which requires steps) 5,10	1,9	5,10,2,3		4	7 → 8 / → 6	Abstract 7

Personal Construct Changes and Reflections — Discussion

The personal constructs which Nathan developed on his repertory grid accurately reflected his "fundamental patterns of thinking," and both at the beginning and at the end of the course, the constructs remained "easy for (Nathan) to see (nursing activities) in the categories (he) divided them up into." In Nathan's view, nursing activities were either "easy to violate ethics" or "not easy to violate ethics," "cognitive" or "psychomotor," "duty" or "policy," "patient oriented" or "hospital or community oriented," "unit judgement" or "unit policy" and finally, "sequential/concrete or "abstract." In all but this final category, Nathan's ways of rating the nursing activities studied shifted only one or two increments or not at all.

However, his repertory grid did reflect a significant change in thinking about two professional psychiatric mental health nursing activities in relation to whether they were "sequential/concrete" or "abstract." By "sequential/concrete," Nathan meant activities such as hand washing which required a clear sequence of action oriented steps and which could be fairly easily explained or taught. By "abstract," he meant activities such as assessments which required a deeper knowledge base of patients' background as well as their medical diagnosis and prescribed medication and involved critical understanding and contextual nursing judgements.

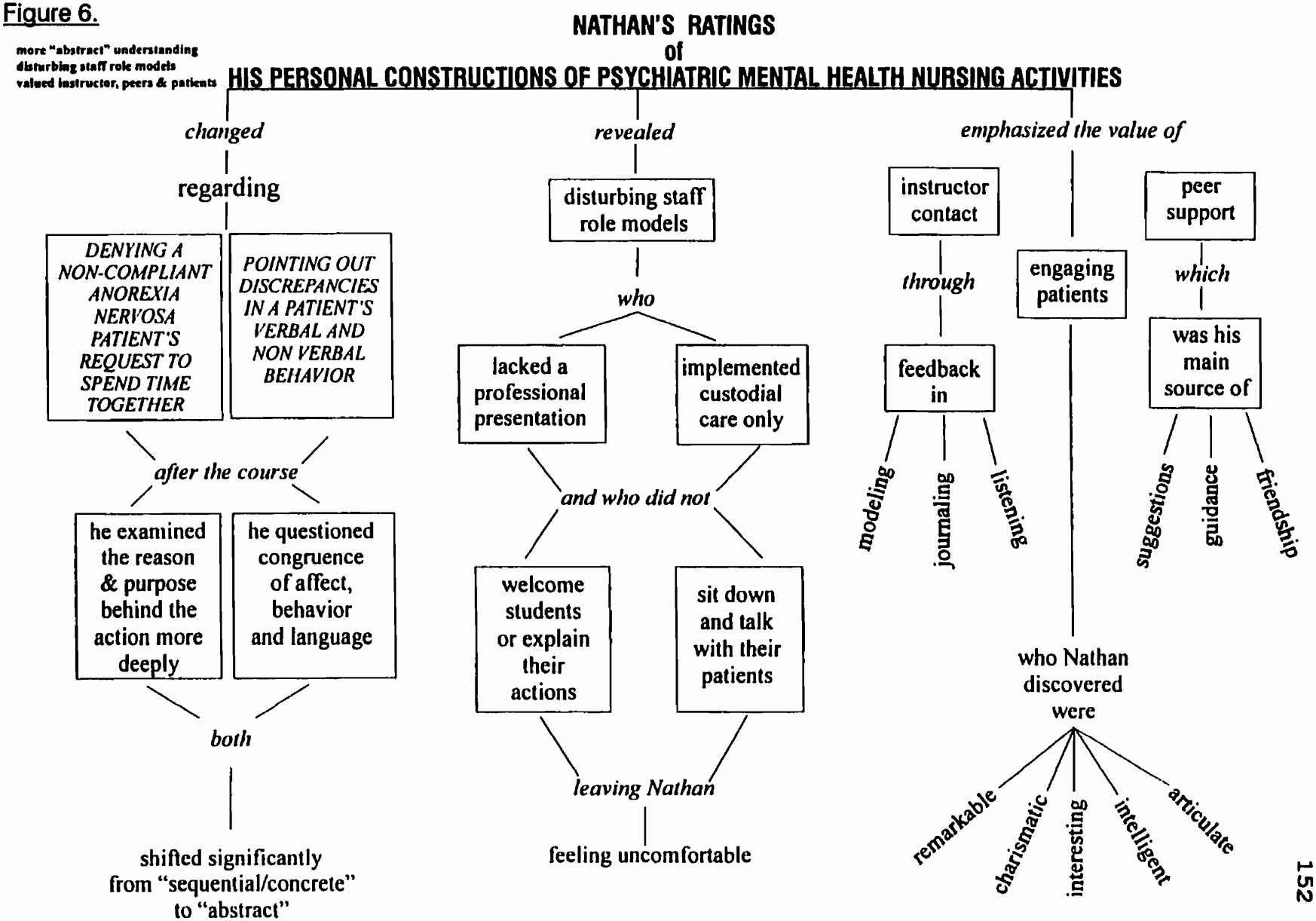
The two nursing activities which Nathan initially rated as "sequential/concrete" but later rated as "abstract" were, first, denying a non compliant anorexia nervosa patient's request to spend

time together, and second, pointing out discrepancies in a patient's verbal and non verbal behavior. In the first instance, when the course was over, Nathan looked at the action of denying a non compliant patient's request to spend time together differently and felt that he "questioned the reason and purpose behind the nursing action more." In the second instance, with regard to pointing out discrepancies in verbal and non verbal behavior, he commented:

> Now I think of it more as you really have to think about what is going on and about what the differences are in what you are seeing and what you are hearing. I think that it is something that becomes very important, especially in psychiatric nursing. It is important to be able to hear what this person is saying, but also to recognize what is happening. Is there inconsistencies between their affect and their behavior or their affect and their language?

Thus, after his clinical experience, Nathan felt he had a more "abstract" understanding of nursing actions like denying patient requests and pointing out discrepancies in patient behavior. On his last clinical day, Nathan was "almost regretful" that the experience was over and he commented: "I am therapeutic."

Figure 6.


NATHAN'S RATINGS
of
HIS PERSONAL CONSTRUCTIONS OF PSYCHIATRIC MENTAL HEALTH NURSING ACTIVITIES
more "abstract" understanding
disturbing staff role models
valued instructor, peers & patients
changed
regarding
DENYING A NON-COMPLIANT ANOREXIA NERVOSA PATIENT'S REQUEST TO SPEND TIME TOGETHER
POINTING OUT DISCREPANCIES IN A PATIENT'S VERBAL AND NON VERBAL BEHAVIOR
after the course
he examined the reason & purpose behind the action more deeply
he questioned congruence of affect, behavior and language
both
shifted significantly from "sequential/concrete" to "abstract"
revealed
disturbing staff role models
who
lacked a professional presentation
implemented custodial care only
and who did not
welcome students or explain their actions
sit down and talk with their patients
leaving Nathan
feeling uncomfortable
emphasized the value of
instructor contact
through
feedback in
modeling
journaling
listening
engaging patients
who Nathan discovered were
remarkable
charismatic
interesting
intelligent
articulate
peer support
which
was his main source of
suggestions
guidance
friendship

Case Report III: Simone

Simone — The Caring Friend

Simone is a 20-year-old Trinidadian student who spent her first year out of high school in general studies in the Faculty of Science. She chose nursing because she "loved people and wanted to care for them in their most vulnerable states." Her final grade in the course was A-. Simone had heard from other students talking about the psychiatric mental health rotation that "it was stressful and that the units were not very receptive to students." Initially, she expected the experience to be both "scary" and "interesting, like (the movie) One Flew Over the Cuckoo's Nest." Although Simone does not expect to work in the area, by the end of the course she felt that she had become more "flexible" and commented that the practicum "was better than I thought it would be."

Simone came from a close knit "loving" family who stood by one another in times of crisis. When Simone's grandfather became gravely ill in the middle of her clinical experience, Simone did not want to leave her mother and father alone at home. While her parents insisted that she continue with her course, Simone frequently felt torn between attending to her family and concentrating on her studies. Simone's clinical instructor was not aware of her family concerns. The issues of depression, suicide and sexual abuse which many of Simone's patients and their families struggled with were new issues for her. In Simone's own family, these kinds of issues had never come up. In the process of setting her own goals for the

practicum, Simone wondered "how far I can get with myself" to be able to "actually help my patients."

Lack of curriculum preparation and a closed staff group

During Simone's program of study, lectures explaining mental health concepts such as psychosis, dementia and suicide were integrated with medical surgical content and were offered concurrently with the clinical experience component. Specific mental health content had not been introduced in her first year of nursing education, and clinical orientation was limited due to the large number of students rotating through four clinical sites and the brief six-week exposure to the area. With no "pre session readings or assignments, and no information about mental illness in the syllabus," Simone's curriculum left her "unprepared for this clinical." When the university term began after Christmas break, Simone attended class Monday morning, bought her textbook that afternoon and began her clinical experience the next day.

On her first day on the unit, Simone approached two nurses standing in the medication room with a question. One nurse asked her to leave and closed the medication room door. Standing outside the glass room and looking in at the two nurses, Simone wondered whether "they know what kind of impact they are having on us." She was not invited to ask her question at another time nor was she acknowledged again later. In her view, the professional staff group was closed to new members.

Later on in the rotation, Simone noticed how one staff member "talked to the unit clerk for half an hour at the nurses' station and then went on her break." She saw her classmates sitting in the lounge area and introducing patients to one another, but "nurses only seemed to talk to the patients when the patients came to the desk to ask for something." When Simone "sat and talked to a neglected patient (in the lounge)," she "thought (she) was doing something wrong the way the nurses looked at me." On another occasion, Simone expressed how she "felt happy" that a patient had chosen to attend an activity. However, she simply felt "belittled" for sharing her observation when a staff nurse responded: "That'll never happen again!" Simone was surprised by these nursing responses. She commented: "I didn't expect this (behavior); my instructor is so warm and enthusiastic."

During previous clinical experiences, Simone had gained confidence in her role as a patient advocate: "It's not OK to just sit there if you see something wrong." As a first year nursing student, she had readily asked a physician to "have a large pill ordered as a liquid" as a comfort measure for her patient. Yet, during her psychiatric mental health placement, she did not see nurses implementing "obvious" comfort measures such as "cutting long toenails." She wondered if nurses "kept the physical in psych" with regard to "even routine physical assessments (such as) ruling out diabetic shock for a patient on an insulin regime." Similar to findings reported by Davidhizar and McBride (1985), who concluded that students indicated the lowest feelings of success in both clinical nursing care and mastery of theory in the psychiatric area, Simone did not feel the "same" self confidence and efficacy "to speak up" in this placement that she had developed in other clinical areas. From her observations

of psychiatric mental health staff nurses, she concluded: "They (the nurses) don't think they can make a difference so they just give up!"

Meaningful discussions with a friend

Excluded from the staff group, introduced to psychiatric concepts only through an integrated curriculum and unable to draw upon personal or family knowledge about mental illness, Simone often turned to one of her classmates "to talk" and pull in essential theory. Through these discussions, Simone came to see the idea of "(being) crazy as an illness which can be treated." Her psychiatric patients "didn't make themselves this way, it just is." On her own or in conjunction with her friend, she integrated how "discharge planning, medication regimes and follow up are critical to care in the psychiatric clinical area." She came to understand "the positive and negative symptoms of schizophrenia, vegetative shift and (planned) social nursing interventions" more deeply.

During the fifth week of the rotation, one staff nurse, "Irene," asked Simone about her new university nursing program and Irene commented: "I like students." After this exchange, Simone emphasized how "just a couple of people can change your views, although first impressions are pretty strong." After meeting Irene, Simone was

> ... still not satisfied with (professional staff) role modeling, although I'm more tolerant now. I never thought that nurses learn from students. I thought they were here to show us. As students we think we're the lowest link on the food chain, but when a nurse says something like that, I think we're not that low. We're taught to look at our patients holistically, but nurses are people too.

> After talking with Irene, I saw her not only as a nurse, but as a wife and a person outside of this unit. . . . a friend . . . I feel more like I'm part of the milieu now.

Simone described one other "good psychiatric nurse." It is telling that Simone did not know this second nurse's name and could only describe the nurse by the clothes she wore. This nurse's actions included:

> ... approaching us . . . seeing if our meds are done . . . giving suggestions . . . asking us to come back in a couple of minutes if she's busy . . . pulling us in with the physician . . . being willing to listen . . . and joining in with the patients.

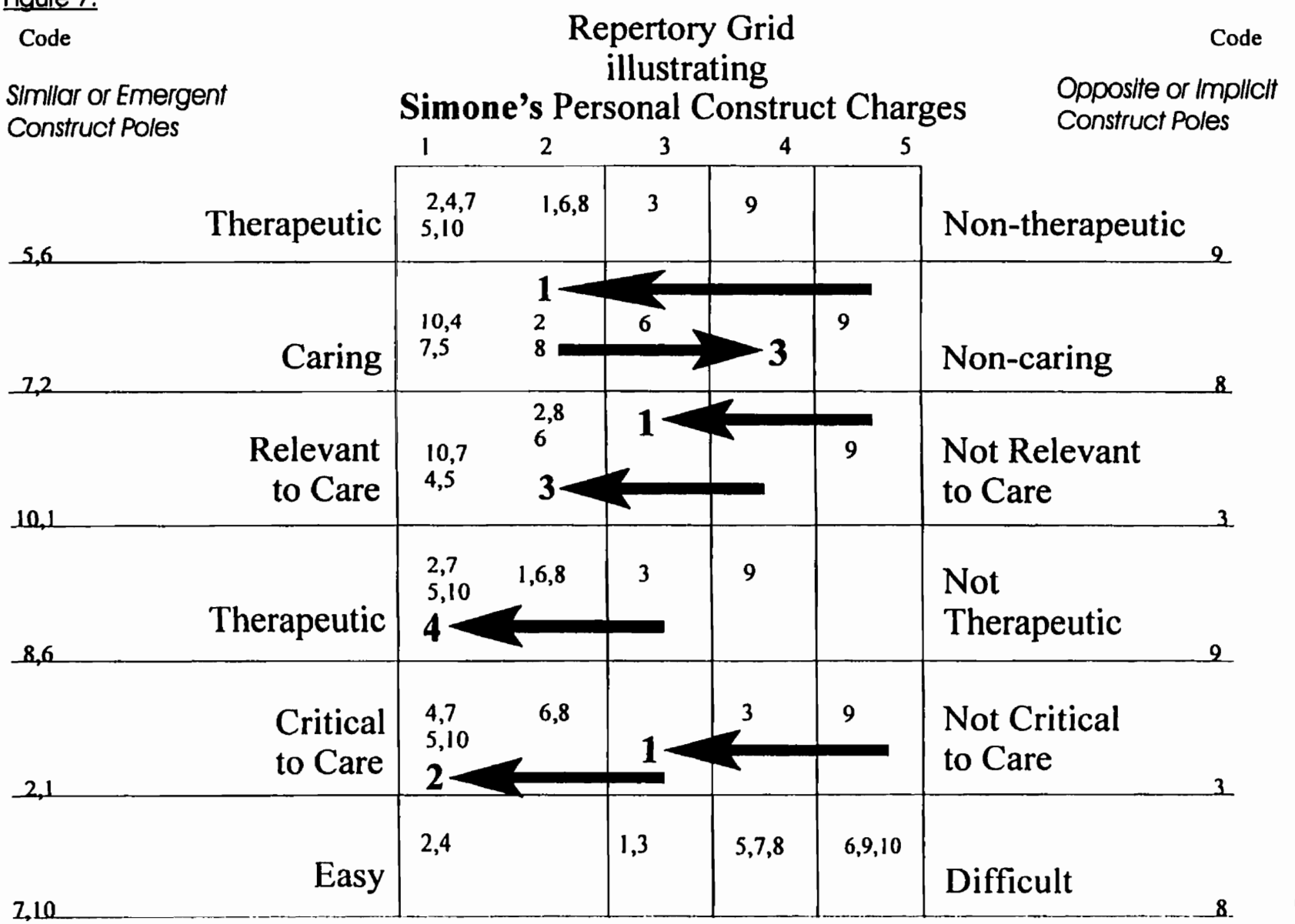
However, during four of the six weeks she spent on the unit, Simone felt so "isolated" from the hospital unit group that she believed the clinical experience "should be eliminated." During our first interview, she remarked: "I wouldn't mind working in psychiatry if I could come in and know I had buddies." At the end of the course, in response to Perese's (1996) question: "What did you like least about your experience?", Simone wrote: "The way staff nurses would treat students and patients."

The relationships which Simone formed with students and staff in her practicum environment played a crucial role in enabling the process of meaningful learning to take place for her. Griffin (1988) identified that the human mind learns through six capabilities: rational, which most university curriculums address, emotional, physical, metaphoric or intuitive, spiritual and relational. Griffin (1988) compared these six capabilities to the six strings of a guitar. She

compared playing a guitar with only one string to learning opportunities which focus exclusively on the rational mind. According to Griffin (1988), exploring the five remaining and "often-overlooked capabilities ... (will) enhance the learning and teaching process" (p.105). Dealing with the relational aspect of learning (which was so important to Simone), Griffin (1988) pointed to the importance of incorporating the "special and deliberate relationships created with other learners in the class and often outside of the class" into formal learning experiences. In Griffin's (1988) view "the teacher's aid and awareness of these relationships is important" (p. 105).

In conclusion, one of the most personally meaningful aspects of learning for Simone was her conversations with a fellow student. When both her curriculum and her hospital role models failed to equip her with the information she needed, she turned to her peers and found a learning partner with whom she could share her ways of understanding and coming to know about psychiatric mental health nursing. With the exception of the present study, Simone's relational learning, that is, her work with a friend and learning partner was not acknowledged within the framework of the course or in the formal evaluation of her clinical performance. Simone's experience begs the question once again of how a brief six-week psychiatric mental health clinical placement, with no introductory level courses, and few opportunities to recognize the personal learning resources which students employ, can best introduce students to the complex and changing field of hospital mental health nursing.

Figure 7.


Repertory Grid
illustrating
Simone's Personal Construct Charges
Code
Similar or Emergent Construct Poles
Code
Opposite or Implicit Construct Poles
1
2
3
4
5
Therapeutic
2,4,7
5,10
1,6,8
3
9
Non-therapeutic
5,6
9
1
Caring
10,4
7,5
2
8
6
3
9
Non-caring
7,2
8
2,8
6
1
Relevant to Care
10,7
4,5
3
9
Not Relevant to Care
10,1
3
Therapeutic
2,7
5,10
4
1,6,8
3
9
Not Therapeutic
8,6
9
Critical to Care
4,7
5,10
2
6,8
1
3
9
Not Critical to Care
2,1
3
Easy
2,4
1,3
5,7,8
6,9,10
Difficult
7,10
8

Personal Construct Changes and Reflections — Discussion

On her repertory grid, Simone viewed the ten nurses' activities studied as "therapeutic or not therapeutic," "caring or not caring," "relevant to care or not relevant to care," "critical to care or not critical to care" and "easy or difficult." At the end of the course, she rated five of the activities three increments closer to her opposing construct pole than when she rated them at the beginning of the course. Only one activity, that of wearing street clothes on the unit, moved more than three increments between the construct poles. Simone initially saw wearing street clothes as "not caring." After her clinical experience, she viewed the activity as "caring." She explained: "At first, it wasn't very caring. I do think it's very caring now because you don't want to (impose) a hierarchy. You don't want to make patients feel that you are superior . . . or, (to) make you feel that you are superior (either)." Also, "because of the hierarchy," she saw the activity as more "relevant to care" than "not relevant to care," and more "easy" than "difficult."

