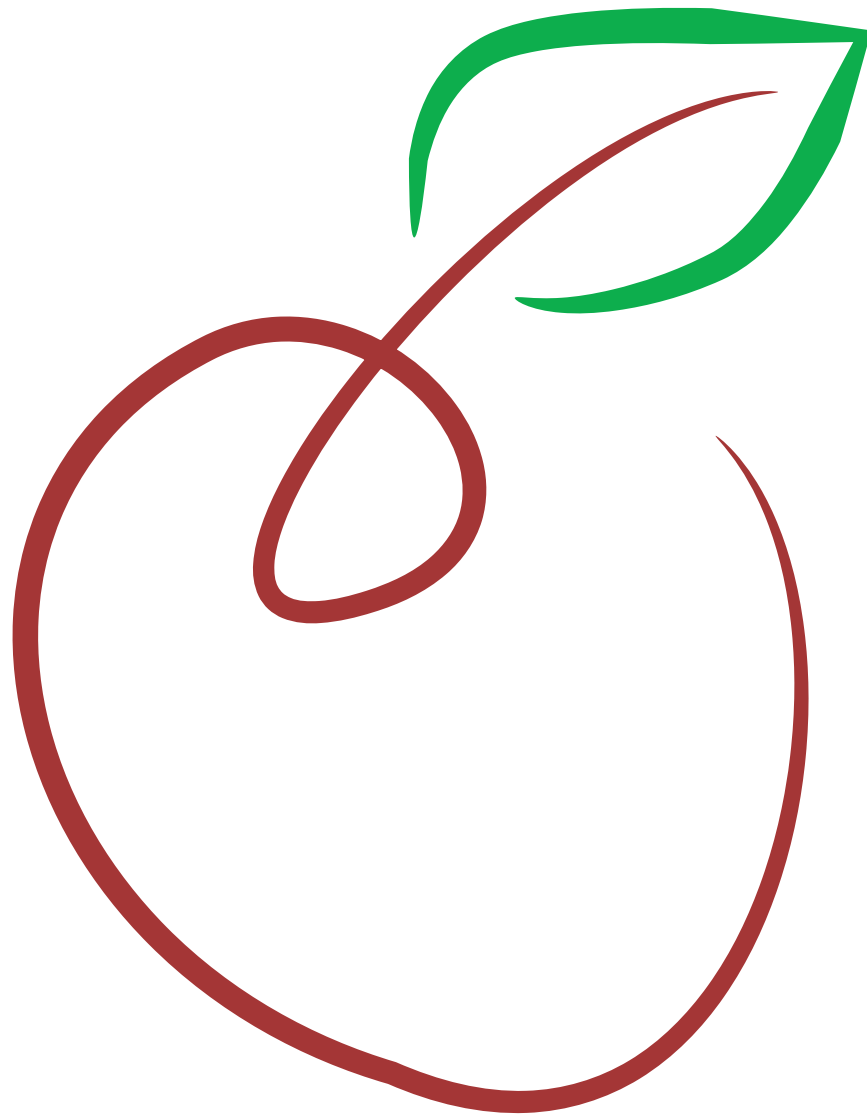




Sherri Melrose
Publications

Sherri Melrose Publications: A Virtual Memory Box

Sherri Melrose Publications: A Virtual Memory Box

MELROSE, SHERRI

SHERRI MELROSE PUBLICATIONS
CALGARY



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My Publications



Dr. Sherri Melrose

Welcome to my Virtual Memory Box! A memory box is something where people put keepsakes so that they are all in one place and are easy to find. My memory box is virtual and it contains a selection of academic keepsakes that I have created during my career as both a psychiatric nurse and a teacher. I divided my academic keepsakes into three general sections: **books** (Open Education Resources – or OER e-books that are available for free); **journal articles** from a variety of refereed publications; and **teaching resources**.

With a background in both psychiatric mental health nursing and education, I worked on forensic, acute assessment and day hospital psychiatric units; and taught in traditional diploma schools of nursing, community colleges and universities. I have been an Associate Professor at Athabasca University for nearly twenty years, where I authored and instructed in both undergraduate and graduate classes.

During my tenure at Athabasca University, I served as Chair of the Research Ethics Review Board for two terms. I also chaired the

Canada-wide Clinical Teaching Interest Group for four terms and served as President of Western and Northern Region Canadian Association of Schools of Nursing (WRCASN). I am a winner of the *Canadian Association of Schools of Nursing (CASN) Award for Excellence in Nursing Education* and the *WNRCSN Educational Innovation Award*.

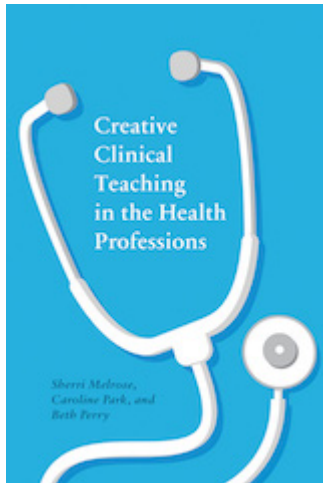
My research projects have been funded by the Social Sciences and Humanities Council (SSHRC), the Collaborative Research Grant Initiative (CRGI), WNRCSN and Athabasca University. In the community, I am an active volunteer with my local United Church of Canada, community kitchen and animal rescue shelter.

My Teaching Philosophy

My Teaching Journey

My Curriculum Vitae

Creative Clinical Teaching in the Health Professions



[Read Book](#)

Sherri Melrose, Caroline Park, and Beth Perry

For healthcare professionals, clinical education is foundational to the learning process. However, balancing safe patient care with supportive learning opportunities for students can be challenging for instructors and the complex social context of clinical learning environments makes intentional teaching approaches essential. Clinical instructors require advanced teaching knowledge and skills as learners are often carrying out interventions on real people in unpredictable environments.

Creative Clinical Teaching in the Health Professions is an indispensable guide for educators in the health professions. Interspersed with creative strategies and notes from the field by clinical teachers who offer practical suggestions, this volume equips healthcare educators with sound pedagogical theory. The authors focus on the importance of personal philosophies, resilience, and professional socialization while evaluating the current practices in clinical learning environments from technology to assessment and evaluation. This book provides instructors with the tools to influence both student success and the quality of care provided by future practitioners.

Melrose, S., Park, C., & Perry, B. (2021). *Creative clinical teaching in the health professions*. AU PRESS.
<https://www.aupress.ca/books/creative-clinical-teaching-in-the-health-professions/>

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Centring Human Connections in the Education of Health Professionals



[Read Book](#)

Sherri Melrose, Caroline Park, and Beth Perry

Many of today's learning environments are dominated by technology or procedure-driven approaches that leave learners feeling alone and disconnected. The authors of *Centring Human Connections in the Education of Health Professionals* argue that educational processes in the health disciplines should model, integrate, and celebrate human connections because it is these connections that will foster the development of competent and caring health professionals.

Centring Human Connections in the Education of Health Professionals equips educators working in clinical, classroom, and online settings with a variety of teaching strategies that facilitate essential human connections. Included is an overview of the educational theory that grounds the authors' thinking, enabling the educators who employ the strategies included in the book to assess their fit within curriculum requirements and personal teaching philosophies and understand how and why they work.

Melrose, S., Park, C., & Perry, B. (2020). *Centring human connections in the education of health professionals*. AU PRESS.
<https://www.aupress.ca/books/120289-centring-human-connections-in-the-education-of-health-professionals/>

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Creative Clinical Teaching in the Health Professions



[Read Book](#)

Melrose, Sherri, Park, Caroline, Perry, Beth

This peer reviewed e-book is a must-read for nurses and other health professionals who strive to teach with creativity and excellence in clinical settings. Each chapter presents current evidence informed educational practice knowledge. Each topic is also presented with text boxes describing 'Creative Strategies' that clinical teachers from across Canada have successfully implemented. For those who are interested in background knowledge, the authors provided a comprehensive literature base. And, for those interested mainly in 'what to do,' the text box summaries offer step-by-step directions for creative, challenging activities that both new and experienced instructors can begin using immediately.

Melrose, S., Park, C. & Perry, B. (2015). *Creative clinical teaching in the health professions*. Retrieved from <https://clinicalteaching.pressbooks.com>

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Teaching Health Professionals Online

Frameworks and Strategies



[Read Book](#)

Sherri Melrose, Caroline Park, and Beth Perry

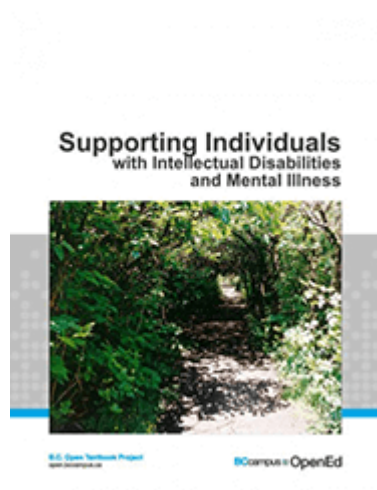
Teaching Health Professionals Online is a must-read for professionals in the health care field who strive to deliver excellence in their online classes. Intended for a wide range of professionals, including nurses, social workers, occupational and radiation therapists, chiropractors, dietitians, and dental hygienists, this compendium of teaching strategies will inspire both new and experienced instructors in the health professions. In addition to outlining creative, challenging activities with step-by-step directions and explanations of why they work, each chapter in the text situates practice within the context of contemporary educational theories such as instructional immediacy, invitational theory, constructivism, connectivism, transformative learning, and quantum learning theory. The authors also address other issues familiar to those who have taught online courses. How can a distance instructor build teacher-student relationships? How does one transform the assumptions often held by students in the health fields from the confines of the virtual classroom? Most importantly, how can the instructor support his or her students in their future pursuits of knowledge and their development as competent professionals? By considering these and other concerns, this handbook aims to help instructors increase student success and satisfaction, which, the authors hope, will ultimately produce the best possible patient care.

Melrose, S., Park, C. L., & Perry, B. (2013). *Teaching health professionals online: Frameworks and strategies*. AU Press. <https://www.aupress.ca/books/120234-teaching-health-professionals-online/>

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Supporting Individuals with Intellectual Disabilities & Mental Illness

What Caregivers Need to Know



Sherri Melrose, Ph.D. and Melrose, S., Dusome, D., Simpson, J., Crocker, C., Athens, E.

This multidisciplinary resource develops topics of interest to all those who care about and for individuals with co-occurring intellectual disabilities and mental illness. Each chapter presents current evidence informed practice knowledge. Each topic is also presented with audio enabled text boxes emphasizing 'Key Points for Caregivers.' For those who are interested in background knowledge, we provided the comprehensive literature base. And, for those interested mainly in 'what to do,' we provided text box summaries for reading and listening.

Melrose, S., Dusome, D., Simpson, J., Crocker, C., Athens, E. (2015). *Supporting Individuals with Intellectual Disabilities & Mental Illness: What Caregivers Need to Know*. Vancouver, British Columbia, Canada: BCcampus. Retrieved from <http://opentextbc.ca/caregivers/>

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[Read Book](#)

Journal Articles

Education



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Pre-Service Learners

Classroom

[Facilitating Constructivist Learning Environments Using Mind Maps and Concept Maps as Advance Organizers](#)

[Balancing Reflection and Validity in Health Profession Students' Self-Assessment](#)

[Pass/Fail and Discretionary Grading: A Snapshot of Their Influences on Learning](#)

Clinical

[Mentoring non-traditional students in clinical practicums: Building on strengths](#)

[Lunch with the theorists: A clinical learning activity](#)

[What works? A personal account of clinical teaching strategies in nursing](#)

[The role of the clinical instructor](#)

Online

[Peer E-Mentoring Podcasts in a Self-Paced Course](#)

[Instructional immediacy online](#)

In-Service Learners



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Practical Teaching Strategies for Diabetes Educators

Commentary: Posing questions to support and challenge – A guide for mentoring staff

Keeping clients safe on the night shift

Self-Mentoring: Five practical strategies to improve retention of long-term care nurses

Immunizing Children Who Fear and Resist Needles: Is it a Problem for Nurses?

Malawian Health Care Workers' Perceptions of Western Midwives: Towards Becoming a Welcome Guest

Mandatory Practice Hours

Professional Development Needs of Non-Radiology Nurses: An Exploration of Nurses' Experiences Caring for Interventional Radiology Patients

LPN to BN Learners



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Asynchronous online peer assistance: Telephone messages of encouragement in post licensure nursing programs

Resisting, Reaching Out and Re-imagining to Independence: LPN's Transitioning towards BNs and Beyond

Licensed Practical Nurses becoming Registered Nurses: Conflicts and responses that can help

Becoming Socialized into a New Professional Role: LPN to BN Student Nurses' Experiences with Legitimation

From vocational college to university: How one group of nurses experienced the transition

LPN to BN Nurses: Introducing a New Group of Potential Health Care Leaders

Overcoming barriers to role transition during an online post LPN to BN program

Online Post LPN to BN Students' Views of Transitioning to a New Nursing Role

"RN means Real Nurse": Perceptions of Being a "Real" Nurse in a Post LPN-BN Bridging Program

Psychiatric Mental Health Learners



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Creating a psychiatric mental health portfolio: An assignment that works

Clinical teaching in mental health nursing

Learning psychiatric mental health nursing: One student's experience

An exploration of students' personal constructs: Implications for clinical teaching in psychiatric mental health nursing

Students' perceptions of their psychiatric mental health clinical nursing experience: A personal construct theory exploration

A clinical teaching guide for psychiatric mental health nursing: A qualitative outcome analysis project

A message from Simone

Challenge and opportunity in an inner-city practicum

Clinical instruction in mental health nursing: students' perceptions of best practices

Graduate Studies Learners



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- Online Graduate Study Health Care Learners' Perceptions of Instructional Immediacy
- Research Ethics Review Processes: Potential Teaching Tools for Health Professions Students
- Skills for succeeding in online graduate studies
- Mentoring online graduate students: Partners in scholarship
- Graduate students' experiences with research ethics in conducting health research
- Online Interest Groups: Virtual Gathering Spaces to Promote Graduate Student Interaction
- Instructor immediacy strategies to facilitate group work in online graduate study
- Online Graduate Study Health Care Learners' Perceptions of Group Work and Helpful Instructional Behaviors
- Help-Seeking Experiences of Health Care Learners in a WebCT Online Graduate Study Program
- Facilitating help-seeking through student interactions in a WebCT online graduate study program

Depressive Disorders



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- Late life depression: nursing actions that can help
- Persistent Depressive Disorder or Dysthymia: An Overview of Assessment and Treatment Approaches
- Recognizing and Responding to Depression in Dementia
- Seasonal Affective Disorder: An Overview of Assessment and Treatment Approaches
- Perfectionism and Depression: Vulnerabilities Nurses Need to Understand
- Paternal postpartum depression: How can nurses help?
- How to uncover post-stroke depression
- Post-stroke depression: How can nurses help?
- Practical approaches in treating depression: Alleviating the debilitating symptoms of depression in LTC

Addictions



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Understanding and Supporting Adults with Fetal Alcohol Spectrum Disorder – Strategies for Health Professionals: an Opinion Piece

“It was worse than my son passing away.” The experience of grief in recovering crack cocaine addicted mothers who lose custody of their children

When the Worst Imaginable Becomes Reality: The Experience of Child Custody Loss in Mothers Recovering from Addictions

Developmental Disabilities



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Supporting Persons with Developmental Disabilities and Co-occurring Mental Illness: An Action Research Project

Beyond Physical Inclusion: A Grounded Theory of Belonging

Developmental disabilities co-occurring with Mental illness

Action research: Supporting the developmentally disabled and their caregivers



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Topics of Interest

- Relocation stress in long term care: How staff can help
- Reducing relocation stress syndrome in long term care facilities
- Schizophrenia: A Brief Review of What Nurses Can Do and Say to Help
- Naturalistic generalization

Teaching Resources

Open Educational Resources

Open Educational Resources



Melrose, Sherri, Swettenham, Steve

This collection of Open Educational Resources (OERs) was created for deployment in a graduate course at Athabasca University. They are available free of charge and can be repurposed as per the Creative Commons license. This project/resource was Funded by the Alberta Open Educational Resources (ABOER) Initiative, which is made possible through an investment from the Alberta government.

Melrose, S., & Swettenham, S. (2016). Open Educational Resources. Retrieved from <http://epub-fhd.athabascau.ca/oer/>

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Welcoming Students to a Graduate Course 'Dissemination'



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Welcoming Students to a Graduate Course 'Clinical Teaching & Learning'



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Welcoming Students to a Graduate Course 'Teaching in Health Disciplines'



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My Teaching Philosophy

“Good teachers possess a capacity for connectedness. They are able to weave a complex web of connections among themselves, their subjects, and their students so that students can learn to weave a world for themselves.” Parker Palmer

I have been teaching for several decades now, and my teaching philosophy, or what I believe and value most about teaching and learning continues to evolve. As an educator, my goal, as Parker Palmer wrote so eloquently, is to guide learners towards independence and to *weave a world for themselves*.

The learners I support are either pre-service or in-service nurses and other health professionals. I may share their learning journey during times when they are first beginning a program of study in their chosen profession (such an undergraduate nursing course), or when they are continuing their education (such as an interdisciplinary graduate studies course). I may meet my learners in classrooms, clinical practicums or online.

As a humanist educator, I believe that the health professions learners I support are self-directed and self-motivated people who actively seek out opportunities to grow and develop. I strive to get to know my students; to explore their individual interests and goals; and to respond to their learning needs with instructional approaches that are educationally sound and personally meaningful. I place high value on providing my learners with choices and control throughout their learning experiences.

Graduates of programs where I teach must provide safe health care to members of the public. As members of practice disciplines, my learners deserve theoretically sound, evidence-based and experience-centred educational opportunities. I hold myself accountable to advocate for these experiences at both the curricular and instructional levels.

It is important to me to understand how my learners feel about what they are learning and to create safe spaces where they can share these feelings. Whenever possible, I integrate opportunities for learners to self-evaluate, partner with peers and participate in small group collaborations.

Teaching is a reflective process of growing and developing, for me as well as for my learners. I learn with and from the health professionals I support. I encourage feedback on my teaching approaches and make a point of integrating any new ideas, strategies and critique that my learners or fellow faculty members suggest. In the sections which follow, I discuss **My Teaching Journey** and present **My Curriculum Vitae**.

Palmer, P. (1997). *The courage to teach: Exploring the Inner Landscape of a teacher's life*. San Francisco, CA: Jossey-Bass.

My Teaching Journey

Beginning with My Beliefs

I believe that the nurses and other practicing health professionals I teach are self-directed, reflective practitioners who are able to think critically. The innovative approaches I seek to implement, both in my clinical and online classrooms, extend and build on learners' strengths. These approaches affirm students' own efforts to learn and support them towards constructing relevant, meaningful new knowledge. Beyond my own classroom, I strive to make these innovative approaches available to an international audience of health educators.

Three of my peer-reviewed e-books describe a series of creative, student-centered activities that can be readily used in a variety of different clinical and academic settings. The activities are grounded in educational theory and developed through my ongoing program of educational research. [Centring Human Connections in the Education of Health Professionals](#) emphasizes how educational processes in the health disciplines should model, integrate, and celebrate human connections because it is these connections that will foster the development of competent and caring health professionals. [Creative Clinical Teaching in the Health Professions](#) presents evidence-informed clinical teaching strategies that have been successfully implemented by health educators from across Canada. [Teaching Health Professionals Online: Frameworks and Strategies](#) outlines online teaching strategies and situates each technique within the context of a particular theory of learning. These e-books are open educational resources that provide clinicians with the teaching tools they need to instruct their students from post-secondary programs of training in health disciplines.

Introduction and Context

Throughout my career as a clinical and academic educator of nurses and other health professionals, I have grounded my teaching in the assumption that learners bring valuable existing knowledge to any educational experience. I am interested in understanding how people learn and how I can best support them towards constructing the additional knowledge they need. I am a Registered Nurse and Associate Professor in the Faculty of Health Disciplines at Athabasca University, Canada's Open University. My [faculty page](#) introduces my teaching interests and includes a short video in which I comment on my ongoing program of educational research.

In these reflections on my teaching journey I discuss innovative educational approaches that invite teachers to listen to students and constructivist innovations that build on what students already know. I highlight how my process of disseminating these approaches through open educational resources (OER's) provides an international audience of post-secondary health educators with creative, evidence-based teaching tools that work.

Listening to Students

My teaching philosophy has consistently centered on the unwavering belief that learners bring experience, wisdom and passion to their learning. In my practice as a clinical instructor with undergraduate student nurses, and as an online instructor with graduate students in the health disciplines, I enjoy daily reminders of the wisdom my students bring to their learning. As an educator, my goal is to implement teaching approaches that affirm students' own efforts to learn and to support them towards constructing relevant, meaningful new knowledge.

My health disciplines students may be novice practitioners who are just beginning to learn about their chosen profession, or they may be experienced clinicians continuing their education through graduate study. While their backgrounds, experiences and levels of knowledge may differ, my students all have personal goals they are striving to achieve and unique challenges they are overcoming. To translate my teaching philosophy into practice, I begin with the steps of listening carefully to students and inviting them to share what the experience of learning looks like through their own eyes.

Hearing the Voices of Student Nurses

Learning in Clinical Settings

In the following paragraphs, I outline educational research I conducted that was geared to listening to the voices of student nurses as they completed clinical or practicum experiences in health care settings. Hyperlinks to published studies are included. A comprehensive reference list of my publications is included in the 'Curriculum Vitae' section of this virtual memory box.

During one of their practicums, where Registered Nurse (RN) students worked with clients experiencing mental health issues, learners expressed how much they valued non-evaluated discussion time with their instructors ([Melrose & Shapiro, 1999](#)). Opportunities for students to clarify their own personal and professional growth were particularly important to them ([Melrose & Shapiro, 2001](#)). Knowing the importance students place on non-evaluated discussion time and conversations about how they view their learning, I was inspired to incorporate strategies to support these opportunities into my clinical teaching.

When I listened to the voices of Licensed Practical Nurse (LPN) students advancing their education to become RNs, I learned that they were seeking out mentors in their workplace to overcome barriers they were facing ([Melrose & Gordon, 2011](#)). I also learned that they experienced feelings of loss as they transitioned into a new professional role ([Melrose & Gordon, 2008](#)). Creating opportunities to articulate previous accomplishments bolstered their confidence ([Melrose, 2010](#)). Feeling a sense of collegiality with staff during practicum experiences was especially valuable ([Gordon, Melrose, Janzen & Miller, 2013](#)). For this group of learners, suggesting that they were 'becoming nurses' (when they felt their existing knowledge already legitimized their identity as nurses) was not helpful in socializing them towards a new professional role ([Melrose, Miller, Gordon & Janzen, 2012](#)).

Developing independence was difficult for these students as they transitioned to a more complex nursing role ([Melrose & Wishart, 2013](#)). In this area, instructors can expect that students may need additional support. Internationally, programs providing opportunities for LPNs to become RNs are limited. This educational research project used a grounded theory methodology to understand students' experiences in a unique and small group.

I also listened to the voices of experienced instructors who guide and support student nurses during their practicum experiences. The everyday mentoring strategies they implement with non-traditional students such as those in Post LPN to BN programs often go unnoticed. In this qualitative study, instructors shared how they supported students by validating their individual strengths; challenged them by building on those strengths; and created vision by linking their present activities to competencies needed in their own future practice ([Melrose, 2018](#)).

Hearing the Voices of Students in Online Graduate Programs

Learning in Asynchronous Settings

In my practice as an online educator, I also developed educational research projects that explored graduate students' perceptions of their learning experiences. As with my work listening to students in clinical settings, my intention with online graduate learners is always to listen carefully to my students and then respond with teaching approaches that support their needs and efforts. Two areas that I investigated in depth were how online graduate students seek help when they are struggling, and the kinds of instructional behaviours that communicate immediacy or friendliness.

Help-seeking One study investigated online graduate students' activities related to help-seeking. This study revealed that a primary source of help for them was fellow students in their classes (Melrose, Shapiro & LaVallie, 2005). Similarly, participating in discussion groups helped them feel successful (LaVallie & Melrose, 2005). Creating these student-to-student connections became an important aspect of my teaching.

The importance of instructional immediacy. Another study explored online graduate students' perceptions of instructional immediacy. Most prominent was the importance to students of observing their instructors demonstrating and modeling the kinds of interactions expected in classes (Melrose & Bergeron, 2006). While teachers in face-to-face classrooms often demonstrate immediacy non-verbally through facial expressions and body language, teachers in text-based online learning environments can usually only project immediacy through written messages (Melrose, 2009). In responses, I make every effort to avoid short terse comments and to ensure that the language in my written messages communicates friendliness.

Constructivist Approaches That Build on What Students Already Know

As the preceding discussion illustrates, my approach to creating educational innovations for my own use or use by other teachers begins by listening to students. Next, equipped with a beginning understanding of what students already know, I imagine and develop strategies that will fit well with their circumstances, their needs, and the autonomous learning activities they may already be engaged in.

Undergraduate Teaching Strategies

Clinical Teaching Innovations

After learning how much my undergraduate nursing students valued non-evaluated discussion time with their instructors and opportunities to clarify their own growth during their practicums, I developed a clinical teaching guide for other teachers (Melrose, 2002). Examples of strategies suggested in the guide include

- phoning students before the course begins
- co-constructing personal learning plans
- posting sign-up sheets for talk-time appointments
- framing evaluative comments positively
- closing the course by identifying unanswered questions.

After reading the guide, a new instructor thanked me for providing “*simple suggestions that help me become a more caring teacher.*”

In another publication sharing clinical teaching strategies that ‘work,’ I also encourage instructors to initiate discussions about the individual barriers their students are facing (Melrose, 2004). Sharing with their teachers how they are coping with traveling significant distances to attend practicums and balancing their work, family and study commitments can feel affirming to students. At a national conference for nurse educators, a participant showed me an inservice manual from her institution. She pointed out that my article had been included in this manual and that she and her colleagues found it useful.

An additional approach that I find helpful in building on what students already know is to use advance organizers such as mind maps and concept maps as demonstration and evaluation tools (Melrose, 2013). Mapping information can help students visualize priorities. Maps can be used by teachers and clinicians as demonstration tools when explaining aspects of patient care. They can also be used by students as evaluation tools to showcase their understanding of a topic. If critical information has not been included on a student’s concept or mind map, teachers can see at a glance areas needing remediation. Both teachers and students have commented that this publication provides an easy-to-understand explanation of mapping. This publication has been cited by authors as far away as Iran and China.

Further, after learning that developing independence was particularly difficult for LPN nurses transitioning to the role of RN, I developed a portfolio assignment as another evaluation tool (Melrose, 2006a). Suggestions from this publication were later referenced in the British textbook *Study Skills for Nursing and Midwifery Students*.

One artefact in the portfolio assignment required students to collaborate with health care staff and construct a case study. Directions led students to begin their work with a staff member but to complete the case with minimal, if any, further staff input. Another artefact had students imagine they were having lunch with theorists they had learned about in the course (Melrose, 2006b). This activity invited them to use their own words to describe the advice and direction that theorists might provide. Feedback from students, instructors and clinical staff has been positive with this portfolio activity. Authors citing this publication include two from the field of business and three from the field of nursing education.

The following comments, from anonymous end-of-course student evaluations of clinical courses I taught, reflect the positive reception of my innovations by my undergraduate students.

- *I really feel that I have a better, and definitely bigger, picture of what the world of mental health looks like. The learning strategies and assignments touched on all the major areas of mental health which helped me to broaden my view.*
- *I had fun with the activities in this course. Thank you for taking the extra time to get to know me Sherri.*
- *One day I would be extremely proud if anyone ever held me in the same esteem as I see you.*

Graduate Teaching Strategies

Connecting Asynchronous Learners

Following through with my research findings that other students in their classes are a primary source of help for online graduate students in asynchronous learning environments, I developed innovations to create connections among learners. For example, at the curricular level, I called for allocating participation marks to students who discuss course topics in forums (Melrose, 2006c).

At the instructional level, at the beginning of each class, I collate students’ introductory postings and pictures into a ‘Yearbook.’ At a glance, students find information about who their classmates are, where they come from and what their interests are. The following comments from recent anonymous course evaluation data are typical of how this innovation is consistently appreciated by online graduate students:

- *I liked the yearbook strategy which captured everyone's pictures and introductions, as this helped us to better get to know one another and be aware of each other's respective backgrounds.*
- *[Sherri's] use of the yearbook was neat, it was nice to see each individuals faces and a brief description about them.*

As a way of connecting asynchronous online learners with like-minded others who share similar clinical interests, I worked with faculty colleagues to create virtual spaces where students could gather outside of their classes (Getzlaf, et al., 2012). While university students in brick and mortar learning environments usually have communal spaces where they can gather and enjoy informal conversation, students in online programs typically do not have access to casual gathering spaces.

Our faculty group participated in the gathering spaces and we assigned student facilitators to support the discussions. We surveyed participants to evaluate the innovation. Responses indicated that although busy health care practitioners had only minimal time to devote to optional program activities, those able to take part in online discussions found the innovation very valuable. The impact was reflected in survey response comments such as *"I enjoyed the opportunity to connect with other clinicians across the country;"* and *"the space was a safe comfortable place to get to know other graduate students."* Another survey response indicated that the participant *"felt open to be very honest"* when sharing experiences with other graduate students and faculty members. The virtual gathering spaces provided program-wide opportunities for student-to-student interactions that would otherwise be missed in online courses.

Another innovation that I designed to connect asynchronous learners with one another invited alumni or senior students to dictate audio messages of encouragement to junior students or those just beginning their studies (Gordon & Melrose, 2011). The dictated audio files were subsequently embedded in an orientation manual for undergraduates in a post-licensure program for nursing students at Athabasca University. Whenever students accessed their online course, they could literally listen to the voices of fellow students who had successfully completed most or all of their program. Although data measuring student satisfaction with the orientation manual was not collected, anecdotal comments indicate that this innovation is an excellent fit for this specific group of busy adult learners, who may want to listen to the experiences of fellow students but have limited time and opportunity to do so. One student stated that listening to the messages helped her connect to classmates *"without having to spend time I don't have."*

This innovation was so well received by undergraduate students that it was incorporated into an orientation manual used in an Athabasca University graduate program as well (Melrose & Swettenham, 2012). While I also include in my asynchronous online classes my own 'me-to-you' video messages and a variety of online multimedia presentations developed by experts, students have commented that these simple messages from successful peers have been especially inspirational. In a class posting, one student wrote that she *"would absolutely [implement a particular strategy]."* Another student extended the discussion by commenting that she valued *"just knowing they [the senior students] wanted to give us suggestions."*

Modeling Immediacy

Findings from another of my educational research projects revealed that when learners work collaboratively in small groups, they progress through predictable stages. Student participants in this study consistently reported that an instructor's facilitation comments such as *"I'm here if you need me"* communicate immediacy, presence and a willingness to help (Melrose & Bergeron, 2007). When I present the importance of this one-line message at conferences, attendees express appreciation for how this strategy is so easy to use and yet can be so impactful to learners.

The following comments, from anonymous end-of-course student evaluations of my online graduate courses, illustrate how students feel about the innovative strategies I integrate into my teaching.

- *I very much enjoyed how Sherri created a warm, welcoming online learning environment. One of the strategies used to create this type of environment which I liked, was Sherri's video introduction which not only gave us the opportunity to see her as she warmly welcomed us, but it also gave us insight on the direction of the course. I feel that this helped decrease any anxieties that some may have had at the beginning of the course. I also very much appreciated the example assignments as*

well as the additional resources provided that were not included in the course content.(i.e. puzzles, journals, youtube videos, etc.)”