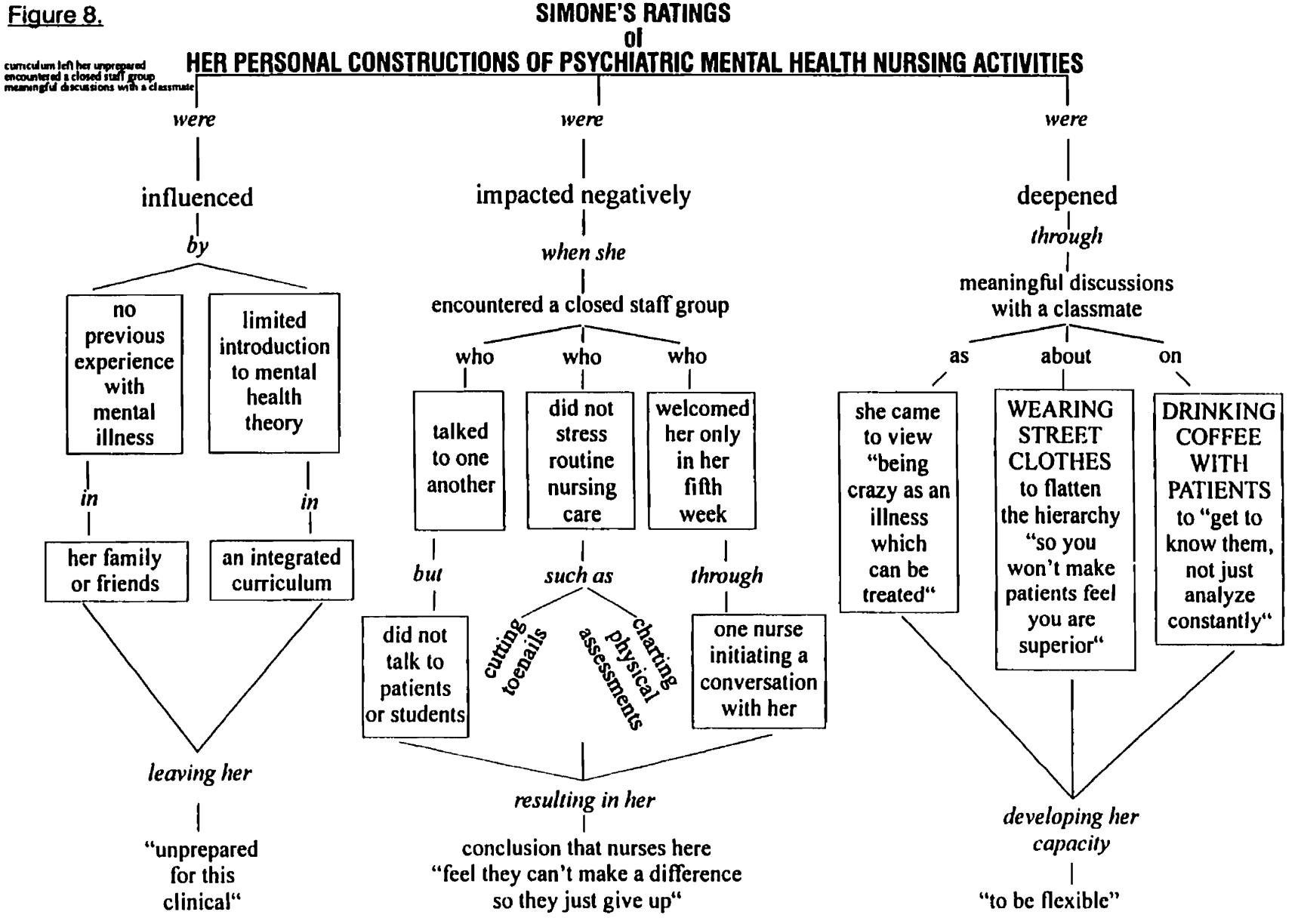
The remaining four activities which Simone rated differently by three increments were, accompanying a patient on a smoking break, administering a PRN medication, sitting down and drinking a cup of coffee with a patient and denying a non compliant anorexia nervosa patient's request to spend time together. While Simone rated the activity of accompanying a patient on a smoking break more "not caring" than "caring," she clarified: "That's just because I don't like smoking." While she rated this activity "not relevant to care" at the beginning of the experience, by the end of the rotation, she believed it was more "relevant to

care." She thought: "taking (patients) for a break would mean a lot to them so that would probably decrease their anger to you and let them be a bit more open." Administering a PRN medication was "difficult at first but it got easier because you could see that sometimes that's the only thing we can do to decrease the anxiety and the violence." In Simone's words, sitting down and drinking a cup of coffee with a patient:

> ... went from not critical to care to critical to care and that's because sitting down with them and getting to know them as a human being is a lot more important than just analyzing them constantly. They're not just there for analysis, they're there to be helped.

Finally, Simone initially regarded denying an a non compliant anorexia nervosa patient's request to spend time together as "relevant." However, despite what she saw hospital staff nurses doing, Simone believed "from what I am reading, I really think we should talk to (patients diagnosed with anorexia nervosa) regardless of what they are doing."

Figure 8.


SIMONE'S RATINGS
of
HER PERSONAL CONSTRUCTIONS OF PSYCHIATRIC MENTAL HEALTH NURSING ACTIVITIES
curriculum left her unprepared
encountered a closed staff group
meaningful discussions with a classmate
were
were
were
influenced
by
no previous experience with mental illness
limited introduction to mental health theory
in
in
her family or friends
an integrated curriculum
leaving her
"unprepared for this clinical"
impacted negatively
when she
encountered a closed staff group
who
who
who
talked to one another
did not stress routine nursing care
welcomed her only in her fifth week
but
such as
through
did not talk to patients or students
cutting toenails
charting physical assessments
one nurse initiating a conversation with her
resulting in her
conclusion that nurses here "feel they can't make a difference so they just give up"
deepened
through
meaningful discussions with a classmate
as
about
on
she came to view "being crazy as an illness which can be treated"
WEARING STREET CLOTHES to flatten the hierarchy "so you won't make patients feel you are superior"
DRINKING COFFEE WITH PATIENTS to "get to know them, not just analyze constantly"
developing her capacity
"to be flexible"

Case Report IV: Heather

Heather — The Novice Psychiatric Nurse

Heather is an adult student who completed a Bachelor of Arts degree before enrolling in the Faculty of Nursing. Heather majored in psychology and one of her reasons for choosing nursing was that a "career counselor told me about psychiatric nursing, and I thought it might fit with my degree."

Heather was the only participant in the present study who expressed an interest in the field of psychiatric mental health nursing before completing the practicum. She was also the only participant who chose to attend the provincial mental institution site for her clinical experience. The institution is about a three-hour drive from Calgary. Throughout the six-week clinical placement, the students and their clinical instructor drove out individually to the facility on Thursday mornings. They met as a group for a pre conference, joined the unit staff for a two-to-ten shift that evening and then spent the night in a two-room staff "house" located on the hospital grounds. On Friday mornings, the students and their instructor were part of the day shift from seven-to-three, attended a post conference and then went their separate ways to drive home Friday evening. Canadian winter driving conditions were often unpredictable and Heather's clinical instructor frequently arranged a "cavalcade of cars" and ensured that "someone had a cell phone when we were on the highway." The students who chose this placement were a self selected group, many of whom "knew each other before the

experience." One of the students in Heather's group commented that: "We wanted the best experience and we knew this was it." Heather earned a clinical grade of A in her practicum and shortly after the course began, her clinical instructor noticed that she was a "strong student." Heather is single and her family live out of province. She boards in Calgary and works twenty to forty hours a week as a waitress.

At the end of the course, Heather continued to be interested in the field of psychiatric mental health nursing, but "probably not as a hospital staff nurse." She left the experience with "more questions" about the area and wondered what working in "forensic psychiatry or with teenagers in schools" might be like. The clinical placement was her "favorite so far" and she described it as "excellent — interesting and stimulating." However, Heather's clinical experience failed to provide her with adequate opportunities to reflect upon her own process of constructing knowledge. Heather demonstrated the required competencies for her nursing course and she readily adapted to the unique milieu of a provincial mental institution. Yet, beyond the required and expected competencies, her repertory grid suggested that she also clearly demonstrated dramatic changes in her own personal growth and professional development as a result of the rotation. Even with the intense 24-hour exposure to instructors and peers, with the exception of the present project, these profound personal changes were essentially unacknowledged within the framework of the course. For this student, the narrative research approach of reflecting on personal construct changes developed by Shapiro (1986, 1991, 1994) was particularly valuable and did provide an opportunity to recognize learning which otherwise may not have been acknowledged.

Personal and professional growth

When Heather first arrived on her assigned unit, she felt "insecure" in the stark "bare" environment. Handed a set of keys, she was immediately drawn into the institutional protocol of unlocking and "securing" the heavy hospital doors. She felt welcome and included by the hospital staff group and sensed that a spirit of community existed between staff and patients. On acute psychiatric wards in urban general hospitals, professional staffs are often indistinguishable from their patients. In this provincial institution setting however, several of the patients wore hospital pyjamas and robes and many wore slippers rather than street shoes. Some staff members wore large badges with their name and affiliation and all staffs were required to carry keys. Heather was struck by the "silence" of the facility and as she looked at the patients, she thought: "I see the people here as sick, I feel bad and I want to help."

Young and Osborne (1991) interviewed nurses who worked at this particular facility during two time periods, the first was between 1950 and 1960 and the second between 1970 to the present. After listening to the nurses, these authors concluded that psychiatric nursing in this provincial hospital was "more than a job, (it was)a way of life, a way of knowing what was really important to people whether you were a patient or a staff member" (p.11). Young and Osborne (1991) summarized the work environment of this institution as follows: "It wasn't easy work and for some it gave financial security, but after a while those things don't matter as much as your feeling of belonging" (p.11). Heather sensed this feeling of belonging and subsequently found the concept of a therapeutic milieu "easier" to understand.

The day I joined Heather on her clinical unit mid way through the course, she shared how her own learning was progressing generally. In particular, she commented on two issues she was in the process of working through. The first issue centered on establishing therapeutic boundaries. The second issue involved distinguishing activities specific to nursing from activities implemented by other professional groups. Looking at the first issue, Heather questioned how she could establish therapeutic boundaries with an "infatuated" female patient "who likes me and follows me around." Heather wondered how to "cope with the frustration and burnout" when a patient "can be admitted 35 times." Another patient told Heather that "I'm not getting the help I need here." Heather found herself feeling "upset, exhausted, funny, and disjointed" when she left the clinical laboratory.

As Heather reflected on the second issue of separating nursing activities from those of other professional staff groups, she looked at the activities she saw nurses engaging in. She observed: "They're always busy, but I'm not sure what they're doing." Heather noticed that psychiatric mental health nurses "spend a lot of time advocating for patients when they're on the phone with physicians." She saw nurses "locking, unlocking and checking the doors a lot." Heather admired one nurse who "had the patients all making chili in the kitchen"one evening. Similarly, she appreciated how another nurse "sat and looked at pictures" with a patient. Piecing together the unique nature of mental health nursing, Heather did not have a clear picture of what the role of the psychiatric nurse entailed.

> I wonder what the nursing role really is. We're not trained in some things. The social workers deal with child abuse, the occupational therapists arrange outings like bowling. I think it would be nice if nurses were more involved.

During this mid term interview, Heather also mentioned that she was enjoying her experience and "learning a lot." She did not observe any "cruelty" or "nurses talking down to patients here." She felt that she had "help" with strategies to establish the necessary boundaries in her relationships with patients. She also felt that she was developing a deeper understanding of what a therapeutic milieu "feels like." Joining staff and patients on outings away from the institution, Heather enjoyed the rapport she felt with the staff-patient group: "Going into town for bowling was fun. On the bus ride, we had the music turned up loud and we were all singing together."

Unlike many student Registered Nurses who have little if any interest in a career in psychiatric mental health nursing, Heather entered her practicum with the intention of working in the field. Moir and Abraham (1996) examined how six final year undergraduate nursing students at a Scottish university who chose the psychiatric speciality area as a career justified their choice and constructed an occupational identity. Moir and Abraham (1996) found that although these novice psychiatric nurses believed a general nursing career path offered more rewards, they also viewed mainstream nursing "as technical ... involving routine task completion (and a career which) curtailed opportunities to form relationships with patients or provide investigative and diagnostic challenges" (p.297). By contrast, they saw the less structured psychiatric field as more challenging because of "the lack of established knowledge ... the professional autonomy ... and the sociability (inherent within) the psychological nature of psychiatric nursing" (p. 298). While these researchers did not comment on whether or not the students in their study were interested in psychiatry before enrolling in their nursing

program, their findings indicated that novice psychiatric nurses had clearly constructed their occupational identity by their final year of study. This identity developed through a process of contrasting psychiatry with general nursing. Extracts from conversations with the students in Moir and Abraham's (1996) research reveal how students who chose the psychiatric field felt "included ... valued ... and listened to" in psychiatric settings but simply "measured on how quickly you can do things" in medical surgical areas (p.297). Similarly, in the present study, Heather felt a strong sense of identity within the psychiatric area and did not find it difficult to "fit in."

Reflective time

In concert with her existing interest in the field and the feeling of inclusion which she experienced during her practicum, Heather's identity as a novice psychiatric nurse did become more developed as she completed her rotation. However, in addition to her clinical practicum, she found driving six hours each week and keeping up with a job and her other course requirements exhausting. She described waking up one morning "not knowing right away whether I was at clinical or at the restaurant or at home!"

Without time to reflect and interpret the new ideas and knowledge she was seeking to assimilate, the richness of the clinical experience was diminished for Heather. Brookfield (1988) criticizes higher education experiences which neglect "praxis, that is ensuring that opportunities for the interplay between action and reflection are available in a balanced way

for students" (p.50). Brookfield (1988) asserted that higher education curricula typically "rush through masses of content and ... assign (tasks which measure) familiarity with that content so thick and fast that there is barely time to assimilate new ideas and knowledge" (p. 50). He encouraged teachers and students to take time for "mulling over ... and making interpretive sense of what is happening to them. (p.50)." The course curriculum provided Heather and her fellow students with an opportunity to share their feelings by designating group post conferences. However, as Heather explained:

> Working two-to-ten, up the next day at five-thirty in the morning, work until three and then the drive home — it just didn't lend itself to rest time much. By the time post conference rolled around, we were all pretty tired. Then, it's over and you're alone again.

It was difficult for this student to create a space within her clinical practicum to process and interpret all of the new information she was exposed to. Through the experience of sharing overnight accommodation with fellow students and her clinical instructor, Heather found she valued informal debriefing discussions and that these opportunities did stimulate reflection.

> I know nursing used to be like this. You'd be in a residence of nurses and personally I know for all my rotations that would really help me because when I talk about nursing, that's when I learn the most. I'm not around nurses a lot because of my job and where I live. It was great to be totally focused in that environment. I thought that environment was excellent.

After the course was over, I asked Heather what stood out for her. She replied:

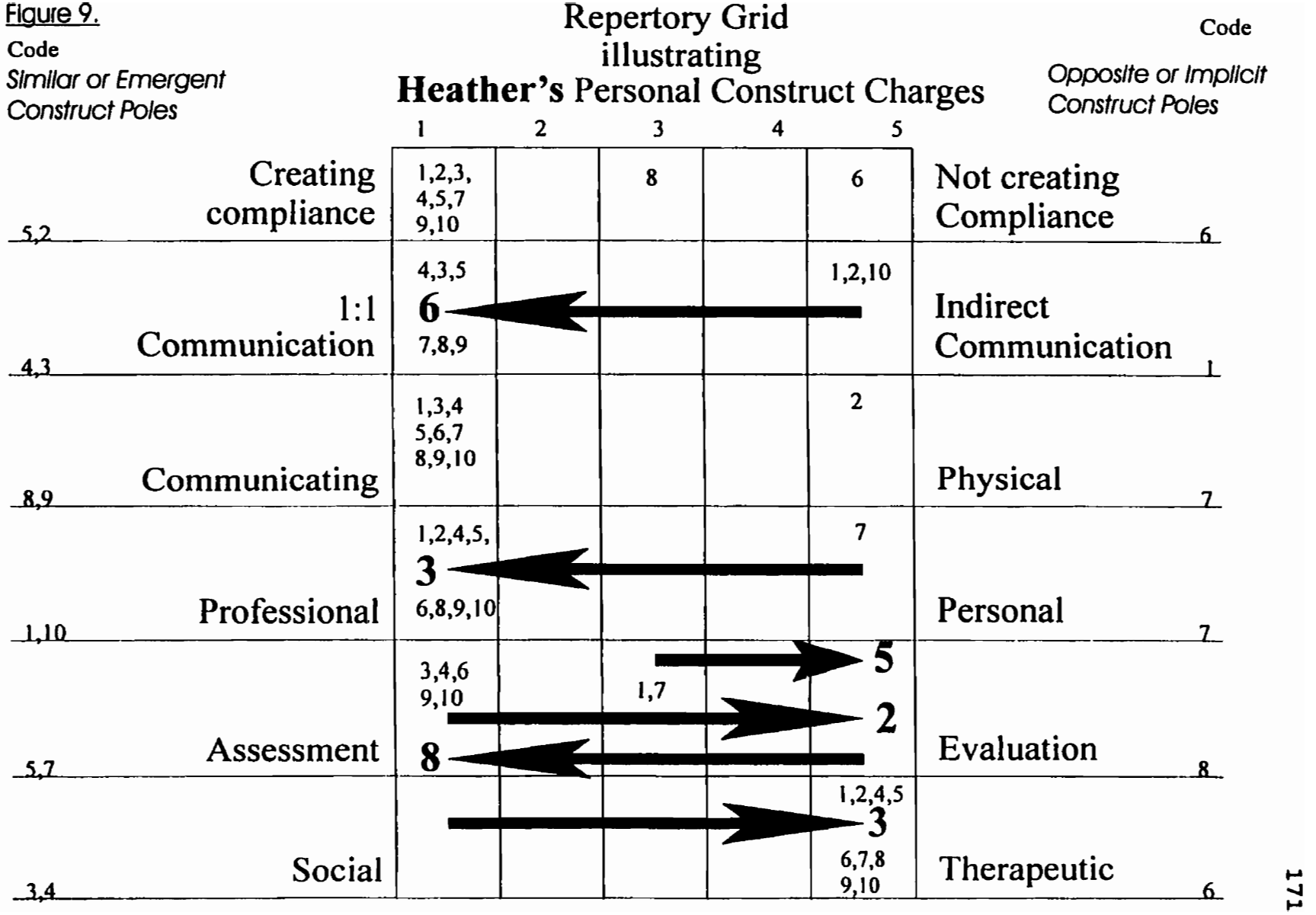
> Just how exhausted I could be after playing cards or going for walks. You're always thinking. You're always trying to assess (patients) and you're using

> so much of your mind. It's draining! That stood out for me. I had a patient cry with me and I was just shaking. I have never experienced anything like that before, except with my friends, but never in a therapeutic way. I was shaking, I didn't know what to do. I talked her through it and I felt fine until after and then I felt like crying because it really affected me. Some days I'd go home and feel really depressed and kind of disjointed almost, not all together.