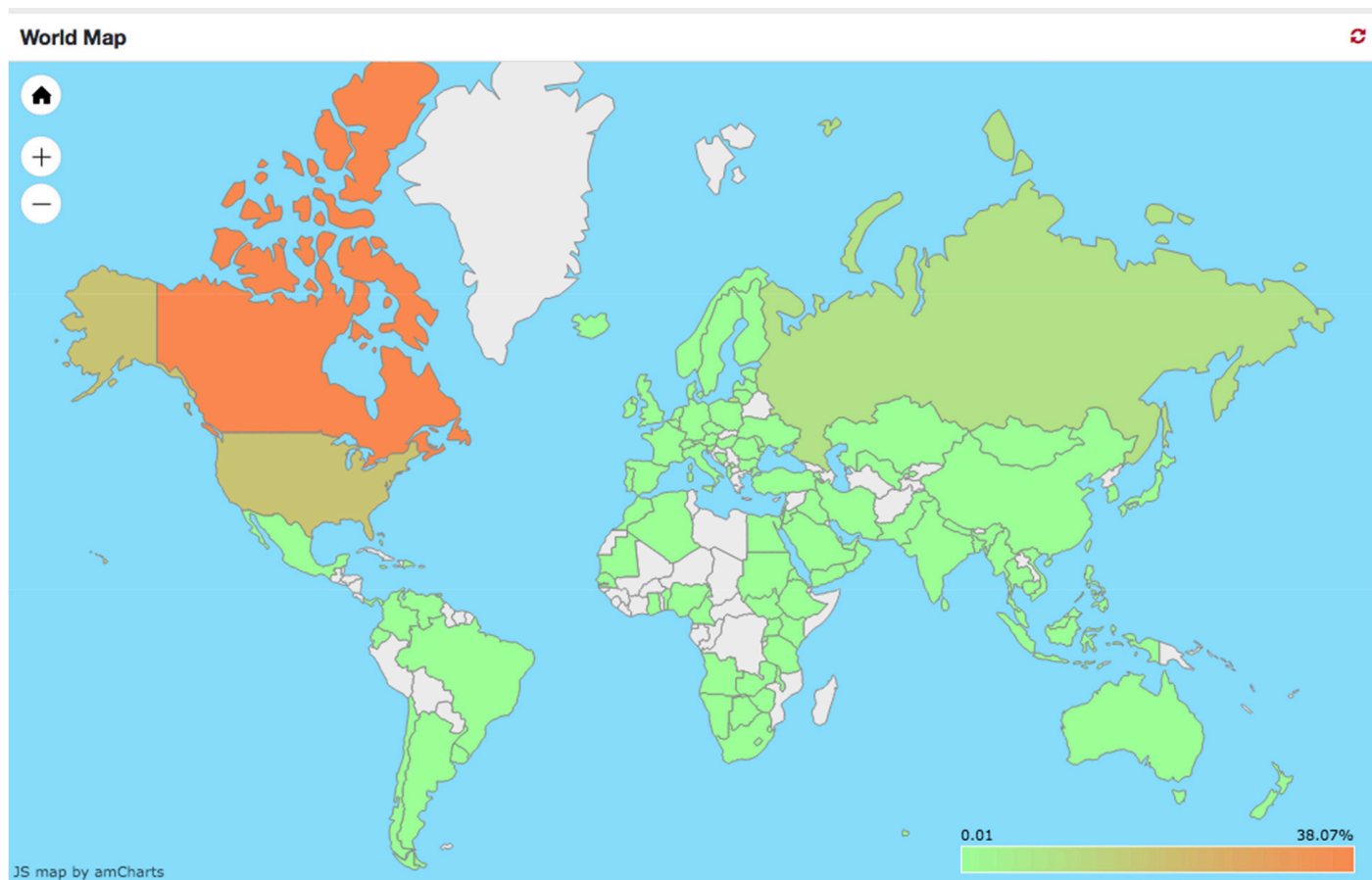
- Sherri is an exceptional instructor, one of the best I have had in post-secondary
- My instructor this term was Sherri Melrose. I do not feel I can put into words how excellent I think she is as an online educator. She is absolutely fabulous. There is something very humble about her, she loves sharing her personal experience and past stories. She makes a point to grade each student fairly and treat them equally. She helps me make connections between previously learned material and new material. In her assignment feedback to students, she is very thorough, making sure to not only tell you areas you need to work on but the areas you did really great in as well. She has a great way of opening each of the discussion units and summarizes each unit very well. I can honestly say she has had such a positive influence on me as an adult learners. How I wish she could teach all of my remaining courses!!

As a more quantitative example, all 16 students in the one session of my online graduate course Nursing 625 (Collaboration in Teaching) rated my instruction overall as Excellent.

Open Access E-Books to Share Innovations

As I continued to receive positive feedback on my innovations from students, colleagues and those reading my peer-reviewed publications, I decided that it was important to organize the approaches and make them freely available to international audiences. Working with colleagues who shared my passion for innovative teaching, I created a series of open access e-books for health educators.

One of these peer-reviewed e-books, [*Creative Clinical Teaching in the Health Professions*](#) presents evidence informed clinical teaching strategies that health educators from across Canada have successfully implemented (Melrose, Park & Perry, 2015). One measure of this e-book's impact is the numbers of page views and downloads. In one 90 day period, (2016-10-28 to 2017-01-25), the book had 16,563 page views by humans from 2,940 unique IP addresses, with 485 downloads of the ebook file. This map, with non-access areas in grey, illustrates how the information is reaching people around the world.



Peer reviewers, commissioned pre-publication by the Canadian Association of Schools of Nursing (CASN), provided the following comments:

- The text is easy to read and follow and would be a great addition to the course on Clinical Instruction that CASN hosts. There are great hands-on examples and templates and is great to see the sections that include the input from the interest group members. It's also interesting that the title is broader than nursing. We had a lab tech join the course because she couldn't find a course in her field and I think she is finding it useful, so this text can also be used by any clinical instructor in the health field, which is great.
- A great and necessary addition to the resources for clinical teachers. Very practical examples are helpful and relevant. The Canadian perspective is welcomed.
- The approach to learning on which the book is based is clearly articulated and reflects a current and a forward thinking view. This perspective is unique to books for health care educators, but especially as it relates to clinical teaching.
- The topics covered are reasonable and it's a good "quick" read or perhaps overview of important considerations as a Clinical Instructor.

This e-text was selected for inclusion in the BCcampus OpenEd textbook project and currently has an overall online rating of 4.6 out of 5. Faculty reviews included the following comments:

- The amount of information provided is enough to give the reader a quick understanding of each topic that is just enough to make the practical tips offered comprehensible and situated within their proper context.
- The text covers relevant concepts applicable to the clinical teaching environment and contains helpful "From the Field" ideas for bringing innovation and creativity to the process of providing orientation to the clinical area. The provided review of theoretical foundations of clinical learning was applicable to clinical teaching and succinct. This is a welcome resource for novice educators.

A second peer-reviewed e-book, [Teaching Health Professionals Online: Frameworks and Strategies](#), outlines online teaching strategies and situates each technique within the context of a particular theory of learning (Melrose, Park & Perry, 2013).

Peer reviews of this book, commissioned pre-publication by the publisher, included the following comments:

- *The [e-book] makes a very important contribution in two ways. First, teaching strategies presented in the book are aligned clearly with the theories that underpin them. One of the weaknesses in the field of higher education teaching is that strategies are presented as atheoretical; thus, educators do not make the link between theories and strategies, which can lead to a lack of coherence in teaching. The other significant contribution that the book makes is to show how a potpourri of theories and strategies can be used to guide teaching. Often in the field, one theory is presented as being the answer to teaching and learning when in practice it takes a range of theoretical perspectives to work in such a complex context as health education.*
- *This is a fabulous book, one that we so need in my teaching unit. Publish it soon please!*

A third peer reviewed e-book, [Centring Human Connections in the Education of Health Professionals](#), highlights how educators can humanize their teaching by creating personal and meaningful connections with and among their learners.

All three of these peer-reviewed e-books have been adopted as course texts in three online graduate teaching courses at Athabasca University. Students can access these e-books, at no cost, online and on Smartphones, tablets and e-readers. Previous teaching texts were costly and dominated by American content. In course evaluation surveys, students express appreciation that their texts are free and rich in Canadian content. As open educational resources, these e-books provide clinicians with the teaching tools they need to instruct students in post-secondary health disciplines programs.

Finally, [Open Educational Resources](#) is a compendium of interactive online activities that can assist health educators in learning more about educational terminology (Melrose & Swettenham, 2016). The activities include interactive mind maps, puzzles, case studies and visual aids. As CC-BY-NC-SA 4.0 international licensed resources, all the resources included in the ebook are freely available for educators to use. All source files have been included with the activities so they can be modified and adapted.

Conclusion

These reflections on my teaching journey discussed educational approaches that students, fellow teachers and readers of my published works have viewed as innovative. I emphasize that none of the innovations described are my creations alone. I listened to students and learned with and from them. I also listened to and observed exemplary educators, and they inspired and influenced my work.

Through a process of hearing the voices of health professions students in clinical and online learning environments, I developed constructivist teaching approaches that extend and build on what learners already know. The approaches are student-centered and illustrate practical strategies that teachers can use to enhance learning for students in both undergraduate and graduate programs.

The innovations were organized into a series of e-books, which are available as open educational resources. Reading the e-books will support health educators towards making more informed decisions in their teaching practice. The e-books are currently being used as course texts in graduate teaching courses at Athabasca University, Canada's Open University.

Making required course texts available to students online and at no cost has the potential to impact post-secondary education in several ways. Benefits for students include easy access and saving money. Benefits for faculty include capacity building. For example, reading an OER ebook may cue faculty to create their own e-book course text. Beyond the academic community, e-books such as those I co-created offer resources to an international audience of health educators who might not otherwise have access to current and innovative practices. That access is crucial because many of these health educators

do not have formal training as educators. They are often the health practitioners who are tasked with training new generations of health professionals.

Curriculum Vitae

Sherri Melrose PhD, RN

COMPLETED ACADEMIC DEGREES

Degree Name	Subject Area	Where Completed	Completion Date
PhD	Educational Research	University of Calgary	1998
MEd	Education	University of Calgary	1995
BN	Nursing	University of Calgary	1979

ACADEMIC APPOINTMENTS

Appointment Level	Institution	Dates	Subject Area
Associate Professor	Athabasca University	10/22/2012-2023	Nursing
Assistant Professor	Athabasca University	09/1/2005-2012	Nursing
Instructor (sessional)	Athabasca University	2001-2005	Nursing
Instructor (sessional)	Mount Royal College	1995-2001	Nursing
Nurse Educator	Foothills Hospital School of Nursing	1980-1995	Nursing

COURSES WRITTEN at Athabasca University

Courses Written	Institution	Dates
MHST 625 <i>Personalizing Learning through Collaboration & Mentoring</i> (authoring team)	Athabasca University	2015-2016
MHST 624 <i>Teaching in Health Disciplines</i> (authoring team)	Athabasca University	2008-2009
MHST 623 <i>Clinical Teaching</i>	Athabasca University	2002-2003
NURS 435 <i>Psychiatric Mental Health Nursing</i>	Athabasca University	2001-2002

COURSES TAUGHT/COORDINATED at Athabasca University

Courses Taught	Institution	Dates
NURS 324 <i>Concepts and Theories in Nursing Practice</i>	AU	2018-2019
NURS 432 <i>Management and Leadership in Nursing Practice</i>	AU	2015-2017
MHST 625 <i>Collaboration in Teaching</i>	AU	2016-2022
MHST 624 <i>Teaching in Health Disciplines</i>	AU	2009-2022
MHST 623 <i>Clinical Teaching and Learning</i>	AU	2003-2022
MHST 611 <i>Dissemination Strategies</i>	AU	2001-2018
NURS 435 <i>Professional Practice in Mental Health Promotion</i>	AU	2002-2008 2019-2020
NURS 328 <i>Understanding Research</i>	AU	2001-2003

GRADUATE STUDENT SUPERVISION

Role	Student name/Degree sought/University	Year
Thesis Supervisor	Chris Wenzell MN/AU	2019-20
Thesis Supervisor	Andra Carley/MN/AU	2018-20
Thesis Supervisor	Wendy Petillion/MN/AU	2015-20
Thesis Supervisor	Kathrine Janzen/MN/AU	2008-20
Independent Study Advisor	Maureen McKay/MDE/AU	2012
Independent Study Advisor	Sue Goulding/MN/AU	2011
Independent Study Advisor	Shelley McEwan/MN/AU	2011
Independent Study Advisor	Margot Underwood/MN/AU	2011
Independent Study Advisor	Sandra McGirr/MN/AU	2010
Independent Study Advisor	Patti Tracy/MN/AU	2006
Independent Study Advisor	Mary Ives/MN/AU	2006

SCHOLARSHIP and RESEARCH

Books, Monographs and Chapters Authored or Edited

Melrose, S., & Moore, S. (2022). Suicide and non-suicidal self-injury. In C. Pollard, S. Jakubec and M. Halter (Eds.), *Varcarolis' Canadian foundations of psychiatric mental health nursing*. North York, ON: Elsevier Canada.

Melrose, S., & Perry, B. (Eds.). (2022). *Clinical teaching in Canadian nursing*. Ottawa, ON: Canadian Association of Schools of Nursing.

Melrose, S., Park, C. & Perry, B. (2021). *Creative clinical teaching in health professionals*. Athabasca, AB, Canada: AU Press.

Melrose, S., Park, C. & Perry, B. (2020). *Centring human connections in the education of health professionals*. Athabasca, AB, Canada: AU Press.

Melrose, S. (2018). Understanding and supporting professionals' own efforts to learn in online health disciplines courses. In B. Sharpiron (Ed.), *Actions of their own to learn*. Dordrecht, Netherlands: Sense.

Melrose, S., Park, C. & Perry, B. (2015). *Creative clinical teaching in the health professions*. <http://epub-fhd.athabascau.ca/clinical-teaching/>

Melrose, S., Dusome, D., Simpson, J., Crocker, C., Athens, E. (2015). *Supporting individuals with intellectual disabilities & mental illness: What caregivers need to know*. Vancouver, British Columbia: BCcampus. Available at <http://opentextbc.ca/caregivers/>

Melrose, S., Park, C. & Perry, B. (2013). *Teaching health professionals online: Frameworks and Strategies*. Athabasca, AB, Canada: AU Press: Available at <http://www.aupress.ca/index.php/books/120234>

Melrose, S., Moore, S. & Ewing, H. (2013). Chapter 5: Online interest groups for graduate students: Benefit or burden? In V. Wang (Ed.), *Advanced research in adult learning and professional development: Tools, trends, and methodologies*, 121-132. Hershey, PA: IGI Global.

Moore, S. & **Melrose, S. (2013).** Chapter 25: Suicide. Relevant theories and therapies for nursing practice. In M. Haase (Ed.), *Foundations of psychiatric mental health nursing*, Canadian edition. Toronto, ON: Elsevier Canada.

Melrose, S. & Moore, S. (2013). Chapter 3: Relevant theories and therapies for nursing practice. In M. Haase (Ed.), *Foundations of psychiatric mental health nursing*, Canadian edition. Toronto, ON: Elsevier Canada.

Melrose, S. (2013). Chapter 19: Inpatient care settings. In Mohr, W (Ed.), *Psychiatric-mental health nursing* (8th ed., pp. 357-367). Philadelphia, PA: Lippincott Williams and Wilkins.

Peer Reviewed Journal Articles

Jones, K., **Melrose**, S. & Wilson-Keates, B. (2022 Forthcoming). Reflections on the experiences of Black undergraduate nursing students in Canada. *Canadian Journal for the Scholarship of Teaching and Learning*.

Wenzel, C., **Melrose**, S., Lane, A. & Kent-Wilkinson, A. (2022). Clinical instruction in mental health nursing: Students' perceptions of best practices. *International Journal of Nursing Education Scholarship*, 19(1), 20210147.

Carley, A., **Melrose**, S., Rempel, G. Diehl-Jones, W & Schwarz, B. (2021). Professional development needs of non-radiology nurses: An exploration of nurses' experiences caring for interventional radiology patients. *Journal of Radiology Nursing*, 40(2), 1-6.

Melrose, S. (2018). Late life depression: Nursing actions that can help. *Perspectives in Psychiatric Care*, 55(3), 453-458.

Martyniuk, A. & **Melrose**, S. (2018). Understanding and supporting adults with fetal alcohol spectrum disorder: Strategies for health professionals, an Opinion Piece. *Internet Journal of Allied Health Sciences and Practice*, 16(3) Article 2.

Melrose, S. (2018). Mentoring non-traditional students in clinical practicums: Building on strengths. *Journal of Clinical Nursing Studies*, 6(3), 39-45.

Wishart, P. & **Melrose**, S. (2017). Beyond inclusion: A grounded theory of belonging. *National Association for the Dually Diagnosed NADD Bulletin*, 20(5), 83-90.

Petillion, W., **Melrose**, S., Moore, S.L., Nuttgens, S. (2017). Research ethics review processes: Potential teaching tools for health professions students. *Journal of Medical Education and Training*, 1(5), 1:026.

Melrose, S. (2017). Balancing reflection and validity in health profession students' self-Assessment. *International Journal of Learning, Teaching and Educational Research*, 16(8), 65-76.

Melrose, S. (2017). Recognizing and responding to depression in dementia. *SM Journal of Psychiatry and Mental Health*, 2(1), 1008.

Melrose, S. (2017). Pass/Fail and discretionary grading: A snapshot of their influences on learning. *Open Journal of Nursing*, 7(2), 185-192.

Melrose, S. (2017). Persistent depressive disorder or dysthymia: An overview of assessment and treatment approaches. *Open Journal of Depression*, 6, 1-13.

Petillion, W., **Melrose**, S., Moore, S. & Nuttgens, S. (2016). Graduate students' experiences with research ethics in conducting health research. *Research Ethics*, 1-16.

Melrose, S. (2016). Treating seasonal affective disorder with cognitive behavioral therapy is comparable to light therapy. *Evidence Based Mental Health*, 19(3), e21. Invited Commentary.

Melrose, S. (2016). Post-stroke depression: How can nurses help? *Canadian Nursing Home*, 27(1), 5-9.

Nevers, S. & **Melrose**, S. (2016). Posing questions to support and challenge: A guide for mentoring staff. *Internet Journal of Allied Health Sciences and Practice*, 14(3),

Janzen, K. & **Melrose**, S. (2016) "It was worse than my son passing away." The experience of grief in recovering crack cocaine addicted mothers who lose custody of their children. *Illness, Crisis and Loss*, 25(3), 232-261.

Melrose, S. (2015). Seasonal affective disorder: An overview of assessment and treatment approaches. *Depression Research and Treatment*. Volume 2015, Article ID 178564, 6 pages.

Melrose, S. (2013). Action research: Supporting the developmentally disabled and their caregivers. In *Sage Research Methods Cases*. Thousand Oaks CA: Sage.

- Janzen, K. & **Melrose**, S. (2013). When the worst imaginable becomes reality: The experience of child custody loss in mothers recovering from addictions. *Janus Head*, 13(1), 176-213.
- Melrose**, S., Wishart, P., Urness, C., Forman, B., Holub, M. & Denoudsten, A. (2013). Supporting persons with developmental disabilities and co-occurring mental illness: An action research project. *Canadian Journal of Psychiatric Nursing Research*, 3, 32-40.
- Melrose**, S. (2013). Facilitating constructivist learning environments using mind maps and concept maps as advanced organizers. *JPACTe Journal for the Practical Application of Constructivist Theory in Education* (7(1), 1-11.
- Gordon, K., **Melrose**, S. Janzen, K. & Miller, J. (2013). Licensed Practical Nurses becoming Registered Nurses: Conflicts and responses that can help. *Clinical Nursing Studies*, 1(4), 1-8.
- Janzen, K., **Melrose**, S., Gordon, K & Miller, J. (2013). "RN means "Real" Nurse in a Post LPN-BN bridging program. *Nursing Forum*, 48(3), 165-173.
- Melrose**, S. & Wishart, P. (2013). Resisting, reaching out and re-imagining to independence: LPN's transitioning towards BNs and beyond. *International Journal of Nursing Education Scholarship*, 10(1), 107-113.
- Melrose**, S. (2013). Relocation stress in long term care: How staff can help. *Canadian Nursing Home*, 24(1), 16-19.
- Melrose**, S. & Swettenham, S. (2012) Asynchronous online peer assistance: Telephone messages of encouragement in post licensure nursing programs. *Journal of Peer Learning*, 5(1), 1-5.
- Gordon, K., & **Melrose**, S. (2013). Keeping clients safe on the night shift. *Mental Health Practice*, 16(5). 12-18.
- Melrose**, S. (2013). Developmental disabilities co-occurring with Mental illness. *Knowledge Notes*, KN-11, January. Alberta Addiction and Mental Health Research Partnership Program Publication. Available at http://www.mentalhealthresearch.ca/Publications/Documents/KN-11_Developmental_Disabilities_Co-occurring_with_Mental_Illness_Jan2013.pdf
- Getzlaf, B., **Melrose**, S., Moore, S., Ewing, H., Fedorchuk, J. Troute-Wood, T. (2012). Online Interest Groups: Virtual Gathering Spaces to promote Graduate Student Interaction. *International Journal of Online Pedagogy and Course Design*, 2(4), 63-76.
- Melrose**, S., Miller, J., Gordon, K. & Janzen, K. (2012). Becoming socialized into a new professional role: LPN to BN student nurses' experiences with legitimization. *Nursing Research and Practice*. vol. 2012, Article ID 946063, 8 pages doi: 10.1155/2012/946063
- Gordon, K. & **Melrose**, S. (2011). Peer e-mentoring podcasts in a self-paced course. *Academic Exchange Quarterly* 15(3), 145-149.
- Melrose**, S. (2011). Perfectionism and depression: Vulnerabilities nurses need to understand. *Nursing Research and Practice*, vol. 2011, Article ID 858497, 7 pages doi:10.1155/2011/858497
- Gordon**, K. & **Melrose**, S. (2011). Self-Mentoring: 5 practical strategies to improve retention of long-term care nurses, *Canadian Nursing Home*, 22(2), 14-19.
- Gordon**, K. & **Melrose**, S. (2011). LPN to BN nurses: Introducing a new group of potential health care leaders, *e-Journal of Organizational Learning and Leadership*, 9(1), 121-128.
- Melrose**, S. & Gordon, K. (2011). Overcoming barriers to role transition during an online Post LPN to BN program. *Nurse Education in Practice*, 11(1), 31-35.
- Melrose**, S. (2010). From vocational college to university: How one group of nurses experienced the transition, *Journal for the Advancement of Educational Research*, 6(1), 88-97.
- Melrose**, S. (2010). How to uncover post-stroke depression. *Nursing Made Incredibly Easy*, 8(4), 31-37.
- Melrose**, S. (2010). Paternal postpartum depression: How can nurses help? *Contemporary Nurse*, 34 (2), 199-210.

- Ives, M. & **Melrose**, S. (2010). Immunizing children who fear and resist needles: Is it a problem for nurses? *Nursing Forum*, 45(1), 29-39.
- Melrose**, S. (2009). Schizophrenia: A brief review of what can nurses do and say to help, *Journal of Practical Nursing*, 59(2), 3-4.
- Melrose**, S. (2009, October). Naturalistic generalization. *Encyclopedia of Case Study Research*. Edited by Albert J. Mills, Gabrielle Durepos, and Elden Wiebe. Thousand Oaks, CA: Sage Publications.
- Melrose**, S. (2009, January). Instructional immediacy online. In P. Rogers, G. Berg, J. Boettcher, C. Howard, L. Justice and K. Schenk (Eds.). *Encyclopedia of Distance Learning*, 2nd ed., Vol. III (pp. P1212-1215). Hershey, PA: Information Science Reference. Available at: <http://www.igi-global.com/reference/details.asp?id=9703>
- Solohub, N. & **Melrose**, S. (2008). Challenge and opportunity in an inner-city practicum. *The Canadian Nurse*, 104(8), 6-8.
- Melrose**, S. & Gordon, K. (2008). Online Post LPN to BN students' views of transitioning to a new nursing role. *International Journal of Nursing Education Scholarship*, 5(1), Article 14. Available at: <http://www.bepress.com/ijnes/vol5/iss1/art14>
- Adkins, B. & **Melrose**, S. (2007). Malawian health care workers perceptions of volunteer midwives. *Canadian Journal of Midwifery Research and Practice*, 6(1), 13-17.
- Melrose**, S. & Bergeron, K. (2007). Instructor immediacy strategies to facilitate group work in online graduate study. *Australasian Journal of Educational Technology*, 23(1), 132-148. Available at: <http://www.ascilite.org.au/ajet/ajet23/melrose.html>
- Melrose**, S. & Bergeron, K. (2006). Online healthcare graduate study learners' perceptions of instructional immediacy. *International Review of Research in Open and Distance Learning* 7(1). Available at <http://www.irrodl.org/index.php/irrodl/article/viewArticle/255/477> or <http://www.irrodl.org/index.php/irrodl/article/viewFile/255/497>.
- Melrose**, S. (2006). Creating a psychiatric mental health portfolio: An assignment that works. *Nurse Education in Practice Journal*, 6, 288-294.
- Melrose**, S. (2006). Facilitating help-seeking through student interactions in a WebCT online graduate study program. *Nursing and Health Sciences* 8, 175-178.
- Melrose**, S. (2006). Lunch with the theorists: A clinical learning activity *Nurse Educator*, 31(4), 147-148.
- Bergeron, K. & **Melrose**, S. (2006). Online graduate study health care learners' perceptions of group work and helpful instructional behaviors. *Journal of Educational Technology*. 3(1) 74-80.
- Melrose**, S. (2006). Practical approaches in treating depression: Alleviating the debilitating symptoms of depression in LTC. *Canadian Nursing Home*, 16(2), 12-16.
- Melrose**, S. (2006). Mentoring online graduate students: Partners in scholarship. *Education for Primary Care*, 17(1), 57-62.
- LaVallie, C., & **Melrose**, S. (2005). Skills for Succeeding in Online Graduate Study. *Academic Quarterly* 9(3), 176-181.
- Lister, T. & **Melrose**, S. (2005, Summer). Practical teaching strategies for diabetes educators. *Diabetic Quarterly*, p 5.
- Melrose**, S., Shapiro, B. & LaVallie, C. (2005). Help-seeking experiences of health care learners in a WebCT online graduate study program. *Canadian Journal of Learning and Technology*, 31(2), 5-21. Available at: <http://www.cjlt.ca/content/vol31.2/melrose.html>
- Melrose**, S. (2004). Reducing relocation stress syndrome in long term care facilities. *Journal of Practical Nursing* 54(4), 15-17.
- Melrose**, S. (2004). What works? A personal account of clinical teaching strategies in nursing. *Education for Health* 17 (2), 236-239.

Melrose, S. (2002). A clinical teaching guide for psychiatric mental health nursing: A qualitative outcome analysis project. *The Journal of Psychiatric and Mental Health Nursing*, 9(4), 381-389.

Melrose, S. & Shapiro, B. (2001). Learning psychiatric mental health nursing: One student's experience. *Partners in Psychiatric Health Care Journal*, (3)2 23-32.

Melrose, S. & Shapiro, B. (2000). A message from Simone. *The Canadian Nurse* (96)2, 45-46.

Melrose, S. & Shapiro, B. (1999) Students' perceptions of their psychiatric mental health clinical nursing experience: A personal construct theory exploration *The Journal of Advanced Nursing* (30)6, 1451-1458.

Melrose, S. (1998). An exploration of students' personal constructs: Implications for clinical teaching in psychiatric mental health nursing. Unpublished PhD dissertation, 1998, University of Calgary, Alberta, Canada.

Melrose, S. and Kirby, D. (1996). Mandatory practice hours. *The Canadian Nurse* 92(3), 51-52.

Melrose, S. & Shapiro, B. (1996). Clinical teaching in mental health nursing. In What's new in research ... a cross-country sampling of recent initiatives and works in progress. *The Canadian Nurse* (92)10, 20.

Non-Peer Reviewed Journal Articles

Melrose, S. (2013, March 13). Supporting individuals with developmental disabilities and mental illness. CRGI SNAPSHOT – 02. <http://www.mentalhealthresearch.ca/Publications/Pages/CRGISnapshots.aspx>

Melrose, S. (2013, April). Supporting individuals with developmental disabilities and mental illness. CRGI Final Report. http://www.mentalhealthresearch.ca/KeyInitiatives/ResearchGrants/Seniors_PwD/Grants/Pages/FinalReports.aspx

Melrose, S. (2007, July). Compassion fatigue. *Health 2007 Professional Edition*, 6-7.

Melrose, S. (2003, June). Strategies for facilitating staff learning. *RESOURCES Education Resources Centre for Continuing Care Newsletter* (8)3, Pages 1,3.

Melrose, S. and Shapiro, B. (2001, September). Not just kid stuff – Warning signs of Violence in children. *Calgary Community Publications*. p.5.

Melrose, S. (2001, November). Would you like to talk about it? Recognizing the signs of post-traumatic stress disorder. *Calgary Community Publications*, pages 6,12,13.

Conference Presentations

Melrose, S. (2021, May 3-5 online). Assessing and evaluating non-traditional students in clinical practicums: building on strengths through mentoring: Pre-recorded Paper presented at the *Responding to the Complexity of Nursing Education and Practice CASN Virtual Nursing Education Conference*. CASN, Ottawa, ON.

Melrose, S. (2020, May 25 Accepted but Conference Cancelled). Assessing and evaluating non-traditional students in clinical practicums: building on strengths through mentoring: Paper accepted to be presented at the *Responding to the Complexity of Nursing Education and Practice CASN Biennial Canadian Nursing Education*. Westin Hotel, Calgary, AB.

Melrose, S. (2019, May 3). Depression in Dementia: Journeying Through the Fog Together. Paper presented at the *Canadian Association of Gerontological Nurses Older Persons Climbing Mountains: Journeys and Transitions*. Calgary, AB.

Melrose, S. (2019, Feb 22). Balancing reflection and validity in students' self-assessment: Demonstrating Authentic Interest. Paper presented at the *WNRCSN Rejuvenating Nursing Education Through Relational Practice Conference*. University of Alberta, Edmonton, AB.

Melrose, S. (2018, May 7-9). *Learning in Practice* – Sessions Chair. Research, Scholarship and Evaluation. 7th International Nurse Education Conference (NETNEP). Banff, AB.

- Melrose, S., Park, C. & Perry, B. (2018, April 28).** *Creating and Publishing a Pressbook: An AU Open E-Learning Resource*. Paper presented at the Athabasca University Learning Conference. Athabasca University, Leduc, AB.
- Melrose, S. (2018, Feb 22).** Questions as an Assessment Strategy: Revitalizing a Foundational Educational Practice. Lightning Talk presented at the WNRCSN *Reimagining Nursing Education: Innovations for the Future Conference*. University of Calgary, Calgary, AB.
- Melrose, S., Park, C., Perry, B. (2018, Feb 22).** Re-envisioning Clinical Teaching: A Free E-Book of Creative Strategies. Lightning Talk presented at the WNRCSN *Reimagining Nursing Education: Innovations for the Future Conference*. University of Calgary, Calgary, AB.
- Melrose, S. (2017, Oct 11).** Breaking the Stigma of Mental Illness: An E-Book for Recognizing and Responding to Unmet Needs. *Pacific Rim International Conference on Disability and Diversity*. Center on Disability Studies, University of Hawaii, Honolulu, HI.
- Melrose, S. (2017, Oct 9).** Supporting Individuals with Intellectual Disability and Mental Illness. *Pacific Rim International Conference on Disability and Diversity*. Center on Disability Studies, University of Hawaii, Honolulu, HI.
- Melrose, S. (2017, May 11).** Open Educational Resources: An E-book for Educators in the Health Professions. OER Summit, University of Alberta, Edmonton, AB.
- Melrose, S. (2016, Nov 9).** OER's For Teaching Health Professionals. Invited Table Presentation at the *Open Education In and Across Disciplines Conference*, Mount Royal University, Calgary AB.
- Melrose, S. (2015, Oct 23).** A Free Book for Caregivers of Individuals with Intellectual Disabilities and Mental Illness: Showcasing an Innovation. Paper presented at the Canadian Federation of Mental Health Nurses National Conference *Celebrating Canadian Psychiatric and Mental Health Nursing Achievements*, Niagara Falls, ON.
- Melrose, S. (2015, Sept 30).** *If You Build It They Will Come: An OER Story*. Presentation at the FHD Faculty Development Day, Edmonton, AB.
- Melrose, S. (2015, June 20).** A Free Book for Caregivers of Individuals with Intellectual Disabilities and Mental Illness: Showcasing an Innovation. Paper presented at the 16th *Canadian Collaborative Mental Health Care Conference: Jump on the Bandwagon!* Conference, Calgary, AB.
- Melrose, S. (2015, May 11).** A Free Book for Caregivers of Individuals with Intellectual Disabilities and Mental Illness: Showcasing an Innovation. Paper presented at the *Making a Difference Together: Showcasing Collaborations in Nursing and Health Research Conference*, Winnipeg, MB.
- Melrose, S. (2015, Feb 19).** Strategies Experienced Clinical Teachers Implement to Mentor Adult Learners: Reform-in-action. Paper presented at the WNRCSN *Nurse Educators Conference*, Cranbrook, BC.
- Melrose, S. (2014, Sept 3).** Theory of Clinical Instruction and Mentoring in/relation to Post LPN BN Students. Presentation at the BNPC *Clinical Teaching Workshop: Tips for Your Toolkit*. Calgary, AB.
- Melrose, S. (2014, April 30).** Stories of Courage: Living with Co-occurring Developmental Disabilities and Mental Illness. Paper presented at the YAI Network's 2014 International Conference on *Intellectual and Developmental Disabilities, Designing the Future*. New York, NY.
- Melrose, S. (2014, March 7).** Supporting individuals with developmental disabilities and mental illness. Paper presented at the Alberta Addiction and Mental Health Partnership Program conference *Found in Translation" Sharing Alberta Research for Mental Wellness in Seniors and Persons with Disabilities*. Edmonton, AB.
- Melrose, S. (2014, February 20).** Creating Innovative Teaching Strategies: How Understanding Educational Theory Can Help. Paper presented at the WNRCSN conference *Embracing Challenges: Nursing Education in the 21st Century*. Winnipeg, MB.

- Melrose, S.** (2013, October 4). Stories of Courage: Living with Co-occurring Developmental Disabilities and Mental Illness. Paper presented at the Canadian Federation of Mental Health Nurses conference *Mental Health Nursing...A Journey of Collaboration, Culture and Change*. Kelowna, BC.
- Melrose, S., Urness, C., Forman, B., Holub, M., Denoudsten, A. & Wishart, P.** (2013, March 7). Supporting Individuals with Developmental Disabilities and Mental Illness. Poster and Poster Discussion presented at the Alberta Addiction and Mental health Partnership Program conference *Found in Translation” Sharing Alberta Research for Mental Wellness in Seniors and Persons with Disabilities*. Edmonton, AB.
- Melrose, S.** (2012, March 8). Creating a Self Managing Plan for Mental Wellness: Strengthening Quality of Life for Persons with Cognitive Disabilities and Complex Needs. Poster presented at the Alberta Addiction and Mental Health Partnership Program conference *Found in Translation” Sharing Alberta Research for Mental Wellness in Seniors and Persons with Disabilities*. Edmonton, AB.
- Melrose, S.** (2012, February 23). Fostering Online Student Collaboration: Gentle Breezes that Help Create Connections. Paper presented at the WRCASN 2012 conference *Winds of Change: Diversity and Divergence*. Lethbridge, AB.
- Melrose, S.** (2011). This Worked for Me! Podcast Messages of Encouragement from Senior to Junior Students in an Asynchronous Self Paced Online Course. In *Proceedings of World Conference on E-Learning in Corporate, Government, Healthcare, and Higher Education 2011* (pp. 1486-1492). Chesapeake, VA: AACE. (Oct 18).
- Melrose, S.** (2011, May 13). Learners’ perceptions of instructional immediacy in an online environment. Paper presented at the *Retreat with Lulea University Professional Development Day*. Calgary, AB.
- Melrose, S.** (2011, February 19). Perfectionism and depression: Are nursing instructors and our students vulnerable? Paper presented at the WRCASN 2011 conference *Fostering Quality Learning Environments: Scaling the Heights of Nursing Education*. Vancouver, B.C.
- Melrose, S.** (2010, November 3). From vocational college to university: How one group of nurses experienced the transition. Paper presented at the Association for the Advancement of Educational Research 11th annual conference: *Achieving Excellence through Inquiry*. Hutchinson Island, Florida.
- Melrose, S.** (2010, May 13). Creating a client self managing plan for mental wellness: Strengthening quality of life for persons with cognitive disabilities and mental health needs. Paper presented at the 11th Canadian Conference on Collaborative Mental Health Care: *Keeping One Step Ahead: Practical Approaches to Mental Health Promotion*. Winnipeg, Manitoba.
- Melrose, S.** (2010, May 4). This worked for me! Audio messages of encouragement in an online course. Paper presented at the Canadian Association Schools of Nursing Nurse Educators conference: *Traditions & Transitions: The Evolving Legacy of Nursing Education Scholarship*. Winnipeg, Manitoba.
- Melrose, S.** (2009, December 10). Supporting the transition from Licensed Practical Nurse to Registered Nurse: Lessons learned from nurses with experience in both roles. Paper presented at the Workplace Integration of New Nurses conference: *Value the Past, support the Present, Secure the Future*. Winnipeg, Manitoba.
- Melrose, S.** (2009, November 6). From Licensed Practical Nurse to Registered Nurse: Easing the transition. Paper presented at the Association for the Advancement of Educational Research 10th annual conference: *Bridging Educational Practice and Discipline through Research*. Hutchinson Island, Florida.
- Melrose, S.** (2009, August 26). Easing the transition from LPN to BN: Advice from graduates of a Post LPN BN program. Paper presented at the Teaching Development Unit Conference: *Teaching for and from practice: Critical conversations about education*. University of Calgary, Calgary, Alberta.
- Melrose, S.** (2009, February 20). Ten top tips for teaching online. Paper presented at the WRCASN 2009 Conference: *Teaching from Within: Supporting Nurse Educators for the Future*. University of Calgary, Calgary, Alberta.

Melrose, S. (2008, February 22). Online Post LPN to BN students' views of transitioning to a new nursing role. Paper presented at the WRCASN 2008 Conference: *Caring for People, the Profession and the Earth: Interrelationships among health, healing and the environment*. University of Victoria, Victoria, British Columbia.

Melrose, S. (2007, May 25). Online graduate study health care learners' perceptions of instructional immediacy. Invited Speaker at the CIDER (Canadian Institute for Distance Education Research) series of Elluminate presentations. Athabasca University. Available at <http://cider.athabascau.ca/CIDERSessions/sessionarchive/>

Melrose, S. (2007, May 15). Online graduate study health care learners' perceptions of instructional immediacy. Paper presented at the *Canadian Association of Distance Education CADE/AMTEC Conference: Connecting in the Global Village*, University of Manitoba and Red River College, Winnipeg, Manitoba.

Melrose, S. (2006, August 26). A clinical teaching guide for psychiatric mental health nursing: A qualitative outcome analysis project. Paper presented at *2nd Annual Education Conference: Power, Politics and Pedagogy: The Puzzle of Clinical Teaching Conference*, University of Calgary, Calgary, Alberta.

Melrose, S. (2006, May 14). Help-seeking experiences of health care learners in a WebCT online graduate study program. Paper presented at the *1st Nurse Education International Conference: Developing Collaborative Practice in Health and Social Care Education Conference*, University of Salford, UK and University of British Columbia, Vancouver, BC.

Melrose, S. (2006, February 25). Creating a psychiatric mental health portfolio: An assignment that works! Paper presented at the *WRCAUSN 2006 Nursing Education: Shaping the Future Conference*, University of Alberta, Edmonton, Alberta.

Melrose, S. (2005, Sept 25). Help-seeking experiences of online graduate students. Paper presented at the *CACHE (Canadian Association of Continuing Health Education) Conference*, Calgary, Alberta.

Melrose, S. (2005, June 2). Creating a psychiatric mental health portfolio: An assignment activity that works! Invited Speaker at the *ADETA (Alberta Distance Education Training Association) Professional Development Presentations*. Mount Royal College, Calgary, Alberta, Canada.

Melrose, S. (2005, May 13). Creating a psychiatric mental health portfolio: An assignment activity that works! Paper presented at the *Transformational Networks, McGraw-Hill Ryerson 2005 Teaching Learning and Technology Conference*, University of Alberta, Edmonton, Alberta, Canada.

Melrose, S., (2005, February 18). Mentoring online graduate students. Paper presented at the *WRCAUSN 2005 See the Future: Partnerships for Nursing Education Conference*, University of Manitoba, Winnipeg, Manitoba, Canada.

Melrose, S., (2004, October 18). Help-seeking experiences among graduate students in an online WebCT program – Preliminary findings. Paper presented at the *NAWeb 2004 Web Based Teaching and Learning Conference*, University of New Brunswick, Fredericton, New Brunswick, Canada. Available at <http://naweb.unb.ca/04/papers/Melrose.html>

Shapiro, B., Kappelman, J., **Melrose, S.** & Tse, S. (2003). Tools for use in observation and the interpretation of help-seeking in an elementary science classroom. Paper presented at the *XXXI Annual Conference for the Study of Education Conference*, Dalhousie University, Halifax, Nova Scotia, Canada.

Melrose, S. (2001, February 23). Applying qualitative outcome analysis to create a clinical teaching guide for psychiatric mental health nursing. Paper presented at the *2nd Advances in Qualitative Methods Conference*, The University of Alberta, Edmonton, Alberta, Canada.

Melrose, S. (1999, June 18). Clinical teaching in psychiatric mental health nursing – Sandra's Story. Paper presented at the *International Nursing Research Conference, Research to Practice*, The University of Alberta, Edmonton, Alberta, Canada.

Melrose, S. (1999, February 19). An exploration of students' personal constructs: Implications for clinical teaching in psychiatric mental health nursing. Paper presented at the *4th European Mental Health Nursing Conference, Valuing Mental Health Nursing*, Royal College of Nursing, London, England, (Location: Channel Islands).

Shapiro, B. & Melrose, S. (1997, July 11), Using personal construct changes to bring learner voice into professional development and socialization experiences. Paper presented at the XIIth International Congress on Personal Construct Psychology Conference, University of Washington, Seattle, Washington, United States.

Research Grants

Title of Grant	Source of Funding	Date
\$10,000.00 Alberta Open Educational Resources OER Project titled: "Championing OER's with Educators in the Health Professions: A Model Online Graduate Course."	Campus Alberta OER Initiative	2016-2017
\$15,000.00 Alberta Open Educational Resources OER Project titled: "Creative Clinical Teaching in Health Disciplines" textbook.	Campus Alberta OER Initiative	2014-2015
\$6,000.00 Mission Critical Research for project titled: "Mentoring Post LPN to BN Students in Clinical Practicums: Instructional Approaches That Work."	Athabasca University	2014-2015
\$10,000.00 BCcampus Open Access Textbook Publishing for textbook titled: "Supporting Individuals with Intellectual Disabilities and mental illness: what Caregivers Need to Know."	BCcampus Publishing	2014-2015
\$2,000.00 from Collaborative Research Grant Initiative: Mental Wellness in Seniors and Persons with Disabilities for editorial support for online open access textbook project.	Alberta Health Services	2014-2015
\$6,000.00 Academic Research Fund for project titled: "Supporting Persons with Developmental Disabilities and Mental Illness: Creating an Online Resource."	Athabasca University	2013-2014
\$24,975.00 from Collaborative Research Grant Initiative: Mental Wellness in Seniors and Persons with Disabilities for project titled: "Creating a Client Self Managing Plan for Mental Wellness: Strengthening Quality of Life for Persons with Cognitive Disabilities and Complex Needs."	Alberta Health Services	2011-2013
\$5,938 Academic Research Fund for project titled: "This Worked for Me! Podcast Messages of Encouragement in Asynchronous Online Graduate Courses."	Athabasca University	2011-2012
\$28,434.00 SSHRC funding for the project titled: "From Licensed Practical Nurse to Registered Nurse: Easing the Transition."	SSHRC	2010-2011
\$1,541.64 2009 Educational Innovation Award for project titled: "This Worked for Me! Audio Messages of Encouragement in an Online Course."	Western Region Canadian Association of Schools of Nursing	2010-2011
\$5,816.00 Academic Research Fund for project titled: "Post LPN to BN Students' Perceptions of their Professional Socialization Experiences."	Athabasca University	2010-211
2007 SSHRC New Scholar funding for project titled: "From LPN to BN: How can online education ease the transition?" was not approved but was given a rating of 4A which means that if money becomes available, the project may be funded. This rating also entitled me to funds from the ARC at AU in the amount of \$4000. Funds were used for the project titled: "Exploring Post-LPN to BN Learners' Personal Constructions of the Registered Nurse Role: Phase Two."	SSHRC	2007-2008
\$4,432.00 Academic Research Fund for project titled: "Exploring Post-LPN to BN Learners' Personal Constructions of the Registered Nurse Role: Phase One"	Athabasca University	2006-2007
\$4,883.00 Mission Critical Research Fund for project titled: "Graduate Students' Perceptions of Participation in Online Clinical Interest Groups."	Athabasca University	2006
\$4,877.00 Mission Critical Research Fund for project titled: "Exploring Online Graduate Study Learners' Perceptions of Instructional Immediacy."	Athabasca University	2005-2006
\$1,900.00 Mission Critical Research Fund for project titled: "Exploring Help-Seeking Experiences Among Health Care Learners in an Online Graduate Study Program."	Athabasca University	2004-2005
\$5,000.00 Educational Needs Research Project titled: "Psychiatric Technicians: An Exploration of Possibilities for Employment."	Southern Alberta Institute of Technology	1998

PROFESSIONAL MEMBERSHIPS, QUALIFICATIONS and EXPERIENCE

Professional Memberships

CARNA – College and Association of Registered Nurses of Alberta

CFMHN – Canadian Federation of Mental Health Nurses

Professional Qualifications

RN – Registered Nurse

Non-Academic Teaching Experience

Grant MacEwan College, Calgary AB site **Nursing Refresher Program Tutor** 2001-2002. Mentor Registered Nurses returning to practice

Grace Hospital, Calgary AB **Childbirth Education Instructor** 1986-1994. Independent contracting to develop and implement programs for expectant parents, grandparents and siblings.

Professional Experience

Foothills Hospital Calgary, AB **Mental Health Worker – Psychiatry** 1974 to 1980. Assessing/managing inpatient & outpatient caseload, in both the hospital and the community.

Health Sciences Center, Winnipeg, Manitoba **Staff Nurse – Forensic Psychiatry** 1971 to 1973. Assessing and evaluating acute forensic psychiatric patients.

AWARDS and NOMINATIONS

Dates	Awards/Nominations	Association
2018	Nominated for the <i>Distinguished Academic Award</i>	Canadian Association of University Teachers (CAUT)
2017	Nominated for the <i>Brightspace Innovation in Teaching and Learning Award</i>	Society for Teaching and Learning in Higher Education (STLHE)
2013	Nominated for the <i>Pat Griffin Nursing Education Research Scholar</i> award	Canadian Association of Schools of Nursing (CASN)
2011	Received the <i>Award for Excellence in Nursing Education</i>	Canadian Association of Schools of Nursing (CASN)
2009	Received the <i>Educational Innovation Award</i> for project titled: “This Worked for Me! Audio Messages of Encouragement in an Online Course.”	Western Northern Region Canadian Association of Schools of Nursing (WNRCSN)

SERVICE TO ATHABASCA UNIVERSITY and COMMUNITY

Dates	Activity	Role
2020-2022	Western Northern Region Canadian Association Schools of Nursing	President
2017 and 2022	CASN Nurse Educator Exam	Invited Exam Question Writer/Reviewer
2014-2017	Athabasca University Research Ethics Board	Chair
2015-2022	Calgary Nursing council	Member
2005-2014	CNHS Expedited Ethics Review Committee	Chair
2005-2014	Athabasca University Research Ethics Board	Member
2009-2010	Athabasca University Academic Council	Member
2013-2014	Athabasca University Academic Learning Environment Committee	Member
2005-2006	Athabasca University Education Working Group (Middle States)	Member
2014-2018	Canadian Nurse Educator Group on Clinical Instruction	Chair
2001 -2020	Western Northern Region Canadian Association Schools of Nursing	Member at Large representing CNHS at AU
2015-2020	Calgary Community Kitchens	Board of Directors Member
1995-present	Community Outreach, St David's United Church, Calgary	Member
2015-2016	Calgary Nursing Council	Member
2013	SIAST Psychiatric nursing degree program-evaluation	Program Reviewer
2008	CRNE Blueprint Committee for 2010-2015 Cycle	Member
2005	Jurisdictional Review Committee RN Exams	Member
2001-2004	CARNA Nursing Education Programs Approval Board NEPAB	Member

Student Voices

Audio Messages of Encouragement

In many teaching settings, educators can facilitate meaningful learning by inviting alumni or former students to ‘come back’ and share insights and encouragement with current students. Graduates of the online Master of Nursing and Master of Health Studies programs at Athabasca University were invited to offer tips and encouragement to students presently enrolled in the programs. This is a playlist of voice messages from graduated students who wanted to share the strategies that worked for them during their studies at Athabasca University.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://sherrimelrosepublications.pressbooks.com/?p=2510#audio-2510-1>

Releases

Since compendium publication on December 08, 2019, this page is a record of changes for this book site. This open e-book is a dynamic project may be modified at any time, upon review of reader feedback.

Future Versions – August 24, 2022

According to a Pressbooks.com administrative notice:

On September 29, 2022, [we will no longer host books](https://pressbooks.com/) on <https://pressbooks.com/>. Because you've chosen to publish **Sherri Melrose Publications: A Virtual Memory Box** with an open license, we will migrate it to our new [pressbooks.pub](https://pressbooks.com/changes-at-pressbooks/) platform and continue hosting it in a read-only state at no charge. (<https://pressbooks.com/changes-at-pressbooks/>)

- Therefore, future revisions will be released on <https://on-linelearning.ca/sherrimelrosepublications/>

Version 7.0 – September 16, 2022

- added new chapter – <https://sherrimelrosepublications.pressbooks.com/chapter/the-role-of-the-clinical-instructor/>
- updated releases page and my publications

Version 6.0 – February 4, 2022

- Added new front matter – [Student Voices](#)
- Minor HTML code cleanup

Version 5.0 – February 16, 2021

- Added new book version – *Centring Human Connections in the Education of Health Professionals* – in [My Publications](#)

Version 4.0 – February 14, 2021

- Added new article – [Professional Development Needs of Non-Radiology Nurses: An Exploration of Nurses' Experiences Caring for Interventional Radiology Patients](#)

Version 3.1 – November 18, 2020

- Cover image replaced for *Centring Human Connections in the Education of Health Professionals*

Version 3.0 – February 28, 2020

- My Publications upgraded

Version 2.0 – January 27, 2020

- New front matter content and web conversion corrections

Version 1.0 – December 08, 2019

MY E-BOOKS

Teaching Health Professionals Online - Frameworks and Strategies



[PDF – 1.4 MB]

Citation

Melrose, S., Park, C.L., & Perry, B.I. (2013). Teaching Health Professionals Online: Frameworks and Strategies.

Aknowledgements

The inspiration for this book came first from our students, who challenge us to become better teachers and often serve as a test population for new teaching strategies. Their criticisms and suggestions have helped us refine many of the ideas presented here. We are also grateful to our colleagues in the Faculty of Health Disciplines at Athabasca University—inspiring educators who continually refine their teaching approaches. Many of them responded generously to our call for information about teaching techniques and activities that they have found to be productive and that we might include in this book. We extend our sincere thanks to Carol Anderson, Diana Campbell, Cheryl Crocker, Sharon Moore, and Joyce Springate for their contributions. Finally, a special thanks to Katherine Janzen, with whom the theory of quantum learning originated and who graciously agreed to write a chapter for the book on that topic.

Introduction

You are a teacher at heart. Your goal is to inspire students to excel professionally in one of the many health disciplines. Your students may be nurses, social workers, dietitians, physiotherapists, occupational therapists, chiropractors, dental hygienists, or radiation therapists, or they may be learners who have not yet entered their chosen health care profession. You teach at least some of your courses online, and you find it challenging to be effective, personally engaging, and “real” to students when teaching via the Internet. If this is your story, this book is for you.

Our aim is to equip health care educators, whether they are new to teaching online or already have some experience in that area, with a variety of effective (and proven) online teaching strategies and learning activities. The book offers teaching techniques that can be put into practice immediately and generally demand little by way of technological skill, the investment of time, or other resources. Teachers who find themselves at a loss for inventive ways to challenge their students can flip through these pages, scan the activities, and find an idea to suit their purpose.

This book is both practical and theoretical. It is often helpful to understand why certain teaching strategies are effective in engaging learners. The teaching activities and techniques included in this book are therefore presented in the context of contemporary educational theory, supported by scholarly literature. Teachers often struggle to understand how theories such as constructivism or connectivism or transformative learning apply to actual learning situations. By linking specific theories to concrete examples of teaching activities, this book aims to demystify theory. It is our hope that after reading this book, instructors will be comfortable discussing educational theory and may even be inspired to develop their own teaching activities based on educational theories that align with their personal teaching philosophy. Educational theory kindles ideas and inspires us to improve our teaching.

The teaching strategies and learning activities presented in this volume are drawn from the practice of many professors, instructors, and tutors who currently teach online in the Faculty of Health Disciplines at Athabasca University. Athabasca University was Canada’s first open university, and, today, most of its courses are taught online. The Faculty of Health Disciplines boasts about 2,000 undergraduate and 1,500 graduate students, as well as some forty professors, instructors, and tutors who have a combined total of many years of experience with online teaching. (Many of the courses offered in the Faculty of Health Disciplines have been taught online for a decade or more.) When we set out to write this book, we solicited input from colleagues in the Faculty of Health Disciplines, asking them to share their most successful online teaching strategies and activities. We also included techniques that we have developed and found effective in our own teaching. Once we had an assemblage of activities, we grouped them according to the educational theory with which they were most closely aligned. Of course, in developing teaching techniques, instructors often integrate elements drawn from a variety of theories. For the purposes of this book, however, we assessed the “best fit” in order to illustrate the relationship between practice and theory.

This book is very much a collaborative effort. However, we chose to divide up the primary responsibility for specific chapters according to our individual areas of interest and theoretical expertise. Thus, chapter 1, on instructional immediacy, is principally the work of Sherri Melrose. As she explains, the theory of instructional immediacy holds that demonstrating availability, projecting warmth and friendliness, and taking time to get to know students as individuals all play a major part in an instructor’s effectiveness. Her discussion of the theory is followed by suggested ways in which teachers can encourage collaboration while also supporting individual learners as they progress through the expected stages of development in class groups.

Invitational theory is the focus of chapter 2. In it, Beth Berry discusses “the plus factor,” a way of thinking and being with students that creates a warm and welcoming online educational environment. She examines how trust, respect, optimism, and intentionality exert a positive influence on educational outcomes.

In chapter 3, Sherri Melrose reviews constructivist thinking, a teaching approach that builds on what learners already know. She describes ways in which teachers can provide learners with the scaffolding, or support, that they need in order to progress toward competence and independence.

The theory of connectivism stresses the role of networks in learning. As Caroline Park explains in chapter 4, in a connectivist approach, teachers and students use digital technology to create complex and diverse networks of people who can help them find the information they need. She offers connectivist techniques that can help learners to create informal and perhaps unexpected connections that support their specific learning needs and interests. In addition to locating information, however, students must learn to organize the information they gather and evaluate it critically.

In chapter 5, Park turns to the concept of transformational learning, which she describes as a process of changing learners' attitudes and deeply entrenched beliefs and assumptions. When teachers provide learners with opportunities for critical reflection and challenge them to question commonly accepted truths, exciting new perspectives can be gained.

Chapter 6, contributed by Katherine Janzen, concerns the theory of quantum learning. Janzen draws from principles of quantum physics to illustrate how the basic elements of virtual classrooms—teachers, students, and course content—are connected and entangled, just as electrons are. She explains how teachers in quantum learning environments can create virtual classrooms that feel real and alive.

In the concluding chapter, we describe the six principal lessons we have learned about how to make online courses more engaging. Fundamentally, we acknowledge that wonderful online teaching strategies alone do not inevitably lead to success. The teacher matters. Online teachers, however, face special challenges. How can online teachers ensure success? How can they transcend the emptiness of cyberspace to become real to students and create learning environments in which classmates become as tangible to one another as they would be if they were sitting side by side? This final chapter addresses these questions and provides online teachers with important takeaway messages.

We acknowledge that online education changes at a breathtaking pace. With each new technology, fresh teaching approaches become possible. To be on the cutting edge in the dynamic world of online education, we focus here on the most contemporary of learning theories, theories that are likely to remain relevant as Web 3.0 technologies continue to emerge. The importance of social media in online education is also given consideration throughout the book. Some of the teaching strategies described use social media as the primary platform for learning, and many of the suggested activities can be adapted to employ social media as needed.

Future online learning will undoubtedly be more open, mobile, and flexible than it is today. Open educational resources, the adoption of mobile devices, free online tools and courses, and the rise of cloud computing are four trends that will propel changes in online teaching and learning. This book provides a foundation that will enable you to make optimal use of these and other transformations that will shape online learning in the years ahead.

If you are a novice online teacher, this book is a place to start. If you are a seasoned educator who has just been asked to convert some of your face-to-face courses to online courses, read this book first. If you have been teaching online for years and feel that you are “rusting out” and getting stuck in your old ways, our theory-based techniques and activities may refresh your teaching. If you are a highly regarded online teacher emulated by others, we hope that you will find some hidden gems in this book that will help you to continue to be a leader in online education.

In sum, the purpose of this book is to inspire great teaching by providing you with theory-informed techniques and activities to help make you an exemplary online educator. The end result will be enhanced quality of education, increased student success and satisfaction, and, ultimately, the best possible health care professionals.

EDUCATION (PRE-SERVICE LEARNERS)

Mentoring non-traditional students in clinical practicums: Building on strengths



[PDF – 201 KB]

Citation

Melrose, S. (2018). Mentoring non-traditional students in clinical practicums: Building on strengths. *Journal of Clinical Nursing Studies*, 6(3), 39-45.

Abstract

Background: As nurse educators respond to increasing numbers of adult learners attending practicum experiences, clinical instructors are one of our richest resources. And yet, the everyday strategies they implement to mentor these non-traditional students towards success may go unnoticed. This article describes findings from a qualitative descriptive research study that listened to the voices of experienced clinical instructors.

Objective: The objective of the study was to describe effective mentoring approaches that instructors in a Post Licensed Practical Nurse to Bachelor of Nursing (Post LPN to BN) program used to support students' learning and build on their strengths during instructor led clinical practicum courses.

Methods: The research was framed from a constructivist worldview and Laurent Daloz's mentoring model. Digitally recorded and transcribed interview data was collected from 10 clinical instructors who had been teaching for more than 5 years. The transcripts were analyzed for themes which were confirmed with participants through member checking.

Results: Findings revealed that instructors supported students by validating individual strengths; challenged them by

building on those strengths; and created vision by linking their present activities to competencies needed in their own future practice.

Conclusions: These findings provide valuable insights and guidance to practicing Registered Nurses (RN's) interested in teaching non-traditional students during their clinical experiences.

Key Words: Non-traditional students, Post Licensed Practical Nurse to Bachelor of Nursing students, Clinical instructors, Mentoring approaches

I. INTRODUCTION

Schools of nursing, like most post-secondary institutions, are experiencing steady growth in the number of non-traditional students attending their programs.[1–5] Non-traditional students, also referred to as mature students or adult learners, are usually over 25, have delayed their post-secondary enrollment or are returning to their studies, have one or more dependents, attend school part time and are employed full time.[6] Interestingly, since 1996, nearly 70% of all undergraduate students also possesses at least one of these “non-traditional” characteristics.[6] Many learners attending post-secondary institutions today are juggling responsibilities related to their roles as employees, partners and parents in addition to their roles as students.[3] For many, their educational needs have been neglected, particularly in relation to the limited periods of time they are able to spend away from their employment setting.[7]

For non-traditional nursing students, practicum experiences, where attendance at clinical sites for consecutive days and weeks at a time is required, can be especially challenging.[8–10] Yet, it is often their practicum experiences that most help adult students become socialized into a new professional nursing role[11] and to re-imagine their professional identities in new ways.[12] Mentoring approaches that experienced clinical instructors believe are effective can make an important difference to these students, but they are seldom disseminated beyond individual educational institutions.

Existing research provides direction for mentoring adult learners during their experiences in higher education in general,[13–17] as well as for mentoring different groups of student nurses.[18–21] Further, in academic areas, information on mentoring Licensed Practical Nurses earning their baccalaureate degree is available. For example, assessing individual learning obstacles and creating plans to address these;[22] monitoring entrance GPA, ongoing GPA and cumulative GPA;[23] and rigorous preparation classes for national registration examinations.[24]

However, there is a “gap” in our understanding of the kinds of mentoring based instructional strategies that work best for these non-traditional students during their practicums. Nurses with experience instructing in clinical areas are a rich resource and the approaches they implement may go unnoticed. Findings from this study, which listened carefully to the voices of nurses directly involved in clinical teaching, will contribute to existing literature on instructional mentoring and will inform nurses interested in mentoring LPNs and other non-traditional students.

As part of an overarching program of research investigating the experiences of one group of non-traditional students and instructors, those involved in an LPN to BN (Licensed Practical Nurse to Bachelor of Nursing) program, 10 experienced Registered Nurse (RN) instructors were invited to discuss the mentoring approaches they implemented during clinical practicums. In some jurisdictions, Licensed Practical Nurses (LPN's) are also known as Registered Practical Nurses (RPN's) and Licensed Vocational Nurses (LVN's). In some regions, the word “mentor” denotes the practitioners in clinical settings who support and precept learners in practice. Although definitions of mentoring continue to be developed,[25–27] in this study, the term “mentoring” refers to the following definition accepted by the American Nurses Association: “Mentoring is a broad caring role that encompasses formal or informal supporting, guiding, coaching, teaching, role modeling, counseling, advocating, networking, and sharing”.[28] The instructors who participated were employed by the university to facilitate learning for small groups of students during their clinical practicums.

The objective of the study was to describe effective mentoring approaches that instructors in a Post Licensed Practical Nurse to Bachelor of Nursing (Post LPN to BN) program used to support students' learning during their instructor led clinical practicum courses. This article reports research findings where clinical instructors shared practical, everyday mentoring strategies that helped support their students towards success. The strategies will be of interest to nurse educators and practitioners involved in the clinical education of non-traditional students.

2. METHODS

2.1 Research approach

2.1.1 Conceptual framework

The study was grounded in constructivist student centered epistemology[29, 30] and incorporated ideas from Laurent Daloz's model of mentoring.[13, 14] Daloz asserted that in order for mentoring activities to enhance learning, the dimensions of support (affirming activities); challenge (generating dissonance and cognitive tension); and vision (envisioning future outcomes) must all be present. Support alone, although a foundational element in any mentoring relationship, is incomplete. When learners feel a high sense of support, but a low sense of challenge and/or a low sense of vision, development and progression does not occur. Similarly, when support and vision are low, but feelings of challenge are high, learners can feel intimidated, unmotivated and often withdraw completely. Alternatively, when support, vision and challenge are all low, learners simply remain in a static state.[13, 14] Therefore, in this study, the dimensions of support, challenge and vision were used to help organize the interview data.

2.1.2 Design

A qualitative descriptive design guided the study. A qualitative descriptive design provides a clear, straight description of experiences, perceptions, or events using language from data collected; usually involves minimally or semi structured interview guides; and uses low inference interpretations to summarize findings into themes or categories.[31–36] Researchers remain close to the surface of the data and describe events from participants' own viewpoints.[37, 38] The goal of descriptive research is to communicate directly with participants and search for precise accounts and rich descriptions of the experiences, events, and processes that most individuals would agree are accurate.[31, 33, 39] Two main elements consistent with qualitative descriptive research are that researchers learn from participants and their descriptions and then use this knowledge to influence interventions.[31, 34]

2.1.3 Setting and participants

The study was implemented at a Canadian open university offering a post LPN to BN program available to students from across the country. Letters of invitation to hear more about the study were e-mailed to the 15 full-time and contract faculty who were instructing in practicum components of the program. These faculty all had five or more years of teaching experience. 10 faculty members expressed interest and agreed to participate. Most of the participants were employed primarily in clinical practice and only taught with the university on a contract basis. Full ethical approval was granted by the university's Ethics Review Board.

2.2 Data sources

Data sources were 10 digitally recorded, transcribed telephone interviews with these participants. The interviews were approximately an hour long and conducted by a research assistant who was not employed by the university and who was not in a position of “power over” participants. In keeping with a qualitative descriptive research design, a minimally structured interview guide, which allowed the interviewer to explore and delve further into participants’ comments about their mentoring approaches, was used. The following six questions were used to guide the interviews:

1. Let’s begin with your background. Please share a bit about your teaching experience.
2. What does the concept of “mentoring” mean to you? What is a mentor?
3. Talk about the kinds of mentoring approaches you are implementing in your clinical practicums.
4. Can you think of ideal mentoring approaches you believe in and would like to implement?
5. How might you describe your mentoring in relation to being mentored yourself?
6. What barriers and challenges have distracted from implementing mentoring approaches?

2.3 Data analysis

The interview transcripts were analyzed for themes initially using line by line coding to group participants’ phrases and conversations (indicators) into meaningful qualitative units or categories of concepts.[40] Daloz’s[13, 14] emphasis on the importance of support, challenge and vision in mentoring were considered as each category emerged. Next, in keeping with naturalistic inquiry, these categorizations led to the development of overarching themes.[41] The transcripts were thoroughly read and re-read. To achieve investigator triangulation, the primary researcher and research assistant met regularly to discuss interpretations. Member checking, or sharing interpretations of the findings with participants, ensured trustworthiness and authenticity.