The preceding comments once again reflect a contrast between psychiatric nursing and mainstream nursing. Even Heather's familiarity with knowledge from both nursing and psychology did not provide her with a way of structuring and organizing the emotionally charged learning experiences she faced in this practicum. She had "never experienced anything like that before" and it was "really different." Her course lectures linked concepts in medical surgical nursing to similar concepts in psychiatric nursing in her integrated course, but Heather often found this "confusing." Terms which "fit" in other clinical areas seemed to have little relevance in this rotation. She was struck by how different the experience was and although she "loved it," she also "needed time to sort it all out."

In conclusion, Heather demonstrated striking changes in her ways of constructing knowledge about psychiatric nursing during her practicum at the provincial mental institution. She was motivated and interested in the field before the course even began. She grew personally and professionally as she learned to establish therapeutic boundaries with her patients and to define the psychiatric nursing role in a personally relevant way. However, time to reflect and discuss emotional responses or the profoundly different nature of the experience was limited.

Figure 9.


Repertory Grid
illustrating
Heather's Personal Construct Charges
Code
Similar or Emergent
Construct Poles
Code
Opposite or Implicit
Construct Poles
1
2
3
4
5
Creating compliance
5,2
1,2,3, 4,5,7 9,10
8
6
Not creating Compliance
6
1:1 Communication
4,3
4,3,5
6
7,8,9
1,2,10
Indirect Communication
1
Communicating
8,9
1,3,4 5,6,7 8,9,10
2
Physical
7
Professional
1,10
1,2,4,5,
3
6,8,9,10
7
Personal
7
Assessment
5,7
3,4,6 9,10
1,7
5
2
8
Evaluation
8
Social
3,4
1,2,4,5
3
6,7,8 9,10
Therapeutic
6

Personal Construct Changes and Reflections — Discussion

Heather's repertory grid reflected the most dramatic changes in thinking of all of the six study participants. Through the process of constructing and rating the grid before and after the clinical placement, I learned of Heather's background in the field of psychology, her belief that "behavior can be modified," her pre session interest in psychiatric nursing, how she developed her ability to set boundaries, what it was like for her to drive the six hours each week to attend the clinical site and how the experience left her physically and mentally exhausted. On her grid, Heather categorized the ten nursing activities studied as "creating compliance or not creating compliance," "one to one communication or indirect communication," "communicating or physical," "professional or personal," "assessment or evaluation," "social or therapeutic."

Heather constructed her grid thoughtfully and took care with the words she chose. At one point during the post course interview, as Heather rated the nursing activities as either "assessment" or "evaluation," she commented: "I'm having problems with this construct." At the beginning of the course, she found the everyday mainstream nursing terms of assessment and evaluation adequate to classify the psychiatric nursing activities. However, after her clinical experience, the "concrete" terms did not seem comprehensive or "abstract enough." In response to the more in-depth view of the distinct and separate nature of psychiatric nursing she gained through her practicum, Heather's ways of categorizing nursing activities seemed to loosen and become more open.

Shapiro's (1986, 1991, 1994) repertory grid approach emphasizing narrative inquiry and reflection revealed that, for Heather, a complete reversal in thinking occurred for four out of the ten activities studied. In all four instances, at the end of the course, Heather rated the psychiatric nurses' activities on the opposite end of the five point scales.

The first activity which reversed was administering a PRN medication to an agitated patient. Originally, Heather categorized this nursing task as "assessment," but after the course she saw it as "evaluation." She explained her reasoning: "When you give the medication you've already made the assessment. You've evaluated the behavior and made the decision to give the medication." One of Heather's fellow students described a situation where staff members role modeled a team approach to subduing an agitated patient with a PRN medication. The student equated the nursing actions to "cardiac arrest code procedures" and described the observation as "exciting."

The second activity where Heather's thinking reversed was pointing out discrepancies in a patient's verbal and non verbal behavior. At the beginning of the course, Heather felt this was "evaluation," but rated it as "assessment" at the end of the course. "Now I think that if you're pointing out discrepancies, you're not really evaluating the person, you're pointing out discrepancies to see how the patient is going to react. That's all part of assessment."

The third activity which Heather rated in reverse on her grid was denying a noncompliant anorexia nervosa patient's request to spend time together. While Heather did not have an

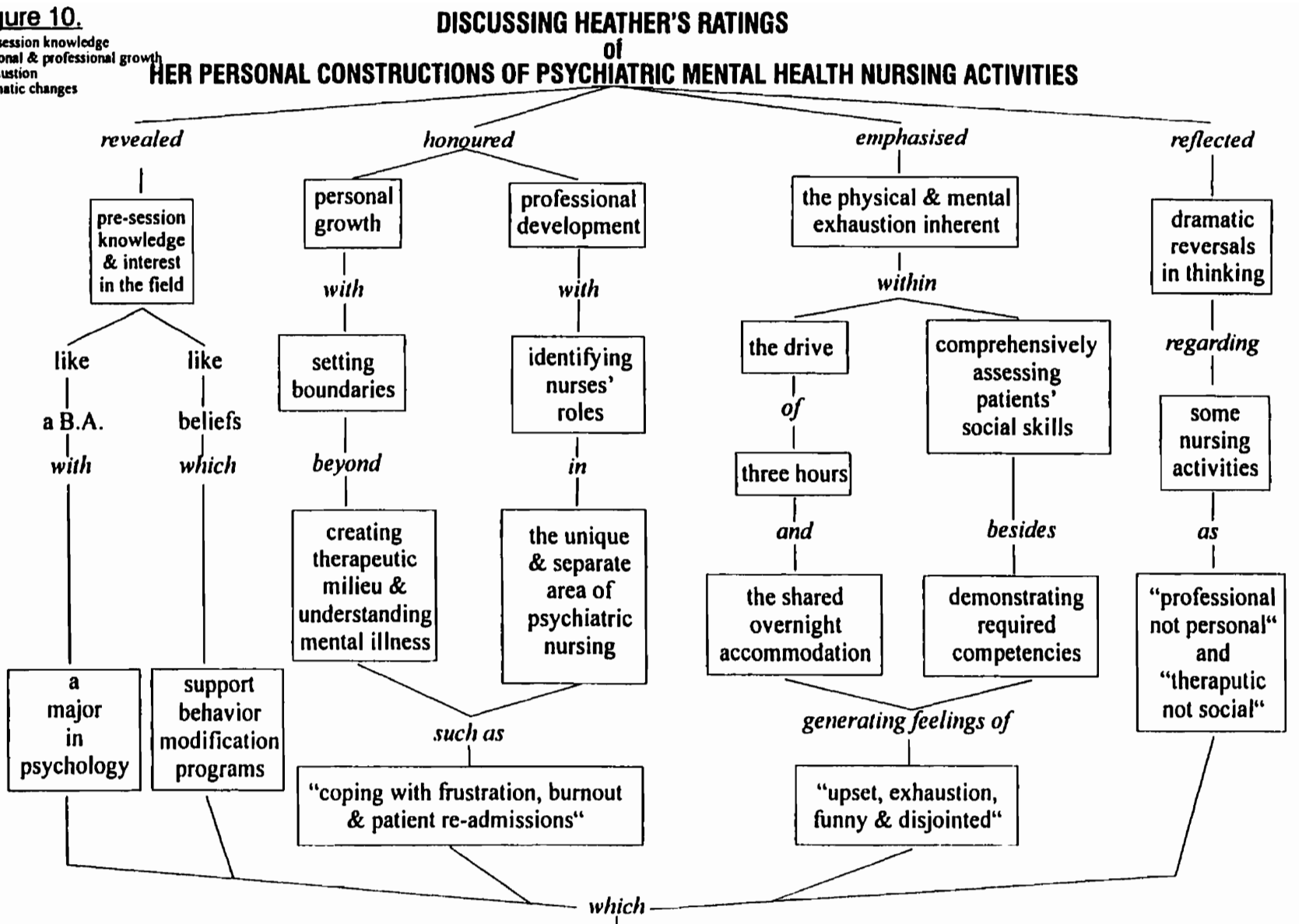
opportunity to work with a patient diagnosed with anorexia nervosa, she did find herself in the position of having to "say no" to non compliant patients. At the beginning of the course, she saw this as "indirect communication . . . because indirectly you're trying to modify (patients') behavior." At the end of the course, she commented: "Now I see it more as telling them straight off that we can't spend time together and that's it." Heather agreed that she had developed a more confident capacity to project a firm approach and to set limits as a result of her clinical experience.

Heather viewed the fourth and final activity, accompanying a patient on an off unit smoking break, completely differently in two of her personal constructs by the end of the course. She looked beyond just the action of "smoking." She construed the element under study as any off-unit patient excursion or game. She initially viewed these activities as simply "personal," but later rated them five increments over beside "professional." Similarly, at the beginning of the course, she viewed joining patients in activities as "social" but at the end of the course, viewed the task as "therapeutic." Heather clarified what she meant by joining patients in activities as "professional not personal" and "therapeutic not social."

> Before I had the experience on the unit, and even from other students, I heard that all you do is color and play cards and that it's boring. I didn't find it boring at all — I found it exhausting. That was a big change for me.
>
> Outside the hospital, things like smoking, drinking coffee or going on outings like bowling seem like personal or social activities because you're not evaluating someone's behavior. In this setting, anything you do with patients — you're assessing them. You're assessing social skills like task mastery, concentration, ability to deal with things like winning/losing . . . You're at work, nothing you do should be personal or social, it should all be professional or therapeutic.

Figure 10.

pre-session knowledge
personal & professional growth
exhaustion
dramatic changes



Case Report V: Beth

Beth — The Professional

Beth is a 21-year-old student who entered the faculty of nursing after two years of general university studies. She chose nursing because a friend in her third year of the program had spoken highly of nursing. Beth mentioned that she would not have chosen nursing if the program was offered "in a hospital and not associated with a university." Beth valued obtaining "a degree rather than a diploma." She believed that: "It's the technical (aspects) which draw a lot of students into nursing. I came in looking at nursing as a profession." Beth does not expect to work in the psychiatric mental health area when she graduates. While she was "open to new learning experiences," both at the beginning and at the end of her rotation, Beth expressed an interest in pursuing a career in "oncology or pediatrics." Beth earned a grade of A in the course.

A well-read self-directed student

Beth approached me to participate in the study. In fact, of all the six participants, Beth was the only student who came forward solely in response to my Letter of Introduction handout. The five other students were all recruited when I spoke personally about my research proposal either in classes or to clinical groups on their assigned hospital units during conference times. Beth volunteered because she is "pro-volunteer." She is active in student

groups on campus, often in a leadership capacity. Beth also volunteered extensively at a hospital, an agency for the brain injured and she was employed as a camp counselor.

I met Beth when she introduced herself to me after she had attended one of my lectures as a guest student. She offered to participate in the study and showed me a recent article in *Scientific American* which was particularly relevant to the lecture I had just delivered. I made overhead transparencies of photographs which accompanied the article and shared them with my class the following week. On another occasion, Beth referred me to a video reference on anorexia nervosa. When Beth and I met later in the rotation to discuss her clinical experience, I also learned that she subscribed to both the provincial nursing association's *Newsletter* and *The Canadian Nurse*. Beth was familiar with a variety of medical-surgical nursing journals, felt comfortable seeking information from the literature and had been encouraged by one of her professors to revise a previous assignment and submit it for publication. As well, earlier in the year, and on her own initiative, Beth conducted "a survey of interest groups which different faculty members belong to." Beth was particularly interested in learning about local oncology nursing interest groups. She was "surprised" that few other students were intrigued either by these interest groups or by specific speciality area nursing journals.

Beth did not choose a mental health nursing topic for the term paper assignment stipulated in her integrated medical-surgical and psychiatric mental health nursing course. As a result of this, Beth was not introduced to the unique psychiatric literature base. In addition to her two required textbooks, Beth turned to a textbook, required in her first year, for a

supplemental reference. Beth felt that she needed additional information when she observed staff members at the desk who "just seemed to want patients to go away" and a nurse group therapist who "lectured and did one-to-ones instead of getting patients to support each other." Beth wondered why staff nurses did not seem to "pick up on (patients') cues" or "invite patients to talk later if they (the nurses) are busy." While Beth did not necessarily agree with the behavior she observed, on her own, she did find some clarification of the nurses' actions in the distinction between "person-centered" and "task-centered" nursing responses. Again, Beth was the only student in the present study who mentioned using a strategy of turning to the literature as a method of understanding nursing behaviors which can initially appear, as Perese's (1996) students expressed: "Unprofessional and uncaring" (p. 283). It is disturbing to note that this well read student left the experience with limited exposure to the scholarly resources specific to mental health nursing.

In the process of describing her observations of staff behavior to me, Beth took care to balance any negative comments with positive ones. For example, she elaborated upon how "calm" the staff remained when "a manic patient wasn't stable and another girl acted out." She found staff were "good at limit setting and behavior modification." Describing an incident where security had been called to restrain a patient while Registered Nurses administered a PRN medication, Beth explained: "I saw that as doing it only when necessary. She (the patient) should have been stabilized before." Beth emphasized: "I hope I haven't left a negative impression because (the experience) hasn't been negative at all. I've actually really enjoyed it!"

In the second last week of her clinical experience, I asked Beth what stood out for her in terms of her own self-initiated goals. She replied:

> I have developed a bit more as a nurse. I'm more direct with my patients now. For example, I'm not as worried about bothering them. If I wonder about an issue, I'm more likely to bring it up.

"Pro-counseling" family background and beliefs

Beth, like Simone, lives with her primary family. Beth feels that her parents are an important influence in her life and that they are a continuing source of support for her. It was Beth's father who had pointed out that the *Scientific American* piece might relate to her psychiatric mental health nursing course. In turn, Beth shares articles and information on men's health from her courses with her father. Beth's mother is a pharmacist who recently returned to university to complete a masters degree in education. Beth commented that her mother had two brothers who were disabled, and that her mother believed that her siblings had been "over-medicated." Beth described her mother as "pro-counseling." Both Beth's mother and father "read books about psychology and sociology" at home. Beth believes in the concepts of "giving positive feedback and praise and identifying strengths." She mentioned an activity she initiated at children's camp where she "woke up everyone in the middle of the night for a sharing circle. We all sat around and told people why we liked them." Beth entered the rotation with the conviction that "elevating self-esteem is important."

During our first few conversations, I noticed that Beth had a strong command of psychiatric mental health vocabulary. I shared my observation with Beth and asked her if this might be a product of her family background and camp counseling experience, or whether she was integrating terms and expressions she had heard on the unit. She replied that her experience on the unit "validated things I knew before and puts (the words) into a different perspective."

Limited guidelines

When Beth first began her clinical experience, she was "a bit unsure about what to expect and worried (she) wouldn't know what to do or say (to patients)." She had a "negative view" of the rotation and had been influenced by "other nursing students' (comments)" and movie characters such as the overly controlling "Nurse Ratchet" depicted in the 1979 movie *One Flew Over the Cookoo's Nest.* Beth's first reaction to the psychiatric unit was "scary, but great once I started talking to my patient. It was a lot better than I expected."

Unlike Sandra, Simone and Nathan, before Beth was required to report to her clinical placement, she did have the opportunity to attend six weeks of university classroom lectures and tutorials which integrated medical-surgical and mental health nursing content. In spite of both this opportunity and the previously mentioned background familiarity with counseling concepts, Beth expressed similar comments to those made by Simone. (Simone's family had no previous exposure to mental illness issues and Simone began her clinical experience after only one university lecture.) Both students did not feel that their nursing program, which

integrated medical-surgical and psychiatric mental health nursing, prepared them for the hospital unit experience. Beth noted that previously in her clinical experiences, "we have focused on tasks." Beth felt that the integrated program left psychiatric mental health nursing knowledge "overshadowed." In Beth's view "(the subjects) should be separate. So much discussion could go on with mental health, but it isn't brought out." Further, Beth pointed out that while her integrated classes emphasized the comprehensive experience of hospitalization "from the patients' perspective – exam questions test specific nursing actions. We are not learning our role as nurses."

Beth also noted that the psychiatric mental health unit staff did not seem to have clear guidelines for the students' clinical experience either. She found it difficult to "try and consult staff without knowing the expectations (of students). Every staff (member) has different ideas about what students do." At the end of her course, as she reflected upon what had been missing in her experience, Beth identified that "a new (and more effective) beginning (or orientation)" would have helped. She added: "We were supposed to have a buddy day, but that day we were also assigned to a patient, so I spent time with my patient, not my buddy."

Beth was designated to attend the evening shift throughout her rotation. She appreciated not being rushed" and "meeting patients' family and friends." However, she noticed that patients "had students all day too" and so Beth made every effort to respect the time demands which her course requirements could impose on her assigned patients. In total, 30 students completed their clinical placements on Beth's unit during the thirteen-week winter university

term. No second year nursing students were present on the unit at any other time of the year.

When I asked Beth if she had been challenged throughout her evening experience, she replied:

> Challenged to where I'd like to be challenged -- no. Challenged to a certain point -- probably -- just by being here. I've always considered my communication skills to be some of my weaker skills so just being here is to a certain extent challenging. Questions (Beth asked) and feedback from the instructor (was useful) but I think I could have probably learned more.

As a consequence of the combination of limited guidelines offered through her university classes and a permanent evening rotation on a hospital unit saturated with learners during only one term of the year, Beth left her clinical experience with a very "limited view of what psych mental health nursing is." She spoke of another student who "had never wanted to work on the psych unit either," but who "got placed in a day program." This student "just loved it and is going to do his focus in that in fourth year." Beth did not believe that she left the experience with a "broad perspective of mental illness." She did not have a sense of "what happens to patients when they leave here." Beth felt that even with her own capacity for self-direction, the seeming lack of clear curriculum guidelines often left her wondering what was expected of her on the hospital unit.

Exhaustion

Like Heather, Beth also left her psychiatric mental health experience physically and mentally

exhausted. After her shift ended at eleven, Beth often "couldn't sleep, (she would) go over what to do or say and (she) couldn't settle." Unit circumstances dictated that Beth's assigned patients "were mostly all diagnosed with depression." Two of her female patients, a fifteen-year-old who demonstrated borderline personality disorder traits and a suicidal twenty-year-old university student, were "hard (to help). You can't provide a quick fix for them."

Further, a peer also disclosed a personal struggle with a mental health problem to Beth in confidence. Beth respected her classmates' confidentiality and therefore a discussion of this individual's specific problem is not included in this report. However, it is important to mention that ethical questions can arise when students, instructors, practitioners or researchers become aware that someone in their acquaintance is experiencing a mental health problem. For example, how do we determine whether the individual is safe or not? Should the individual be accompanied to a hospital emergency room for immediate psychiatric assessment? Would encouraging the individual to seek counseling be appropriate and if so, how do we determine which local agency might help? Does this agency accept walk-in clients or is a physician's referral required? Beth knew that her classmate did have access to further counseling help if she needed it but the lack of straightforward answers to these kinds of questions left Beth feeling "drained."

She described the complexity of encountering other young women who were so close to her own age, and who were in such obvious emotional pain as "exhausting." I asked Beth what it was like for her to hear about the mental health problems which her classmates as well as

her patients faced. Beth responded:

> "I feel fortunate. Myself and my immediate family don't have to deal with this. I'm amazed at peoples' strengths, with their insights and with how they handle things (like depression, suicide, personality disorders, anorexia, bulemia)."

Instructor time

What Beth liked most about her psychiatric mental health rotation was feedback from her instructor. She felt that "being challenged to look at things in a different way" and "having direct feedback (regarding her) viewed interaction and after talking to her patients" was "like a catalyst." With her classroom learning "overshadowed by medical-surgical nursing" and hospital role models who sometimes "just seemed to want the patients to go away," Beth viewed her clinical instructor as an important source of knowledge. Beth noticed that her instructor "prepares a lot." Both during one of our mid-course interviews and on her written questionnaire response, Beth commented that her instructor "had seven other students in the group to get to." She explained further:

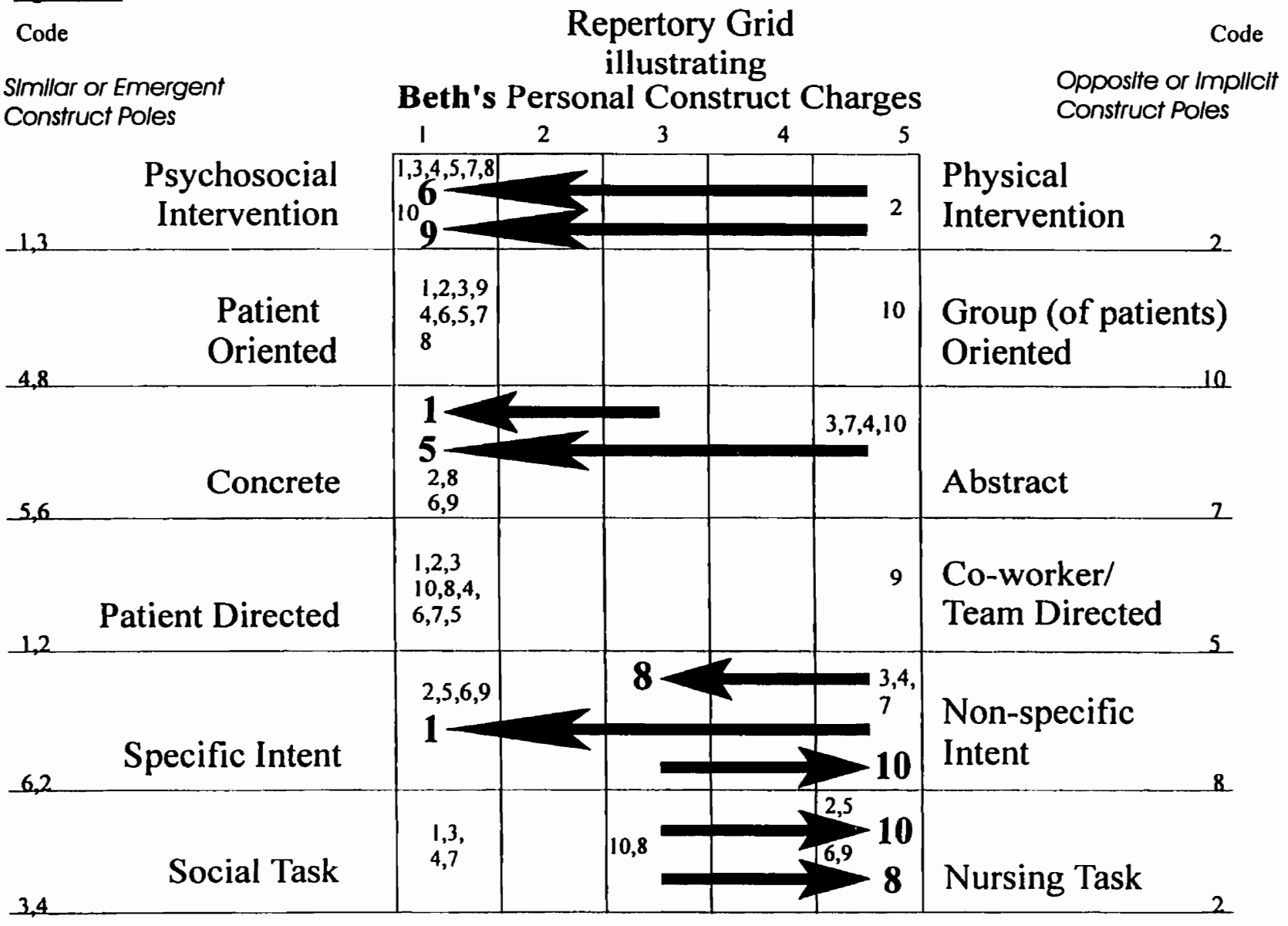
> It's really hard having eight students to one instructor. Just to get through everything like the med teaching. I mean, the viewed interactions are wonderful but to have one and that's all because that's all the instructor has time for is a bit hard because it's one situation, and you learn so much from that in feedback and it would be nice to have several of them.

Beth concluded that in addition to more pre session "background information and role-playing, a decreased student-to-teacher ratio would have been helpful" during her clinical

experience. Beth's sessionally employed clinical nursing instructor was not the same individual who taught Sandra, Simone and Nathan's group and she did not teach Heather either. Yet, for all these students, their times with their instructors discussing non evaluated encounters with patients consistently stood out as positive and important learning accomplishments.

In summary, important changes occurred for Beth during her psychiatric mental health clinical rotation. Beth is a well read, self-directed student from a "pro-counseling" family background. She left the experience with "a more concrete understanding" of nursing activities by the end of the course. She viewed the study elements as "psycho social not physical, specific, not non-specific and nursing not social tasks." The knowledge she gained from medical-surgical content "overshadowed" the mental health content in her integrated university nursing course, and orientation on her permanent evening shift offered her limited guidelines. The combination of these factors left Beth with a very "limited view of what psych nursing is." Beth did find the experience "valuable" and she felt that she grew in her ability to "be direct with patients." The clinical experience was exhausting for her, particularly when she consistently worked with patients diagnosed with depression. Beth discovered that her classmates as well as her patients struggle with mental illness. Overall, throughout her course, Beth especially valued the non evaluated times with her instructor. During these times, the teacher-student discussion centered on Beth's interactions with her patients and Beth received valuable feedback and "challenges" to improve her interpersonal communication skills.

Figure 11.


Repertory Grid
illustrating
Beth's Personal Construct Charges
Code
Similar or Emergent Construct Poles
Code
Opposite or Implicit Construct Poles
1
2
3
4
5
Psychosocial Intervention
1,3
1,3,4,5,7,8
6
10
9
2
Physical Intervention
2
Patient Oriented
4,8
1,2,3,9
4,6,5,7
8
10
Group (of patients) Oriented
10
Concrete
5,6
1
5
2,8
6,9
3,7,4,10
Abstract
7
Patient Directed
1,2
1,2,3
10,8,4,
6,7,5
9
Co-worker/ Team Directed
5
Specific Intent
6,2
2,5,6,9
8
1
3,4,
7
10
Non-specific Intent
8
Social Task
3,4
1,3,
4,7
10,8
2,5
10
6,9
8
Nursing Task
2

Personal Construct Reflections — Discussion

Beth viewed the ten nursing activities studied as "psycho social interventions or physical interventions," "individual (patient) or group (of patients) oriented," "concrete or abstract," "patient directed or co-worker/team directed," "specific intent or non specific intent," and as "a social task or a nursing task." Beth's repertory grid reflected three complete reversals in thinking and five examples of how her positioning of the elements moved from right in the middle of the grid at the beginning of the course to a clear position directly beside one of her construct poles at the end of the course. The only ratings on Beth's grid which did not reverse completely or assume a more decisive position were her depictions of whether or not an intervention was implemented to benefit one individual patient or to benefit a group of patients and whether an intervention was directed to patients or to co-workers.

The first instance where Beth's grid revealed a complete reversal in her thinking related to whether nursing activities were "psycho social or physical." Beth explained:

> My ideas about psycho social interventions have broadened. (When the nurse denies a non-compliant anorexia nervosa patients' request to spend time together), she is trying to do behavior modification with the patient. But, she isn't taking something physical away from the patient. (She is taking away) an interaction (with herself).

The second instance where Beth's thinking completely reversed related to how she viewed the element of pointing out discrepancies in a patients' verbal and non-verbal behavior. At

the beginning of the course, Beth rated this element as "abstract." At the end of the course, she rated the element five increments over next to "concrete." Beth explained that her personal constructs of "abstract or concrete" denoted her understanding of the element. At the beginning of the course, she had only an "abstract or vague" understanding of the element, but by the end of the course, her understanding had become more "concrete or clear." Beth clarified her view with the following comments.

> It seems more concrete to me now than it did before. There's a concrete reason for doing that. You're challenging patients to have them look at their behavior. Probably (it is) because I've experienced seeing other nurses do that or myself saying that to a patient . . . like, you're laughing but your eyes are looking very sad to me. I just have a better understanding of it now.

Similarly, in the third instance where Beth's thinking reversed completely, she also felt she gained a deeper understanding of a nursing action. At the beginning of the course, she rated the element wearing street clothes on the unit as an activity with a "non-specific intent." However, by the end of the course, she believed wearing street clothes on the psychiatric mental health unit had a "specific intent." In Beth's words:

> There's a reason why we're doing it. I guess I just see the importance of (wearing street clothes) in creating, not a home-like environment but a therapeutic environment and that's really important.

Finally, Beth's grid suggests five examples of rating an element right between the two construct poles at the beginning of the experience and then rating it clearly beside either the emergent or implicit pole once the course was over. In the following five examples, Beth's

thinking shifted from being "not sure so I put it in the middle," to actually being able to conceptualize the elements with her own words and personal categorizations by the end of the course. First, by the end of the course, Beth saw the element of presenting a patient to the health care team during unit rounds as a "psycho social not a physical intervention." Second, by the end of the course, she viewed the element of wearing street clothes on the unit with a more "concrete (understanding) rather than (an) abstract (or vague)" understanding. Third, by the end of the course, Beth considered the element of facilitating a group therapy session as a "non-specific rather than specific intent." She elaborated that:

> ... in the facilitating role, more importance is placed on the patients. With a specific intent, you expect to see a direct result from what you do. (With a group) you wouldn't see cause and effect. It's not really a clear result.

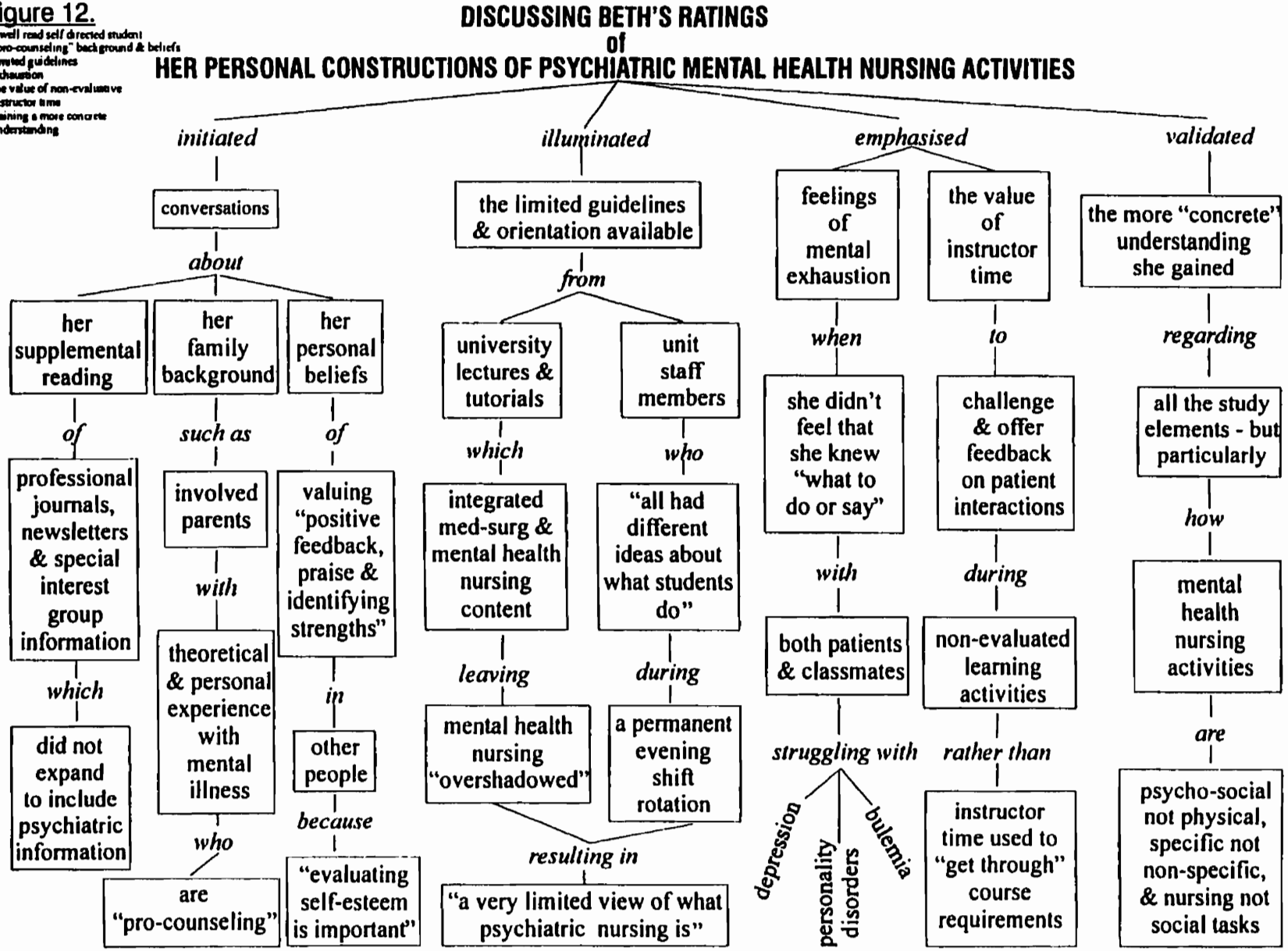
Fourth, by the end of the course, Beth believed that the element of pointing out discrepancies in a patient's verbal and non-verbal behavior constituted a "nursing task rather than a social task." She clarified:

> As I was saying before, there's a reason why you're doing it and it's sort of like a direct intervention so I view it as a nursing task. It's not really a social task. You're not doing it exactly to just build a relationship with the patient or give them support or things like that. It's a step beyond that. The social forms the basis for allowing you to do these more professional tasks.

Fifth, by the end of the course, Beth rated the element facilitating a group therapy session as a "nursing task rather than a social task," again suggesting a more decisive view of how to categorize the nursing activity.

Figure 12.

- a well read self directed student
- "pro-counseling" background & beliefs
- limited guidelines
- exhaustion
- the value of non-evaluative instructor time
- gaining a more concrete understanding



Case Report VI: Casandra

Casandra — The Gentle Helper

Casandra is a nursing student who preferred not to include extensive background information in her case report. She entered the faculty of nursing after completing her grade twelve and currently lives with her primary family. She has one sibling, a sister who is also involved in a post secondary education program. Casandra choose nursing because she "wanted to help people to have better care in hospital than what (she) saw when (her) own family members were in hospital."

Other than the fleeting and often sensationalist images depicted in television, movies and the media, Casandra had no previous exposure to mental health issues or treatment facilities. Initially, Casandra felt "scared and anxious." She "didn't know what the patients would be like" and feared that "some might be violent." The concepts of "hallucinations and delusions" at first seemed hard for her to grasp and it was in this area where Casandra's personal constructs reflected her deepening understanding of the field. Casandra described her psychiatric mental health clinical rotation as "a good learning experience" but she did not express an interest in working in the area after her graduation. Casandra earned a grade of B in the course.

Casandra volunteered to participate in the study when she learned that I needed only one

more participant to complete my study group. While I was on her assigned hospital unit, she noticed that I was prepared for a student interview, but that the student who I had arranged to meet would not be on the unit until the following week. Casandra graciously came to my aid and offered to participate. Previously, in one of her first year courses, nursing instructors had called for student volunteers to assist exchange students from Nepal. The exchange students had a limited command of English and needed considerable help with living accommodation, transportation to classes or clinical experiences and studying as they completed a nursing course with Canadian university students. In response to this request, Casandra had also came forward to "help." She offered invaluable time and assistance to our international guests. In my conversations with Casandra, I also learned that the reason she attended an evening practicum was because she had given her day shift placement to a fellow student who had child care responsibilities.

Thorough preparation

Casandra made a point of checking what the anticipated time commitment would be before involving herself in the present study. In her first year of the nursing program, she found herself preparing "as many as eight hours" for her medical-surgical clinical placements. In her second year, "buying drug cards" reduced her clinical preparation time to "one or two hours." However, Casandra prepared extensively for her learning opportunities in the clinical area, and she was careful not to take on more than she felt she could "handle" in a new practicum. Casandra was able to complete the study, and once again, her help was invaluable.

Casandra's approach to patient care in the clinical area was both thoughtful and thorough. When she was completing an assignment where she was required to teach her client about his prescribed MAOI inhibitor antidepressant medication, she incorporated information from six different sources. When her required course textbook indicated that certain foods could only be consumed in moderation, Casandra consulted me, a pharmacy textbook, a pharmacy handout, the hospital unit dietician and the Internet. She constructed a chart to clarify what "moderation" could mean and used it during teaching time with her patient. I shared Casandra's work with my own students as an example of exemplary preparation for mental health clinical nursing. She also showed me study cards which she had created for previous courses. She summarized information such as IV formulas and calculations and noted them on index cards. She explained that she altered this approach somewhat during her psychiatric mental health clinical course by "trying to learn the medications by classifications here."

Personal insights

Beyond demonstrating the required competencies stipulated in her course, Casandra gained valuable personal insights from her psychiatric mental health clinical experience. Casandra's time with both her clinical instructor and her patients were key factors in facilitating these important personal insights. During our discussions, she often mentioned her teacher and the kinds of supplemental instructional strategies which her teacher implemented.

Casandra, like all of the five students described previously, valued how her clinical instructor

role modeled patient interviewing and invited students to observe from behind a two-way mirror. Additionally, Casandra's clinical instructor facilitated role play exercises where students "played our own patients and one student was the nurse and the other students observed (behind the two-way mirror)."

Despite "feeling self conscious because my friends were watching behind the mirror," Casandra gained meaningful personal awareness and knowledge from this non evaluated role-playing exercise. She explained:

> We started (the peer reviewed role play exercise) with strengths but then we picked each other apart (laughs). One example of feedback I got is that I fiddle with my pen when I talk — (doing that) I can't take in what people say. Another thing I need to do more is make eye contact and pick up on people's cues that they want to talk about something. (During the exercise) my partner actually started crying. I validated that she was really upset. (In response to my question of: "What was that like for you?" Casandra continued:) It was hard because I felt responsible. It was the first time I had to deal with a teary patient. Now I know I could move my chair over and touch the other person.

Further, during written and verbal discussion opportunities with her clinical instructor, Casandra appreciated sharing her observations and perceptions and asking for guidance. She did not understand why "some patients get better and go home . . . but some have got better and gone home and (then) they're back. (One patient) came back for the same reasons." Like Beth, Casandra was assigned to a permanent evening rotation so she did not have an opportunity to attend morning rounds or other professional patient care conferences. Casandra did not view hospital staff nurse role models as mentors or even as consistent

sources of psychiatric nursing knowledge. At the end of the course, in response to Perese's (1996) question: "What did you like least about your experience?" Casandra wrote: "the nurses." Discussion time with her instructor was the central venue where she could seek clarification and sort out her thoughts. In Casandra's words:

> Some of the nurses were useful. I think I've had about three in the whole nine days we've been here that I feel I can go to and discuss where I'm at with patients. It would have been nice if we could have had a better relationship and understanding with the nurses. If they had been more helpful, I think that would have added to the learning experience because on the days we've had nurses we've been able to talk to and communicate with, I find that I came away from those days better and with a little bit more of a learning experience than others. I wrote in my journal about one nurse who made negative comments in report for two weeks in a row. A patient had been here for seven weeks and whenever this nurse heard a report about this patient — he'd sort of blast: "This patient is **still** here?" The instructor has been really good in being able to go to and discuss things though.