3. RESULTS

3.1 Theme one: Support students by validating their individual strengths

Participants frequently mentioned the sincere respect they felt for their students. Comments such as “Some of my students know far more than I do in their areas of practice” were common. In particular, they remarked on how the LPN to BN students brought valuable nursing experiences to their practicums. One participant stated: “[non-traditional] students are more goal-directed than the young ones [meaning traditional students] who maybe don’t know exactly what their goals are in life or in their career.” Another participant remarked on how their students “are nurses who [are already] providing care to people who are struggling or troubled in some way. So, you can always draw on that.”

Participants also often talked about the difficulties their students were facing and the perseverance needed to overcome these. Students in the program are required to attend designated clinical sites for their two to four-week practicums. As a national program at an open university, students come from across the country. For many, attending practicums meant temporarily relocating to a new city, leaving behind their families and full-time employment. In one participant’s words: “they have kids, they have families, they’ve been around the block a few times and lots of them are new to the country and they are still learning English. Just getting to clinical is an ordeal.” As an example, another participant described a new mum who relocated with her infant, so she could continue breastfeeding. The students’ mother also left her family and full-time employment to care for the infant while the student attended clinical.

Several participants emphasized the importance of first recognizing and then validating students' commitment to advancing their education. In turn, *"letting students know that you understand, or at least can try to understand what they are going through [demonstrates support]. When instructors understand their students' circumstances, they can more effectively identify their special strengths."* As one participant expressed: *"[non-traditional] students are extremely taxed. They are very tired, and they are juggling a lot of things to get through school. But, that all points very loudly to the tremendous tenacity and strength they have within themselves. So, when they are struggling or having hard times, find out what they have done in the past to succeed. Validate what they've done to get this far. That's what you do to get them through."*

Participants further validated strengths with an inherent belief that their students could and would accomplish both their personal objectives and those designated by the program. Fostering a sense of pride was an important element of mentoring for several participants. In her explanation of what she believed a mentor was, a participant stated:

"a mentor is someone who can mirror back the greatness in others. So, if my students leave me feeling profoundly proud of who they are and really certain of their potential, then I've done a great job. That's what will take them forward, what will make them want to keep learning, what will make them want to care for people. Not me, not the little morsel of education I give them. I want them to leave [this practicum] feeling fantastic about their particular contributions. I have a strong belief that that each student that I meet has specific and unique potential in themselves that only they can share. There's no one else on earth who will share and be just like them. So, what I really want is for them to see is their own kind of greatness."

In essence, the experienced clinical instructors in this study suggested that effective mentoring support includes knowing the difficulties students face and validating the individual strengths students themselves draw on to succeed. Strategies they suggested for validating individual strengths included providing students with one-to-one discussion times where they could explain what they were doing well; setting a positive, success oriented tone during post conferences; and ensuring self-evaluation opportunities included a balance of strengths as well as areas to grow.

3.2 Theme two: Challenge students by building on those strengths

With an understanding of their students' individual strengths in place, participants expressed ways they could incorporate Daloz's[13, 14] mentoring dimension of "challenge" (introducing cognitive tension) to build on those strengths. The following comments typify how participants challenged students to stretch and grow beyond their personal best. *"I don't tend to compare them too much to each other, or to generic [meaning traditional] students. I just want them to really know more when they leave than when they came to the unit."* *"... I like them to think about their own progress. They are all quite varied in where their strengths are. But they all have strengths and skills, so we work together to add in what else they need to know to meet the competencies."*

One participant approached the mentoring dimension of challenge by setting high expectations. She believed her students *"can succeed and they will succeed"*. In her view *"I don't want them to be average – I want each student to be exceptional. Even when someone could pass or demonstrate the competencies on the first day – they need to work towards being really exceptional for who they are and what they have to offer."*

Several participants introduced challenge into their supportive mentoring by involving students' peers. During post conference, one participant routinely engaged in the following round robin discussion activity. *"Name one thing that you're really proud of and that you think went great. [Then] name one thing you think kind of wasn't that great. We do that as a group and the others offer their ideas. It shouldn't all be about what went well."* Another participant mentioned how she *"does everything"* to make sure students *"don't feel alone. I have them work in pairs and part of that is to tell each other what it really hard for them and what they are doing about making it not so hard."*

Specific strategies that participants described included providing examples of well-written charting. This strategy was especially valuable to English as a Second Language students. When students compared their charting drafts to the examples, they could self-identify points that were missed before actually entering information on patient/client charts. Another

strategy was to have students create mind maps to illustrate what they knew about and had researched for their patient/client. The instructor reviewed each of the mind maps and identified concepts that were incomplete. As students developed and added to their mind maps, a succinct visual of how they were overcoming the challenges of what they did not know emerged. Unlike more cumbersome written descriptions of patient/client conditions, the diagrammatic mind maps communicated student progress at a glance.

3.3 Theme three: Create vision with links to future practice

All of the participants remarked on the importance of asking students about the areas where they hoped to practice in future. Knowing where students hope to work after graduating made it much easier to create links between competencies required in the future, with those they were achieving in their present placement. As adult learners, non-traditional students are likely to question why they are required to learn a skill or master a concept in a clinical area, when they do not believe they will ever work in that area. The vision of “yes – you will need this later and here’s why” helped guide students towards outcomes that felt relevant to them. In one instance, when students commented on how they would not be working in mental health, a participant described how she *“told stories about using mental status exams and other psych/mental health skills in all kinds of other areas. Then they could see they would actually use [mental health skills].”*

“Getting them to think outside their comfort zone” was the expression two participants used when commenting on how they incorporated challenge into their mentoring. Another participant talked about inviting students to imagine themselves practicing in their desired area, and successfully implementing a needed skill.

Strategies for creating vision that participants suggested included encouraging students to initiate a clinical “keeper file” of information they thought would be useful in their future practice. Students could add to this personalized file as they attended different practicums. Another visioning strategy was to create an online group discussion forum. Each week, the instructor posted a competency and required students to comment on how mastering the competency would affect their future practice. They were also required to respond to a minimum of two of their peer’s posts. This exchange of information and interactivity occurred outside their time in the clinical area and helped student groups introduce the idea of visioning into their discussions.

4. DISCUSSION

Although none of the participants held advanced degrees in education, their experience and tacit knowledge equipped them with the capacity to mentor their non-traditional students with support, challenge and vision. Their processes of supporting students by validating their individual strengths reflected an empathic understanding of the difficulties their students faced. By tapping in to what students themselves were doing to overcome these difficulties, they communicated a deep and affirming level of support. When they introduced challenge, they did so by identifying students’ individual strengths and then extending and building on these. They not only wanted their students to achieve required competencies, they wanted them to go beyond their own personal best and excel. By knowing the specific practice areas their students hoped to work in, the participating clinical instructors were able to create vision that was personalized and meaningful for each student. In order to attend their practicums, the LPN to BN students all made significant sacrifices, including leaving their employment for weeks at a time. Creating links between the skills and concepts they were required to master in a practicum area they may not express interest in, and an area they felt passionate about and planned to practice in, could help students feel their time was well spent.

Joseph Chen asserted that most post-secondary programs are youth-centric, generally designed for younger students and neglect non-traditional students, viewing them as “invisible.”[7] Participating instructors in this study, who worked in a program only available to non-traditional students, seized the opportunity to find simple, practical approaches that begin to

address this deficit. Although they could not do anything about the time students were required to be away from their work and families, the instructors found ways to genuinely affirm their sacrifices. By personalizing learning, the instructors were able to work collaboratively to build on what students already knew.

The mentoring strategies that the experienced clinical instructors in this study described can readily be implemented in a variety of different practice areas. Nurses in clinical practice who also take on the role of practicum instructor may have limited opportunities to gain an in-depth understanding of educational approaches that can work well with non-traditional students. However, by simply grounding their instruction in an unwavering commitment to building on their students' strengths, less experienced nurses can make a very special difference.

A limitation of the study is that students' perceptions of the instructional mentoring approaches were not explored. Plans to do so are in place. However, as participants described their students' progress, the pride in and commitment to supporting students' accomplishments was expressed clearly in their tone of voice and word choices. During the interviews and when reading the transcripts, the researchers made an assumption that students may also have sensed that their instructors felt proud of them. When Rylance, Barrett Sixsmith and Ward explored the mentoring relationship, the area where nurse mentors gained the most satisfaction was to see their students' progress.[42] Similarly, in the present study, participants appreciated seeing their students succeed and excel. They wanted to share the approaches that they found valuable with other nurses who provide instruction to students in clinical areas.

5. CONCLUSIONS

Findings from this study indicated that experienced clinical instructors mentored non-traditional nursing students by supporting and validating their individual strengths; challenging them by building on those strengths; and creating personalized vision by linking their present activities to competencies needed in the areas where they hoped to work. Specific support strategies included knowing the difficulties their students were facing as well as the unique ways they were seeking to overcome them. The instructors intentionally created activities for identifying and then building on students' strengths during one-to-one discussions, post conferences, evaluation processes and online discussions when away from the clinical area. They challenged their students with opportunities to use example chart entries to correct drafts of their own charting. They also challenged students to visually represent concepts on mind maps, which the instructors used to identify areas where a deeper understanding was needed. In preparation for their future practice, instructors invited students to initiate a personally meaningful filing system for the clinical knowledge and skills they would put to good use later.

Although post-secondary institutions may not have fully adapted to the educational needs of non-traditional students at the administrative and curricular levels, clinical instructors may be doing so at a grass roots level. As participants in this study illustrated, clinical instruction grounded in a mentoring approach that builds on the strengths students bring to their learning shows promise. Continuing to find ways to support, challenge, and provide vision to students is both a challenge and an opportunity for nurses who instruct clinical practicums.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

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Facilitating Constructivist Learning Environments Using Mind Maps and Concept Maps as Advance Organizers



[PDF – 250 KB]

Citation

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Abstract

Constructivist learning environments, where facilitators build on what learners already know, are grounded in instructional scaffolding. Advance organizers such as mind maps and concept maps are scaffolds that provide students with temporary support as they move toward constructing personally relevant knowledge independently. Examples of mind maps and concept maps are described in order to provide a variety of applications in classrooms for presenting information and evaluating student understanding.

Introduction

Constructivist approaches to teaching and learning are grounded in the idea that students bring valuable prior knowledge to their classes and that teachers help learners build up that knowledge through active and personally meaningful learning activities (Piaget, 1972; Vygotsky, 1978). Teachers who embrace a constructivist approach seek ways to know students as individuals, to understand their unique ways of building, organizing or interpreting knowledge, and then to guide them towards new ways of thinking.

Scaffolding is an educational approach where teachers offer temporary support to learners during their personal processes of constructing meaning (InformED, n.d; Wood, Bruner & Ross, 1976). Similar to scaffolds on construction sites, the support is temporary and not expected to be required for long. Educational or instructional scaffolds are often used to present foundational knowledge or to guide learners through content matter that is expected to be difficult. As students need less help, demonstrate independence and assume more responsibility for meeting their learning needs on their own, the support or scaffolding is gradually withdrawn. In constructivist learning environments, advance organizers provide adaptable, efficient and creative scaffolds for a variety of different learners.

This article explains and differentiates between two advance organizers: mind maps and concept maps. In order to help teachers decide when to implement mind maps and concept maps, a variety of applications relevant to teachers from K-12 through to college are discussed. Strategies for using maps as presentation strategies as well as for using them as evaluation strategies are described.

Advance Organizers

Constructivist facilitators can create scaffolds or support for understanding new information by emphasizing what it is about an area of content that is particularly important. Knowing aspects of a topic that can be expected to be difficult or complex, educators can organize that information in ways that offer learners a different way of looking at the material. Most educators create and present advance organizers such as charts, diagrams or other visual tools for organizing and representing consensually validated knowledge into their teaching practice. Similarly, creating and presenting summaries of course content material into a concise Power Point or Prezi presentation is another common way of incorporating advance organizers that incorporate a graphic or visual element.

Extending the usual teaching practice of providing general overviews or summaries of course material, theorist David Ausubel (1960, 1968) suggested that learners can come to understand ideas, concepts and principles more deeply and more meaningfully when advance organizers include both a reminder about relevant prior knowledge and an emphasis on the relationships that exist among concepts. To this end a learning activity that guides students to recall what they already know about a course topic is an advance organizer. Mind maps and concept maps are two different kinds of graphic advance organizers that help learners assimilate what they already know and what they are about to learn (Davies, 2011).

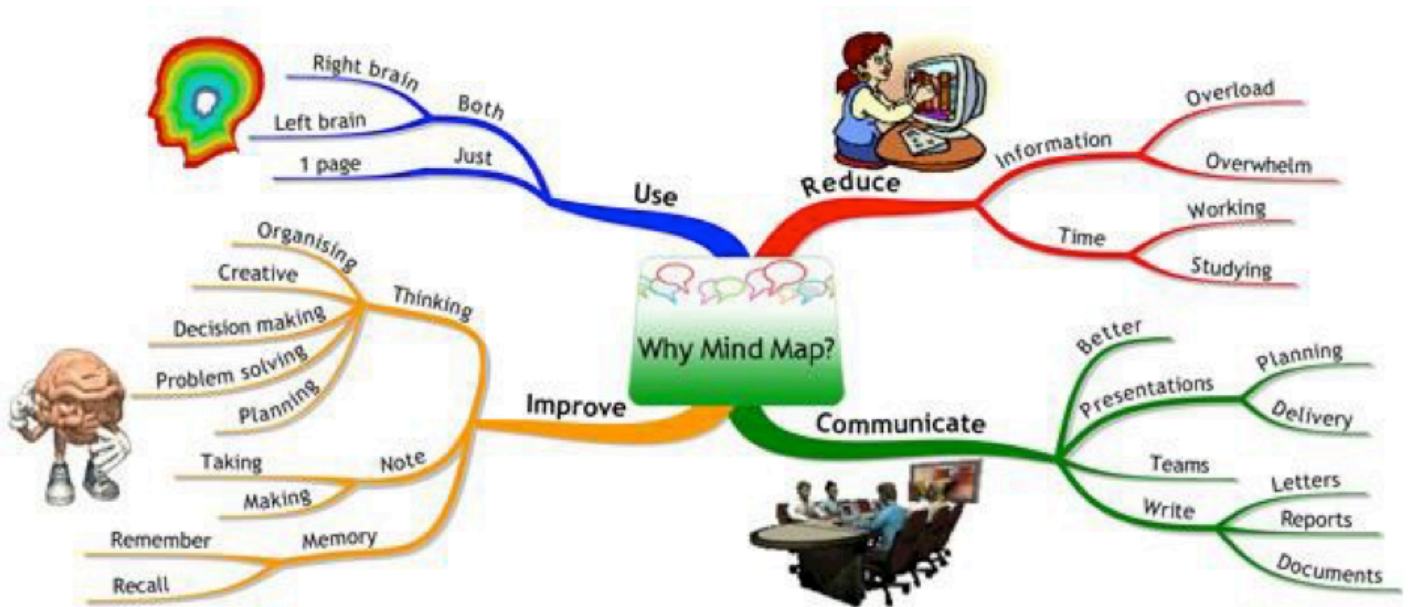
Mind maps

Mind maps, introduced by popular author Tony Buzan (2000), are informal intuitive diagrams used to represent only one single word or idea. Mind maps, like web or spider diagrams incorporate colors, symbols and pictures and are often used as tools for taking notes, for illustrating brainstorming activities or for sketching out thinking. The focus is on creating a visual representation of how relationships exist among ideas.

Construction of a mind map begins by identifying a central word or concept and then later adding descriptions associated

with the concept. Colors and pictures can be included. Online tools with mapping templates are readily available for students and teachers. For example, Figure 1 is an example of a mind map titled *Why Mind Map?* available on the Illumine Training Mind Mapping website (n.d.).

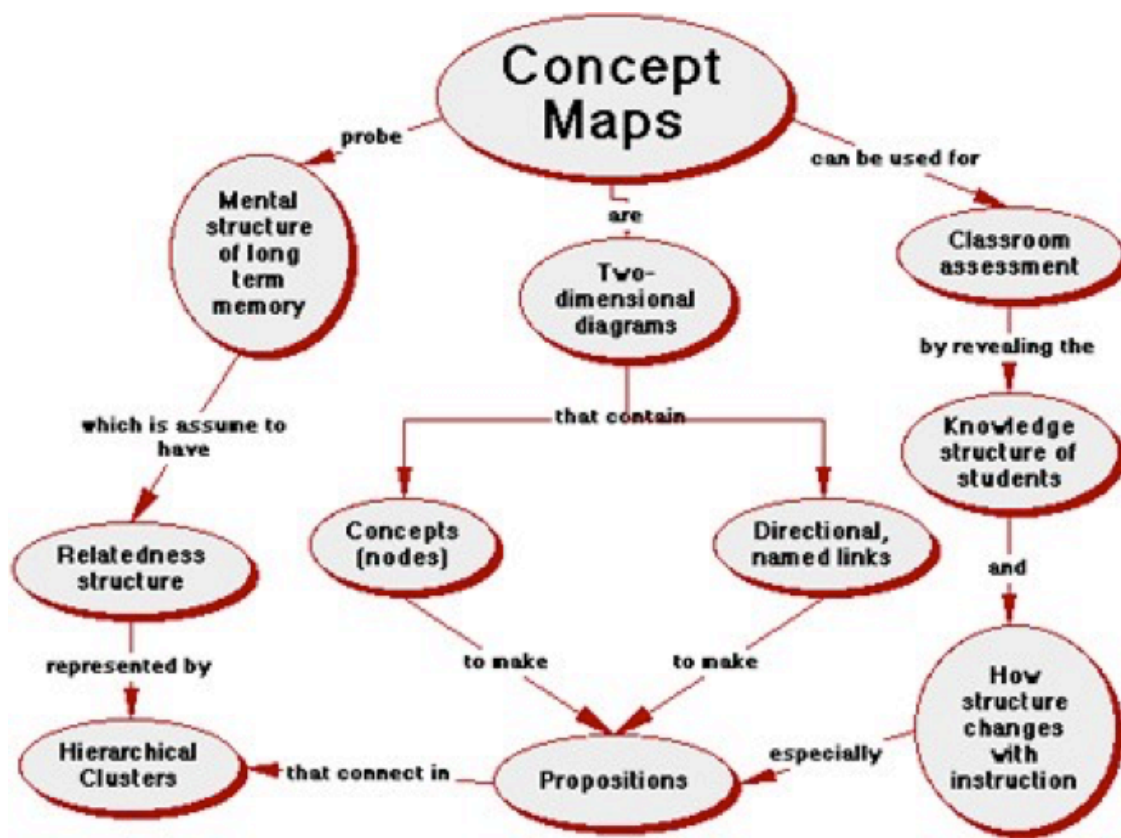
Figure 1
Mind Map: *Why Mind Map?*



Concept maps

By contrast, concept maps, introduced by science educators Joe Novak and Bob Gowan (1984) do not represent only one single word or idea. Rather, concept maps connect multiple words or ideas. Concept maps are hierarchical schematic diagrams that use words or symbols to represent key concepts. Concept maps also use linking words to show the relationship between concepts which then produce meaningful statements or propositions (Novak & Cañas, 2008). With their emphasis on illustrating the relationships, connections and patterns among ideas, concept maps can be considered more complex advance organizers. Figure 2 is a concept map Professor Michael Zeilik at the University of New Mexico created with IHMC CmapTools (IHMC CmapTools, n.d.), a free program, to explain concept maps.

Figure 2
Concept Map of Concept Maps



Michael Zeilik (n.d.)

<http://www.flaguide.org/extra/download/cat/conmap/conmap.pdf>

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Differences between mind maps and concept maps

As the above maps illustrate, mind maps and concept maps are different. Buzan's (2000) informal mind maps were developed to illustrate one key idea and brainstorm key points associated with that one idea. On the other hand, Novak and Gowan's (1984) concept maps, sometimes referred to as Novakian concept maps, were developed to illustrate several key concepts and use carefully contrived linking words to illustrate how relationships exist among the concepts. Notice how the concepts identified in Zeilik's (n.d.) concept map (Figure 2) provide a clear statement when following the arrows. For example, "Concept maps can be used for Classroom assessment by revealing the Knowledge structure of students..." Without efficient and explanatory linking words, Novakian concept maps are incomplete.

Simple mind maps, where sub-topics radiate around one central image are fairly concrete, less rule bound and can be created immediately. Mind maps can capture and record a jumble of freewheeling ideas as they occur. By contrast, Novakian concept maps are more abstract, require thoughtful reflection and can be time consuming. The process of accurately illustrating cross-links and connections among sub-topics calls for a deeper and more systemic understanding.

Comparing the advantages and disadvantages of mind maps with concept maps, Eppler (2006) identified that advantages of

mind maps include that they are easy to learn, apply and expand; encourage self-expression; and provide useful overviews of topics. Disadvantages of mind maps include that they can be idiosyncratic and hard for others to read; represent mainly hierarchic relationships; be inconsistent; and be overly complex.

Advantages of concept maps include that they can offer rapid information; provide an overview using a proven systemic approach; emphasize relationships and connections among concepts; and their evaluation rules afford viewers an ability to assess quality. Disadvantages of concept maps include that they also can be idiosyncratic, not easy for novices to apply, and time consuming both for learners to create and for educators to evaluate. In addition, the overall pattern of a concept map does not necessarily assist memorability (Eppler, 2006). Weighing the advantages and disadvantages of these tools is an important consideration as educators decide which advance organizer might best suit a particular instructional activity. In the following section, applications of mind maps and concept maps are discussed. Examples of these two scaffolding techniques in both K- 12 and college classrooms are presented.

Applying Mind Maps and Concept Maps in the Classroom

Constructivist teachers can use advance organizers such as mind maps or concept maps in different classrooms and in a variety of ways. The tools can be applied as presentation strategies where information is shared with learners and as evaluation strategies to assess learner understanding.

Presentation strategies

Passive presentations. Teachers can create their own conceptualization of knowledge related to a particular topic by drafting mind maps and or concept maps and then sharing the maps with students. This sharing can be done passively by displaying the maps in classrooms as posters. In brick and mortar classrooms the map posters can be taped to walls. In virtual classrooms, the map posters can be posted in forums or discussion areas. Collections of maps can be made available in libraries or resource centers for students to access outside of class. By sharing their own ways of piecing together information through maps, teachers model new ways of thinking.

Mind maps, with their radiant display of ideas related to a central topic would be best suited to posters that loosely expand on that central topic. For example, in K-12 classrooms, sub-topics related to a key theme inherent in a book the class is reading could be drafted. Similarly, in preparation for a science fair, mind maps illustrating different ways a particular science topic can be explored in depth will inspire students as they plan their exhibits.

In college classrooms, teachers can use mind map posters to summarize new research ideas they learned after attending an academic conference on a course topic. Additionally, for new students in professional programs, teacher-constructed mind maps can provide students with a bigger picture of the kinds of sub-topics they will need to know about in order to achieve disciplinary knowledge. In speciality areas such as health care programs, teacher-constructed mind maps can effectively illustrate a holistic approach to treatment by literally drawing patients in the center and surrounding them with health issues needing attention. Research has indicated that students who used teacher-constructed mind maps as study aids scored higher on quizzes than those who did not (Boley, 2008). Further, passive presentations of concept maps, where emphasis is placed on how sub-topics relate to one another, would be most suited to illustrating complex topics.

By contrast, teacher-constructed concept maps can be used to introduce content students can expect to learn more about and then to summarize that content once it has been presented. For example, in both K-12 and college classrooms, concept map handouts can serve as the foundation for a lecture. After the main topic has been explained, teachers can lift up sub-topics and expand on connections. At the end of each separate explanation, the process of referring back to the overarching concept map will help establish a sense of unity and consistency. When students face the difficult task of sorting

through a large volume of information on a topic, both pre-made mind maps and pre-made concept maps can discreetly provide valuable and needed scaffolding.

Active presentations. In addition to providing pre-made maps, constructivist teachers can actively involve students in co-creating mind maps and concept maps. In class groups, teachers can supply a set of related concepts and call for student input to arrange them either radiantly in mind maps or hierarchically in concept maps. Or, teachers can generate the concepts for either type of map from students' comments through brainstorming sessions. The teaching action of calling for student input brings students' prior knowledge into focus and helps them construct new knowledge from what they already know.

Mind maps are generally considered best used at the beginning or planning phase of learners' conceptualization process and concept maps at the ending or summarizing phase. However, their application need not be restricted to specific contexts. A more important factor is likely to be individual teachers' commitment to and comfort with using the tools.

Individually, maps can support communication between students and teachers. Some learners find they learn more from actively constructing maps on their own rather than in interactive groups (Jones, Ruff, Snyder, Petrich, Koonce, 2012). Mind maps can be effective strategies for note-taking in classrooms from K-12 through to college. When teachers review mind map notes, they can see at a glance how subject matter has resonated with their audience.

It is important to note that reaction to the use of mind maps is not always conclusive or positive. For example, although mind-mapping is gaining popularity as a note-taking tool in medical schools, and students expressed that they found the tool useful, research revealed that mind mapping did not actually increase short term recall or critical thinking (D'Antoni, Zipp, Olson & Cahill, 2010; Wickramasinghe, Widanapathirana, Kuruppu, Liyanage, & Karunathilake, 2007).

Mind maps can serve as efficient planning tools. As students plan reports they will submit, teachers can review successive drafts of their planning maps. If an area needs further development, teachers can readily identify the gap before the work is graded.

For younger and more concrete-thinking learners, the colors and images can help students feel engaged. For older and more abstract-thinking learners, the freedom from inserting information in the "correct" way can help them feel confident. In one PhD program, teachers used mind maps for 'pre-analytic idea jostles' to stimulate ideas for literature reviews (Eppler, 2006). Learners at any level could benefit from individual or group discussions of information sources available to them as they begin an assignment.

Evaluation Strategies

When assignments invite students to synthesize what they have learned into their own advance organizers, the process of completing those assignments can become creative and imaginative as well as analytic and evaluative. As mentioned previously, ongoing teacher input into students' maps provides valuable scaffolding and support. Rather than grading maps only when they are complete, evaluation strategies using mapping tools are most effective when they include formative components. Educational measurement of assignment maps is not straightforward. However, identifying improvement and increased knowledge from one submission to the next can be more clear-cut.

Mind maps are most suitable as an evaluation strategy when they illustrate topics that fit into a traditional course outline. Conversely, concept maps are most suitable as an evaluation strategy when they illustrate topics students have explored in depth by delineating relationships among sub-topics. For example, in a health related class, a mind map assignment could require portrayal of a case study, while a concept map assignment could require portrayal of an illness. In both instances, including components where students present their maps to the rest of class and where they also present work in traditional text-based papers will strengthen the value of the exercise.

Rubrics for grading maps should include balanced criteria that address design as well as understanding. Numerous computer

programs are available to assist learners to design mind maps and concept maps. If the purpose of an assignment includes demonstrating competency with these programs, this should be clear. In most instances, however, the purpose of a mapping assignment centres on demonstrating understanding. Without substance, beautifully hand-sketched or computer-generated maps likely reflect superficial comprehension and need further instructional scaffolding.

Conclusion

Constructivist thinking is a process where learners build on what they already know by participating in active and personally relevant learning experiences. Instructional scaffolding, or offering temporary support until learners are able to complete activities independently, is needed most in areas that students typically find difficult. Advance organizers are adaptable instructional scaffolds that teachers can readily implement in their classrooms. Advance organizers, such as simple mind maps that illustrate one key idea, or more complex concept maps that illustrate relationships among concepts, can be used to organize information. Teachers from K-12 through college can apply mind maps and concept maps to present information and to evaluate student understanding.

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Balancing Reflection and Validity in Health Profession Students' Self-Assessment



[PDF – 355 KB]

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Abstract

Students and practitioners in self-regulating health professions are expected to engage in reflective, valid self-assessment activities. However, self-assessment processes can be flawed. People may have a limited understanding of the critical thinking needed to reflect on their performance and they may over-estimate or under-estimate their abilities. This article highlights educational approaches that can help students achieve a balance of reflecting critically and developing more accurate self-assessments. Considerations involved in defining self-assessment are identified. Explanations of how integrating reflection requires critical thinking; information from both internal and external sources; and incidental learning are provided. Suggestions for addressing validity by recognizing that inaccuracies exist; knowing that people's history with academic success can impact their self-assessments; and creating links to affective outcomes are offered. Emphasis is placed on viewing self-assessment as a formative learning activity that is introduced early and consistently in health education programs.

Introduction

Self-assessment, a necessary skill for lifelong learning, requires people to identify standards to apply to their work, and then to make judgements about the extent to which they have met these standards (Boud, 1991; 1995). For practitioners in self-regulating health professions, self-assessment activities are an integral aspect of both their pre-service programs and their ongoing in-service professional development (Eva & Regehr, 2005). Novice practitioners enter their profession with a stronger ability to assess and develop the competencies they need when they have become familiar with assessing their own progress during their education (Boud, & Falchikov, 2006; Kajander-Unkuri, Meretoja, Katajisto, Saarikoski, Salminen et al., 2013; Linn, Arostegui & Zeppa, 1975; Passi & Southgate, 2016). Supporting learners towards developing their capacity to self-assess has been identified as the 'missing link' needed to ensure that future health professionals are truly reflective, self-regulating practitioners (Redwood, Winning & Townsend, 2010).

However, the self-assessment process can be flawed (Melrose, Park & Perry, 2015). For the most part, people overrate themselves and assess their progress as above average (Davis, Mazmanian, Fordis, Van Harrison, Thorpe, et al., 2006; Dunning, Heath & Suls, 2004; Mort & Hansen, 2010; Pisklavov, Rimal & McGuirt, 2014). They often identify areas of weakness inaccurately (Regehr & Eva, 2006). People can overestimate their performance and misjudge the skills they believe they have mastered (Baxter & Norman, 2011; Galbraith, Hawkins & Holmboe, 2008). Students who are least able to self-assess accurately often also demonstrate limited abilities in other areas of study (Austin & Gregory, 2007; Colthart et al., 2008).

The phenomenon of less able people over-assessing their ability and more able people underestimating themselves is known as the Dunning-Kruger effect (Ehrlinger, Johnson, Banner, Dunning & Kruger, 2008; Kruger & Dunning, 1999). Consequently, the validity of self-assessment as an accurate measurement of student learning has been questioned (Falchikov & Boud, 1989; Gordon, 1991; Lundquist, Shogbon, Momary & Rogers, 2013; Ward, Gruppen & Regehr, 2002).

Balancing the merit of reflection in self-assessment with questions about the validity of health profession students' self-assessment is not straightforward. Existing research has focused on evaluation studies and most of this work has been directed to physicians' learning. However, health professionals from a variety of different settings are expected to engage in self-assessment in their learning and in their practice. Increasing understanding of self-assessment among all members of health care teams can make an important difference in helping learners grow into self-regulated professionals. Geared to a multidisciplinary audience, this article provides an overview of how self-assessment can be defined, how reflection can be integrated into the process and how issues of validity can be addressed.

Toward a Definition of Self-Assessment

Assessment provides information about how people are progressing in relation to objectives, goals and outcomes. In health professions programs, assessments usually include standardized measurement tools as well as inferences about what individuals *do* in relation to what they *know* (Melrose, Park & Perry, 2015). In clinical practice settings, specific times at both mid-term (formative) and end of course (summative) are designated for discussing student progress. Self, peer and educator assessment may be included in these discussions. Formative evaluations are diagnostic, ongoing and focused on both what students are currently doing well and areas where they need to improve in future. A final grade is seldom included in formative evaluations as the goal of the activity is to improve student performance (Melrose, Park & Perry, 2015).

Self-assessment, particularly when integrated into formative evaluations, can be construed as a learning activity and not merely a grading activity. When viewed as a learning activity, self-assessment invites students to actively participate in and reflect on their own learning (Boud & Falchikov, 1989). It helps students recognize desired goals, gather evidence about their present position and come to an understanding about ways they can close the gap between the two (Black & William, 1998).

Instead of simply relying on teachers to evaluate their progress, opportunities for self-assessment encourage students to

think critically about the quality of their studies (Andrade & Valtcheva, 2009). Self-assessment assists students to create links among tasks they are presently engaged in, outcomes expected by their profession, outcomes they expect for themselves and future tasks they will engage in (Bourke, 2016). In essence, self-assessment can be conceptualized as a formative, educational, developmental, self-monitoring activity that draws upon both internal and external data, standards, and resources to inform and judge one's performance (Sargeant 2008).

Integrating Reflection

Reflection has a dynamic relationship with self-assessment. As Mann (2010) so eloquently stated: —To be effective at self-assessment requires skills in critical reflection; to be effective in reflection, self-assessment skills are required || (p.311). However, the purposes and goals of reflection are different from those of self-assessment. Reflection is a process of personal self-understanding that can lead to significant discoveries and insights, while self-assessment involves using predetermined performance criteria to determine insights, strengths and needed improvements (Desjarlais & Smith, 2011).

Reflective processes are often retrospective; they do not necessarily involve others or externally imposed performance criteria; and they may not include expectations of improvement. It is important to acknowledge that self-assessment skills are not limited to engaging in reflective activities. However, reflection, particularly critical reflection, plays a foundational role in health profession students' self-assessment.

Critical Reflection Reflection that can be considered critical and therefore of most use in self-assessment goes beyond simply looking back on experiences. Theorists have extended our understanding of the complex reasoning that is involved. Advocating for the use of reflection as an active and deliberate problem-solving process, John Dewey (1933) believed reflection should include recalling an event and then questioning why things happened as they did. Donald Schön (1983), theorized that reflective practice includes both 'reflection-in-action' (intuitively drawing on previous experiences to resolve situations while they are occurring) and 'reflection-on-action' (thinking about an event that has taken place and considering what could be changed in future). Steven Brookfield (1995; 1988) asserted that reflective practice also requires people to become aware of and question their assumptions and their ways of interpreting information. Jack Mezirow (1998) explained how critical reflection requires people to examine the way they perceive events and then transform their thinking in order to find new ways of making meaning. In nursing, Christopher Johns (2017) proposed a structured model calling for practitioners to reflect on experiences by both "looking in" to examine their thoughts and emotions and "looking out" to understand external factors influencing the situation.

The complexities of thinking critically and engaging in reflective practice may seem overwhelming to health profession students, particularly those at a beginning stage of their program. One approach that can help students strengthen their self-reflection skills and to grow as reflective practitioners is to introduce reflective activities early (Falchikov & Boud, 1989; Kanthan & Senger, 2011; Mann, Gordon & MacLeod, 2009).

Tools such as reflective journals can provide opportunities for developing reflective practice skills (Constantinou & Kuys, 2013; Koh, Wong & Lee, 2014; Lew & Schmidt, 2011). While reflective journals are usually written products, Tulgar (2017) notes how reflections can also be captured through Smartphone audio or video self-recordings. Similarly, students can use social media applications to create reflective journals (Dabbagh & Kitsantas, 2012). In clinical practice settings, educators can intentionally invite students to begin any discussion of their performance with self-reflection and self-analysis (Melrose, Park & Perry, 2015). When students are consistently required to engage in critical reflection throughout their programs, the process becomes increasingly familiar.

Extending students' critical reflection skills to strengthen their self-assessment skills involves building in opportunities to cast students' own thinking against predetermined outcomes. When students are performing new clinical tasks, it is not unexpected that their capacity to self-assess is also less accurate. However, later in their programs, self-assessment accuracy improves (Blanch-Hartigan, 2011; Fitzgerald, White & Gruppen, 2003). Therefore, just as providing supplemental opportunities

to practice clinical skills can be helpful, providing opportunities to practice self-assessment can also be helpful. The climate within these practice opportunities should be supportive and non-punitive (Asadoorian & Batty, 2005).

Integrating information from external sources Self-assessment skills also involve integrating information from external sources. For health profession students, the educators who evaluate them (faculty, instructors, tutors, mentors, preceptors and practitioners) are key external sources. Given the power and influence these educators have over students' progress in their chosen profession, feedback from educators is a critical element that undergirds the self-assessment process. Explicit, formative feedback lets students know how their educators perceive their performance. In turn, these perceptions can clarify criteria expected for good performance; they can stimulate learners to identify strengths and weaknesses; and they can help learners focus their efforts productively (Sitzmann, Ely, Brown & Bauer, 2010). Self-assessment that does not integrate educator feedback is incomplete (Motycka, Rose, Ried & Brazeau, 2010).

In many instances, feedback can be difficult to 'hear,' and can leave students feeling distressed; doubtful about their abilities; unmotivated; and reluctant to persevere with their studies (Mann, 2010). Students may view even the most well intended educator comments as a potential intolerance for their mistakes and an indication that they lack knowledge, leaving them reluctant to seek out and act on feedback (Mann, 2010).

Efforts to ameliorate these difficulties can include regular meeting times; educators sharing their anecdotal notes or ongoing records of student progress; and providing specific time-limited strategies for task improvement (Melrose, Park & Perry, 2015). Further, opportunities where students routinely exchange assessment feedback with their peers can help make the process less intimidating. Feedback exchanges, where students apply the same assessment criteria as educators, can be organized as pair-share and small group activities. When feasible, these sessions could involve students in decisions about the assessment criteria being used; the origin and relevance of the assessment criteria; and practice priorities that may impact the criteria.

Incidental learning Affirming learning that students have achieved which does not relate to predetermined goals is a valuable but often neglected aspect of reflection. Incidental learning, also called surprise, unexpected or unintended learning, is learning that occurs as a by-product of doing something else (Marsick & Watkins, 1990; 2001). Incidental learning can emerge from observing others; from discussions with people in the environment; as a consequence of making mistakes; and from being required to adapt to or accept situations (Kerka, 2000). Creating space for students to share and celebrate incidental learning within their self-assessments can highlight accomplishments that may otherwise go unnoticed. To draw out incidental learning, educators can pose questions such as "What surprised you when ...?" or "Talk about what happened that you didn't expect when ..." (Melrose, Park & Perry, 2015).

In sum, integrating reflection into self-assessment can begin by simply reflecting and seeking to gain new personal insights. Developing the skill further can include critical reflection, which involves thinking deeply about ways of solving problems that are occurring or have occurred. Critical reflection requires people to change their thinking and consider new ideas. When the process of reflection becomes especially valuable to self-assessment is when these internal processes are coupled with the integration of information from external sources. For health profession students, feedback from educators and peers is a primary external source. A balance of internal, external and incidental information is needed when students seek to assess their performance in relation to the standards, criteria and competencies required by their profession. In the next section, common concerns related to the validity of students' self-assessments are discussed.

Addressing Validity

As previously mentioned, the Dunning-Kruger effect (Dunning & Kruger, 1999) where less able people over-state their ability and more able people under-state their ability, has influenced people's views about the validity of self-assessment. Questions are often posed about whether self-assessment activities provide accurate, dependable and truthful representations of students' abilities.

Recognize that inaccuracies exist It is important to recognize that inaccuracies in students' self-assessments exist in many health professions. Research evidence indicates that students' self-assessments frequently differ from educator assessments. Comparing classroom test scores, Brown and Harris (2013) found only weakly positive correlations between educator ratings and students' self-assessed ratings; between actual test scores and self-estimates of performance; and between educator and student judgments when the same rubric was used. In simulated emergency situations, Baxter and Norman (2011) found nursing students' self-assessments were significantly inaccurate in comparison with educators' observations of their performance. Similarly, in peer simulation situations, Sanderson, Kearney Kissell and Salisbury (2016) found dental hygiene students' self-assessments were also significantly inaccurate in comparison to those of their educators. Measuring communication skills, Gude, Finset, Anvik, Bærheim, Fasmer et al. (2017) also reported a lack of concordance between medical students' own and their educators' assessment.

Clearly, consistently achieving congruence between student and educator assessment may not always be possible. In these instances, conceptualizing student self-assessment as a formative developmental learning activity can be helpful. Approaches such as video and verbal feedback have been found to enhance the accuracy of students' self-assessments (Colthart et al., 2008; Hulsman & van der Vloodt, 2015; Volino & Das, 2014). Providing easy online access to self-administered tests with answers has the potential to provide students with accurate information about their level of knowledge (Miller, 2008). Reviewing a collection of work, such as a portfolio, capstone project or reflection summary, rather than just single instances of student performance can provide a wider view of how students are meeting competencies (Gadbury-Amyot, Woldt & Siruta-Austin, 2015). Implementing self-assessment activities in contexts where the emphasis is on mastery goals (achieving competence in practice) rather than performance goals (achieving immediate competence completing a task) can also contribute to more accurate self-assessment (Butler, 2011).

Know the impact of a history with academic success Students accepted into health profession programs often have a strong history of academic success. If students are used to performing well in learning situations and have consistently received positive feedback, they are likely to feel confident in their abilities. In turn, they may have a view of themselves as above average. When asked to self-assess, their thinking may be based on potential or ideal performance more than their actual performance (Evans, McKenna & Oliver, 2001).

From this perspective, the lack of congruence between student and educator assessments can be viewed as an opportunity to support students' positive self-concept and self-worth. Rather than emphasizing inaccuracy, educators can prompt students to identify steps they have taken in the past to achieve success, and then encourage them to apply these steps to their present learning situation.

On the other hand, students who do not have a strong history of academic success may be unaware of inaccuracies in their self-assessment or they may be reluctant to disclose them. If students perceive their learning environment as overwhelming, they may not know where to begin identifying what they do not know. In health care environments, where professionals are accountable to the public for providing safe competent patient care, students may not feel that it is acceptable to admit weakness. In these instances, once again, rather than emphasizing inaccuracy, educators can highlight the links between accurate practitioner self-assessment (which includes admitting to not knowing and then seeking out needed information) and patient safety (Sujata, Oliveras & Edson, 2001).

Create links to affective outcomes A further consideration influencing the validity of self-assessment is the distinction between cognitive and affective learning outcomes. Cognitive learning outcomes are more factually based, may relate to a particular course of study, and are associated with external sources such as an exam grade or educator rating (Sitzmann, Ely, Brown & Bauer, 2010). Affective learning outcomes are related to internal sources, extend beyond a specific course or learning event and they include feeling satisfied, motivated, able to carry out tasks and willing to apply and use knowledge gained (Sitzmann et.al.). A meta-analysis of evaluation studies revealed that construct validity of self-assessment was strongly correlated with affective outcomes (particularly satisfaction and motivation) and only weakly correlated with cognitive outcomes (Sitzmann et. al.). Given this correlation, self-assessment activities linked to affective outcomes have a greater chance of yielding a more accurate measurement result.

Practitioners from different disciplines and practice areas all need self-assessment skills that help develop their thinking

beyond the boundaries of a single course or learning event (He & Canty, 2013; Mann, 2010). Therefore, when addressing validity in self-assessment, connections between self-assessment activities and the nature of the outcomes being measured is an important consideration. Knowing the inherent difficulty in quantifying success with affective achievements, addressing validity in self-assessment must be grounded in a commitment to designing activities that are suitable for measuring broad outcomes, mastery goals and critically reflective thinking.

Conclusion

Self-regulating health professionals must be able to assess what they know; what they don't know in relation to what they are expected to know; and what they need to learn in order to provide safe competent care. Self-assessment is a learned skill and one that can be best developed through early, consistent and supportive activities during pre-service educational programs. Conceptualizing self-assessment as a formative learning activity offers a perspective where students and educators focus on improving performance rather than simply grading competencies.

A balance of reflection that taps into critical thinking and accurate representations of students' abilities is needed for self-assessment to be viewed as valid. Achieving this balance between reflection and validity is complex. In order to integrate reflection into their self-assessments, students must think critically and find new ways to solve problems and find meaning. They must analyze their performance in relation to pre-determined outcomes. They must also extend their own thinking to include feedback received from educators, peers and other external sources. Further, they must take incidental or surprise learning into account. Journals, either written or audio/video recorded are useful tools for developing reflective thinking. Inviting students to self-assess at the beginning of educator-student conversations; in pair-share discussions; and in small group conferences can provide valuable practice opportunities.

The validity of student self-assessment is often questioned because students' views of their abilities can be very different from those of their educators. Less able students over-estimate their ability and more able students underestimate their ability. Questions about validity can begin to be addressed by first recognizing that inaccuracies exist. Providing video feedback; self-administered online tests with answers; and reviewing a collection of work instead of a single instance can help students' self-assess more accurately.

A history of either success or limited academic success impacts congruence between student and educator assessments. Reminding students of how they achieved success in the past provides useful guidance. Emphasizing how disclosing areas of weakness can lead to increased patient safety offers meaningful rationale for moving forward.

Finally, stronger validity can be achieved when links are created between self-assessment activities and broad affective outcomes related to feeling satisfied with knowledge that has been gained and feeling motivated to apply and use that knowledge. Continuing to find ways to balance reflection and validity in self-assessment is both a challenge and an opportunity for students and educators in the health professions.

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Pass/Fail and Discretionary Grading: A Snapshot of Their Influences on Learning



[PDF – 360 KB]

Citation

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Abstract

This article provides a snapshot of pass/fail and discretionary grading approaches, highlighting the advantages and disadvantages of each. Norm-referenced and criterion-referenced grading practices and their associations with learning are identified. A brief historical backdrop illustrates how grading practices have evolved. The inherent subjectivity of grading is emphasized. Pass/fail grading supports intrinsic motivation and self-direction, but limits opportunities for recognizing excelling students. Discretionary grading, which includes letter (F– to A+) and numeric (0% to 100%) representations, supports extrinsic motivation and self-improvement, but promotes unhealthy competition. Both approaches have merit and can effectively measure student achievement in nursing education programs.

Keywords

Pass/Fail Grading, Discretionary Grading, Norm-Referenced Grading, Criteria-Referenced Grading

1. Introduction

Acquiring the knowledge, skills and attitudes nursing students need to demonstrate competence in their practice is a complex process. Few topics have generated more discussion than the influences that grades can have on student learning. Yet, existing research offers limited evidence that either pass/fail or discretionary grades do adequately measure and influence learning.

Two grading approaches are typically implemented in nursing education programs. The first approach, where students are assigned pass/fail or satisfactory/unsatisfactory, evaluates overall understanding and competence [1] [2] [3]. The second approach, discretionary grading, where students are assigned letters such as F- to A+ or numerical values between 0% and 100% integrates more discriminative information [4].

Lee Cronbach's seminal definition of learning emphasizes that learning is demonstrated when a change in behavior occurs as a result of experience [5]. Clearly, the processes that educational institutions use to grade students are experiences that will influence how they learn and show changes in their behavior. This article provides a snapshot of pass/fail and discretionary grading approaches, highlighting the advantages and disadvantages of each.

2. Grading Practices The Purpose of Grading

2.1. The Purpose of Grading

Educational measurement theorist Peter Airasian defined grades as recognized symbols, the purpose of which are to provide students with feedback about their progress and achievements; to guide students in future course work; to motivate students; and to inform instructional planning [6]. Airasian also emphasized that educational systems rely on grades to determine student rankings in classes, their suitability to progress to the next level; and to graduate [6].

In higher education, grades are usually an aggregate of individual marks from a series of assignments, but they may also be determined from a single major piece of work in a course or unit [7]. In a practice discipline such as nursing, assignments often include both teacher assessment and teacher evaluation. Assessment requires teachers to make inferences about what students' know in relation to what they do, and evaluation requires teachers to make judgements about the value of what students do in relation an objective [8]. Thus, the aggregate of marks within a single grade provides a symbolic representation of overall achievement [7].

2.2. Norm-Referencing

Differentiating between grading practices classified as norm-referenced and those classified as criterion-referenced is a key consideration in understanding the overall grading process. Norm-referenced grading measures student achievement in comparison to peers, ranking them in relation to other students [8]. With norm-referenced grading, in any student group, only a select few will be eligible to earn top grades, most will receive mid-level grades, and at least some will receive failing grades. Norm-referenced grading is based on the symmetrical statistical model of a bell or normal distribution curve [8].

Norm-referenced grading provides programs of study with the opportunity to compare students in a particular location with national norms; to highlight assignments that are too difficult or too easy; to monitor grade distributions such as too many students receiving high or over-inflated grades; and to award scholarships to excelling students [8]. On the other hand, this

grading practice is grounded in the premise that one student's achievements, successes and even failures are unfairly dependent on the performances of others [8].

2.3. Criterion-Referencing

Conversely, criterion-referenced grading measures do not include comparisons with other students. Rather, student achievement is measured in relation to predetermined criteria [8]. Therefore, all members of student groups are equally eligible to earn top, average or failing grades. The process is transparent and students can make associations between their performance and expected outcomes; and they can link their personal learning needs to opportunities for remediation [8].

Most institutions of higher learning, including those who offer nursing education, now incorporate criterion-referenced grading practices into at least some of their programs [7] [9] [10]. Traditionally, an understanding of where students were ranked in relation to others was believed to communicate useful information to employers, teachers and students; and it was considered a valuable strategy to prevent grade inflation [10]. However, for professional programs, where clear outcomes have been adopted, grades reflecting individual achievement in relation to specific criteria are equally valuable in providing this needed information [10]. Both pass/fail and discretionary grading practices are classified as criterion referenced [7].

2.4. Subjectivity

Subjectivity, where teachers' personal opinions and feelings impact grading, can be expected to affect grading practices in general and criterion-referenced grading practices in particular. In 1912, Starch and Elliot's classic study examining how 147 high school English teachers assigned grades to two identical student papers revealed marks ranging from 50% to 90% for the same paper [11]. Later, in 2011, Brimi replicated the study and obtained strikingly similar results in that 73 high school English teachers assigned marks from 50% to 96% for the same paper [12].

Knowing that subjectivity is likely to occur, strategies geared towards achieving fair measurement of student achievement can be implemented. For example, double-marking, or having more than one teacher assign marks to an assignment is useful [13]. Similarly including peer assessments of student work is valuable [14] [15]. Including opportunities for self-assessment in grading practices is especially important [8] [16]. Melrose, Park and Perry caution that bias can occur in peer assessment when students are hesitant to provide critical feedback to one another and in self-assessment when students overrate their abilities [8].

3. Historical Backdrop

Reflecting on the history of grading provides insight into how practices in use today have evolved. Prior to the late 1800's, when few students advanced beyond elementary school, information about student progress centered on informal communication between student, teachers and parents [17].

By the 1900's, as compulsory high school attendance increased student numbers, and as more students went on to attend university, a shift to percentage grades occurred as teachers and professors accommodated this increase and responded to a need to identify student accomplishments in particular subject areas [17]. In the 1960's letter grades increased in popularity and remain so today [17].

Grading practices created a way to rank individual student performance, but they also provided opportunities to rank the prestige of academic institutions [18]. Critics have questioned whether grades have evolved more for the benefit of

administering and promoting organizations rather than for their intended purpose of providing feedback, guidance and motivation to students [18].

4. Pass/Fail Grading

Pass/fail, as the name implies, provides only two options for grading students. In concert with the shift away from norm-referenced and towards criterion-referenced grading practices, many nursing education programs have incorporated pass/fail measurement of student achievement. Clinical courses are well-suited to pass/fail grading [2].

4.1. Advantages

Pass/fail grading is believed to exert positive influences on learning by supporting students' psychological health and well-being [19] [20] [21]. For example, with medical students, this approach has been found to reduce student stress and promote group cohesion [22]. It has reduced competition among students [23]. Further, a pass/fail approach reduced feelings of emotional exhaustion, depersonalization, burnout and the desire to drop out [24]. It did not decrease performance on qualifying examinations [25]. With nursing students, pass/fail grading was influential in supporting students towards providing safer care to their patients, including a reduction in medication errors [26].

The process of grading itself has been criticized for diminishing interest in learning, creating a preference for the easiest possible task, reducing the quality of thinking, increasing cheating and promoting a fear of failure [27]. Although a pass/fail approach, as a classification of grading, is not immune to these criticisms, it is considered to have a less detrimental effect on learning than discriminatory approaches.

Pass/fail grading is purported to increase students' intrinsic or internal motivation to learn. It allows them to pursue areas that are of most interest and relevance to them, rather than focusing only information that will be tested [4]. In turn, this intrinsic motivation lays a foundation for the self-direction and self-regulation required in nursing and all health care disciplines [4].

4.2. Disadvantages

Pass/fail grading can also exert negative influences on learning. Students who have excelled and demonstrated remarkable achievements may not be recognized or differentiated from those who simply met the requirements to pass [19]. This approach may not depict an accurate picture of the specific learning objectives that were mastered and those that need improvement [28].

Pass/fail grading can create situations where students do not perform effectively on critically important objectives, but achieve a passing grade because they have performed well on those of lesser importance [28]. Additional negative influences can include the subtle suggestion that only the bare minimum is needed to pass; a possible decline in student classroom attendance; weakening of academic performance; and a potential decrease in pass rates for regulatory licensing examinations [19] [21] [23].

5. Discretionary Grading

Discretionary grading, which generally uses the letters F– to A+ or numerical values between 0% and 100%, continues to dominate reporting systems, with letter grades the most widely used [17]. Learning institutions frequently add plusses or minuses to letter grades or pair them with percentage indicators in order to enhance their discretionary function [17] [29].

It is beyond the scope of this article to discuss the many additional variations of numbered, lettered and narrative grading scales that institutions from around the world have developed. The lack of a universally accepted approach to grading scales is an illustration of the controversy that continues to surround the processes teachers use in their efforts to measure student achievement and progress.

5.1. Advantages

In many instances, the advantages of discretionary grading reflect a mirror image of the disadvantages of a pass/fail approach. Rather than decreasing motivation, discretionary grading can increase students' desire to perform well academically [4]. Relationships between grades and short term learning, as well as between grades and extrinsic motivation, or motivation emanating externally from others beyond oneself, have been established [30].

Students may have a tendency to take discriminatory grading more seriously [21]. Expecting a grade can increase students' confidence not only in correct answers but also in understanding answers that are incorrect [31]. Improvement demonstrated through a higher grade can help students experience a sense of satisfaction and pride.

5.2. Disadvantages

The extrinsic motivation associated with discretionary grading may not serve students well after they graduate. Grades are not likely to be part of everyday nursing practice and they do not usually factor into the self-regulation required by professional governing bodies.

The inherent ranking of students in relation to one another that is often associated with discretionary grading can create hierarchical categories. Students hoping to continue their education by attending further undergraduate or graduate study programs will need to identify their grades on program applications. The pressure to achieve these grades can be daunting.

Students' social status can be affected as they strive to get grades that are comparable to or higher than their peers [31]. While healthy competition with peers and oneself may not be problematic, anxiety, depression and inability to absorb material can result when students become overly focused on their grades [1] [19].

Although both letter and numeric discretionary approaches provide a range of grading options, faculty tend to cluster their scores around a portion of the scale instead of utilizing the whole scale [32]. This tendency may be related to how higher education courses usually have a specific minimum pass point, often a C or 60%. This higher pass point has been linked to clustered scores [33]. As a consequence, clustered scores do not fully meet the obligation of discriminating learning achievements among students.

6. Conclusions

In summary, this snapshot of pass/fail and discretionary grading practices highlighted the advantages and disadvantages of the two most commonly used educational measurement tools in nursing education today. As criterion-referenced rather than norm-referenced approaches, both seek to report student achievement in relation to predetermined criteria. Both are considered inherently subjective.

A brief historical backdrop illustrated how these approaches have been used in different educational settings over time, with neither considered superior. Pass/ fail grading, well suited for clinical courses can complement the discriminatory grading widely used by nursing programs in higher education settings.

Pass/fail grading can promote the self-directed, intrinsically motivated learning expected in professional nursing practice and it can support students' psychological health and well-being. However, it limits opportunities for recognizing excelling students.

Discretionary grading, through the extrinsic motivator of earning a high grade, can encourage students to perform better academically. Ranking students on a range of scores between F- and A+ or 0% and 100% provides a clear and recognizable symbol or illustration of their achievements, both in relation to their previous work, their peers and their program outcomes. Yet, the experience of being ranked can lead to unhealthy competition and unnecessary stress.

Despite the attention that the topic of grading students continues to receive among educators, the process is far from exacting. Elements of both pass/fail and discretionary grading have merit as nurse educators strive to fully and accurately represent student achievements. This is both a challenge and an opportunity for the field.

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Peer E-Mentoring Podcasts in a Self-Paced Course



[PDF – 29 KB]

Citation

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Abstract

This article describes how podcasts from senior students were used as brief peer mentoring tools in an asynchronous, self-paced, text-based, introductory online nursing course. An increasing number of distance educators use peer mentoring approaches to support student success in higher education programs. However, suggestions for implementing peer mentoring in courses where students work alone and at their own pace is limited. Our project illustrates how MP3 audio recordings of students' voices (podcasts) offer advice and encouragement (mentorship) to peers who do not know one another.

Introduction

Peer mentoring can have a positive impact on undergraduate student success in higher education (Budge, 2006; Grant-Vallone & Ensher, 2000; Husband & Jacobs, 2009; Philips, 2009).

Similarly, peer mentoring online or e-mentoring can also have a positive impact on student success (Cavallaro & Tan, 2006; Holland, 2009; Hunt, 2005; Taylor & Zeng, 2008). And, in the field of nursing education, peer mentoring has long been recognized as valuable to student learning (Dennison, 2010; Hansen-Kyle, 2010).

Traditionally, peer mentors offered practical advice and encouragement to new students to help them adapt and feel connected to their learning environment. As Carmichael (2004) explained, by sharing their own process of solving problems, peer mentors can help new students by putting things in perspective rather than being overwhelmed. Peer mentors offer a personal point of view bolstered by the notion that they have “been there and done that” and “survived” (Carmichael 2004). However, in asynchronous, self-paced, text-based online courses, learners work alone and have limited opportunities to interact with fellow students. Due to the independent nature of self- pacing, mentoring relationships seldom develop in these asynchronous online classes. And yet, in nursing education programs, particularly those where vocationally educated practitioners are attending an online university for the first time, practical advice and encouragement from successful peers can be invaluable.

The Project

Our project, implemented in November, 2010, collected and then embedded audio podcast messages of encouragement from students into an online course exploring professional nursing practice in a Post LPN BN program at a Canadian university. Our research team consisted of a Research Assistant who recently graduated with a master's degree from the university and a PhD prepared primary investigator who teaches at the university. The Post LPN Bachelor of Nursing program is designed to provide vocationally prepared Licensed Practical Nurses with the opportunity to continue their education in nursing in a baccalaureate program that offers flexible modes of course delivery. Some non clinical courses, including the targeted course for this project, are delivered through self paced, asynchronous text-based threaded discussions within a MOODLE (Modular Object-Oriented Dynamic Learning Environment) environment. Students work at their own pace individually through a Study Guide and they receive tutor feedback on submitted assignments. Students live all across Canada, usually work full time and can be expected to manage heavy family responsibilities. While optional discussion forum areas and chat rooms are available for learner to learner interaction through text based forums, students have limited opportunities to actually listen to the voices of peers. The course is completed early in the program and is intended to assist Licensed Practical Nurses transition to the role of Registered Nurse. Aspects of their professional socialization can include adjusting to the role of being a student in an online university program.

This educational innovation project, part of a larger program of research examining Post LPN BN professional socialization received ethical approval from the university. Participants for the project were senior students. Twelve female participants were recruited by sending an e-mailed Letter of Invitation to fifty male and female students enrolled in their final cluster of courses.

The Letter of Invitation invited senior students to call a toll free number, any time of the day or night and leave a message of encouragement to students just beginning their program. Messages were recorded on a telephone answering machine and audio digital recorder. Senior students were invited to share the strategies and ideas about “what worked for me” in their program.

When participants telephoned the toll free number, they were prompted by the answering machine recording to verbalize

their consent to having their voices recorded and then to briefly share their message of encouragement. Messages were collected on a digital voice recorder over a three week time frame.

The digital phone recorder created MP3 audio files that were transferred via cable to a computer and played using Windows media player. The audio file messages were embedded into the introductory course in the MOODLE environment as podcasts. Anecdotally, new students reported to their class tutors that the peer e-mentoring podcast messages offered useful strategies and helped them feel “as though I’m not all alone doing this course.” Unfortunately, as students seldom complete their course evaluation forms, empirical data on the effectiveness of the messages is unavailable.

The e-mentoring podcasts were transcribed and both the audio and transcribed files were imported into QSR International NVIVO 9, a qualitative data organization program. Using NVIVO, the research team reviewed the files for repetitive categories and established the following two overarching themes. First, comments offering practical advice were identified. Second, comments offering encouragement were identified. The themes were validated by independent reviews of the transcripts by the researchers and confirmed with participants. Verbatim comments are italicized.

Peer E-mentoring Podcasts

Messages of Advice

When I start a course, I always look ahead. I look at what the course requirements are. I look at the assignments. I kind of try and prioritize what I need to do for that week, Monday morning or sometime Sunday evening and that gives me my little goals, my little, attainable goals.

I set [a specific] amount of time per week just to work on my projects and my papers.

Use calendars and date plans – get everything organized. And stay with your plan.

You do feel alone and isolated. You don’t have [other] students to bounce things off of, so I can’t [advise] you enough to use the tutors. Keep up the lines of communication, even if it’s every couple of weeks, just check in and tell them how you’re doing and they can give you some really valuable words of encouragement.

Send e-mails to your tutors. Don’t be afraid to contact them.

Stay involved with the [optional class discussion] forums.

The forums and the coffee room discussions are a great way to communicate with fellow students and you’ll learn some really valuable information from those students.

Get out of the house. I found that when I really needed to get stuff done or I wasn’t feeling like I wanted to work, I could always find something in my house that needed to be done – dishes, or laundry, or taking the dog for a walk. There were too many excuses so [I needed to] get outside the house to study. I used the computers in a quiet area at work or went to the library.

Vent to friends, jog, work out at the gym – it helps ease the stress.

Set reward goals. Once I’ve completed an assignment, my reward is to take the next day off from schoolwork and do something I enjoy. So after I submit a paper for marking, the next day, I do what I enjoy – hiking, taking my dogs for a walk or reading a book –but no assignments.

Get out with friends and family [to] kind of just unload and bring you back fresh.

Messages of Encouragement

Learning how to learn can be a little bit daunting and intimidating, but my experience thus far has been the support system is amazing so congratulations if you're just starting. Keep up the good work if you're still working towards your goals and have a lot of fun. Bye for now.

Always look at the positive. Don't look at how much is left to do. Look at how far you've come and say- I've done this. It's only taken me X amount of time. I can do this. I've got this left to do. There's light at the end of the tunnel and I can get there.

Hope this helps and I just want to say good luck to anybody that's just beginning. It's a fantastic program and I've enjoyed everything I've learnt thus far. Bye.

I have not spoken to one student that did not have some kind of stumbling blocks. ... You will feel overwhelmed and alone at times, which is completely normal. You will experience the feelings of "I just want to be done already!" ... [My message to you is that] my experience has been positive and I'm in my final practicum.

You will probably go through phases like I did as you progress. There were times where I felt very discouraged and I felt completely overwhelmed. I felt that I couldn't do it. But, I just kept plodding along and there was a certain point when you know you can't go back. You just keep plodding along and you'll find that near the end, there is definitely a light at the end of the tunnel.

And just have fun! Really, have fun. It's a lot of fun. I hope this [message] helps somebody- hang in there.

Discussion

These messages of advice and encouragement from senior students, which were sent to new Post LPN to BN students through podcasts, offer a snapshot of what e-mentoring can look like in an asynchronous, self-paced, text-based, introductory online nursing course. Vocationally trained nurses beginning university studies may lack the confidence needed to succeed in higher education (Melrose, 2010). While more extensive mentoring opportunities between senior and junior students could be expected to increase learner confidence, Post LPN to BN students have multiple demands on their time. Many work full-time, study full-time and manage heavy family responsibilities, leaving them with little inclination to engage in social interaction in their asynchronous classes. In fact, some may intentionally chose self-paced courses to upgrade their credentials in order to focus exclusively on required learning tasks. Thus, listening to brief practical suggestions that peers found were valuable can begin to help these adult learners feel connected to others in their program without requiring further time commitments.

Parsloe and Wray (2004) viewed the role of peer mentors in undergraduate programs as coaches who assist new students with time management, study skills and goal setting. Traditionally in both face to face and online higher education programs, the peer mentoring role included ongoing and sustained communication between mentors and mentees. Our project describes an alternative approach that is particularly relevant to self-paced courses. Although no relationship exists between the senior student mentors and the new student mentees, the podcast messages fulfill Parsloe and Wray's (2004) essential mentoring functions of advising students about time management, study skills and goal setting. New students can turn to the e-mentor podcasts at any time of day or night to hear practical advice. By simply clicking on the MP3 files embedded as podcasts in their MOODLE course, new students can hear the friendly supportive voices of peers encouraging them to press on.

Conclusion

This paper described a project where peer e-mentoring podcasts of encouragement from senior Post LPN to BN students were collected by telephone and then embedded in an introductory asynchronous, self paced text based course. The messages were presented in two categories; first, comments offering practical advice were identified. Second, comments offering encouragement were identified. Practical advice comments included suggestions to look ahead to plan assignments, set time aside each week, organize with date plans, check in bi-weekly with tutors, e-mail tutors often, use optional class discussion forums, find work space outside the home, set reward goals and get away with family and friends. Encouragement comments included affirming that learning to learn is daunting, that looking at how far new students have already come can help, that the program is enjoyable, that feeling overwhelmed and discouraged is normal and that they should 'hang in here.'