The experience of being with her patients on the unit and sharing their journey towards mental health was a powerfully personal one for Casandra. When I asked her to describe any changes she experienced as a result of her clinical course, she elaborated upon the way she "views things differently now" as follows:

> It's the sort of thing you have to come here to understand. Even though we talked about depression and schizophrenia in class and (hear about it when) we watch TV and read the newspaper . . . you have to come here and see the patients as people. The thing is, other people in my life haven't had this experience. They still think people here are crazy. People here can't stop (their illness) any more than someone with cancer can. You can't tell someone this. You have to experience it. I find myself defending the patients now.

Casandra mentioned only one occasion where she experienced a clear link between classroom knowledge and clinical practice. "The week of lecture (on the topic of schizophrenia), my partner got the same patients in clinical and we presented in tutorial." However, overall, she felt that the knowledge she gained from her psychiatric mental health clinical rotation was "more personal" than theoretical. In response to Perese's (1996) question: "What would have helped you during your clinical experience?", Casandra wrote: "more background knowledge and training." Casandra is clearly an involved well-prepared student. Yet, the combination of distant university curriculum and unavailable hospital role models failed to stimulate or even acknowledge her own personal and special insights. It was only during time with her instructor that she was able to discuss her personal learning and development. Casandra emphasized: "our instructor has seven students to get to — that she has to do throughout a night. She can't be there for all of us all night."

Painful memories

Casandra, as the previous sections emphasized, is a motivated student who is willing to offer assistance to all those around her. What she was not prepared for, however, was her own need to ask for help during the rotation. "Things came up that were issues for me" in the middle of the clinical course. As she conducted a viewed interaction, Casandra's patient initiated a discussion of (the patient's) experience as a victim of sexual abuse. The sexual abuse had been documented in the patient's chart and Casandra did not pursue the topic. During the post interview debriefing session, Casandra's instructor asked her about her

reluctance to pursue a discussion of the patient's experience with sexual abuse. Casandra explained that the "patient didn't want to talk about it." Subsequently, in further discussions with her instructor, and through the process of completing her course journal assignment, Casandra came to remember her own history of sexual abuse. When Casandra shared this information with me, I asked her if she was currently in danger from her assailant and she replied that she was not. In her audiotape-recorded interview with me, Casandra discussed how she came to remember and disclose her own experience with sexual abuse:

> Journalling has really helped. It's been a way for me to think about things and get things out that have come up that have been issues for me . . . One thing that came up that I found helpful to journal about was my history of sexual abuse . . . It was journalling that really helped to get it out. I cried as I wrote my journal but it was good to do that and I know I need to go further.

When I asked Casandra what it was in the learning environment that had allowed her to begin to talk about her own victimization, she replied:

> It came out because my patient (who) I was talking with had a history of sexual abuse and that made me think about it. But, as far as the learning environment, (it was) instructors (who) helped. I've been able to talk to my instructor about it.

Casandra agreed with my observation that both her instructor and her patients had been important facilitators of the deep and meaningful learning and growing which had occurred for her throughout her rotation. While it was inappropriate for Casandra to share her own

process of recovery with any of her patients, Casandra did contract with her instructor to set up an appointment with a local agency for victims of sexual abuse. Casandra's instructor volunteered to "look into" services other than the university student counseling center in order to provide her with additional choices. Her instructor also volunteered to accompany her to her counseling appointment and checked in with her again once the course was over.

When I asked Casandra what piece of advice she would give to those of us who share our knowledge of psychiatric mental health nursing with students, she responded:

> (Students) will have patients with histories and things can come up. Be prepared for it. Maybe ahead of time, (tell) students where they can go if things come up. This, as opposed to having to go weeks afterwards trying to find (a place to talk). You would already know where things are. You need to go somewhere to talk. That would be good.

One local consequence of the global health care reorganization discussed in Chapter Two of this thesis was that Calgary's Sexual Assault Center was in a state of transition itself during the time Casandra was completing her clinical course. Casandra's sessionally hired instructor had only recently moved to Calgary herself and the process of linking her to an appropriate agency was not straightforward. In fact, with three local hospitals and all their satellite programs closing or relocating, it was not clear whether or not an agency mandated to assist victims of sexual abuse even continued to exist at the time this student needed help. However, her instructor discovered that the agency had relocated and been renamed Calgary Communities Against Sexual Abuse and she provided Casandra with the new address and

phone number. Casandra agreed she would also let me know how things were going for her when we corresponded to create and confirm the collaborative case study reports for this thesis. Thus, six months after her course, during our follow up communication, Casandra created her pseudonym from the letters in the CASA agency name and wrote the following comments about her ongoing recovery:

> I was very nervous about going to counseling but I am glad that I did. I really connected with my counselor at CASA and was comfortable enough with her to share more about my history. Originally I only told her about two abusers but after a month and a half I told her about the other two family members. She gave me information on how to handle my flashbacks, recognize triggers and make safe places for myself.
>
> She encouraged me to go to group and had to refer me to another agency for counseling as CASA is short-term. I did not connect with my counselor at (the other agency) and was without counseling for about a month and a half in the fall. At the end of October I reconnected with my counselor at CASA as I was not coping well to the repeated exposure to my abusers (this is presently beyond my control). I now have a new counselor (at the other agency) and so far it is going well.
>
> I participate in a 12-week group that started at CASA in September and I am glad that I did. It was very helpful to my healing to meet and interact with other people that have similar histories to mine. I now have a group of friends that understand me like no other friends ever have.
>
> Although I still have flashbacks and get triggered, I am at a different place than I was in April. I am well on my way in my healing process and believe that some day I will be whole. I do realize that I still have a lot of work to do though.

In conclusion, it is Casandra's story, the experiences of a student who stepped forward to help a teacher with a project, which most eloquently reveals the very personal nature of the kind of learning which can occur during psychiatric mental health nursing clinical rotations.

In keeping with Fromm's (1993) findings that clinical psychology students exposed to films about psychiatric patients construe learning items in a very personal way, Casandra's responses are not unexpected. Fromm (1993), as noted in Chapter One, admonished that the "personal construction of learning items may be quite **disturbing** (emphasis mine)." Studying students' responses to films about psychotic patients which were shown in the classroom of a psychology course, Fromm (1993) concluded that "construing in a very personal way makes some professional knowledge a potential threat to the psychological stability of the students, a possibility that is totally ignored by professional curricula" (p.206). Casandra did not watch films in a university classroom, she spent sixteen hours a week for six weeks interacting face to face with critically ill individuals who had been admitted for medical management of a psychiatric crisis. Marley (1980) suggested that "about two (nursing)students out of ten, each rotation, seek counseling for their own inner turmoil" (p.20). Viney and Epting (1997) urge those who supervise novice counselors clinically to "create a place of safety" (p.6) where the personal issues which come up during counseling interactions can be explored. In Viney and Epting's (1997) view, this place of safety must exist within the supervisor-novice relationship and is analogous to the place of safety provided by counselors for their clients. The supervisor-novice relationship must attend to " . . . acknowledging, identifying and exploring (the novice's) emotional reactions during the counseling" (p.6). Casandra found a place of safety to talk about her reactions to her practicum experiences with her clinical instructor. However, the question for nurse educators who design curriculum remains — are sessionally hired clinical instructors provided with the resources or even the time to carve out a place for this critical process within content driven and academic grade-oriented university curricula?

Figure 13.

Repertory Grid illustrating **Casandra's** Personal Construct Charges

Code *Similar or Emergent Construct Poles*		1	2	3	4	5	Code *Opposite or Implicit Construct Poles*
8,3	Non Traditional Nursing Role	1,3,4 10	8	5,6		2,7,9	Traditional Nursing Role 2
4,5	Engaging with Patients	1,3,4 5,7,10	2	8,9		6	Isolating Patients 6
8,9	Evaluating Patients	8,9		6	2	1,3,4 5,7,10	Supporting Patients 7
7,10	Requires Skill and Training	2,8,10	4,5,6 9			1,3,7	Required no Skill and Training 1
3,5	Communicating with Patients	3,4,5 7,8,10		1,2,6		9	Communicating with Colleagues 9
2,8	Therapeutic	1,2,3 4,7,10	5, **6**			**8** 9	Non-therapeutic 6

Personal Construct Changes and Reflections — Discussion

Casandra viewed the nursing activity study elements as either "a non-traditional nursing role or a traditional nursing role," "engaging with patients or isolating patients," "evaluating or supporting patients," "requiring skill and training or requiring no skill and training," "communicating with patients or communicating with colleagues," and "therapeutic or not therapeutic." She felt that the personal constructs she developed at the beginning of the course also accurately reflect her thinking at the end of the course. She rated the elements the same or within one incremental variation for the first five constructs on both grids. During our post course discussion, Casandra commented that "the only one I had trouble with where to put it was (number two), administering a PRN medication." She explained:

> (Regarding her constructs of "engaging patients or isolating patients.") Administering a PRN — I see it more as engaging than before because you have to figure out what the patient needs. You have to be engaging with them to know that they need the PRN medication because you have to see where they're at and how they're doing and if they're agitated — having EPS side effects — if they're anxious. (Regarding her constructs of "communication with patients or communicating with colleagues.") Administering a PRN does require communicating with colleagues to be sure you're really doing the right thing and they really should have. That's why I put it in the middle because it was kind of half way in-between, because you really have to do both.

Also during our post course discussion, I asked her to talk more about her thinking when she rated one set of constructs, "requires skill and training or requires no skill and training" nearly identically both at the beginning and at the end of the course. Only one element, holding a crying patient's hand, had shifted one increment towards "requires no skill or training" on

Casandra's post course repertory grid. She thought carefully about my question, which may have inadvertently implied that a change **should** be apparent, and replied:

> I guess confronting with the patients, especially the ones who would come to the desk and were really intrusive. At first I thought they (the nurses) were just kind of — I don't think mean is the right word — but just ignoring the patients. They'd tell them we're busy doing this and that. Some of them (patients) were maybe looking for attention. If you give it to them, they're just going to keep coming back. So it requires skill to know who's just looking for attention and who actually needs something.

It is telling that, in response to my question, Casandra searched for an explanation of behaviors which she hadn't thought about which might require skill and training, such as redirecting patients at the nurses' desk. While her initial views about whether an activity required skill and training or not did remain intact, Casandra valued the opportunity to explore additional possibilities and explanations.

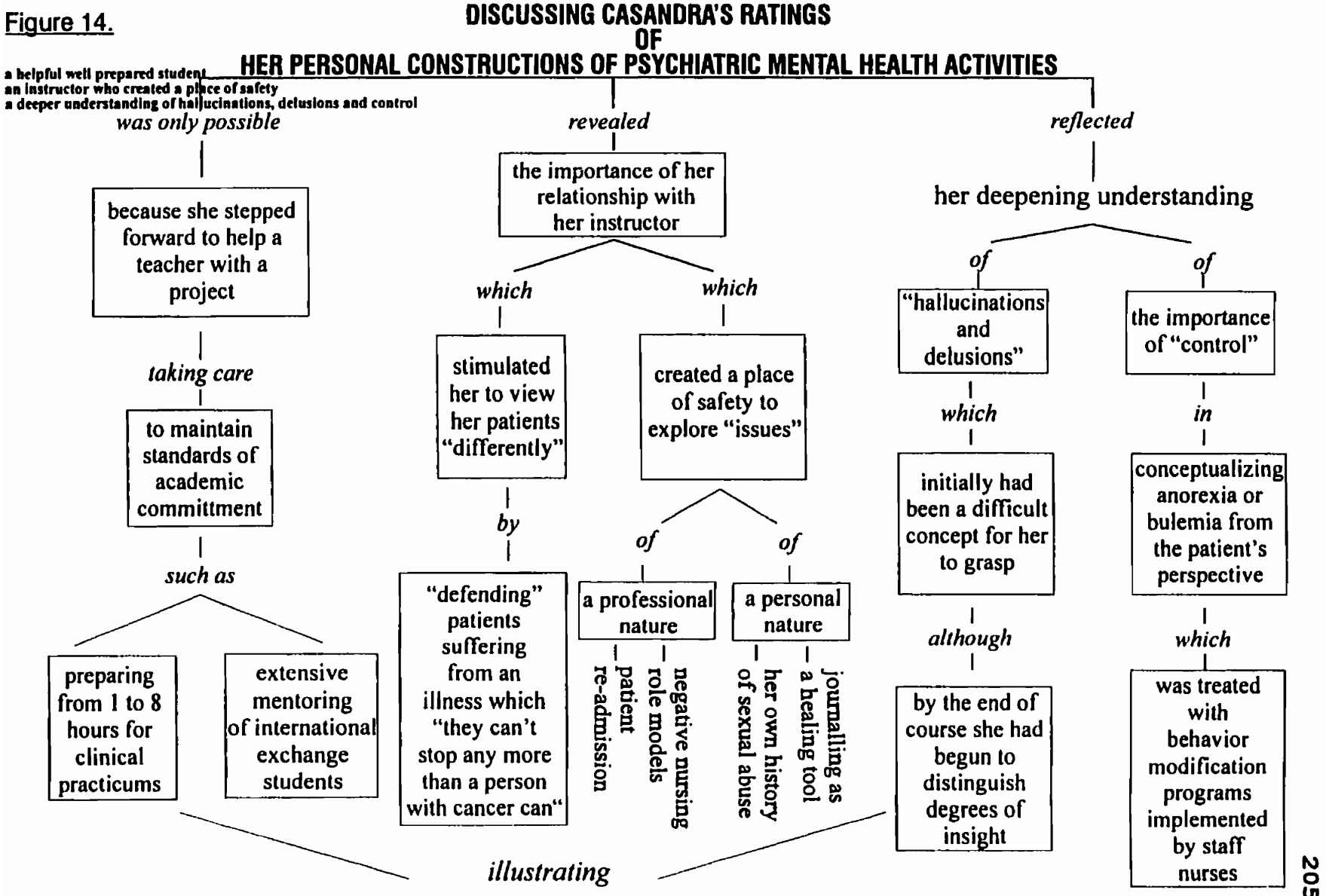
The sixth and final pair of constructs on Casandra's grid, "therapeutic or non therapeutic," did reflect obvious changes in her thinking. Using these constructs, she rated two elements on the opposite side of the grid by the end of the course. First, at the beginning of the course, she viewed the sixth element, denying an anorexia nervosa patient's request to spend time together, as "non therapeutic." However, as she learned more about the hospital nurse's role in implementing twenty-four hour behavior modification programs for patients diagnosed with anorexia or bulemia, her views changed. At the end of the course, her grid reflected a complete reversal in thinking. Casandra elaborated:

> Learning in lecture and discussing it in tutorial . . . it's control . . . We had some bulemic patients on the unit this semester and one wanted to eat her supper in her room. They (the nurses) didn't let her do that and it's good to know that. For two hours after supper they (the patients diagnosed with bulemia) would have to be in the common area. They needed that because otherwise they'd probably go and throw up their supper or do whatever (to induce emesis). They (the patients) had to eat. Their only choice not to gain weight would be to throw up. The only way to stop that was to watch them . . . We had our class on bulemia before that so I understood that they (the patients) needed to gain weight. They needed this. I think maybe before the class I would maybe have had a different reaction to it.

Second, at the beginning of the course, she rated the eighth element, pointing out discrepancies in a patient's verbal and non verbal behavior as "therapeutic." By the end of the course however, her thinking had completely reversed once again and she rated this element only one increment over from "non therapeutic." Here, Casandra's repertory grid used her own words to clearly reflect her growing understanding of the concept of insight related to hallucinations and delusions. During our mid-course interview on the hospital unit, she discussed how it was "easier" to work with a patient diagnosed with depression and who was oriented to reality. It was "hard" for her to work with a patient diagnosed with schizophrenia who was living in an altered state of reality. Casandra's explanation of her post course rating reversal illustrates how she was in the process of piecing together for herself how nurses can help patients who experience hallucinations or delusions:

> Pointing out discrepancies in a patient's verbal and nonverbal behavior. I had it as therapeutic initially and today I put it as non therapeutic. I was thinking more if they're (patients) not ready to see it (the experience which is not real). (With) some patients if there's a discrepancy between verbal and nonverbal, they can see hallucinations or delusions. (With other patients) if you confront them, you're just going to agitate them more and not help them.

Figure 14.


DISCUSSING CASANDRA'S RATINGS
OF
HER PERSONAL CONSTRUCTIONS OF PSYCHIATRIC MENTAL HEALTH ACTIVITIES
a helpful well prepared student
an instructor who created a place of safety
a deeper understanding of hallucinations, delusions and control
was only possible
because she stepped forward to help a teacher with a project
taking care
to maintain standards of academic committment
such as
preparing from 1 to 8 hours for clinical practicums
extensive mentoring of international exchange students
revealed
the importance of her relationship with her instructor
which
stimulated her to view her patients "differently"
by
"defending" patients suffering from an illness which "they can't stop any more than a person with cancer can"
which
created a place of safety to explore "issues"
of
a professional nature
patient re-admission
negative nursing role models
of
a personal nature
her own history of sexual abuse
journalling as a healing tool
reflected
her deepening understanding
of
"hallucinations and delusions"
which
initially had been a difficult concept for her to grasp
although
by the end of course she had begun to distinguish degrees of insight
of
the importance of "control"
in
conceptualizing anorexia or bulemia from the patient's perspective
which
was treated with behavior modification programs implemented by staff nurses
illustrating
HOW EVEN A WELL PREPARED STUDENT WHO IS WILLING TO HELP OTHERS MAY NEED "SOMEONE TO TALK TO"

CHAPTER FIVE

IMPLICATIONS OF THE STUDY

Reflecting on the Reports and the Research Approach: Listening to the Students' Voices

> ...there are always alternative constructions available to choose among in dealing with the world. No one needs to paint himself [sic] into a corner; no one needs to be completely hemmed in by circumstances; no one needs to be the victim of his [sic] biography (Kelly, 1955/1991, p.15).

The individual case reports presented in Chapter Four were framed from the following three broad research questions. How do student nurses construe professional staff activities? What changes, if any, do student nurses perceive in their personal ways of knowing about mental health nursing? Does the construction of a repertory grid help student nurses articulate what they learn? These questions guided the process of listening to the students and involving them in writing their "stories." The collaborative case studies were developed to add perspective on students' thoughts, feelings and personal learning intentions and these unique reports offer important insights as clinical teachers seek to create alternative constructions about how to best facilitate student learning in the midst of dramatic change. The project attempts to understand and articulate how nursing students themselves go about making sense of their experience as first time learners on a hospital psychiatric unit. The study was created to provide awareness, appreciation and reflection on nursing students' own ways of knowing and to view their experience from a perspective oriented more towards the knowledge which

students as individuals construct than towards the knowledge which they are expected to receive from their required curriculum. Clinical teachers, students and practitioners alike may glean insights from this constructivist orientation.

Today's psychiatric nursing instructors work in a climate of tumultuous change. Growing numbers of hospital based "training" programs have been abandoned in favor of university "educations" for both Registered Nurses and Registered Psychiatric Nurses. Clinical teachers are generally employed on a sessional or contractual basis and are expected to deliver a curriculum they have had minimal if any involvement in designing. At the same time, they are responsible for teaching and evaluating students with no previous psychiatric knowledge on acute hospital wards assailed by government cutbacks and downsizing. For the most part, at these clinical sites, nursing instructors are also seldom fully fledged members of the staff nurse work group and thus find themselves isolated and marginalized by both their academic and practicing peers. Many hospital nurses "worked" during their own clinical practicums and have only a cursory understanding of the curricular revolution embraced by nursing education in the 1980'S.

Within this new paradigm, hospital psychiatric nurses are expected to mentor student nurses, and yet their employment itself is constantly in jeopardy and their once autonomous role is frequently reduced to simply carrying out basic or custodial nursing activities on the unit. As a consequence, for both nurse educators and practitioners, the possibilities of involving university nursing students in traditional and engaging therapeutic milieu practicum programs

on psychiatric units have dwindled. Adapting to this changing environment and creating alternative constructions and ways of dealing with the world as Kelly (1955/1991) advises, poses an unprecedented challenge for clinical nursing teachers.

A Fresh View of Clinical Teaching

As discussed in Section One of Chapter Two, many studies and approaches undertaken in clinical teaching seek to characterize students' responses and reactions to teacher imposed requirements. The majority of these studies assess and explain how student nurses can be guided to assimilate the competencies expected of them within the profession. While these studies offer significant solutions to specific identified problems and provide contributions to the nursing education knowledge base, the emphasis on received knowledge can divert attention away from understanding how students themselves make sense of clinical placements. In the psychiatric clinical area, where few students seek employment or graduate study, exploring how learners construct knowledge which is both lasting and personally meaningful is particularly relevant.

Ramsden (1992) emphasized that the clear definition of problems in higher education is more important than the provision of solutions. Putting on constructivist "goggles" as Kelly (1955/1991) espoused and employing Shapiro's (1987, 1991, 1994) adaptation of repertory grid technique to listen intently to the students' voices provided clarity and a fresh perspective to the task of defining the kinds of problems and challenges inherent in clinical teaching today.

Further, crafting the students' words into "stories" validated the difficulties and successes they experienced within their learning and invites readers into their world. Advocating the enduring value of case studies as a clinical teaching tool, Oliver Sacks (1990) suggested "deepening a case history to a narrative or tale" (p.viii) to put human beings at the center of the process and convey 'who' the subject of the case really is as well as 'what' their experience was. The following sections illustrate how reading and reflecting on the students' "stories" can stimulate new ideas and approaches within psychiatric clinical teaching.

Sandra's experience: Engaging an independent learner

Sandra's story was that of an independent learner who actively rejected many of the psychiatric nursing practices she saw being implemented. Her experience emphasized how thorough pre-clinical preparation specific to the unique nature of mental illness has become more necessary than ever when assigning Registered Nursing students to today's hospital units. The problem of feeling "completely unprepared" discouraged and disengaged Sandra.

Ironically, this complete lack of engagement was particularly detrimental for this student. As noted on page 35 of this thesis, psychiatric nurses have been criticized for practicing nursing more from a medical model than from nursing oriented frameworks. Sandra enrolled in the faculty of nursing as a "logical stepping stone to medicine" yet she left this area without accessing important information about psychiatric applications of the medical model.

This omission only became apparent when the present research provided an opportunity for Sandra to articulate her own personal learning goals. Perceiving a required clinical nursing practicum as an undergraduate credit course rather than a foundation to practice nursing may be a new concept to some nursing instructors. However, this was Sandra's reality and connecting her own frame of reference to her clinical learning may have engaged her interest and enabled her to view the nursing activities she observed as directly relevant to her own learning aspirations. In essence, the gesture of attempting to look at the world through Sandra's eyes may actually have engaged her interest enough for her to see for herself how the psychiatric clinical area could provide an excellent introduction to the medical model.

Nathan's experience: Facilitating inclusion within the learning group

Nathan's story provides a compelling illustration of the changing picture of clinical teaching. This young man, a team player who was initially drawn to nursing by the sense of community and cohesion he experienced when he joined groups of nurses, actually saw no evidence of therapeutic milieu or any demonstration of team spirit among staff and patients during his psychiatric clinical experience . With specialists rather than hospital staff nurses implementing traditional group therapy or recreational programs, Nathan did not directly observe hospital nurse role models applying psychiatric nursing knowledge of group process. As a result, facilitating the link between Nathan's natural interest in group dynamics to psychiatric nursing activities which promote group cohesion was not a straightforward process and consequently, Nathan left the experience without ever finding a place on the clinical unit "team."

Nathan did feel included and valued within his student clinical group and may have benefitted from learning to name the processes which developed right in that group. Listening carefully to this student's own words and way of looking at the world actually revealed how a valuable learning resource, his own clinical group, was readily at hand. Applying a psychiatric nursing framework of group dynamics to his own clinical group process would build on a natural inclination he brought to the learning experience. Taken a step further, the terminology and confidence mastered through this exercise could lead him to initiate contact with nurse specialists with advanced preparation in group therapy. In situations where hospital nurses do not demonstrate group work with patients, looking into developing the student clinical groups themselves as a forum for learning introductory group processes may be a possibility worth investigating.

Simone's experience: Recognizing a learning partnership

Simone's story, that of a student who literally found herself cast outside the door of a staff nurse discussion, reveals the problem of how hospital nurses today simply may not be accessible to students. Simone viewed herself as a caring friend, and in her psychiatric practicum, she believed that it was mainly during private conversations with her friend and classmate that she was able to piece together what she heard in lectures and observed in the clinical area. Simone was not " just chatting" or passing time with her classmate; she was actively involved in discussion with a colleague. While group conference time is an accepted aspect of clinical teaching, learning partnerships or planned one-on-one conversational time

with peers may also be an important venue to structure into students' experiences. Unlike Nathan, who enjoyed participating in group discussions, Simone was most comfortable relating to just one person. Her learning partnership provided her with valuable air time to voice questions and ideas and listen to the opinions of her peer.

Heather's experience: Enhancing motivation

Heather, the novice psychiatric nurse, was the only student in the study who, prior to the course, expressed an interest in working in the field of psychiatric nursing. Her repertory grid reflected dramatic and obvious changes in thinking after her experience at a provincial mental institution and she was readily able to articulate the growth and development she achieved in the complex area of establishing therapeutic nurse-patient boundaries.

It is interesting to speculate on how Heather's pre course interest in the field and her knowledge from a previous university degree in psychology may have influenced her personal motivation to learn during the course. Questions about how to stimulate similar pre course interest in other students subsequently comes to mind. Might introducing psychiatric concepts and terminology in first year nursing courses establish a foundation of confidence and curiosity? Would granting course option credits to students who complete university psychiatric nursing courses pique interest? Could clinical placements in community psychiatric mental health facilities supplement hospital unit placements? How could concepts from the university psychology, abnormal psychology, sociology and social psychology

optional courses many students take be woven into clinical teaching curricula? What about pre session assignments completed before students even arrive on the unit?

Heather's success with her learning generates a plethora of exciting instructional possibilities, however, without creating the opportunity to listen to Heather in the first place and discover the insights which she brought to the course, these kinds of questions may not have emerged.

Beth's experience: Challenging a strong student

Beth's story provides us with a glimpse of a scholarly, professional learner who did not find her clinical practicum as challenging as she hoped it would be. Beth came from a family where sophisticated discussions about mental health issues seemed commonplace and it was this student who a peer sought out to disclose a personal struggle with mental illness.

Beth felt that she left the learning experience without really understanding how patients came to be admitted to the psychiatric unit and what happened to them once they were discharged. Although she subscribed to both provincial and national nursing publications, initiated a research survey of faculty interests and had been encouraged to submit a paper she wrote for publication, this strong student did not use the opportunities which were available to her to delve into the psychiatric nursing literature base at any point during her course.

The learning opportunity Beth valued most was discussing nurse-patient interactions with her

instructor; she appreciated the individual feedback. Looking at this learning opportunity through Beth's eyes, we see how Beth sensed a conflict between her own learning needs and the needs of her patients and her instructor. Assigned to the evening shift in a teaching hospital, she saw patients inundated with a variety of health care students throughout the day, causing her to hesitate before impinging on their time further. As well, she saw her instructor striving to attend to all of the students in the group, and again, she did not want to monopolize precious instructor time. Unit circumstances dictated that her patient assignments repeatedly consisted of individuals suffering from depression and as the rotation progressed, Beth found herself emotionally exhausted. As the university term drew to a close, she continued to attend to any request made of her with competence and care, but quite possibly at the expense of her own needs. Reflecting on Beth's experience sparks consideration about how curriculum in the psychiatric area must not only accommodate students with no previous knowledge of the area, but also consider students like Beth who excel academically and clinically, but who just do not feel challenged during this particular clinical practicum.

Casandra's experience: Caring for a student caregiver

Casandra's touching experience, that of a gentle helpful student who found she needed help herself during her psychiatric mental health rotation, is one which is perhaps more common than we would like to believe. Disturbed by her patient's disclosure of sexual abuse, Casandra initially avoided the issue, but when pressed by her instructor, she did risk examining her response, and through this process, came to remember the sexual abuse she had

suffered in her own past. Issues of sexual abuse are certainly not exclusive to psychiatric hospital unit patient populations and nor are those related to domestic violence, eating disorders, depression or a host of other mental health concerns. Nursing students struggling to cope with stresses such as these are in an extraordinarily vulnerable position when they find themselves in the position of caring for others burdened with these same problems. Reading and reflecting upon Casandra's story of personal growth highlights the importance of creating a place of safety within clinical practicums where students can explore these issues.

Sharing this student's story in the present research was possible because Casandra stepped forward to help me with a project. Throughout the study, when Casandra and I discussed how her memories of childhood sexual abuse had surfaced, and how she was choosing to deal with these painful memories, we set aside our files and notes, and just spent time together talking. Casandra included this deeply personal aspect of her learning in her final case report in order to "help" once again. She hoped that reading about her experience might pave the way for other students to risk disclosing issues that might come up for them during their psychiatric rotation, and to seek help themselves.

During our discussions, we talked about how psychiatric nursing instructors, many of whom are also nurse-therapists, can pick up on personal problems which students are experiencing, but cannot and should not be expected to engage in a therapeutic relationship with students. It is customary to refer students to campus counseling centers in these situations, and yet, students may not always feel comfortable seeking help at their learning institution. We

addressed this issue in Casandra's "story" by emphasizing how her teacher had supported her efforts to attend an appropriate outside agency and we included the specific details involved in referring students to counseling centers. For example, Casandra's instructor was new in town, and due to health care budget cutbacks the counseling agency oriented specifically to sexual abuse had moved and been renamed, making it difficult to locate. Her teacher found the agency's current phone number, offered to accompany her to her first appointment and called to follow up on her progress once the course was over. As well, in writing the case report, Casandra and I outlined a similar process whereby I listened to her disclosure, supported her choice to seek help and achieved closure by building in an appropriate follow up opportunity to hear how things were going six months after the research data was collected. Thus, the "story" outlines a method which instructors or even peers could implement to support students dealing with personal issues which surface during psychiatric mental health clinical placements.

As the preceding discussion demonstrated, reflecting on the student experiences depicted in this thesis provides a fresh view of clinical teaching. It requires a shift in the way nurse educators often think about students, away from traditional approaches that focus almost exclusively on received knowledge and towards providing students with tools to explore the new world of clinical learning which has emerged on hospital units and to understand it in their own way and on their own terms. The "stories" in this thesis are one such tool and, in the section which follows, I comment briefly on students' responses and reflections when I incorporated them into curricula introducing psychiatric mental health nursing.

Students' Responses to the "Stories"

In January 1998, I shared the "story" section from each of the six case reports presented in Chapter Four with two groups of students who were beginning their integrated medical surgical and psychiatric nursing course. On the first day of class, I distributed the "stories" and the following week we discussed students' responses. Although a few students found the fifty pages of reading "too long", overall, the writing was well received and generated lively discussions. On page 237 of this thesis, I explain how I structured this exercise and the focus questions which I provided as a guide to the activity.

When students discussed Sandra's experience, some of their comments included: "I didn't know that the instructors had to buy books the same way that we do or that nurses could 'bump' into another speciality. ... Sandra didn't seem to try very hard to understand what the nurses were trying to do. ... I know what she meant about feeling scared of the aggressive patients, I feel that way too — I hope I don't still feel that way by the time the course is over though!"

Simone's "story" kindled several remarks about the importance of making friends during clinical experiences. In both groups, students recounted incidents where they had helped one another or been helped by a classmate or staff nurse during a clinical placement. They seemed to enjoy identifying these special experiences and the climate within the groups became more supportive as the discussion continued.

Nathan's experience stimulated the most animated comments. Several students on a surgical unit described reactions of "shock" or "surprise" in response to the illustrations of negative professional role modeling. Another sub group of students, who were on a psychiatric unit, however, emphasized that " (the description) is just like our unit — it really is like that." One student commented that she "identified the most with Nathan because (she viewed herself as) a team player too."

Heather's "story" effectively led into a discussion about establishing therapeutic boundaries with patients and the difficulty students can experience as they seek to define the role of a psychiatric nurse. Because the "story" was "easy to understand", several students shared incidents where they were also encountering difficulty with the concept of boundaries. When a student expressed: "I had a patient follow me around too, she wanted to touch my hair," others offered ideas which might help. A student in the group who attended the provincial mental institution site remarked on how the description of "nurses carrying keys and locking all the doors stood out for me too."

Beth's and Casandra's stories both invited questions and comments about supporting colleagues and patients who grapple with painful memories. Casandra's pseudonym, chosen to highlight the name of a local sexual abuse counseling agency, "made (the name) easy to remember." Responses to the "stories" were positive and the activity was worth repeating. While each case study presented in this thesis was unique, the reports all had four overarching themes in common and I discuss these similarities in the next section.

Four Overarching Themes of the Case Reports

Theme one: The research approach: An invitation to constructivist clinical teaching

From the evidence presented in this study, I would argue that the psychology of personal constructs provides a suitable framework for the explanation of student experiences during a psychiatric mental health clinical practicum. Personal construct psychology is a theory of people: how they interpret their experience and seek to anticipate what lies ahead, through the use of what Kelly (1955/1991) conceptualizes as personal construct systems. In higher education programs preparing professional practitioners generally and in clinical nursing instruction specifically, understanding how students piece together and make sense of information they are expected to know is essential to the process of creating relevant and engaging curricula. In this research, students views of their own growth and change were reflected accurately and meaningfully through a research methodology involving the combination of replicating Perese's (1996) questionnaire and the collaborative construction of repertory grids, concept maps and case study reports. Shapiro's (1987, 1991, 1994) adaptation of repertory grid technique and involving students in all facets of the project were useful tools in the exploration of learners' perceptions of clinical teaching. The constructivist orientation framing the work enabled a student centered rather than faculty centered account of how nursing activities can be construed and effectively created an opportunity to listen to students and invite them into important conversations about their learning.

Beyond the dimension of exploring and explaining student experiences, personal construct psychology also stimulated an atmosphere of respect and collegiality within the relationships I established with students. A prominent feature of conducting the study was how much I enjoyed the time that I spent listening to students as they shared their progress and challenges. Freed of commitments to evaluate student competence in relation to course requirements or fellow students, it was an honor to be a part of each student's special learning journey and to celebrate their personal learning accomplishments. Students expressed their enjoyment in the project as well, and commented on how they valued our time together. In the students' words: "There should be more before and after course tests, it shows how far I came, even if my mark didn't" (Sandra). "It's interesting to see how articles get written, I want to write something myself some day" (Nathan). "I wish other students could have had this chance to talk about things" (Simone). "What you're doing is a lot like we're supposed to do with the patients, listen and be empathetic. This is a good way to learn counseling" (Heather). "I really enjoyed reading over your draft. It was so interesting to look back on my psychiatric nursing experience, and think about the things I had learned" (Beth). "Thanks" (Casandra).

Theme two: Anxiety related more to feeling unable to help than to mentally ill patients

Without exception, at the beginning of their psychiatric mental health clinical practicum, all of the students in this project described feeling afraid of patients on the unit who might hurt them and feeling anxious about their own ability to help. By the end of the rotation, none of the students expressed fear of mental illness and openly shared their admiration and respect

for the patients who they met on the hospital unit. This finding was not unexpected and is consistent with many existing studies in psychiatric clinical teaching. However, we would also expect students to leave this clinical area with at least a basic confidence in their own ability to help patients who struggle with mental illness. In the present research, themes from the students' experiences emphasized that this was not the case. These students left the experience still feeling anxious about their ability to help mentally ill patients.

Hospital psychiatric nursing activities often look different from those which students have observed and participated in on other units and introductory nursing courses seldom include nursing care plans for suicidal, hypo manic or deluded patients. Traditionally, the anxiety associated with incorporating the new and sometimes disturbing knowledge associated with psychiatric nursing dissipated as students completed pre-clinical lectures explaining the unique nature of the speciality and then became involved with the therapeutic milieu of the unit, joining staff nurse mentors to implement "hands on" nursing care. However, for the students in this study, their integrated curriculum offered no pre-clinical introduction to the foundations of psychiatric nursing. With the exception of the provincial mental institution, the short patient stays and acutely ill patient populations on hospital units diminished the possibilities for creating therapeutic milieus. Further, institutional restructuring and downsizing limited staff nurses from allocating time to mentor students. As a consequence of this combination of circumstances, these students found themselves without many of the conventional and reassuring learning resources historically associated with psychiatric clinical practicums. They were expected to learn advanced medical surgical nursing and optional

university courses in addition to their psychiatric clinical requirements and believed that they were evaluated stringently in the clinical area. Thus, looking at the experience through the eyes of these students, we see that the source of their persistent anxiety related to acquiring new helping skills in an environment where the learning resources were ambiguous and not to a fear of mental illness. As Beth expressed: "We are not learning our roles as nurses."

Through the process of inviting students into conversations about their learning and writing their "stories" collaboratively, the present study revealed a different way of conceptualizing student anxiety in the psychiatric clinical area. This perspective suggests a view of clinical teaching where a need for directing students towards acquiring helping skills takes precedence over raising their awareness about mental illness.

Theme three: The lack of feeling included as a part of the staff group

This research was conducted on hospital units where professional staffs were not in a position to integrate students into their working groups. Although they joined practitioners right at their work site and remained there for two eight-hour shifts each week for six weeks, by the end of the course, none of the students on any of the three different hospital units felt that they were part of the staff groups. Without requiring orientation to tasks or technological aspects of nursing care, students did not know how to involve themselves on the unit. On other hospital wards, students, like the nursing staff around them, all wore uniforms clearly identifying how they were part of a common group sharing the task of caring for physically

incapacitated patients. However, wearing street clothes instead of nursing uniforms was a new and difficult requirement for all of the students and one which did little to facilitate their feeling of inclusion in staff groups. The students had a lot of questions about what they should wear and how they were expected to adhere to psychiatric dress codes. To students, psychiatric staff did not seem to do things the way other nurses did, they did not look like other nurses and their language included a new lexicon of terms drawn from the fields of counseling and medicine. While students initially wanted to be included in the staff groups, they did not know how to establish contact, they were disturbed by some nurses' lack of professional presentation, and without background information explaining behavior modification treatment programs: they found some of the nursing activities related to rewarding only positive behaviors distasteful.