Our educational innovation extends existing research by illustrating a new approach to online peer mentoring that is particularly fitting in self-paced courses geared to adult learners. By embedding podcasts in their MOODLE course, we provided new students with the actual voices of successful peers who wanted to share their advice and encouragement. This educational innovation may be of interest to other educators who teach in asynchronous courses.

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Instructional immediacy online



[PDF – 2.2 MB]

Citation

Melrose, S. (2009, January). Instructional immediacy online. In P. Rogers, G. Berg, J. Boettcher, C. Howard, L. Justice & K. Schenk (Eds.). *Encyclopedia of Distance Learning*, 2nd ed., Vol. III (pp. P1212–1215). Hershey, PA: Information Science Reference.

Abstract

Educators in both traditional and online learning events have consistently recognized a link between teachers who demonstrate warm, friendly behaviors and the creation of welcoming interactive learning environments. One critical instructional strategy that facilitates a sense of community and fosters a learning climate rich in social presence is immediacy. While teachers in face-to-face classrooms often demonstrate immediacy non-verbally through facial expressions and body language, teachers in online learning environments may be required to project immediacy exclusively through written messages.

THE CONSTRUCT OF IMMEDIACY

Immediacy is demonstrated through behaviors that express an emotional attachment or closeness to another person. The construct was originally developed by social psychologist Albert Mehrabian in the 1960s (Mehrabian, 1967; 1971; Wiener and Mehrabian, 1968). Immediacy is founded on the premise that individuals are drawn toward persons and things they like, evaluate highly and prefer. As an expression of affect, immediacy includes both verbal and non verbal behavioral cues. A “we” or “our” statement communicates immediacy while a “you” or “your” statement does not. Subtle variations in language indicate different degrees of separation or non-identity of speakers from the object of their communication.

Table 1. Verbal expressions of instructional immediacy (Gorham, 1988)

-
- Use personal examples
 - Engage in humor
 - Ask questions
 - Initiate conversations with students
 - Address students by name
 - Praise student work
 - Encourage student expression of opinions
-

IMMEDIACY IN EDUCATION

Adapting the construct of immediacy from communication theory to applications in higher education classrooms, Andersen (1979) introduced the idea of nonverbal instructional immediacy to college teaching. Andersen explained that immediacy is a nonverbal manifestation of high affect and is demonstrated through maintaining eye contact, leaning closer, touching, smiling, maintaining a relaxed body posture, and attending to voice inflection. Later, as summarized in Table 1, Gorham (1988) identified specific verbal expressions of instructional immediacy. Also, Christophel (1990) and Christophel and Gorham (1995) established that links exist among instructional immediacy, student motivation and affective learning.

Demonstrating instructional immediacy in online classroom environments is not straightforward. However, despite limited or absent non verbal visual cues, virtual teachers can still communicate likeability and a willingness to become affectively close to their students. While research studies in online learning may offer only moderate correlations between immediacy and cognitive learning, the experience of liking and feeling close to the instructor has been linked to positive effects in the classroom (Hess & Smythe, 2001). Correlations between immediacy and affective learning have been established (Baker, 2004). And, significant correlations between perceptions of the instructor's presence with both affective learning and with student learning satisfaction have also been established (Russo & Benson, 2005). These outcomes are consistent with findings on teacher immediacy literature in traditional classrooms and they underscore the role of the teacher in establishing an engaging climate in any learning environment. Translating verbally immediate behaviors from face to face classrooms to online learning events includes responding promptly and adapting Gorham's (1988) original suggestions (Arbaugh, 2001; Baker, 2004; Hutchins, 2003).

IMMEDIACY AND SOCIAL PRESENCE

Instructional immediacy impacts social presence, which in turn, can strengthen the sense of community within learning experiences. Social psychologists Short, Williams and Christie (1976) defined social presence as the degree of salience within interpersonal relationships in mediated communication. Salience implies feelings of presence, engagement, affection,

inclusion, and involvement. In essence, an individual who demonstrates social presence in an online environment is one who is perceived by others as a “real person.” Table 2 summarizes the bi-polar scales that Short and colleagues developed to measure social presence. A higher level of social presence online suggests that an individual consistently demonstrates attributes that are more sociable, more personal, more sensitive, and warmer.

According to Gunawardena (1995), immediacy increases social presence and thus enhances the degree to which a person is perceived as ‘real’. Rourke, Anderson, Garrison, and Archer (2001) defined social presence as the ability of learners to project themselves socially and affectively into a community of inquiry. Social presence has been found to be related to students’ perceived learning and satisfaction (Gunawardena and Zittte, 1997; Richardson and Swan, 2003), persistence with their courses (Rovai, 2002), more complex discussion postings (Polhemus, Shih and Swan, 2001) and a significant factor in improving instructional effectiveness (Tu, 2002).

Social presence, with its underpinnings of immediacy, is considered a key element in establishing strong communities of inquiring and connected learners. In learning events where social presence is absent, participants may not feel comfortable and safe enough to express disagreement, share viewpoints, explore differences or even to accept support from their peers and teachers (Anderson, 2004; Garrison, Anderson, & Archer,2000).

DEMONSTRATING IMMEDIACY ONLINE

Exploring online students’ perceptions of immediacy, Melrose and Bergeron (2006) identified how learners value instructional behaviors that model engaging and personal ways of connecting; that maintain collegial relationships; and that honor individual learning accomplishments. Table 3 summarizes specific strategies from this study that demonstrate instructional immediacy online.

Table 2. Measuring social presence online (Short, Williams, & Christie, 1976)

• Sociable – unsociable • Personal – impersonal • Sensitive – insensitive • Warm – cold

CONCLUSION

Instructional immediacy online is the extent to which teachers are able to project an affect of warmth and likeability within their written communication. Instructors who demonstrate immediate behaviors such as those identified by Melrose and Bergeron (2006) can be expected to engage students individually and to strengthen social presence within learning communities. Understanding ways to translate traditional non verbal expressions of friendliness to online classrooms and continuing to seek out new approaches that demonstrate immediacy online is both a challenge and an opportunity for distance educators.

Table 3. Demonstrating instructional immediacy online (Melrose & Bergeron, 2006)

-
- Respond promptly
 - Post self-introductions that include pictures & appropriate personal/professional information
 - Create a document which includes biographical information about all members of the class
 - Initiate private e-mails to express personal interest
 - Include affective learning elements such as poems, metaphors and tasteful humor in forum postings to strengthen social presence.
 - Establish a place for social conversation
 - Ensure that social conversation does not dominate or distract from learning
 - Type out individuals' names
 - Choose words with gentle connotations
 - Respond empathically to students' expressions of their individual needs
-

KEY TERMS

Affect: A psychological term referring to experiences of feelings and emotions. Non-verbally, affect is displayed through facial expression and body language. Verbally, affect can be communicated through word choices.

Community Of Inquiry: Garrison, Anderson and Archer's (2000) model of learning online proposes that meaningful learning occurs best when teachers and students form a cohesive community of inquiry. The community of inquiry is based on the interaction of three core components: cognitive presence, teaching presence, and social presence.

Immediacy: An affective expression of emotional attachment or closeness to another person that was originally developed by social psychologist Albert Mehrabian.

Salience: From the field of social psychology, the term implies feelings of presence, engagement, affection, inclusion and involvement.

Social Presence: From the field of social psychology, the term includes both the degree of salience within an interpersonal relationship and the degree to which another is perceived as a "real" person in mediated communication. It implies social and affective involvement.

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Naturalistic generalization



[PDF – 43 KB]

Citation

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Naturalistic Generalization

Naturalistic generalization is a process where readers gain insight by reflecting on the details and descriptions presented in case studies. As readers recognize similarities in case study details and find descriptions that resonate with their own experiences; they consider whether their situations are similar enough to warrant generalizations. Naturalistic generalization invites readers to apply ideas from the natural and in-depth depictions presented in case studies to personal contexts.

Conceptual Overview and Discussion

Generalizing findings from research, either by receiving explicated or propositional understanding deductively from quantitative experiments; or by constructing tacit interpretive understanding inductively from qualitative inquiries: involves a transfer of knowledge from a study sample to another population. Unlike objective scientific generalization, naturalistic generalization generates possibilities for transferring knowledge more privately from subjective accounts such as case studies or stories.

Deborah Trumbull and Robert Stake introduced the term naturalistic generalization. Stake and Trumbull believed that generalizations can be made about particulars. They suggested that in addition to learning from explicated generalizations, individuals also learn from the generalizations they make during their everyday experiences as well as from the authors, teachers and authorities in their lives. In Stake's view, naturalistic generalizations are conclusions arrived at through

personal engagement in life's affairs or by vicarious experience so well constructed that the person feels as if it happened to them. Naturalistic generalization emphasizes practical, functional application of research findings that intuitively fall naturally in line with readers' ordinary experiences.

Discussing how naturalistic generalizations enable the reader to achieve personal understandings, Lincoln and Guba's 1985 work noted that this form of generalization builds on readers' tacit knowledge. In Lincoln and Guba's view, naturalistic generalizations permit detailed probing of an instance in question rather than mere surface description. As readers consider the in-depth particulars described in case studies, they may view similar circumstances in their lives with new empathy and intentionality.

Building on the idea of naturalistic generalization, Lincoln and Guba's 1985 work further established the concept of transferability, (where a hypothesis developed in one context can be transferred to another context) and the concept of fittingness (where a hypothesis from one context is sufficiently congruent or 'fits' in another). Naturalistic generalizations, transferability and fittingness all rely on researchers to provide readers with the thick description and vicarious experiential accounts they need to determine if and how they will use the information in their own lives. These more interpretive processes of generalizing findings, with their heavy dependence on context and reader responsibility, are considered different from traditional scientific generalizations.

However, in 2008, Hellström argued that naturalistic generalization, transferability and fittingness are well accommodated within already established ways of thinking about generalizing statements from one setting to another. Hellström asserted that it is premature to view these interpretive processes as a break with received scientific traditions. Rather, his examination of the philosophical roots of generalization concluded that most forms of generalization require researchers to organize and present their findings in ways that indicate priority points. He asserted that it is the generalization implicit in the thick description which licenses, or even models the temporal sequences of causal propagation through the story/case. So, while aspects of naturalistic generalization clearly differ from other forms of generalization, all generalizations share the common goal of deepening understanding by transferring knowledge from a study sample to another population of interest.

Application

Naturalistic generalization is embedded within readers' personal and unique experiences. Small sample sizes, even single cases, can inform and enlighten. Application stems from readers themselves. In order to assist readers' application and creation of their own personal and relevant naturalistic generalizations, in his 1995 text, Stake emphasized that case researchers need to provide opportunity for vicarious experience. Accounts need to be personal, describing the things of our sensory experiences, not failing to attend to the matters that personal curiosity dictates. A narrative account, a story, a chronological presentation, personalistic description, emphasis on time and place provide rich ingredients for vicarious experience. Stake emphasized that time, place and person are the first three major steps. Additionally, Stake underscored the point that although the researcher is not responsible for directing readers' naturalistic generalizations, it is a responsibility researchers must not ignore.

One seminal example where ethnographic researchers presented a vicarious account that has stimulated readers' naturalistic generalizations for nearly fifty years is *Boys in White: Student Culture in Medical School*, authored by Howard Becker, Blanche Geer, Everett Hughes, and Anselm Strauss in 1961. This case presented readers with a clear picture of the socialization and assimilation processes that student physicians experienced in the 1950's and 1960's. At the time, physicians were believed to be part of a fairly closed group. The detailed depictions of how students interacted with peers and faculty; how they integrated into the hierarchical hospital systems; and how they became immersed in their new professional culture offers readers very personal illustrations that can be immediately visualized and understood. Professors instructing medical and other health care professionals continue to include this case in their curricula. The naturalistic generalizations that students and teachers can still draw from this powerful story remain relevant despite the current shift towards gender equality and professional transparency in health care fields.

Another example where a case study researcher presented a vicarious account that stimulated readers' naturalistic generalizations is *What Children Bring to Light: A Constructivist Perspective on Children's Learning in Science*, authored by Bonnie Shapiro in 1994. This longitudinal piece presents readers with stories of six children in an elementary school science class as they study the topic of 'light.' The stories view the world through the eyes of the children. The cases offer poignant insight into how children bring existing knowledge to science class; how they view their participation in class activities; and how they reflect on the information later. Educators involved with science curricula, those who are interested in engagement with science learning and those who are interested in how children learn can readily and naturally translate these cases into their own day to day experiences.

Critical Summary

The goal of naturalistic generalization is not for researchers to prescribe conclusions. Rather, readers can gauge how and in what ways the particular details and stories presented in case studies may be applicable to their own situations. Sample sizes need not be large. Practical insights from narrative descriptions can evolve naturally and then be transferred or generalized to comparable situations.

Sherri Melrose PhD, RN

See also: intuitive generalization, transferability, fittingness Further reading and references

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Lunch with the theorists: A clinical learning activity



[PDF – 60 KB]

Citation

Melrose, S. (2006b). Lunch with the theorists: A clinical learning activity. *Nurse Educator*, 31(4), 147–148.

Applying theoretical knowledge to practice is the heart of clinical teaching and educators need to facilitate students' personal processes of translating this knowledge in creative, lively, and relevant ways. In the Post LPN to BN program at Athabasca University, Alberta, Canada, we created an assignment in the psychiatric mental health course where students envision what it might be like to engage in lunch conversation with theorists they have only read about.

The process of conceptualizing well-known theorists in a familiar every day activity can help de-mystify the ideas these individuals espouse. Rather than simply reiterating information, the assignment requires learners to personalize both the people who created the theories as well as the immediate relevance of the ideas to current practice.

The task is only one artifact in a comprehensive portfolio assignment that also includes writing scholarly papers, assessing incidence and prevalence of disease, evaluating referral instruments, practicing with licensing examination questions, and constructing clinical case studies. Balancing these more academic learning activities with a playful affect-centered requirement enhances educational measurement possibilities for clinical instruction and has been well received by students.

Inviting Theorists to Lunch

Imagine that you have an opportunity to join Hildegard Peplau and 2 psychological theorists for lunch. In your portfolio, write up a 1-page or 2-page account of the kind of conversation that might occur among your group. No references are required, however, your work is expected to demonstrate an understanding of the ideas and thinking purported by the theorists that

you have chosen. You are invited to incorporate humor and to present the disagreements that would be expected between members of your lunch group. Be sure to join in the discussion yourself and interject your own thoughts. Submit your assignment by course mail attachment to your instructor by the end of week 6. Post your work in the Lunch With the Theorists forum.

Students receive these instructions in a course study guide at the beginning of their psychiatric clinical rotation. Because our course also has an online component, the final written work is shared by posting in a forum. Throughout the course, students are encouraged to share their ideas, plans, and personal interpretation of knowledge for their lunch with fellow students, staff members, and instructors. In the mental health clinical area, members of the staff team come from a variety of disciplines other than nursing. Physicians, psychologists, social workers, recreational therapists, and chaplains may all join the lunch discussions. Therefore, in addition to content presented in a final written piece, the process of discussing practical applications of theory continues throughout the learning experience.

These instructions could be adapted to any clinical or classroom educational event. The activity is designed to engage learners in a personal way, to build on their existing knowledge and to involve others in collaborative discussions.

Although measuring completed lunch assignments against evaluative criteria is not straightforward, educators can honor learner creativity when designating marks. Strengths such as demonstrating clear understanding of a concept by applying it to a conversational message can be identified. Similarly, selecting appropriate topics for the theorists to address requires a comprehensive knowledge base. Comparison and differentiation are required when the theorists are expected to disagree. On the other hand, areas to grow become clear when learners attribute a comment to a theorist that does not seem to relate to published accounts of their work. And, creating surface conversations that do not address deeper implications can reveal important knowledge deficits.

In our course, students have presented a variety of different approaches to the assignment. Some framed their lunch conversations around suggestions theorists might offer clients they met in the clinical area. Others have incorporated their perceptions of what theorists might suggest if they could attend their own family gatherings or workplace settings. Several targeted their discussion around care for individuals with a particular illness.

Student Examples

One student approached the assignment by reflecting on how she might offer a nursing contribution to a devastating current event. She imagined she would be working as a nurse-volunteer with victims of the 2005 Hurricane Katrina disaster and asked Hildegard Peplau, Eric Erickson, and Victor Frankl for their suggestions and advice. Addressing each theorist by their first name, she included comments from Hildegard about the nurse-patient relationship, comments from Eric on stages of psychosocial development, and comments from Victor on finding meaning and purpose in life. When Eric seemed to place an overemphasis on developmental stage, Hildegard assured the lunch group that nurses can establish relationships at any developmental stage. This student concluded her work with a research idea for Victor.

Another student immersed herself in a scenario where she hoped to assist the families of 4 policemen tragically killed while investigating a marijuana growing operation in a nearby town. Her conversation was with Hildegard Peplau, BF Skinner, and Abraham Maslow. She included comments from Hildegard explaining that the nurses' role might be one of offering resources or counseling. She also included comments from Abraham that the families' needs for safety and security might be compromised. After comments from BF that the families should be taught the steps of mourning and offered positive reinforcement when they displayed them, this student scripted a fairly sharp retort from Hildegard. Hildegard disagreed with BF that all behavior is learned and questioned whether we can or even should be telling someone how to act, rewarding them when the act as they have been told, and expecting a rosy result.

Lessons Learned

As these examples illustrate, the experience of looking for theorists to talk with, sitting around the lunch table with them, and discussing possibilities for bringing their work to life invites learners to interpret theoretical knowledge in different ways. Feedback has been positive and course evaluations reflect that students enjoyed the assignment. Although theorists were drawn from the fields of psychiatric nursing and psychology for this lunch, the assignment could be modified to work with theorists from any discipline or nursing specialty area.

Students found it humorous to address esteemed scholars by their first name. The invitation to incorporate a conversational tone rather than academic writing was welcome. The requirement to share their final product with peers as well as an instructor invited a commitment to the process. And, perhaps most importantly, the lively conversations among participants, staff teams, and instructors leading up to presenting the final product illustrated the collaborative possibilities inherent within this simple lunch assignment. The process of co-creating this assignment at different stages of development was genuinely collaborative.

In contrast, practical suggestions for implementing this strategy can also be drawn from the difficulties these participants experienced. Initially, students did express some questions about what the final product was expected to look like. Also, the idea that incorporating peer and instructor feedback prior to submitting work was collaboration rather than cheating was a new concept for some students. Further, when one student's public lack of understanding about a theoretical concept became apparent, it was difficult to build in private remedial strategies.

In conclusion, the simplicity of this assignment is appealing. Imagining what famous people might say if they joined us for lunch is intriguing, and adapting the idea to an educational event can add a playful element to the experience.

What works? A personal account of clinical teaching strategies in nursing



[PDF – 50 KB]

Citation

Melrose, S. (2004). What works? A personal account of clinical teaching strategies in nursing. *Education for Health*, 17 (2), 236–239.

KEYWORDS

Clinical teaching, learning strategies.

What Works? A Personal Account of Clinical Teaching Strategies in Nursing

Few definitive lists of simple but effective strategies that could be applied to a variety of practicum settings are available to nurse educators. Although clinical education textbooks (Gaberson & Oermann, 1999; O'Connor, 2001; Diekelmann, 2003) and research oriented journals such as *The Journal of Nursing Education* and *Nurse Educator* provide academic direction, practical suggestions are also valuable. This brief communication provides a synthesis of instructional strategies that are easy to implement and that both students and teachers value.

Which Clinical Teaching Approaches Work in the Eyes of Students?

Seminal research in undergraduate education suggests learners value a facilitative approach that includes collaborative and involving activities with time to interact with course content and one another (Chickering & Gamson, 1987; Ramsden, 1992; Davis, 1993). Participants in a clinical placement seldom appreciate standing by and only listening or observing.

(1) Identify Barriers Students Face

Learners appreciate when instructors initiate a process of questioning who students are, what the clinical environment might look like through their eyes and what challenges and anxieties are present.

Many student nurse populations can be expected to include a variety of different learners. In addition to recent high school or post-secondary graduates, pre-service nursing students may be adult learners supporting families or newcomers to a country who are continuing to work on their language and literacy skills. Tuition rates may be so high that debt after graduation will continue to be a burden. For some, competition to achieve the highest marks possible may be a concern. Others may travel significant distances and balance heavy study commitments before even arriving at the clinical site. And, student nurses often fear they might make mistakes that could result in harming patients or failing their program.

(2) Consider Learning Styles

While a variety of assessment instruments exist to label different and preferred ways of learning, clinical nurse educators may not have ready access to these tools in the field. However, students value an opportunity to articulate the ways they learn best. Questioning whether learners prefer instructional methods focused on vision (reading, charts, illustrations and films), hearing (spoken direction, audio-tapes and musical lyrics) or kinesthetic (handling equipment, moving around and practicing a skill) can help.

(3) Plan Activities Collaboratively

Student nurses welcome opportunities to choose among a variety of activities and to contribute their own suggestions. For example, in addition to teaching approaches such as grand rounds, patient simulations, role plays, skill demonstrations, guided discussions, case studies, question and answer periods, overheads, handouts and videos and small group activities, such as creating a game to summarize a clinical topic, can engage interest. Software programs are available to generate crossword puzzles for word or concept definitions. “Stories” of student’s personal experience with clinical topics and ethical dilemmas with no easy answers are well received.

(4) Create a Learning Community

Learners may need assistance to feel they are part of the staff group. When discussing a clinical placement, learners often comment on whether or not they felt a sense of belonging. In spite of heavy staff workloads, budget restrictions and a high level of acute patient presentations, strategies can be established to forge connections between learners and practitioners. For example, encourage students to learn the names of all employees, both professional and non-professional and provide

opportunities for learners to join staff during their breaks and meetings. Reaching out to include staff members in student conferences is useful as well.

Similarly, learners treasure connections with their instructor and other members of their learning group. They value acknowledgement of their personal process of constructing meaning during non-evaluated student-instructor conversations. Establishing specific opportunities where these conversations might occur include telephone learners before the course, co-construct individual learning plans with each student, generate group guidelines with the clinical group, initiate optional student phone support lists, establish peer learning partners, share examples of excellent student work and post sign-up sheets for non-evaluated talk time with instructor.

(5) Research Effective Clinical Teacher Characteristics

Research shows that instructors who students viewed as effective demonstrated characteristics such as being knowledgeable, enthusiastic, clinically competent and relating effectively with students (Gaberson & Oermann, 1999). Instructors, who students viewed as helpful, consistently modeled professional behavior and demonstrated a positive attitude and humanistic orientation (Laurent & Weidner, 2001). Instructors, who students viewed as responsive to their needs, posed open-ended questions, highlighted student achievements, responded promptly to undesirable student performance, modeled a personal process of clinical decision making and ensured that opportunities were available for learners to share their personal or professional concerns (Wagner & Ash, 1998).

(6) Extend Evaluation Possibilities

Final evaluations indicating student performance in relation to course objectives are an established aspect of clinical learning. However, in addition to a final summative evaluation, Ghazi and Henshaw (1998) noted that student nurses found strategies, such as formative or mid-term evaluations and individualized learning contracts or plans throughout the course, helped sustain their motivation.

Also at mid-term, in addition to offering written feedback on strengths and areas to grow, students enjoy opportunities to evaluate the course and instructor anonymously. Learners are reassured when any necessary correction of their work is done promptly and privately. They value affirmation of any incidental or unexpected learning that occurred.

Which Clinical Teaching Approaches Work in the Eyes of the Teachers?

(1) Designate Time to Plan Clinical Activities

For academic educators, research, commitment to curriculum and course development, publishing work in scholarly journals or presenting at professional conferences, may leave only nominal time to attend to developing as a clinical teacher. However, given the importance of clinical education in a practice discipline such as nursing, academic institutions and professional associations may have resources to support individual instructors with workload planning. Even 1 or 2 hours each week is significant.

(2) Encourage Questions

In addition to assisting learners to acquire knowledge, teachers value approaches that provide students with the tools to pose and then answer questions themselves. In most clinical areas, gaps in professional knowledge exist and further research is needed. Throughout the practicum, inviting students to articulate research questions and issues pertinent to the setting is effective. Schmidt Bunkers (1999) emphasized that educators must pay attention to creating space for listening, reflecting and not knowing.

Conclusion

In conclusion, questioning what effective clinical teaching approaches look like through the eyes of both students and teachers is important. Perhaps the process of seeking to understand both points of view and combine the ideas is as important as the answers themselves.

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The role of the clinical instructor

[PDF – 250 KB]

CHAPTER 2

2

The Role of the Clinical Instructor

Sherri Melrose

This chapter examines the role of the clinical instructor in Canada. Characteristics of an effective educator are discussed, elements of curricula are outlined, and successful collaborations are considered.

Chapter Objectives

- After completing this chapter, the reader will be able to:
 - discuss the characteristics of an effective educator
 - outline the elements of program and course curricula
 - describe how to establish successful collaborations

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Sherri Melrose

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Introduction

Nursing is a practice-based profession, and clinical learning experiences play an important role in helping student nurses to develop the knowledge, skills, and attitudes they need to work in a wide range of practice settings and specialty areas. The

role of the clinical instructor (CI) is to facilitate students' progress and to prepare them to meet entry-to-practice competencies.

To fulfil that role, CIs must extend their expertise as practitioners to also become effective educators. They must demonstrate a comprehensive understanding of the curriculum their students are required to follow at both the program and the course level. They must also understand the policies, procedures, and everyday tasks in the clinical areas where they teach students. As key members of both academic communities and practice communities, CIs are required to establish collaborations among their students, their faculty colleagues, and the health professionals they encounter in clinical placements. To help define this role, CASN created a set of competencies for the CI (see Appendix).

Straddling the complexities of the CI role is not easy. This chapter presents a broad overview of what novice nurses can be expected to know when they take on the role of CI. Following a brief discussion of the background and history of the CI role in Canada, a general discussion of the characteristics of effective educators is presented. Basic elements essential to understanding program and course curricula are outlined. Considerations for establishing successful collaborations are described. Throughout the chapter, emphasis is placed on the positive impact an educator's own commitment to lifelong learning can have on the CI role.

Background and History of Clinical Instructor Role in Canada

As Chapter 1 explains, practice-based learning in Canada has changed significantly over the years. Registered nurses (RNs) were not always educated in universities. Traditionally, they acquired skills by providing services or unpaid work to organizations in return for an education. Known as *service for training*, this approach to learning was grounded in an apprenticeship model, where, as the name implies, training was provided in return for service (Canadian Association of Schools of Nursing [CASN], 2012; Wytenbroek & Vandenberg, 2017).

In addition to attending classes, students were instructed and supervised by senior nurses in the workplace. Student nurses worked alongside practising nurses and were expected to function as contributing members of patient care teams. Although these practising nurses were not identified as CIs, they were among the first to undertake this role.

Before the 1990s, most schools of nursing were housed in hospitals, and hospitals relied heavily on student nurses to provide care for patients. Therefore, students' clinical education often revolved around hospital workplace requirements, and hospital administrators controlled many educational practices (Melrose et al., 2020). Classrooms were often located right on the hospital units and the role of the instructor included teaching in both classroom and clinical areas.

It was not until hospital schools of nursing moved into community colleges and university settings that the role of an educator dedicated exclusively to clinical instruction was identified. By 2000, Canadian RNs were required to hold a baccalaureate degree in nursing (Pringle et al., 2004). The transition away from hospital-based training programs granting diplomas and towards university-based programs granting baccalaureate degrees led to more specialized educational roles.

With classrooms situated in university buildings, travel to hospitals and other clinical placement areas was cumbersome. Faculty employed at universities were expected to lead and implement research projects, leaving less time for clinical teaching. In turn, the shifting demands of the academic role created opportunities for expert clinicians to step in as CIs and share their hands-on knowledge and skills with student nurses. Thus, the role of CI is still relatively new, and the associated responsibilities and expectations continue to evolve.

However, the CI role is clearly an educational role that requires demonstration of effective instruction. The next section discusses how expertise, positive role modelling, and a passion for the profession are characteristics of effective educators that are especially relevant to clinical instruction.

Characteristics of Effective Educators

Expertise

Effective educators bring expertise to their role. For CIs, this expertise includes clinical knowledge and instructional knowledge. CIs are expert practitioners, making the skills and experiences they share with students highly valued. Additionally, CIs expertise must also include instructional knowledge. Fostering and maintaining clinical and instructional expertise is an inherent expectation of all nurses who take on the CI role.

Clinical Expertise

To be effective educators, CIs must have the content knowledge associated with their area of expertise (Collier, 2018; Niederriter et al., 2017; Reising et al., 2018; Sadeghi et al., 2019). Before educators can help students transfer knowledge from lectures, labs, simulations, and other program learning activities to the clinical setting, they must first have a comprehensive understanding of the subject matter themselves.

When CIs maintain their clinical competence, they project confidence (Niederriter et al., 2017; Reising et al., 2018). In turn, CIs who feel confident in their own practice inspire similar feelings of confidence in their students, thereby creating more meaningful learning experiences (Collier, 2018; Needham et al., 2016; Niederriter et al., 2017; Reising et al., 2018; Sadeghi et al., 2019). Conversely, CIs who lack current clinical knowledge and who are unfamiliar with common procedures in their clinical area hinder the quality of students' experiences (Reising et al., 2018).

When accepting an offer of employment as a new CI, nurses must assess their capacity to practise competently in a particular clinical area. This assessment includes considering the applicability of their existing experience and available professional development opportunities. Schools of nursing may provide compensation for time spent orienting to a clinical teaching area, but CIs are responsible for identifying their own learning needs and finding the resources to meet these needs. Examples include attending national and international conferences focused on clinical topics, reviewing literature related to conditions commonly occurring in the area, attending staff in-services, buddying with staff, and practising with equipment that students will use. Although educators can never prepare for all contingencies, initiating self-directed learning strategies well in advance of meeting students establishes a strong foundation.

Instructional Expertise

CIs are educators, yet the responsibilities inherent in an educator role can be overshadowed by the pressures of maintaining clinical competence. Instructional competence requires CIs to seek out information and tools from the discipline of education that will allow them to convey their knowledge and teach others. In many instances, undergraduate and graduate programs have not provided nurses with this foundation to being an excellent teacher. Therefore, once again, CIs must be self-directed and look for opportunities to strengthen their knowledge of teaching and learning. Chapter 3 introduces readers to the pedagogy of clinical teaching.

Opportunities for developing instructional competence include completing continuing education courses such as those offered by the CASN's Canadian Nurse Educator Institute (2022). Similarly, graduate studies courses focused on teaching and learning are available to non-program students in the Faculty of Health Disciplines at Athabasca University, Canada's online university (Athabasca University, n.d.). Informally, CIs can read refereed journals, books, and open educational resources

(OER) geared to nurse educators. OERs are free online resources that can be accessed anytime and anywhere. One example of an OER of value to Canadian CIs is Creative Clinical Teaching in the Health Professions (Melrose et al., 2021).

CIs who cultivate and demonstrate their instructional expertise have a positive impact on students' learning (Needham et al., 2016; Niederriter et al., 2017; Sweet & Broadbent, 2017). Conveying knowledge to others involves a different skill set than acquiring knowledge, and students appreciate CIs who know how to pass along what they know (Janse van Rensburg, 2019; Reising et al., 2018). When CIs are unable to convey their knowledge effectively, students perceive them as disorganized, inefficient, and out of their depth (Needham et al., 2016).

Positive Role Modelling

Effective educators are positive role models. A role model is a person worthy of emulation, a positive example of a member of the profession (Perry, 2009). Students see behaviours that they aspire to and want to emulate in all their educators, but in clinical settings, CIs can and should model the kinds of professional behaviours they expect from students. Students pattern their own actions on what they see CIs doing during their everyday interactions and activities, as well as when they are providing formal instruction. Whether intentionally or unintentionally, what CIs do can exert more influence than what they say (Melrose et al., 2020).

When students observe CIs consistently role modelling positivity, enthusiasm, and caring, they feel more satisfied with their learning experiences (Jack et al., 2017). CIs can consciously integrate positive role modelling behaviours by communicating a supportive attitude, an approachable demeanor, and a passion for the profession.

Supportive Attitude

Students need to feel unwavering support from their CIs. They must trust that CIs will always be there for them as a guide and an advocate (Niederriter et al., 2017). Wanting to thrive in clinical settings, students rely on CIs to help them find ways to reduce anxiety, to understand what is expected of them, and to achieve required competencies. CIs can begin to communicate a supportive attitude by acknowledging and normalizing feelings of anxiety, by projecting a willingness to remain emotionally available, and by displaying patience (Janse van Rensburg, 2019).