As the course progressed, the students did became more comfortable with wearing street clothes, but they continued to feel alienated from staff members. Concerned with fulfilling the graded assignments designated by their course requirements and still feeling uncertain about their place within the unit groups, the students eventually no longer even tried to involve themselves in staff groups. Instead, they went their separate ways to create individual situations where they could use their clinical time well. Sandra distanced herself from the nursing unit and "studied" towards her eventual goal of attending medical school. Nathan turned to a subgroup of peers, naming the informal time he spent with them his "life support." Simone found a friend and learning partner who she could share her experiences with. Beth, intending to practice in the medical surgical area, focused her intellectual energy on this more

concrete component of the course. Casandra established an important relationship with her instructor. Even Heather, a member of the self-selected group who traveled together, shared accommodation and were exposed to a therapeutic milieu environment at the provincial mental institution, did not imagine herself ever becoming a member of a group of hospital psychiatric nurses. She was interested in the field "but not on a hospital unit."

Again, by considering the practicum experience from the student's perspective, the present research leads us to appreciate the difficulties students experience as they grapple with psychiatric nursing concepts and how valuable being included a group can become during this process. When group involvement was missing for the students in this study, their initial intrigue waned and they became disengaged. Neither the staff work groups nor their clinical groups compelled student attention, but individual grades and assignments clearly did. Designating time and opportunities within the curriculum for students to attend to climate setting and team building within their student groups takes on new significance when we realize how valuable an inclusive group experience can be to student learning in the psychiatric mental health area.

Theme four: The vital importance of non evaluated student-instructor discussion time

The students in this study consistently identified dialogue with their instructors as their most important learning resource and the one which they wanted more opportunities to pursue. By count, students emphasized the importance of non evaluated discussion time with their

instructors the greatest number of times during our discussions. From their point of view, few other resources seemed accessible. None of the students felt that their psychiatric nursing textbook offered sufficient explanations of the physician directed treatment they observed being implemented on the units. While students did mention turning to library resources such as journal articles for their required term paper assignment, they did not find them helpful. Casandra explained that "it's hard to read them when we don't know anything to begin with." Beth was the only student who turned to a textbook for answers to her questions about disturbing staff behavior, and the reference she chose was from a first year textbook.

Beth and Casandra were both protective of their instructor's time, noticing how she had "seven other students to get to," and they were reluctant to "ask again" or "bother her." Sandra, Simone and Nathan, who arrived on the units before their integrated course lectures explained psychiatric nursing care, all emphasized that instructor time was their only resource and that they needed more of it. Nathan explained that his clinical instructor also "talked" with him through her comments in his reflective journal and that he valued this exchange as well. Heather "sorted out" how she could establish personal boundaries with her patients during discussion time with her instructor and it was this area where she progressed so successfully. Casandra found a "safe" place during talks with her instructor.

While the clinical instructors all spent time evaluating students and providing feedback on the activities they were required to complete for their course, it was the non evaluated discussion time which students spoke of when they were asked to describe experiences which were

personally meaningful to them. When we consider how disturbing it can be for students to learn about psychiatric nursing, the need for adequate time to debrief becomes clear. Casandra's "story" demonstrated the personal nature of issues that can come up for students as they meet and bond with their patients in this unique clinical area. Similarly, Beth's peer also described a personal struggle with a mental health problem. None of the students in this study escaped feeling "touched" by their patients and each participant found the rotation emotionally draining. Three of the students in this small sample described times when they "cried" after a clinical day. We do not encourage students to discuss clinical experiences with their own friends or families, clinical conference times can focus on content or the needs of vocal students and university nursing students do not necessarily develop confiding relationships with peers in their clinical groups, limiting the debriefing opportunities available to many students.

Learning about psychiatric nursing is complex. Understanding and accepting personal responses to the speciality is a gradual process and one which requires time and opportunities to dialogue with professionals in the field. For the students in this study, this important dialogue occurred during conversations with their teachers. Constructing personally relevant connections among ideas about nursing activities, physician's medical treatment and patients' own experiences with mental illness may not happen if students are preoccupied with tasks required by their course. While non evaluated time set aside strictly for discussion may seem frivolous in relation to today's fast paced clinical nursing curricula, it is important to remember the lasting benefit students attribute to this special time.

Reconstructing Clinical Teaching From a Student Centered Perspective

The preceding sections described ways of reflecting on the individual case study reports presented in this thesis and four overarching themes which were common to all of the students who participated in this study. Readers are once again invited to consider psychiatric clinical practicums from the students' point of view and to speculate upon how this fresh perspective might be incorporated into their own educational practice.

The present work adds to our understanding of clinical teaching by demonstrating that not only does the university nursing student have his or her individual views about the field of psychiatric mental health nursing, the patients who seek treatment within the speciality and the kinds of nursing interventions currently being implemented, but that these views are also profoundly influenced by the paradigm shifts occurring in both hospitals and nursing education. According to Ramsden (1992) " . . . becoming a good teacher in higher education involves listening to one's students and changing one's understanding of teaching" (p. i). In order first to listen deeply to students and then to change one's understanding of teaching, a tool specifically geared towards active listening is invaluable. In this project, Shapiro's (1987, 1991, 1994) adaptation of Kelly's (1955/1991) repertory grid technique set a tone of empathy and respect for students' views and consistently generated opportunities to listen attentively and ground conversations in students' own words and ways of expressing their thoughts. Listening attentively to students revealed different ways of looking at anxiety, group inclusion needs and non evaluated time with instructors. Previously, student anxiety

in the psychiatric clinical area was considered to be related to fear of bizarre or aggressive patient behavior and this anxiety was expected to dissipate, once students came to know their patients and became involved in the therapeutic milieu of the unit. However, this thesis suggests expanding our ideas about students' anxiety to include their persistent concerns related to feeling unable to help their patients. In turn, this understanding affirms the importance of addressing students' expected fear of mental illness, but perhaps more importantly, it can also guide us towards providing students with additional resources which explain current treatment approaches. Similarly, knowing how much students value learning opportunities where they are part of a cohesive group and the times they spend talking with their instructors prompts us to ensure that these experiences are actually available.

Towards a Curriculum Which Includes the Voices of Student Nurses in the Scholarly Dialogue Surrounding Their Learning

> A good conversation is neither a fight nor a contest. Circular in form, cooperative in manner and constructive in intent, it is an interchange of ideas by those who see themselves not as adversaries but as human beings come together to talk and listen and learn from one another (Martin, 1985 p.10).

This research demonstrated a process where students' voices were included in the scholarly dialogue surrounding their learning. The study was about engaging nursing students in conversations which encouraged talking, listening and learning from one another. We preserved the experience in the form of "stories" so others might benefit from the difficulties

and successes we uncovered. In this thesis I call for the creation of more opportunities to listen to students, to incorporate their thinking, and most importantly, to change what we do in response to what they say.

At the 1996 *Create the Future Celebrate the Past* International Nursing Education Conference in Hamilton Ontario, Stephen Brookfield (1996) opened the proceedings by praising historical hospital nurses' "training" programs for their strong commitment to facilitating bonds between students. In particular, he commended the "big sister" relationship between senior and junior nurses which many hospital nursing curriculums established. When students enrolled in traditional apprenticeship oriented programs, they were assigned a "big sister" who was expected to mentor their progress and adjustment. This often involved passing on informal knowledge and tips for surviving and succeeding within the hospital environment. The present project assumed a "big sister" function in that it related practical information from students who completed a psychiatric mental health rotation to other students just beginning the course. The "stories" were passed along using students' own words and ways of looking at the world and conveyed helpful information not expected to be outlined in a formal course syllabus or textbook.

Students in this study enjoyed talking about their personal ways of constructing knowledge and how their thinking changed or did not change throughout their course and again when the rotation was over. The project demonstrated a method of extending clinical instruction beyond focusing exclusively on received knowledge and toward a curriculum which facilitates

and honors constructed knowledge. In the section which follows, I present constructivist teaching strategies which could also encourage accessing and listening to learners ideas about their experiences during psychiatric nursing courses.

Suggestions for Clinical Teaching Strategies

Actively involving students in their learning is an established pedagogical principle. In the field of higher education, leaders committed to providing excellent instruction to university students agree that strategies to engage and include students must be planned with the same attention and energy academics devote to research activities (Davis, 1993; Johnson, 1995; McKeachie, (1986); Ramsden, 1992). In nursing education, Tanner (1997) equated the importance of involving students in their learning with the fundamental nursing principle of encouraging patients to ambulate postoperatively. New possibilities for involving students in their learning unfolded when nursing instruction moved out of hospitals and into universities. However, with student nurses no longer "working" during their clinical rotations, we can no longer assume that they will continue to integrate into hospital learning communities. Evidence from this thesis indicated that specific instructional strategies to engage and sustain student involvement during clinical practicums are necessary if we expect students to construct meaningful and lasting knowledge in the clinical laboratory. Three broad areas of educational practice geared towards involving students in their learning are first: organizing information, second: creating a climate for listening and speaking about experiences and third: ensuring time for reflection and self-evaluation. In the sections which

follow, I use these broad concepts as headings to suggest practical teaching strategies for the psychiatric mental health clinical area.

Area one: Organizing information

Introducing Psychiatric Nursing in First Year. First year nursing students could benefit from an introduction to the fundamentals of psychiatric nursing. Many nursing curriculums require students to attend psychiatric clinical practicums only during their second year of study, and introduce mental health nursing concepts at that time. Early introduction of information about how anxiety, depression and disordered thinking can lead to loss of function would begin to familiarize first year students with mental health subject matter. Community mental health agencies often have a "Speakers Bureau" where individuals recovering from mental illness do volunteer speaking engagements with interested groups. Students who are able to meet these speakers in person and hear about their true experiences with mental illness may become intrigued and want to learn more. Traditionally, students' first exposure to mental illness was often when they met individuals hospitalized for management of an acute exacerbation of their condition. Talking with recovering individuals before this initial hospital experience might leave students with a substantially different and more positive first impression of the field.

Advance Organizers. Johnson (1995) describes an advance organizer as a way of helping students establish a general mind set for what is about to happen. Concept maps, explained

on page 108 of this thesis and illustrated in the case reports presented in Chapter Four, are a useful way of structuring information. Appendices 7 and 8 are two concept maps I created to introduce psychiatric content in my own psychiatric nursing courses. Appendix 7 illustrates psychiatric conditions students can expect to learn about on hospital units and Appendix 8 illustrates medications commonly administered in this speciality area. Updating the concept maps in response to clinical advances is not difficult and several of my students commented on how this teaching strategy was a useful orientation tool.

Bulletin Boards. Elementary school classrooms often have enticing and colorful displays of information on bulletin boards. In higher education settings or hospital units, bulletin boards are also sources of information, but they are seldom arranged or decorated systematically. I found that requesting space on hospital unit bulletin boards was an efficient method of communicating course material. I used brightly colored poster paper to designate an "education area" which was separate from notices and inter-unit communication. I made pockets on the poster paper with heavy plastic and labeled them with large computer generated labels. In one pocket, I posted my lecture notes; in another, I included relevant articles and in the remaining pocket, students' patient assignments. I changed the display each week before students arrived on the units and made a point of keeping it colorful. Unit staff members also accessed the information and joked with me when I didn't change the display during reading week. As the course progressed, students and staff also made contributions to the display and this process initiated a visual link between university curricula and the practicum site.

Newspaper and Magazine Files. I have found it beneficial to maintain an ongoing file of newspaper and magazine articles related to mental illness. Students generally find them easier and more stimulating to read than journal articles. We discuss the differences and similarities between popular and professional literature, focusing on issues such as how sensationalist writing can intensify the stigma associated with mental illness. We also talk about what it might be like to write different kinds of articles and students expressed a view of themselves as authors instead of simply readers which was new and appealing.

Sample Test Questions. Davis (1993) and Johnson (1995) advocate providing university students with sample exam questions early in their courses. In the psychiatric clinical area, nursing students may not be given written examinations, but will write professional licensing examinations at the end of their program of study. I have perused Registered Nurses' examination guides and test question booklets from Canada and other English speaking countries and provided students with examples of questions related to psychiatric mental health nursing. Students found this concrete strategy helpful and commented on how it offered a broader perspective of some of the nursing activities they observed being implemented on their local hospital units.

Workshop Formats Integrating Clinical Instructors. Students in the present study expressed little or no anxiety related to caring for suicidal patients. This content had not been introduced during their first year of study and could be expected to be disturbing. However, for these students, it was not. Early in their rotation, clinical instructors and their students

all attended a full day "suicide workshop" together. The workshops were held in university classrooms and students and their teachers shared the experience of listening to speakers and watching films about suicide. At different points throughout the day, individual clinical groups moved into break away rooms and discussed the information presented. Both the students and their instructors felt that the experience provided practical guidance which could be transferred to clinical settings.

Assignments Requiring Students to Teach Others. Students in this study were required to teach a patient about his or her prescribed medication. While the medications were often difficult to research and physicians frequently changed their prescriptions or discharged patients before students could complete this assignment, the process was valuable in raising important issues about how medication is used in the treatment of mental illness. A variation on this assignment might be to teach a younger or more junior student or a member of the public about a mental illness or treatment. The process of translating professional jargon into everyday language can be an effective way of understanding new ideas and terms. I find it useful to collect or make copies of teaching assignments that students create and share them with both students and staff members. Elbow (1986) encouraged instructors in higher education to design assignments which will be read by peers. Students can learn from the content of their peers' assignments as well as the process their fellow students engaged in as they completed the task. I found that unit staff, particularly those who were new to the area, sincerely appreciated the students' work and that this was another way of linking university curricula to busy hospital units.

Area two: Creating a climate for listening and speaking about experiences

Assigning a Mark for Group Participation. Cohesive groups seldom develop without careful facilitation and planning. Traditionally, when student nurses staffed hospital units during their clinical practicums, participating in conferences or group activities was often an established norm within health care institutions. However, in university education settings, a different cultural norm exists. Contemporary nursing students in colleges and universities may be involved with laboratory learning where no commitment to the group is required. In fact, Davis (1993) asserted that even class or laboratory attendance in higher education is a non academic factor and should not be included in grading policies. According to Davis (1993), student grades should be based solely on students' mastery of the course content. A dialectic tension between hospital "training" and university "education" emerges once again for nursing students and their instructors as they consider the importance of clinical group participation. If clinical group involvement is expected, valued and perceived as a learning resource, then assigning a mark for group participation and stipulating ways participation can be graded communicates this message clearly.

Structured Exercises to Promote Group Cohesion. Creating a place for fun and playfulness within psychiatric clinical curriculums may be a way of engaging and sustaining student interest in the area. I have found that at the beginning of the rotation it is useful to provide students with a list of typical ground rules that different types of groups might establish and I ask students to construct their own set of rules. I type out the "rules" the

students generate and distribute them at the next meeting. I have also received positive student feedback when I invite students to add their names and phone numbers to an optional class list. I ask students to identify a "buddy" or learning partner within the group and check to ensure that no one has been left out.

Another exercise which students enjoy involves drawing on flip chart paper. I break students into groups of three or four and invite the small groups to draw both their dreams and nightmares for the course. I bring in colored pencils and markers and we use masking tape to display the pictures on the wall and explain them to the larger clinical group. On the "dreams" posters, students have drawn huge evaluation forms with "A" scrawled across the paper, stick figures of patients carrying suitcases out of the hospital and returning to productive lives, and happy faces depicting successful nurses. The "nightmares" posters have included "F" evaluations, knives or other symbols of aggression and injured nurses. Drawing rather than discussing or writing offers students a non threatening way of expressing themselves and the exercise can fill the conference room with laughter as students call upon infrequently used artistic talent. Involving the students in carefully shredding and disposing of the pictures at the conclusion of the exercise stimulates discussion about professional and confidential ways of debriefing when disturbing clinical experiences occur. Arnold and Nieswiadomy (1997) described another structured exercise effective in acknowledging and reducing nursing students' anxiety about psychiatric placements where students form triads and take equal time to identify specific situations which are frightening to them.

As mentioned previously, discussing the case studies presented in this thesis was also an effective strategy in creating a climate for listening and speaking about experiences within clinical groups. At the end of our first class, I distributed the six "stories" and asked students to read all of them for the next week but to pick one which they would like to discuss in depth. I suggested they write comments on three focus questions. The first two questions related to the case study student. They were: First, what had this student learned and second, what had he or she found difficult during this practicum? The third question related to the student reading the "story" and was: What surprised you when you read about this experience? When the students met as a group the following week, they formed small subgroups and discussed the student experience of their choice. We concluded the exercise by reporting back to the larger group. Renner (1993) details additional climate setting exercises drawn from the field of adult education which clinical instructors could adapt to clinical learning groups. Students also bring lively ideas about activities which can contribute to group cohesion and may be more inclined to share them if their instructors carve out the time to attend to group process as well as academic content during clinical courses.

Area three: Ensuring time for reflection and formulating questions

As this thesis illustrated, the exercise of constructing pre- and post-course repertory grids was an effective way of creating a non evaluated opportunity for students to reflect upon their learning. The before and after dimension of the task engaged student interest at the beginning of the course and then provided closure once the course was over. Other ways of insuring

that time to reflect and question is available to students include reflective journal assignments, sign up sheets for talk time with instructors and designated times for discussion with peers. Students in this study found that the experience of working in pairs and role playing their own patient was useful. I have also found that students benefit from joining me when I observe student-patient interviews behind two-way observation mirrors. The comments and questions students raise during discussions with their peers, the ways students listen to one another and the questions which have few or no easy answers can be examined further during group conference time. Encouraging students to identify the kinds of questions which remain unanswered for them as they leave the course can also stimulate meaningful reflections. Johnson (1995) suggests praising students for asking excellent questions, but without keeping time open to allow questions to emerge, this important aspect of learning could be overlooked.

Future Research

Replicating this project in other clinical areas could stimulate further meaningful conversations among students and their teachers, tap into key areas where learners potentially encounter difficulty and acknowledge progress which might otherwise go unacknowledged. Future studies could involve participants in the construction of elements and use laddering techniques on the repertory grids. Clinical instructors, unit staff nurses and students could all construct repertory grids from the same element list to compare and find common ground in their thinking.

In Endings There are Beginnings

Wolcott (1990) wrote that qualitative research yields implications "to help others to understand themselves by seeing things through the perspective we provide" (p.55) but does not provide conclusions. In this closing chapter, I concluded my work by teasing out the implications which became possible when I listened carefully to the voices of student nurses and told their "stories." By weaving a common thread between the two research areas of personal construct theory and clinical teaching, I was able to explore different ways of looking at the experience of learning psychiatric mental health nursing on hospital units. Clearly, student nurses face new and complex challenges in their personal process of acquiring clinical nursing knowledge and I hope that my findings have implications for all those who seek to understand this experience. Questioning and discussing what students bring to learning and how they make sense of the health care world around them is the foundation of constructivist clinical teaching. In this thesis, I emphasized the resounding need to listen to students and to support their own ways of knowing. It is at this juncture that collaborative nursing education can truly begin.

The era of "training" nurses in hospital settings has come to an end. However, nursing education's history of supplying unpaid student labor to hospitals cannot be denied. My project suggested that clinical teaching in hospital settings continues to be influenced by the needs of hospital institutions and that while these needs may undermine many students' experiences, new beginnings are always possible. In my analysis of existing clinical teaching

literature, I identified how current research is limited in scope and dominated by faculty discourse. Themes related to feeling anxious, being overwhelmed by evaluation and having important learning go unacknowledged emerged when nurse researchers invited students to share their perceptions. In the mental health area, negative responses to the nature of psychiatric nursing and the underutilized role of hospital nurses have been presented. In the present project, I extended our understanding of what it's like for students during their clinical practicums by developing six in-depth case reports and identifying four overarching themes. In my work, I found that a personal construct theory approach did provide a suitable framework to explore student perceptions, that students can be more anxious about helping their patients than about the behaviors which mentally ill patients might manifest, that students felt a lack of inclusion in hospital unit staff groups and that non evaluated student-instructor discussion time is vitally important. I called for the inclusion of student nurses' voices in the scholarly dialogue surrounding their learning and suggested teaching strategies to bridge the gap between university curriculums and hospital practicum sites. Creating a space for students' own ways of knowing within the curriculum may force the rethinking of some dearly held traditions. This is both a challenge and an opportunity for the future of nursing education.