It is common for students to use the same verbal and non-verbal expressions of support with their patients that they experienced during interactions with their CIs. In some instances, students even replicate CIs mannerisms and colloquial language. This observation serves as a reminder to CIs that the interactions they are modelling with (and in front of) students can have a profound and lasting impact.

Approachable Demeanour

When CIs present an approachable demeanour to students, they invite conversations and questions that might not otherwise emerge. Students are more able to accept feedback (both positive and constructive) from CIs who are approachable. An approachable CI is friendly, respectful, and generally relaxed, and readily establishes relationships with most members of health care teams (Collier, 2018; Hababeh & Lalithabai, 2020; Niederriter et al., 2017; Reising et al., 2018; Sweet & Broadbent, 2017).

Approachability can be communicated through simple gestures such as smiling frequently, making eye contact, stopping a task whenever possible to talk, and expressing genuine interest in students' comments and questions. During times of crisis in clinical settings, these expressions of approachability can easily be neglected. CIs inadvertently may use a brusque tone or

utter a sharp word. In these instances, acknowledging and apologizing for lapses that have occurred can also communicate approachability. Here again, CIs are modelling behaviour they expect from students, who will also have times where they appear unapproachable to others.

Knowing that CIs evaluate their progress, students can feel hesitant to reach out for help. Fearing reprisal, students may be reluctant to disclose errors, and that fear results in unsafe patient care. Overcoming the inherent power differential in instructor-student relationships is not easy. Yet when CIs make a conscious effort to communicate that they are willing to be approached, students are more likely to feel safe in doing so.

For many students, approaching a CI is viewed as a risk. Negative experiences with previous educators, lack of success in other educational activities, cultural barriers, traumatic life experiences, and other personal factors can all influence students' decisions to approach (or not approach) CIs.

CIs who identify how to reach them communicate that they are approachable. Throughout each clinical shift, students must know the specific times and communication devices to use to connect with their CI. In traditional clinical settings, such as hospitals or clinics, where instructors and students remain in the same building, CIs may expect students to come and find them. In clinical settings where CIs travel between sites, communication may occur through telephone, text, email, or online learning platforms. When CIs facilitate clinical learning online, they may use additional social media tools.

It is important for newly employed CIs to understand the expected methods of communication between students and CIs. For example, some nursing programs may encourage CIs to implement communication tools commonly used by the public. Others may impose restrictions on their use. Additionally, CIs must consider their own personal boundaries and let students know the times they are not available.

Passion for the Profession

Enthusiastic, positive CIs who love what they do and who feel excited about sharing their knowledge with the next generation of nurses are strong role models. Students appreciate knowing why their educators chose the nursing profession, what areas sparked (and continue to spark) their interest, and how they find joy in their work. CIs communicate their passion for teaching by genuinely valuing students' successes and taking pride in students' accomplishments.

On the other hand, when CIs seem to focus on what is not going well, challenges not being overcome, and barriers being imposed by programs or clinical sites, any feelings of passion they may have for the profession are muffled. Students view this apparent lack of passion as apathy and even laziness (Reising et al., 2018). When CIs seem more interested in focusing on mistakes than successes, they are viewed as dispassionate, intimidating, and condescending (Reising et al., 2018).

In addition to embodying the characteristics of effective educators described above, the CI role requires a basic understanding of the program and course curricula of the schools of nursing in which the CIs are employed. These elements are outlined next.

Elements of Program and Course Curricula

CIs are required to have a general understanding of the curricula that guide students' programs and a more in-depth grasp of the curriculum for the specific clinical course they are teaching. The term curricula refers to different educational and instructional practices. A curriculum, the singular form of curricula, is defined as a formal plan of study that provides the philosophical underpinnings, goals, and guidelines for delivery and evaluation methods that a specific educational program will implement (Keating, 2015; Melrose et al., 2020).

The word derives from the Latin *currere*, which carried directly over into English and means “running a race [or a] course,” with a secondary meaning of running around a racetrack (Egan, 1978, p. 10). The metaphor of running a race suggests that curricula, like racetracks, have predetermined structures clearly in place. Curricular structures include explicit plans for learners to interact with instructional content and processes and for evaluating the attainment of educational goals (Melrose et al., 2020).

Program Curricula

At the program level, CIs can begin to understand curricula by reviewing the program’s website. Program websites are a key source of information for prospective and current nursing students, and they can be a valuable resource for CIs as well. Reading the program philosophy, messages from leaders, courses that are required, and general directions to students will reveal important insights. Scanning course outlines will offer a snapshot of the kinds of teaching approaches, learning activities, and evaluation methods that students are familiar with. In some instances, CIs may be able to audit students’ classes when topics of interest are presented.

Similarly, CIs can learn more about the program curricula that guides their students’ learning by attending faculty meetings and participating in academic projects. Informal conversations with other members of the faculty group can be valuable. As attendance is voluntary, and CIs are not usually compensated, this strategy can be difficult. Because of time constraints, orientation workshops cannot provide new CIs with a total overview of all aspects of the program. These orientation sessions usually focus on the clinical courses that attendees will be teaching. Therefore, piecing together other elements of the curriculum is an individual CI responsibility.

Course Curricula

CIs can expect to be provided with curricular materials for the courses they have been hired to teach. These materials should include course guides that specify competencies that students must achieve and evaluation tools for measuring students’ progress. The materials should also include relevant policies and procedures associated with the academic institution.

It is important to note that curricula are revised frequently. This is in response to the constant changes that occur in both academic and clinical environments. Consequently, CIs may receive information only as courses begin. This leaves limited time for careful review and reflection. Knowing in advance that blocks of time will be needed to review and reflect on curricular materials, CIs can adjust their schedules accordingly. The first week of a clinical course can be hectic. Experienced educators often advise new CIs to keep other work, family, and study commitments to a minimum whenever possible during this time.

Orientations to individual clinical sites are not typically included in curricular materials. Creating site orientations for students and setting up recording systems to chronicle student progress are part of the preparatory planning CIs must do on their own (Baker, 2020). Similarly, CIs must also seek out relevant policies and procedures issued by the clinical institutions.

Some documents and resources may be available on institutional websites. As access can be restricted to staff members, CIs not employed in the clinical areas where they teach students will need to apply to gain access. A strategy CIs may find helpful in organizing their student orientation package is to create a private website or use a learning management system accessible only to students currently attending a clinical site. In essence, CIs are responsible for curating information from clinical sites and finding ways to communicate this information to students.

As the above discussions illustrated, the CI role is multifaceted. At times, responsibilities associated with being an effective educator and delivering both academic and clinical curricula can feel overwhelming. Networking and creating connections

with colleagues can make an important difference in ameliorating some of these feelings. Next, suggestions for establishing successful collaborations are offered.

Establishing Successful Collaborations

Instructor-Student Collaborations

Nurses who succeed in the role of CI establish successful collaborations. In their collaborative relationships with students, CIs work as supportive partners. The goal of any instructor-student partnership is to support students in achieving required course competencies. Certainly, the goal cannot be attained by instructors and students working alone. However, as emphasized throughout this book, the collaborative relationships CIs establish with students set the stage for all subsequent collaborations with other educational partners.

In genuinely collaborative instructor-student relationships, students are invited to actively engage in their learning. This includes working together to match teaching styles to learning needs (as discussed in Chapter 3) and to create safe spaces for critical reflection. This approach is built on a foundation of mutual trust and respect. CIs generate building blocks for this important foundation when they get to know students as individuals. Questions such as why students chose nursing, what area they hope to practice in, and how they handle life challenges can initiate meaningful conversations.

Successful instructor-student collaborations can only be maintained when CIs consistently remain open to the *exchange of feedback*. Collaborative feedback involves CIs providing students with feedback on their progress (instructional feedback), and it requires CIs to invite feedback on their own teaching (student feedback). In clinical settings, instructional feedback is usually based on direct observation. Students are most receptive to feedback when it is shared as soon as possible after an activity has been observed.

When students sense that their CIs are genuinely committed to supporting them to be successful rather than finding fault, their anxiety decreases. Comments should always include a balance of both positive and constructive or corrective statements and should clearly relate to course learning outcomes. Effective feedback “provide[s] an unbiased critique of performance, recounting events as they occurred, with the intention to correct errors and increase understanding” (Atmiller, 2016, p. 118). Discussions must never occur in front of other students, staff, or patients.

Similarly, any exchanges in which students share feedback on CIs activities should also be grounded in a mutual commitment to student success. Program curricula may establish only limited opportunities for students to evaluate CIs. For example, anonymous written end-of-term course evaluations may include sections where students can comment on their CI’s teaching effectiveness.

Rather than waiting until the clinical experience is over, when CIs invite student feedback throughout the course, they model a process of receiving, accepting (or rejecting with explanation), and acting on feedback. Student feedback can be solicited during impromptu discussions and can be scheduled into student evaluation meetings. Student input can also be gathered anonymously in suggestion box collection areas or through online opportunities. Importantly, students must feel that their feedback is welcome and that their relationship with their CI is a collaboration.

Student-Student Collaborations

Facilitating student-student collaborations is equally important. Peer interactions, both during and outside time in clinical areas, will foster learning. Assigning student partnerships at the beginning of a rotation and then later inviting students to

form their own collaborations promotes inclusivity. Providing pre- and post-clinical discussions on online platforms supported by the nursing program provides opportunities for students to share and extend their thinking with like-minded others. Requiring students to establish what they expect from one another during a collaboration (and the consequences if expectations are not met) is a facilitation strategy that CIs can implement (Melrose et al., 2013).

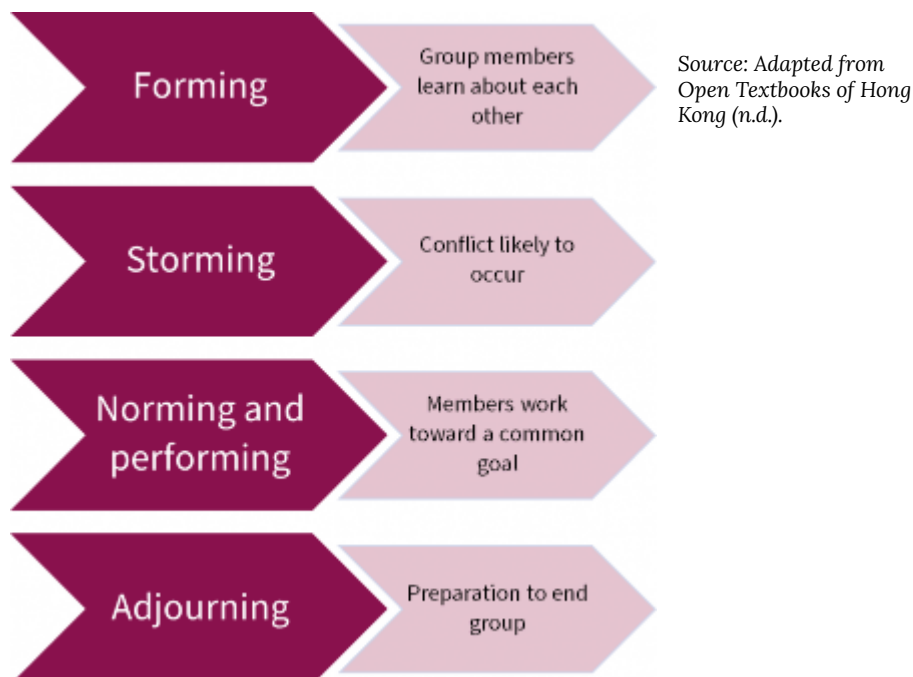
Successful student-student collaborations do not just happen. They must be carefully cultivated. Whether students come together in pairs or triads for activities such as skills demonstrations, in groups of three or four to complete a project assignment, or in small groups of ten or more for clinical conferences, dynamics related to group processes will occur. Understanding how groups progress and how to promote positive group dynamics is an important function of the CI role.

Most nurses are familiar with general background information on group dynamics. For example, Tuckman (1965) and Tuckman and Jensen (1977) identified that groups progress through four stages. Groups form (members learn about one another), they storm (conflicts are likely to occur), they norm and perform (they work effectively together towards a common goal), and they adjourn (close or end the group). The stages, represented in Figure 2.1, may not occur sequentially and not all groups are able to work together successfully.

Knowing that issues (such as conflict) are expected to emerge when students collaborate in groups, CIs can build in strategies to help. For example, when student partnerships and groups are first forming, they value knowing that they are not on their own, that their CIs are available if students need them, and that it's safe to contact their CI (Melrose & Bergeron, 2007; Melrose et al., 2013). When storming occurs and students struggle to manage conflict, particularly in relation to participation and evaluation, they need to be certain that their CI is willing and able to step in and help.

As students move through norming and performing, CIs can mistakenly assume that they are not needed. Although joining student groups and participating directly in discussions during this stage may not be necessary, it is important for CIs to maintain communication with all students individually. This one-to-one communication assures students that their personal learning needs and goals have not been forgotten. Finally, intentionally planning opportunities to debrief and reflect when groups adjourn provides students with closure.

Figure 2.1 Tuckman and Jensen's (1977) Stages of Group Development



Instructor-Faculty Collaborations

CIs are also required to establish successful collaborations with other faculty and instructors at the academic institution where they are employed. Although CIs may attend formal meetings only infrequently to understand program and course curricula fully, networking with colleagues can offer valuable insights. Exchanging contact information and connecting with fellow educators can quickly clear up misconceptions that may have developed. Informally sharing practical tips for navigating instructional requirements over a cup of coffee or tea can inspire new ways of thinking.

Instructor-Program Collaborations

Collaborations with nursing programs also require CIs to understand services that are available to students. For example, students may require language support services, counselling services, math tutoring, or English writing support (Melrose et al., 2020). CIs must be aware of policies associated with failing grades and grade appeals. They must know what steps both students and instructors can take if they believe they have been treated unfairly.

Notably, CIs must know well in advance the procedures to follow if they are ill or otherwise unable to attend the clinical area (Melrose et al., 2021). Unlike K-12 educational institutions, schools of nursing do not usually have lists of qualified substitute teachers who can step in and supervise students on short notice. When they are ill, CIs are required to notify all their students, the academic institution, and the clinical site in a timely manner.

Having a student contact plan in place is essential and especially useful when illness occurs just hours before a scheduled shift. Students' clinical experiences will likely be cancelled when a CI is ill. Unfortunately, clinical experiences cannot be rescheduled; shifts at the clinical placement locations are booked months, or even years, in advance, and the sites provide practical learning opportunities to learners from a variety of health profession programs. Students often travel long distances and juggle complicated childcare and employment commitments to get to clinical sites. To arrive and find their clinical experience cancelled is frustrating.

Instructor-Clinical Collaborations

Successful collaborations with administrators and staff in clinical areas are invaluable as CIs prepare nursing students for entry into the profession. Just as both formal and informal connections with academic institutions contribute to students' success, collaborations in clinical settings also make a difference. Discovering where to access policies, procedures, and resources takes time. Often, orientation programs are provided to new staff members, and when possible, attending these orientations can be useful. Instructors who taught in the area previously may have materials and information a new CI can use. For CIs not employed at the site where they teach, working alongside staff, participating in unit projects, and communicating a willingness to pitch in fosters relationships. When students' written assignments are relevant to patient care, sharing these with staff may be appreciated.

Summary

The role of the CI emerged when nursing education moved away from hospital-based service-for-training approaches to educating nurses in university settings. CIs supervise students' progress in clinical settings and prepare them to meet entry-to-practice competencies. As educators, CIs must maintain both clinical and instructional expertise. They must strive to demonstrate characteristics of effective educators, which include role modelling behaviours they expect students to

emulate, communicating a supportive attitude, projecting an approachable demeanour, and sharing their passion for the nursing profession. CIs must understand elements of program and course curricula that apply to their students. Further, they are expected to establish successful collaborations with and among students and with colleagues in both the academic and the clinical institutions where they teach.

Conclusion

CIs are essential members of nursing education teams. They play a vital part in supporting students in successfully meeting learning outcomes. The CI role provides nurses with a variety of opportunities to grow as clinicians and instructors, and it creates exciting possibilities for collaborations among diverse groups of colleagues. CIs are self-directed lifelong learners who enjoy sharing what they know with future Canadian nurses.

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EDUCATION (IN-SERVICE LEARNERS)

Practical Teaching Strategies for Diabetes Educators



[PDF – 448 KB]

Citation

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Participant learning in diabetes education is enhanced by dynamic and enriching experiences. Three key teaching strategies to facilitate meaningful patient-centred learning experiences are responding to immediate needs, incorporating group work and offering a variety of instructional methods. Effective teaching strategies bridge the gap between knowledge and practice, and guide patients through the lifestyle change process (1).

Respond to immediate needs

Effective teaching occurs when diabetes educators meet patients' immediate needs and accept their learning needs and goals (2). To this end, they should:

- Assess learning needs and preferred learning methods to create an individual plan.
- Capture teachable moments. Motivation is highest during these moments, which are likely to occur when the patient perceives the need to learn new skills or change existing habits.
- Address 'burning' questions. Providing telephone communication shortly after diagnosis is an effective means of addressing important questions and capturing teachable moments (3).

Incorporate group work

Adults want control over what and how they learn (4). Diabetes educators can facilitate adult learning through the structure of group classes with the following:

- Give the responsibility of learning to the learner (2).
- Create stimulating learning environments. Small-group teaching is generally well accepted by learners; group discussions can also foster the discussion of realistic solutions by those with similar experiences (4,5).
- Appropriate scheduling will improve attendance. Shorter classes focusing on 1 topic are more effective than those that incorporate many topics over several days (6). Short sessions with mini-topics offered at various times provide the option of attending

classes when the need for knowledge has been identified by the patient.

- Encourage lifelong continuing education by providing interesting and fun events. Those that offer hot topics or a form of entertainment will encourage attendance. Ongoing education reinforces knowledge and enhances lifestyle change efforts (7).
- Develop strategies that promote the participation of all and reduce the dominance of a few, e.g. invite participants to construct group rules at the beginning of the session and encourage reluctant participants to interject comments by requesting round robin responses.
- Limit presentations to 20 minutes, with a recap every 7 to 10 minutes followed by a discussion with strategies for behaviour change (8).

Offer a variety of instructional methods

Not all adults learn the same way, so it is important to provide a variety of teaching tools (4,5):

- Educational videos are helpful for low-literacy individuals (4,5).
- Case studies integrate knowledge and enhance problem-solving skills (9).
- Have fun! Well designed games are effective for promoting praxis, reinforcing complex facts and assessing knowledge and skills (4). Crossword puzzles can introduce new vocabulary in a comfortable, non-threatening way and can be created with software programs (10).
- Humour enhances the learning environment by increasing the comfort level of participants. It also enhances the development of problem-solving skills and encourages experimentation with new thoughts and ideas (11).
- Establish opportunities for self-directed learning that extend beyond formal sessions. A lending library of videos and books is an effective, efficient and economical strategy for alternative learning.

Conclusion

The current literature suggests that adult education should respond to patients' immediate needs, incorporate group work and offer a variety of instructional methods, all of which clearly enhance learning experiences. Interaction with and involvement from participants in personally meaningful ways enhances the learning environment.

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Commentary: Posing questions to support and challenge -- A guide for mentoring staff



[PDF – 382 KB]

Citation

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Abstract

Staff development educators seeking to mentor health care practitioners towards thinking more critically may integrate a questioning approach into their teaching. However, posing questions that both support and challenge learners is an intentional process. This article provides an overview of the contextual considerations, dynamics and mechanics that educators need to understand in order to pose high level questions that invite learners to engage in reflection, problem solving and evidence informed practice. The approaches are framed from a constructivist theoretical perspective, a mentoring model of instruction and Socratic dialogue. The suggestions are practical mentoring strategies that can be readily integrated into everyday interactions with staff members. The suggestions are summarized into a succinct one-page guide.

INTRODUCTION

“No one can teach, if by teaching we mean the transmission of knowledge, in any mechanical fashion, from one person to another. The most that can be done is that one person who is more knowledgeable than another can, by asking a series of questions, stimulate the other to think, and so cause him to learn for himself.” —Socrates, 5th century BC.¹

It is widely acknowledged that educators who pose thought provoking questions can invite learners to view the world in new ways. This article provides a guide for healthcare leaders seeking to mentor practitioners towards thinking more critically, by explaining how to pose questions that support and challenge. The guide is framed from a constructivist conceptual perspective, a mentoring model of instruction and Socratic dialogue. The suggestions are organized according to contextual considerations, the dynamics of questioning and the mechanics of questioning. Figure 1 (the guide) is a succinct summary of the suggestions.

THEORETICAL BACKDROP

Constructivist Thinking

Constructivist thinking suggests that learners bring valuable existing knowledge to any learning experience, and that the role of the teacher is to build on that existing knowledge by providing personally meaningful activities and interactions with informed others.^{2,3} A constructivist perspective emphasizes the importance of promoting learner self-direction and independence.⁴ In staff development and workplace settings where professional leaders are involved with the education and mentorship of practitioner learners over extended periods of time, integrating skillful questioning approaches can help clarify both what learners already know as well as what new areas of knowledge could be relevant. Viewing questioning through a constructivist lens, the process of posing questions can be construed as an essential tool for engaging practitioners and supporting them towards success in their own personal learning journey.

Mentoring model of instruction

A mentoring model of instruction, which aligns with constructivist thinking, also integrates intentional questioning into relationships between educators or mentors and learners or mentees. Mentoring is defined as a meaningful reciprocal relationship between two people, often with one more experienced and one less experienced individual.⁵ A mentoring model of instruction is usually non-evaluative and is not defined by time limits.⁶⁻⁹

In his seminal book, *Mentor: Guiding the Journey of Adult Learners*, Daloz explained that educators can best mentor learners by providing both support and challenge.¹⁰ When learners feel supported and trust their mentor educators, they can begin to feel more open to taking on new perspectives and to the possibility of making mistakes. In turn, mentors can introduce the kinds of high level and even disorienting questions that trigger new insights and ways of constructing knowledge. Questioning grounded in a mentoring instructional model can set the stage for thinking differently and more critically.

Critical thinking involves analyzing, assessing and re-constructing.¹¹ Individuals who think critically seek out relevant information and make judgements, interpretations and inferences based on evidence and context.¹²⁻¹⁶ Socrates was one of the first educators to espouse the use of questioning methods by teachers to require learners to think deeply, challenge their own assumptions, and gather evidence before accepting new ideas.¹⁷

Socratic dialogue

Socratic dialogue, also known as Socratic questioning or the Socratic method of teaching, aligns well with education grounded in constructivist thinking and framed from a mentoring model of instruction. Socratic questioning challenges learners to think deeply and critically about concepts they often take for granted and is especially effective when addressing issues with ethical or moral dilemmas.^{17,18} As practitioners respond and reflect during Socratic dialogue with staff development mentors, they are challenged to make comparisons, give evidence for cause-and-effect relationships, and provide suggestions for why an issue or practice might be realistic or unrealistic. While “right or correct answers” are not expected, Socratic questions draw out learners’ beliefs and challenge them to consider ideas from more than one point of view.¹⁷

However, despite the merit of questioning as a fitting tool for constructivist educators seeking to mentor learners, existing evidence indicates that many teachers are not always posing the kinds of questions that do promote critical thinking.¹⁹⁻²³ These researchers consistently recommend training as a means to improve questioning practice. Much of the existing evidence regarding intentional questioning discusses pre-service learning experiences, leaving a gap in our understanding of staff development and continuing education approaches that are relevant to learners in practice environments. This guide, with its emphasis on practical everyday suggestions related to contextual considerations, dynamics and mechanics of questioning begins to address that gap.

POSING QUESTIONS INTENTIONALLY

Contextual Considerations

Questioning, as a form of inquiry, invites an exchange and sharing of experiences.²⁴ However, without careful consideration of context, questioning can disengage and de-motivate learners.²⁵ Poor questioning can leave learners feeling stressed, anxious, intimidated, embarrassed, and fearful they will give incorrect answers, and they can be left frustrated by over questioning.^{24,25}

A safe, mutually trusting, and respectful emotional environment, where learners can risk making mistakes and responding with incorrect answers, is essential.²⁵ In workplace settings, the process of establishing and maintaining trust among colleagues can be a fragile and emotionally charged phenomenon.²⁶ As health care educators in staff development and continuing education interact with practitioner learners over time, poor questioning approaches can generate persistent and unnecessary negative feelings.

In addition to the aforementioned emotional considerations, the physical context or where questioning occurs also impacts the process. In fast paced clinical settings, educators are often engaged on the spot for advice, and do not have time to plan questions directed at specific learning objectives. Typical venues of communication include staff meetings, daily unit based huddles, one to one consultation, rounds, and spur of the moment conversations amidst ongoing care. The tendency in such instances can be to provide answers rather than ask questions. However, doing so can limit the discussion and opportunity for problem solving, exploration of rationale, consideration of alternatives, and the self-discovery so important for enhancing critical thinking.²⁷

It is important to note that clinical site educators in staff development and continuing education often have duties and responsibilities that extend well beyond teaching. Many straddle management and other leadership positions. While the teaching role may take priority for pre-service educators, those in in-service settings may be juggling responsibilities associated with several different roles. When these additional responsibilities include staff performance reviews, questioning

can be construed as an evaluative activity. In turn, the overlap of management responsibilities can exert significant influence on how questioning approaches are perceived.

One strategy for establishing trust that staff development educators can implement is to explain that a questioning approach will be used. The explanation can be further developed by adding that the questioning approach stems from constructivist thinking that honors what practitioners already know and from a mentoring model of instruction that seeks to support and challenge. Even when educators also function in other management and leadership roles, by knowing their intentions, staff are less likely to feel interrogated and tested. Rather they can be aware that questions posed were meant to help mentor their capacity for critical thinking and to trigger new insights.

Another strategy is to ensure that each question asked serves a purpose. Kost and Chen identify purposeful questions as ones that have a specific goal, rather than bombarding staff with questions that can cause intimidation and do not stimulate critical thinking.²⁵ They also suggest that questions should be interpretive, with no right answer, therefore, allowing exploration of prior knowledge and stimulating reflection. Ensuring that staff are informed of how questions will be used and that questions are purposeful can help facilitate trustful mentoring relationships and Socratic dialogue.

A further strategy is to listen actively as staff are responding and discussing their ideas. This includes refraining from interrupting and expressing respect for different perspectives.²⁸ Educators questioning from a mentoring model of instruction should not be thinking ahead to their next question or trying to formulate a solution that would “fix” the problem. Allow sufficient time for responding. Encourage responders to reply in some way to each question asked.²⁹

A final contextual consideration is to assess the extent and quality of the relationship between educator and learner. Similarly, learners’ levels of experience must also be factored in. Questioning may not be relevant in all stages of relationships and situations. Determining that a questioning approach is the most appropriate tool for the desired outcomes is just as important as asking the right questions.²⁴ Staff who have low self-confidence or are highly skeptical may not initially respond favorably to a questioning approach. In these situations, educators may need to spend more time nurturing a trustful mentoring relationship and reserve the use of questioning until later. On the other hand, however, skillfully posing thoughtful questions can contribute to positive trusting relationships that can challenge learners in non-threatening ways.²⁵

Dynamics of Questioning

Wait time

The dynamics of questioning refers to the variety of techniques educators implement to impact the questioning process.²¹ Wait time is a significant dynamic. Wait time is the time an educator waits, after the question is posed, for a response before moving on or clarifying.³⁰ Evidence suggests that educators do not allow sufficient wait time, therefore limiting opportunity to stimulate critical thinking.³¹ A wait time of between 3-6 seconds, depending on the level of question asked, is encouraged to allow adequate time for learners to formulate a response.^{24,29-31}

For in-service educators in leadership positions who are used to managing problems, intentionally using adequate wait time can avert the tendency to jump in and offer a solution. Wait time can also help when responses are initially not forthcoming or are vague. Further, after practitioner learners offer their responses, wait time can communicate a respectful pause that invites further discussion. Wait time is important when posing questions during both individual and group discussions.

Clarifying

When adequate wait time is offered and responses still remain incomplete, clarifying or probing further with lower level questions may be needed. Paul and Elder encourage questions that seek relevant information, probe for rationale, and consider alternative and opposing viewpoints as a way of sustaining the questioning process.³²

Depending on the level of experience of staff, questions may need to be more pointed. For example, with a novice practitioner an educator might ask: “Do you think that could have been a contributing factor?” Whereas, with a more experienced practitioner an educator may ask: “What are potential contributing factors to this issue?” However, in all situations educators should resist fixing staff problems by providing answers. When educators integrate questioning behaviors effectively, novice staff experience how the process can lead to critical reflection and challenging the status quo.³³

Phrasing

Appropriate phrasing of questions is another essential dynamic of questioning.²¹ Use of positive language and tone of voice can impact how staff interpret the use of a questioning approach. It is important that educators not communicate skepticism in their questions. Consider the difference between “why would you do that?” (spoken with a judging tone and furrowed brow), versus “can you tell me some of the reasons why you chose that course of action?” (asked with an inquiring gaze and soft tone). Maintaining eye contact, open body language, and nodding frequently communicates interest and encouragement non-verbally.²⁴

Mechanics of Questioning

Levels of questions

The mechanics of questioning refers to the levels and types of questions educators can pose.²¹ The primary focus of existing research on questioning is the cognitive level at which a question is asked. Benjamin Bloom’s classic taxonomy of the cognitive domain of learning has been used to map questioning levels.^{24,34-36} Bloom identified six hierarchical levels of learning.³⁷ The lowest level of learning is knowledge or simply recalling and memorizing facts. The remaining five levels involve a progressively deeper and more complex understanding of concepts. They are comprehension, application, analysis, synthesis, and finally, evaluation. It is widely accepted that questions posed at a higher cognitive level are more likely to stimulate critical thinking. However, teachers implementing a questioning approach may frequently be doing so at lower cognitive levels.^{19,20,21,22,23}

Boswell outlines the outcomes of questions for each cognitive level.²⁷ At the knowledge level, questions are closed-ended and seek descriptive information. Knowledge questions are aimed at obtaining an explanation and comprehension questions explore the meaning of a single concept. At the application level, questions require responses that link information to a particular case or situation and to find solutions through problem solving. At the analysis level, questions expect responses that differentiate among multiple factors that probe for supporting evidence, that apply new information, and that challenge assumptions and rationale. At the synthesis level, questions call for the creation of new ideas, multiple perspectives, and the development of a plan of action. Finally, questions at the evaluative level demand responses that stimulate assessment of information in order to substantiate judgement and allow for critical decision making.²⁷

Posing questions intentionally involves sequencing the levels of questions, with a gradual progression from describing facts to making sound decisions.^{24,27} Thus, educators often begin by posing lower level questions to gather relevant information.

Incrementally, higher level questions are incorporated to stimulate critical thinking. Constructivist questions grounded in a mentoring model of instruction and Socratic dialogue integrate learners' prior experience, invite additional perspectives, explore assumptions, hypothesize potential solutions, and eventually lead learners towards making their own critical decisions. Through this sequencing of questions, learners become involved in solving problems through reflection, integrating evidence and thinking critically.²⁷

Types of questions

The types of questions educators ask also impact the dynamics of questioning. For example, convergent or closed ended questions, such as those prefaced with: "Do you think ...," "Should ...," "Would ...," "Are ..." and "Is ..." usually require only yes or no responses.³⁸ Learners can view convergent questions as having answers they are expected to be familiar with and that they can anticipate. They usually have one right answer. On the other hand, divergent or open ended questions, which include "who," "what," "where," "when," "how," or "why" invite reflection and more detailed responses.³⁸ These questions have many possible answers. Limiting use of the word "why" is recommended because of its frequent association with accusatory statements.³⁹

Other types of useful questions are those that probe for further information.²⁷ Probing questions are important to ensure mutual understanding. Examples include: "What do you mean by that?" or "When you refer to , do you mean or _?" Probing questions are essential to challenge assumptions, uncover faulty logic, and evaluate reasoning to assist in creating new meaning. Examples of probing questions include: "What is your reasoning behind _?", "What are you assuming by _?", "What would the impact of be?", and "What is the likelihood of occurring?"²⁷

Hypothetical and declarative questions can also be useful. Hypothetical questions challenge practitioner learners to consider alternatives, such as: "What would have happened if you approached the situation from perspective?"²⁷ Declarative questions, such as: "Tell me more about that" can draw out those who do not respond readily to other types of questions.⁴⁰

A GUIDE FOR POSING QUESTIONS THAT SUPPORT AND CHALLENGE

Next, we present a succinct two-part guide (Figure 1) for posing questions that support and challenge. *Part One* identifies the questioning essentials educator mentors can use to ground their thinking. *Part Two* illustrates intentional questioning by noting specific questioning examples. The suggestions in the guide integrate the contextual considerations, dynamics of questioning and mechanics of questioning explained in the preceding sections. They have all been framed from a theoretical backdrop of constructivist thinking, a mentoring model of instruction and Socratic dialogue.