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APPENDIX 1

List of Elements or Nurses' Activities

1. Wearing street clothes on the unit.

2. Administering a PRN medication to an agitated patient.

3. Accompanying a patient on an off-unit smoking break.

4. Sitting down and drinking a cup of coffee with a patient in the hospital dining room.

5. Contracting with a suicidal patient to be kept informed.

6. Denying a non-compliant anorexia nervosa patient's request to spend time together.

7. Holding a crying patient's hand.

8. Pointing out discrepancies in a patient's verbal and non-verbal behaviour.

9. Presenting a patient to the health care team during unit rounds.

10. Facilitating a group therapy session.

APPENDIX 2

PERSONAL CONSTRUCTS FORM (Shapiro, 1991)

Name: _____ Item number _____

Interviewer: _____

Code	1	2	3	4	5	Code
1.						1.
2.						2.
3.						3.
4.						4.
5.						5.
6.						6.

APPENDIX 3

Students' Perceptions of Their Psychiatric/Mental Health Nursing Practicum

1. What did you expect your psychiatric/mental health nursing clinical experience would be like?

2. What experiences influenced your expectations?

3. What were your first reactions/feeling to your experience?

4. What was most difficult for you?

5. What did you like most about your experience?

6. What did you like least about your experience?

7. What would have helped you during your clinical experience?

8. How do you view your community or inpatient experience overall?*

*administered to students placed in inpatient psychiatric units in general hospitals in community-based mental health care settings.

Eris Field Perese, MS, RN
Rm. 901, School of Nursing
State University of New York at Buffalo
Buffalo, New York, 14214

APPENDIX 4

Letter of Introduction

Sherri Melrose is a nurse educator who has been involved in teaching psychiatric mental health nursing for the past few years. She is interested in finding out about student nurses' ways of knowing and how they make sense of what they learn in the clinical area. Would you be willing to hear more about this study? If so, Sherri will arrange to speak with you either in person or by telephone, tell you more about the study and if you are interested, will invite you at that time to participate. Agreeing to hear more about the study does not commit you to participate in the study. If you would be willing to hear more about the study, would you please contact Sherri by telephone at 241-2685.

This is a unique study in that students are asked their opinion about how they construct meaning early in their clinical experience, during the experience, and again when the experience has ended. In six approximately one hour interviews, students will reflect on their clinical learning and see where they start and where they've grown. **It will not impact grades in any way** and the researcher will not be clinically evaluating student participants. The experience is designed to be interesting, enjoyable for students and an opportunity for the researcher to listen to students. Thank you for taking the time to read this and consider the request.

APPENDIX 5

Participant Consent Form

Project: An Exploration of Students' Personal Constructs:
Implications for Clinical teaching in Psychiatric Mental Health Nursing

Purpose of the Research: To investigate how student nurses develop personally meaningful constructs during their psychiatric mental health rotation.
Researcher: Sherri Melrose, RN, BN, MEd, The University of Calgary.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take time to read this carefully and to understand any accompanying information.

You are invited to participate in a study that is exploring how student nurses themselves construct meaning in clinical placements. I am a nursing instructor engaged in PhD studies in the Faculty of Education. I hope to learn more about clinical teaching from the student's perspective in order to ultimately include students' ideas and opinions in designing meaningful curriculum. You were selected as a possible participant in this study because you are currently enrolled in Nursing 4471 and will not be evaluated in class or in the clinical area by the researcher.

If you decide to participate in the study, you will be asked to take part in six personal interviews with the researcher and will be invited to use your own words to describe different kinds of nurses' activities. In the first interview, at the beginning of the course, you will be given cards with typed nurses' activities on them. You will be asked the question "Which two do you think are the same and different from the third?". The words you use to describe the similarities and differences will be written down on a chart. This process will be repeated six times, the chart will have six of your own personal constructions or ways of organizing the activities. Using the chart of your own words, the researcher will then go through the nurses' activities and ask you to rank them from one to five.

In weekly interviews, as the course progresses, the researcher will ask you to talk about your experience in general.

In the sixth interview, when the course is over, the researcher will ask you again to rank the same nurses' activities on the same chart you personally constructed. Together, you and the researcher will compare the way you ranked the nurses' activities on both charts, discuss any changes in your thinking, and reflect on the process. You will also be asked to write answers to eight questions on a questionnaire.

In the final interview, you will be asked to comment on a written report of the experience. The interviews will take about one hour. You may be asked for a short follow up interview (of no more than one half hour) if necessary, to clarify any points.

The interviews will take place in the researcher's office at Mount Royal College at a time that is convenient for you. One interview will be audio taped and transcribed. The transcription of the interview may be preserved for future comparative studies. Your signature acknowledges your agreement to preserve these transcriptions. All tapes will be erased after their use in this study and all transcriptions will be filed by pseudonym only so your identity will be protected. During the study and upon completion of the study, files will be kept in a secure place accessible only to the researcher and the researcher's university advisor/supervisor.

There are no anticipated risks to participating in this study other than the time it takes to complete the interview process. The research has no direct benefit to you but it may be helpful in increasing the clinical teaching knowledge base and in developing curriculum that is meaningful and relevant to student nurses. You will not be compensated for participation in the study.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will only be disclosed with your permission. There will be no way of linking individual names to a particular response. You are under no obligation to participate in this study. If you decide not to participate, this will not effect your grades or

your studies at Mount Royal College in any way. You are free to discontinue participation at any time.

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your relationship with Mount Royal College. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Name_____ Date _____

Researcher _____

Re: any questions about the research, please contact either of the following:
Sherri Melrose. 241-2685, or
Dr. B. Shapiro, Graduate Division of Educational Research. 220-7521

If you have any questions concerning your rights as a possible participant in this research, please contact the office of the Research Ethics Committee, Mount Royal College, 240-6858; Dr. Mike Pyryt, Chair, Faculty of Education Joint Research Ethics Committee, 220-7797; or the Vice-President (Research), University of Calgary, 220-5465.

A copy of this consent form will be given to you. Please keep it for your records and future reference.

APPENDIX 6:

Confidentiality Pledge

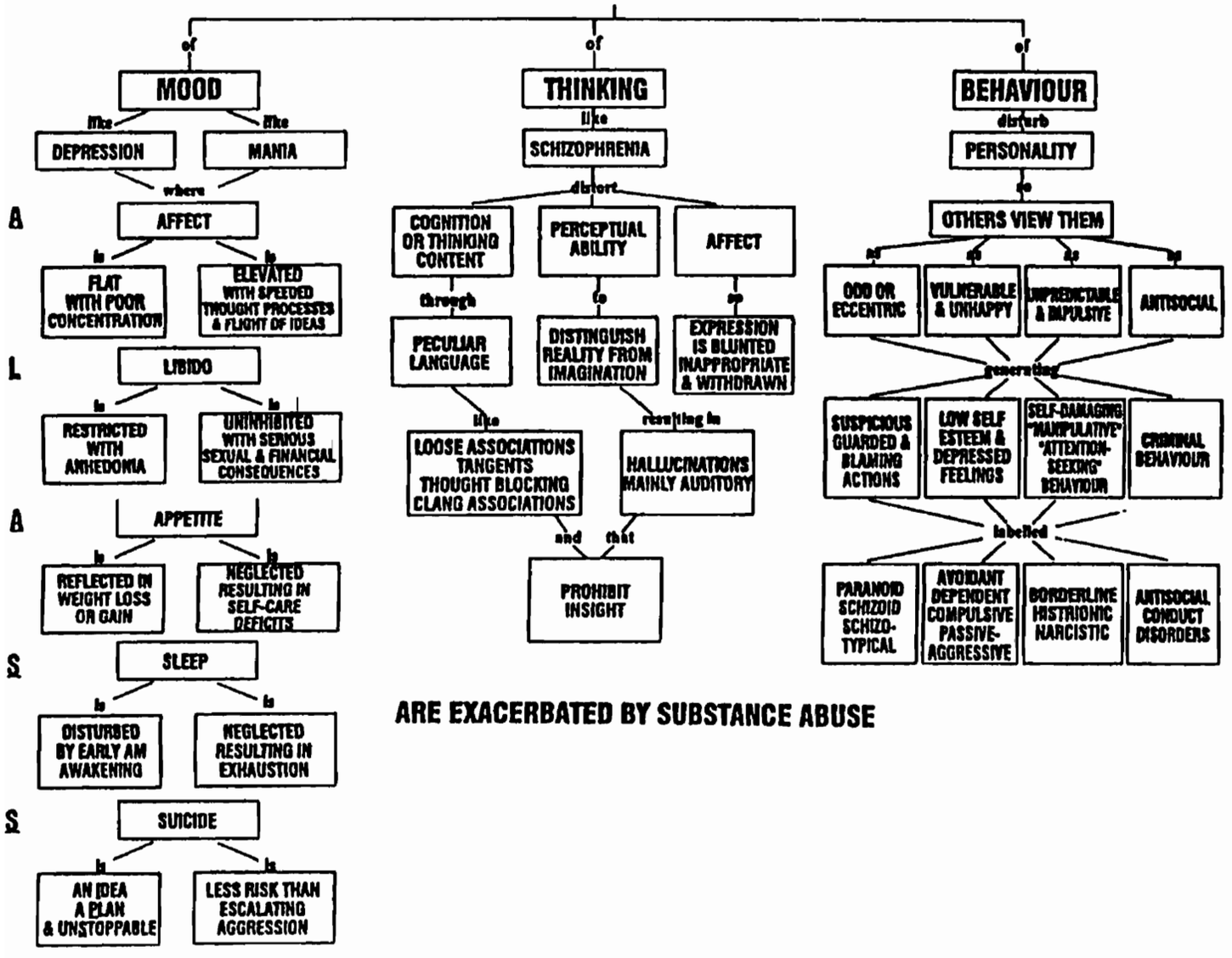
As a secretary undertaking the transcription of the audiotapes from the research study An Exploration of Students' Personal Constructs: Implications for Clinical Teaching in Psychiatric Mental Health Nursing, I understand that I will be transcribing interview data directly from the audio taped interviews. I understand that all possible precautions have been undertaken to protect the identity of the research participants. Further, I pledge to keep all the information strictly confidential and agree not to discuss the information with anyone other than the researcher. My signature indicates that I understand the importance of, and agree to maintain confidentiality.

Secretary_____Investigator_____

Date_____Date_____

APPENDIX 7

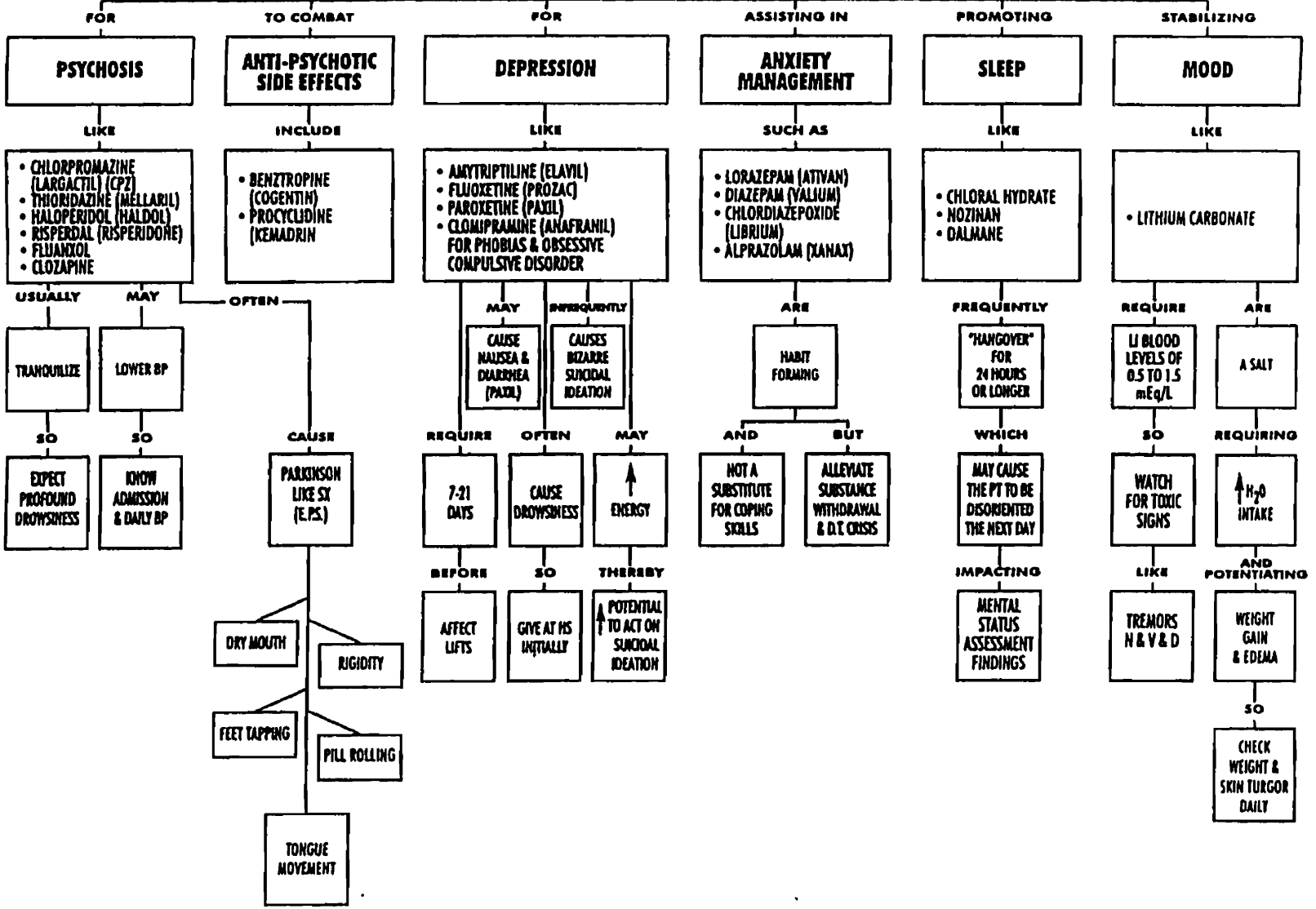
DISABLING MENTAL DISORDERS



ARE EXACERBATED BY SUBSTANCE ABUSE

APPENDIX 8

COMMON PSYCHIATRIC DRUGS



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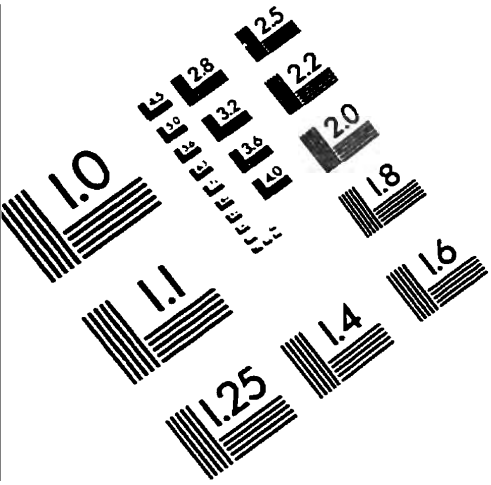

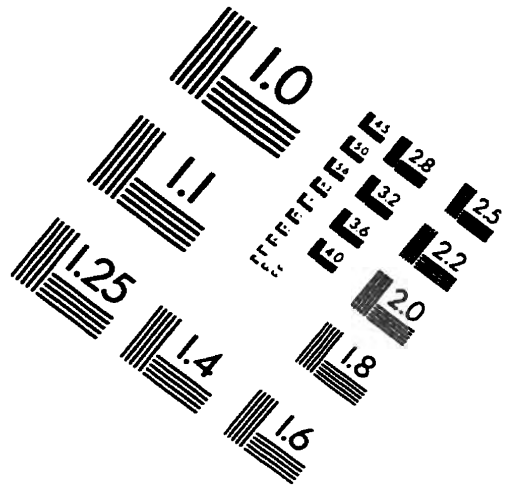

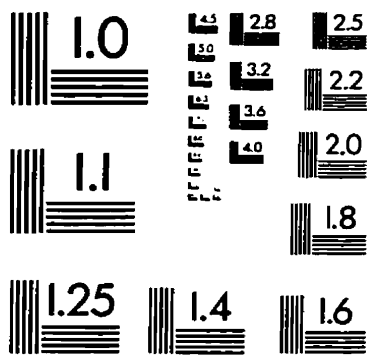

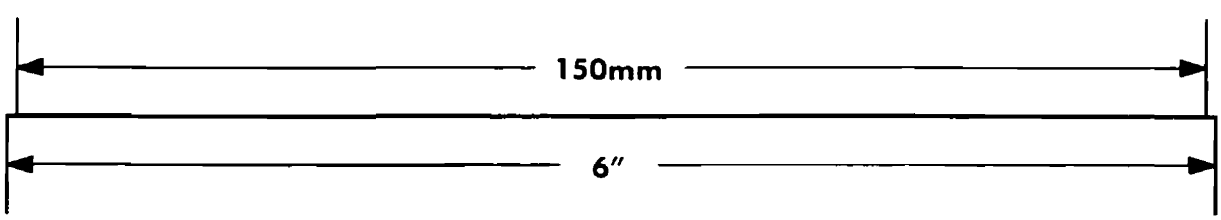

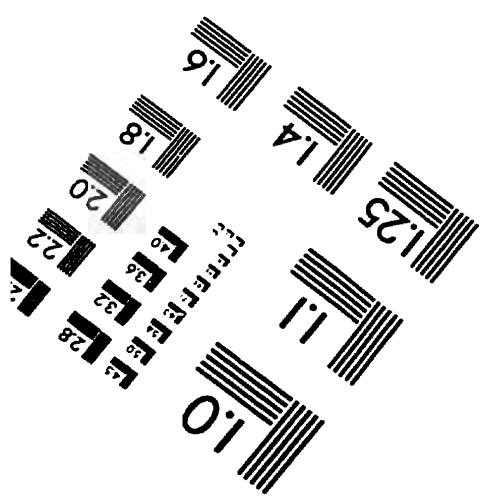

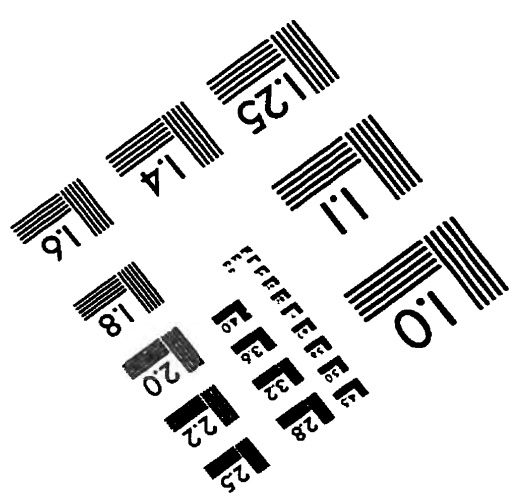

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