Figure 1. A Guide for Posing Questions that Support and Challenge

Figure 1. Part 1.

Part One: Questioning Essentials

Questioning Do's	Questioning Do Not's
Contextual Considerations Is this the right approach to use currently? ✓ Do determine staff readiness to accept a challenge ✓ Do evaluate the relationship of trust How can I ensure a non-threatening approach? ✓ Do explain the use of questioning ✓ Do ensure each question has a specific purpose ✓ Do ask one question at a time ✓ Do wait for and expect a response ✓ Do listen actively	- X Do not assume questioning is applicable for everyone and every situation - X Do not over-probe - X Do not ask multiple or compound questions - X Do not be thinking ahead to your next question - X Do not interrupt during a response
Dynamics Is my technique effective? ✓ Do broaden or focus the questions in line with staff experience ✓ Do provide enough time for staff to formulate a response (3-6 seconds) ✓ Do respond to a staff's question with another question or use storytelling to provide a related experience ✓ Do keep eye contact, use head nodding, and maintain an open posture ✓ Do periodically summarize to clarify mutual understanding ✓ Do provide positive reinforcement of perspectives and probe further as needed to expand thinking ✓ Do phrase questions using positive language	- X Do not use a generic questioning approach - X Do not fix the problem/issue - X Do not multi-task during a conversation - X Do not make assumptions for responses/rationale provided - X Do not question in a way that project criticism
Mechanics Am I asking the right questions? ✓ Do start with low level questions to gather information ✓ Do vary the level of question throughout the discussion ✓ Do gradually progress toward more high level questions that probe reasoning, challenge assumptions, and stimulate reflection in problem solving	- X Do not get stuck on examining facts/minute details - X Do not impose your own opinions

Part Two: Questioning Examples				
Question Level	Cognitive Domain	Question Purpose	Sample Questions	Helpful Tips for Questioning Technique
Low Level	Knowledge	Gather information: describe the situation	Can you tell me about the situation? What happened?	Make sure to clarify mutual understanding: Do you mean __?
	Comprehension	Establish understanding: explanation of problem(s)	Can you tell me why you think this happened? Can you give me an example? Based on these facts, what do you think is the main problem?	Consider interspersing a high level question here to probe assumptions
	Application	Build a solution	Has something similar happened before? What did you do? What was the outcome? What do you think is the best approach to addressing this problem? What would the alternatives be?	Remember to direct questions to learner level of experience It may be necessary to provide suggestions for novice staff: Do you think __ might be an alternative?
High Level	Analysis	Explore reasoning & probe rationale	Would your previous approach work? What is the same/different? What are your reasons for choosing A rather than B? Who benefits the most from this solution? How would this impact the patient/family? The team? Etc. What would another person of the same profession say? A different profession?	Be mindful of body language, tone of voice and words chosen Limit the use of "why" Be careful not to over-probe, vary probing with other types/levels of questions
	Synthesis	Create a plan	What is the best way to proceed? What would the first step be? Next steps? Who needs to be involved?	Remember not to provide answers Ask follow-up questions that highlight flaws in thinking: Are you assuming __? What is missing? Would it be different if __?
	Evaluation	Evidenced based decision making	Is this the best course of action? What evidence supports this plan? What are the risks/benefits? For whom? What are the limitations? How will you know if you have achieved the desired outcomes?	In closing expand thinking further by asking: what are some unanswered questions? Encourage action & build trust: suggest a follow-up discussion or email to let you know the outcome

Figure 1. Part 2.

Figure 1, Part 1 and Part 2. A Guide for Posing Questions that Support and Challenge can be printed on one double-sided page and posted in clinical practice areas where educators and staff members congregate and interact with one another. For example, in patient care stations, offices and team meeting rooms. Making the guide visible can help normalize the process of asking questions as a mentoring approach and may even help engage practitioners in initiating their own questioning activities.

CONCLUSION

The one-page guide for posing questions that support and challenge presented in Figure 1 was designed for those who educate in staff development, workplace, and continuing education settings. The suggestions, framed from constructivist thinking, a mentoring model of instruction and Socratic dialogue are particularly relevant for educators working with practitioners over extended periods of time. Intentional questioning approaches that are skillfully implemented can promote critical thinking and invite practitioner learners to risk looking at the world in new and different ways.

Intentional questioning requires educators to consider context, dynamics, and mechanics. Contextual considerations include establishing trusting relationships where making mistakes or not having right answers is acceptable. Taking care not to solve or “fix” problems is another important contextual consideration. The dynamics of questioning include allowing 3-6 seconds wait time after posing questions, expecting replies for any question asked, clarifying and gathering additional information, and phrasing with positive affirming language. The mechanics of questioning include attending to both the levels and types of questions. To stimulate critical thinking, problem solving, and evidence informed practice, questions should be geared to a high enough cognitive level that learners must analyze, synthesize, and evaluate the topics under discussion. To invite reflection, the types of questions educator mentors pose should be open ended and probing.

The process of mentoring staff by posing questions that support and challenge requires practice and takes time to develop. Some approaches will be more effective than others. Seeking feedback from learners will provide valuable guidance. Certainly, learning more about skillful questioning is time well spent for educators seeking to mentor health care practitioners.

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Keeping clients safe on the night shift



[PDF – 2.4 MB]

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Abstract

The night shift admission checklist helps night nurses to maintain a culture of safety when admitting a person to an inpatient mental health unit. Mental health symptoms can be pronounced on admission but, on night shift, nurses seldom have the opportunity to seek direction from experienced mental health practitioners. Routine safeguards are often adapted at night to promote clients' sleep. Documentation to assess clients' risks for self-harm, violence, comorbid medical conditions and prescribed medications may not be complete, although these are essential to maintain the person's safety on the unit. Although each hospital will have individual admission policies, the checklist can be adapted to include these. This article discusses safety issues at night and presents a checklist designed to promote safe care during night-time admission.

Keywords

Admission checklist, inpatient mental health unit, night shift, safety

LIMITED GUIDANCE is available for night nurses admitting people from emergency departments. Drawing on our clinical

practice knowledge, we have produced a checklist to support nurses during the often unpredictable process of admission to mental health inpatient units on the night shift.

At night, organisational factors can affect safe transitions. For example, environmental safeguards, including routine processes, can be rushed; paperwork to assess the person for self-harm, violence, comorbid medical conditions and prescribed medications may not be completed; and inadequate communication can contribute to medication errors. As a result, clients and staff may perceive inpatient mental health units to be unsafe. The checklist offers a set of questions that night nurses can readily use in their practice to help promote a culture of safety.

Guidelines

The National Institute for Health and Clinical Excellence (NICE) guideline on service user experiences in the UK identified the importance of promoting safety in mental health inpatient services by pointing out that ‘transitions from one service to another may evoke strong emotions and reactions in people using mental health services’ (NICE 2011). Clients and families must often give information to several different professionals and, when transfers occur rapidly, processes for handover communication between services may not be straightforward. But, as yet, few tools are available to ensure that mental health units have the information they need to care safely for incoming service users, particularly on night shifts.

In 2006, Johnson and Delaney published a theory for ‘keeping the unit safe’ that identified how dimensions of ideology, space, time and people can influence safety on mental health inpatient units. These factors contribute to safety as follows:

- Ideology – believing that safety is closely aligned with a therapeutic environment.
- Space – maintaining visibility and regulating flow of people through different areas of the unit.
- Time – organising predictable patterns of admissions, activities and staff shifts.
- People – staffing units with a mix of seasoned staff who can assess escalating behaviour.

In addition to checking patients and their belongings, ‘suicide proofing’ involves thorough environmental tours of all areas

A main tenet of the ‘people’ dimension is to understand skills that experienced staff implement to formulate their assessments. Delaney and Johnson (2006) call for nurses to purposefully uncover and articulate the embedded clinical practice knowledge they use to manage everyday situations that keep units safe. In an effort to achieve this, we present a handover tool, framed as a checklist, to support nurses in one such situation – the unpredictable task of admitting a new person while on night shift. First, we discuss night shift safety issues. Next, we describe how clients and staff feel about unit safety. Then we present our night shift admission checklist (NSAC) for mental health admissions.

Systems of care

On inpatient mental health units, research suggests that organisational factors are associated with adverse event outcomes. Hanrahan *et al* (2010) concluded that better management skills, better nurse-doctor relationships, and lower client-to-nurse staffing ratios decreased adverse events, such as wrong medication, falls with injuries, complaints from service users and families, work-related staff injuries and verbal abuse directed at nurses.

Jayaram and Herzog (2009) emphasised that better systems of care are needed to prevent suicide, aggressive behaviour, the use of seclusion, the use of restraints, falls, absconding, complications when dealing with medical comorbidities, and

medication errors. The American Psychiatric Association (APA) Task Force on Patient Safety (2003) identified how systems of care are flawed and that a change toward a culture of safety is required to prevent adverse medication events, seclusion, restraint and suicide. Brickell *et al* (2009) stressed that effective communication, service integration and interprofessional collaboration, especially during handovers and transitions of care, are essential in preventing harm.

Clearly, system-wide policies, full complements of seasoned staff and communication among team members contribute to keeping patients and staff safe. However, on the night shift, staffing can be restricted, team communication opportunities can be limited and transitions of care can be atypical. Published literature offers night nurses little direction on coping with handovers, such as admitting patients from emergency departments, under these circumstances.

Environmental dangers

Suicide Routine processes for assessing environmental dangers and maintaining safeguards, such as checking clients' belongings and all unit spaces for potentially harmful objects, might be rushed when nurses are called on to receive a person on a rapid admission from the emergency department. Items brought in by visitors during the evening shift may have gone undetected and clients may have stockpiled items for self-harm, with or without suicidal intent (Quirk *et al* 2006, O'Donovan 2007).

In addition to checking patients and their belongings, 'suicide proofing' involves thorough environmental tours of all areas of the unit (Cardell *et al* 2009). According to the Joint Commission Resources (2007), the root cause of 84 per cent of inpatient suicides was the physical environment; 75 per cent of these occurred in bathrooms, bedrooms and cupboards, with 86 per cent carried out by hanging from bathroom doors. At night, observation of bedrooms and other areas may not be thorough because of the dark and a fear of waking up clients.

The length of time people have alone has been linked to increased suicide attempts (Litman 1982) and night time offers people more opportunities to be alone than any other time of day. Formal observations, where mental health staff maintain frequent checks on all clients on the unit, consume nursing resources (Manna 2010). Implementing unit rounds to assess environmental dangers and maintaining patient observation leave nurses with only short periods of time in which they can interact with new service users.

Violence and restraint Incidents of aggression and violence are serious issues of concern in nursing and are more common on mental health inpatient units than in other settings (Laker *et al* 2010, Sturrock 2010). Most episodes of seclusion, restraint and assaults that occur in response to mental health symptoms take place soon after admission (Allen *et al* 2009).

Research indicates that mental health nurses who implement restraint are experiencing more frequent and more severe injuries, particularly when they carry out restraint later in the progression of aggression (Moylan and Cullinan 2011).

Short *et al* (2008) call for admitting psychiatrists to ensure orders for emergency medication administration are available to staff as clients move from one treatment setting to another. Nurses' prompt administration of medication in response to escalating mental health symptoms may avert the distress associated with restraint measures (Kynoch *et al* 2009, Moylan 2009). Research also shows that nurses' clinical decision making for 'as needed' (pro re nata – prn) medication is often based on previous experience and levels of knowledge (Usher *et al* 2010). Therefore, knowing that newly admitted people may well demonstrate unpredictable behaviour and that decisions about when to restrain or medicate are not straightforward, environmental support from a team of mental health clinicians provides valuable assistance. However, night nurses have few colleagues available to help them problem solve.

Documentation

People admitted at night can be expected to have fewer documented assessments than those admitted during day or evening shifts. Emergency department nurses may be less likely to record mental health behaviour on the night shift (Schumacher *et al* 2010). When service users deny thoughts of self-harm, non-mental health staff may not be aware that denying suicidal ideation does not necessarily mean that the individual is not a suicide risk. For example, access to means, recent clinical condition, past suicide history, evidence of poor coping, medication non-concordance, diagnosis, family adversity or social loss, living environment and substance misuse can all contribute to increased risk for suicide (Joint Commission Resources 2007).

Risk Furthermore, when individuals initially seem at low risk for violent behaviour, non-mental health staff may not fully document additional indicators. The presence of pervasive developmental disorder, such as autism or Asperger's syndrome, can also make documentation of psychiatric symptoms challenging (Chaplin 2011, Matson and Shoemaker 2011, Krch-Cole *et al* 2012). Here, past levels of risk, previous dangerous behaviour, severity of mental illness, degree of impulsivity, level of insight, non-concordance with treatment, missed contact with clinicians, access to weapons and misuse of substances can all contribute to increased risk for violence. These should be assessed, documented and communicated in handovers between care settings (Ignelzi *et al* 2007). With rapid admissions at night, family members may not be around to offer their input in emergency department assessments, clients can be incoherent, sedated or exhausted.

At night, observation of bedrooms and other areas may not be thorough because of the dark and a fear of waking up clients

Physical health Documentation of comorbid medical conditions may also be abbreviated on night shift. Although seriously mentally ill people experience poor physical health to a greater extent than the general population, assessing physical health needs can be ignored or neglected in inpatient settings (Reeves *et al* 2010, Howard and Gamble 2011). Mental health status can exacerbate asthma (Roy-Byrne *et al* 2008), cardiovascular disease, cancer and perinatal complications (Weiss *et al* 2009). Individuals diagnosed with mental illness, particularly those with the dual diagnosis of mental illness and substance misuse, are at high risk of acquiring and transmitting HIV (Ngwena 2011). Service users may not be able to describe prescribed medications and treatment plans for either their medical or mental health conditions. In these instances, nurses are responsible for documenting that the history is incomplete and identifying areas that need further exploration the following day.

Medication errors A review by the APA's committee on safety revealed that medication errors were second only to suicide as frequent sentinel events occurring during psychiatric care (Perez and Jayaram 2009). The committee emphasised that medication errors on inpatient mental health units happened in large part because of inadequate communication, 'especially at transition points in the treatment process. Situations that require particular vigilance include patient transfer among different levels or locations of treatment... between medical unit and mental health unit'. Night nurses can help prevent errors related to miscommunication of care orders written in the emergency department by reviewing these with the handover nurse before actually receiving the person on the unit (Branowicki *et al* 2003, Chevalier *et al* 2006, Henry and Foureur 2007).

Given the importance of admission documentation in providing safe care, night nurses' assessment of clients' risk of harm to self or others, their comorbid medical conditions and medications are critical. In addition to the challenges of working at a time when organisational factors may not be at their best, when maintaining environmental safeguards are particularly challenging and when vigilant documentation is required, night nurses also experience stress related to an inpatient mental health environment. In the following section, we comment on how service users and staff feel about safety.

Perceptions of safety

Anxiety related to the experience of admission can be heightened for people at night. Through the eyes of our clients, inpatient units can be seen as unsafe places, where they are subject to aggression, bullying, theft of their personal property and widespread use of drugs and alcohol (Jones *et al* 2010). Having a violent patient near their bed is a major source of stress (Latha and Ravi Shankar 2011). Institutional measures of control, such as seclusion and restraint, have been perceived as potentially harmful or traumatic, and may increase feelings of frustration and social exclusion which could, in turn, lead to aggression, self-harm and treatment refusal or deterrence (Grubaugh *et al* 2007, Bowers 2009, Stubbs *et al* 2009).

Inpatient units can trigger feelings of powerlessness and re-traumatisation, particularly among women who have experienced abuse, trauma and violence (Victorian Government Department of Human Services (VGDHS) 2008). Orientation strategies have been suggested for decreasing admission anxiety; for example, creating a buddying system where newly admitted individuals spend time with stable service users (Jones *et al* 2010), discussing the traumatic event with a staff member (Grubaugh *et al* 2007) and creating all-female spaces on the unit (VGDHS 2008). Once again, these options are less likely to be available at night.

Hospital-based nurses on inpatient mental health units have described their work environment as 'perilous' (Kindy *et al* 2005). They report high rates of emotional exhaustion and job strain (Leka *et al* 2010). Staff can feel as though they are frequently subjected to violent and aggressive behaviour from clients and, fearing that they will be hurt, may feel disinclined to engage (Currid 2009). Incidents of self-harm can leave nurses feeling apprehensive and resentful (Thangavelu 2010). Education in compassionate aggression management techniques may play a role in helping nurses to cope with these situations (McGill 2006, Kynoch *et al* 2009, Lepping *et al* 2009, Moylan 2009), but the sessions would likely be held during the day shift. Scheduling may not allow night nurses to attend in-service training opportunities.

Handover tool

As the preceding discussion illustrates, night nurses face unique challenges during admissions. Pressure to decrease emergency waiting times can result in individuals being rapidly transferred into mental health unit beds. Transfer of care information may be incomplete. Managing these admissions in ways that maintain a culture of safety throughout the unit requires a complex understanding of mental health nursing skills, knowledge and attitudes.

Straightforward processes for communicating essential client information during handovers are critical (Nadzam 2009). One such process is a checklist. Checklists can help 'ensure consistency and completeness in carrying out complex tasks' (World Health Organization 2010). They also benefit nurses in that they have been known to minimise paperwork, reduce time pressures and avoid repetition (Reeves 2011).

The following checklist (Figure 1) was created by the authors for our jurisdiction of Calgary, Alberta, Canada, through a process of consulting an administrator, a quality improvement consultant and nurse colleagues in mental health inpatient services. We also reviewed international literature on safe practices in mental health inpatient units and drew on our clinical practice experience.

Literature explaining organisational factors, environmental safeguards, documenting of assessments and of how service users and mental health nurses feel about safety all supported the development of the questions on the checklist.

For example, being aware that:

- Problematic organisational factors, such as medication errors, are associated with the restricted staffing expected on night shift.
- We posed questions to ensure that any medications received before arrival at the unit are communicated.

- High risk environmental safeguards, such as observing darkened private spaces, are difficult to manage on night shift. We posed questions to ensure that clients' belongings are checked for objects they may use to harm themselves or others.
- Documenting assessments such as risk of self-harm, risk of violence and comorbid medical conditions can be abbreviated on night shift.
- We designed our questions to elicit information clearly targeting these critical areas. Since service users and nurses experience incidents of aggression, restraint and seclusion as highly stressful, we set questions to help identify untoward behaviours.
- Miscommunication in relation to patient care orders (medical instructions) can occur during transfers. We suggested that handover nurses should review client care orders with receiving nurses before clients arrive. Receiving nurses can clarify whether assessments and medications are complete or incomplete.

Feedback Anecdotal responses to the tool at our facility have been overwhelmingly positive, particularly for new and temporary staff. Our goal is to offer a starting point for other nurses to create a set of relevant questions. The checklist is designed to be an open-ended handover tool that responds to Delaney and Johnson's (2006) call for nurses to uncover and articulate embedded clinical knowledge. We invite readers to review the checklist (Figure 1), evaluate its construction and consider what else could be included.

Figure 1 Night shift admission checklist

Report taken by: _____ From: _____ Date / Time: _____	
Information /Identity	Name: _____ Gender: _____ Age: _____ If patient is a minor, have their parents/guardians been notified? ☐ Yes ☐ No Is patient an emancipated minor? ☐ Yes ☐ No If patient has a pervasive developmental disorder (PDD) diagnosis, have their guardians been notified? ☐ Yes ☐ No
Diagnosis Reason for Admit	Mental health diagnosis: _____ Reason for admission: _____ Level of care ordered: _____
History	Prior mental health history? ☐ Yes ☐ No If yes, specify: _____ Medical diagnosis/comorbidities? ☐ Yes ☐ No If yes, specify: _____ Did patient come to the hospital voluntarily? ☐ Yes ☐ No
Mental status	What is patient's current mental state? (Tick those which apply) ☐ Agitated ☐ Aggression ☐ Confused ☐ Sedated ☐ Hallucinating ☐ Delusional ☐ Other, specify: _____
Medical status	Are current vital signs normal? ☐ Yes ☐ No If no, specify: _____ Any current acute medical issues? ☐ Yes ☐ No If yes, specify: _____ Any current abnormal lab/diagnostic results? ☐ Yes ☐ No If yes, specify: _____
Legal	Was patient brought to hospital under the Mental Health Act? ☐ Yes ☐ No If yes, specify: _____ Has patient been informed s/he is being detained under the Mental Health Act? ☐ Yes ☐ No If patient is a minor or has a PDD diagnosis, have their parents/guardians been notified of Mental Health Act certificates? ☐ Yes ☐ No Does patient have any current legal concerns (including forensic involvement)? ☐ Yes ☐ No If yes, specify: _____
Self-harm	Has a suicide risk assessment been completed? ☐ Yes ☐ No If yes, what level of risk was assessed? ☐ Low ☐ Medium ☐ High Known incidents of self-harm during previous hospitalisations? ☐ Yes ☐ No If yes, specify: _____
Aggression	Is patient in possession of items of potential risk to self/others? ☐ Yes ☐ No If yes, specify: _____ Prior history of aggression? ☐ Yes ☐ No If yes, specify: _____ Has patient expressed homicidal ideation? ☐ Yes ☐ No If yes, specify target of ideation: _____ Patient's current level of impulse control? ☐ Low ☐ Moderate ☐ High Has seclusion or restraint been required since arrival to the facility? ☐ Yes ☐ No If yes, specify type, frequency and duration: _____
Substance use	Does patient have a history of drug/alcohol misuse? ☐ Yes ☐ No If yes, specify substances/approximate quantity used daily: _____ Is patient currently under the influence of drugs/alcohol? ☐ Yes ☐ No Known history of delirium tremens/blackouts/seizures? ☐ Yes ☐ No Does patient smoke? ☐ Yes ☐ No
Medications	Has patient received medications for mental health or medical reasons since arrival at the facility? ☐ Yes ☐ No If yes, specify: _____ Any untoward side effects? ☐ Yes ☐ No If yes, specify side effect(s) and action(s) taken: _____ Known allergies/sensitivities: _____
Review	On review of patient's care orders with facility staff consider: Asking the handover nurse to review all orders to ensure they are understandable and complete. Do any require clarification? ☐ Yes ☐ No If yes, specify: _____ Are additional orders required given the patient's current mental/medical status? ☐ Yes ☐ No Does the patient's status warrant change into hospital attire before leaving the emergency department? ☐ Yes ☐ No

Conclusion

The checklist presented in this article was created from practical everyday knowledge that night nurses need in their effort to maintain a culture of safety when admitting someone from the emergency department. Mental health symptoms can be expected to be pronounced on admission and new clients may be likely to demonstrate behaviours that can be harmful to themselves or others. Routine safeguards in place during the day and evening shifts are often adapted at night to promote clients' sleep: as a result service users and staff can feel unsafe. Assessment documentation may not be complete. Although each hospital will have individual admission policies, the checklist can be adapted to include these. The work extends existing knowledge about admission assessments by creating questions and highlighting priority issues that are unique to the night shift.

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Self-Mentoring: Five practical strategies to improve retention of long-term care nurses



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Citation

Gordon, K. & Melrose, S. (2011). Self-Mentoring: Five practical strategies to improve retention of long-term care nurses, *Canadian Nursing Home*, 22(2), 14-19.

Unveiling the challenges of working in long term care is not straightforward. As a consequence of an aging population, nursing home clients present with more complex needs.

Our aging population

The identified percentage of the Canadian population aged 65 and older was very small throughout much of the 20th century (5-8%); however, low fertility rates, longer life expectancy and the effects of the baby boom generation have contributed to the aging of the population (Statistics Canada, 2007).

The number of seniors in Canada increased from 2.4 million to 4.2 million between 1981 and 2005 and their share of the total population increased from 9.6% to 13.1%. This trend is anticipated to accelerate with older age groups becoming increasingly represented in future generations (SC, 2007).

Due to the influence of chronic conditions, multiple morbidities and high rates of cognitive impairment, these older adults are at increased risk for adverse incidents such as confusion, falling and incontinence (Turner, et al., 2001; SC, 2007). In turn,

these adverse incidents place mounting pressure on LTC facilities to retain nursing staff with the geriatric-specific knowledge and training needed to care for them (Turner et al., 2001; Hegeman et al., 2007).

Coping with staff shortages

Health Canada (2007) predicts a shortage of 80,000 to 100,000 nurses by the year 2016 and identifies a loss of two to three nurses for every five graduates within the first five years of graduation.

In 2008, the average age of a registered nurse (RN), a registered psychiatric nurse (RPN), and a licensed practical nurse (LPN) was 45.1 years, 47.5 years and 43.4 years respectively (CIHI, 2010).

Scarce nursing resources

The average entry age into nursing professions following graduation is currently age 30 or older, with nurses aged 40 to 60 constituting 58.3% of the RN workforce, 63% of the RPN workforce and 55.2% of the LPN workforce (CIHI, 2010). These statistics suggest a significant portion of the nursing workforce could begin retiring in the next decade.

Scarce nursing resources have been identified as harmful to patient care by the Canadian Health Services Research Foundation (CHSRF, 2001; 2006). This loss of experienced nurses leaves novice staff with limited mentors.

Job Strain

Recurrent episodes of health care restructuring in Canada, with a focus on cost and efficiency, have created job strain (Rankin and Campbell, 2006; Health Canada, 2007). Increased complexity of patient care, staffing issues, shift work, heavy workloads, inter-staff conflict, scarce resources and limited organizational support contribute to stressful work environments (CHSRF, 2001; 2006; Health Canada, 2007).

Health Canada (2007) and Pellico and colleagues (2010) reported that the working conditions of nurses impacts their individual health, their professional satisfaction and the efficiency of the entire health care system – including the capacity of the health care system to retain nurses.

The LTC environment

Long-term care practice environments face additional job strain including:

- an aging population of clients and increasing prevalence of age-related diseases;
- an aging and shrinking nursing workforce in long-term care;
- ageism;
- perceived lack of status for aged care work;
- poor image of aged care nursing;
- the physically and emotionally demanding nature of working with clients over long periods of time;

- troubling turnover rates of direct care staff;
- complex clients who require in-depth assessments, often without the aid of medical technology;
- utilization of a variety of licensed nursing staff and unregulated employees precipitates role confusion and limited training/career advancement opportunities (Health Canada, 2007; Hegeman et al., 2007; Hirschfield, 2009; Fussell et al., 2009).

Coping with increasingly complex clients, nursing staff shortages and sustained job strain are important consideration in the area of nurse retention and mentoring programs.

Benefits of mentoring

Mentoring positively influences professional outcomes and can occur in all domains of nursing practice including direct care, education, research and administration (CNA, 2004). The benefits of mentoring include:

- decreased social stress;
- increased job satisfaction and sense of professionalism (CNA, 2004; Bryson, 2005; Hurst and Koplin-Baucum, 2003);
- development of leadership skills (Owens and Patton, 2003; CNA, 2004; Miller et al., 2008; Morrow, 2009);
- opportunity to become a fully functioning and contributing member of the profession (Thorpe and Kalischuk, 2003);
- increased self-confidence and professional competence (Brey and Ogletree, 1999; Miller et al., 2008); and
- enhanced intrinsic motivation that supports research in aging (Wells and Short, 2010).

Benefits to health care

Health care organizations benefit from nurse-mentoring strategies by the development of nurse leaders (Owens and Patton, 2003; CNA, 2004), and the monetary benefits associated with the retention of committed nursing professionals (CNA, 2004; Grindel, 2004; Scott, 2005; Lacey, 1999). Also, Cummings and colleagues (2008) reported that mentoring increased nurse productivity levels, enhanced organizational communication, and improved retention initiatives and leadership skills.

Lee and colleagues (2009) reported mentoring enables nurses to become more knowledgeable, sensitive, focused and committed to care that is tailored to the specific needs of older adults and their families.

Mentoring positively impacts nurse retention. Ashley (1980) identified the emotional aspects of mentorship (i.e., caring and support) as a potential strategy for nurses to establish a community of caring to improve their ability to gain the necessary power to collectively control nursing practice and the destiny of their profession.

Hale (2004) and Walsh (2008) suggested that social support and mentoring enhanced employee satisfaction and resulted in improved nurse retention. AbuAlRub (2004) acknowledged mentoring as a positive influence on job performance which enhanced quality patient care, reduced stress, and resulted in higher rates of nurse retention.

Block and colleagues (2005) recommended the adoption of a mentoring model which supported long-term growth and retention of nurses by providing structured systems that enhance job satisfaction.

Hegeman and colleagues (2007) offered mentoring programs as one method to increase nurse retention and prevent the deleterious effects of high staff turnover rates on coworker relationships and client care. Lastly, Escallier and Fullerton (2009) highlighted mentoring as having potential in relation to minority student retention.

Loss of public trust

A significant number of Canadian nurses (RNs, RPNs and LPNs) are expected to retire in the near future (CIHI, 2010). Retaining an adequate long-term care workforce who are competent and enthusiastic about caring for older adults will become increasingly critical as the population ages. Failure to act could endanger patients, increase nursing workload, exacerbate staff shortages, deteriorate working conditions, and, perhaps most significantly, result in a loss of public trust in the nursing profession (AARN, 2003; Hirschfield, 2009).

Traditional mentoring programs, heavily reliant on financial and nursing human resources, are in short supply. Innovative problem solving is required to increase the quality and quantity of nurses available to meet the health care needs of our aging society. Simply put, as nurses, we must self-mentor, or guide ourselves. Five practical self-mentoring strategies are described below.

Strategy #1 Reflection

Rapid changes in health care and the increasing complexity of nursing practice can be daunting to both novice and experienced nurses in long-term care settings. Negative impacts on patient care and nurse retention can also result.

Advances in science and technology, changes in the nursing workforce, staffing patterns, the organization and structure of work environments, and a global recession are additional challenges (Yannaco, 2005).

One self-mentoring strategy that helps to combat the sense of professional isolation, uneasiness and discouragement nurses may experience is 'reflection.' Thinking about past events and circumstances, about role models, and work and/or clinical experiences which influenced the pursuit of a nursing career can assist in recognizing the value of caring for the oldest and frailest of our society.

These 'reflections' can help reclaim the courage and spirit to make a difference for these patients/residents and the nursing profession. Nurses need to consider the following:

- individual accountability for growth and development;
- personal levels of self-motivation;
- awareness of personal strengths and limitations;
- comfort with self-directed learning;
- feelings regarding situations in which they are involved;
- openness to and acceptance of feedback and willingness to take risks by accepting challenging assignments and new responsibilities (Theobald and Mitchell, 2002; Bower, 2003; Lacey, 1999; Morrow, 2009).

Taking the time to reflect upon one's practice and learning needs, including supports required, is crucial for the continued evolution of nurse thinking and the advancement of professional knowledge and skill (Lee et al., 2009). 'Reflection' also helps nurses reconnect with the values, beliefs, goals and ideologies of their practice, thereby productively serving the nation's aging population and their health care needs.

Strategy #2 Continuous learning

Nurses have a responsibility to continually grow and refine their practice in light of their patients/residents' needs and the

multiple constraints imposed by the health care system – and using the most current and appropriate information when making decisions. In short, they must become self-mentoring, reflective and autonomous learners.

This type of personal development can take place in a multitude of contexts outside of traditional educational institutions. Consider the following:

- maintaining a spirit of openness and inquiry: learning often comes in unexpected ways and unexpected sources such as exposure to healthy older adults in natural settings (Bernard, 2004).
- Subscribing to journals in geriatrics to enable review of relevant research articles, both qualitative and quantitative (e.g., *Canadian Journal on Aging*, *Nursing Older People* (CAG), *International Journal of Older People Nursing*, *Nursing Perspectives*, *Journal of the Gerontological Nursing Association of Ontario*, *Canadian Nursing Home*, etc.). Clarify if employer/facility funding is available to enable colleagues to access these and other journals.
- Identify online resources (websites) which offer evidence-based information in nursing, such as:
 - RNAO: Long-Term Care Best Practices Initiative: <www.rnao.org/Page.aspx?PageID=122&ContentID=2589&SiteNodeID=133&BL_ExpandID=>.
 - RNAO's "The Nursing Best Practice Guidelines Project: Shaping the future of nursing." <http://cms.tngsecure.com/Hle_download.php?ffile_id=353>.
 - "Patient Safety and Quality: An Evidence-based Handbook for Nurses." <ahrq.gov/qual/nurses/hdbk/>.
- Share articles of interest with coworkers. Consider starting a journal club or discussion group in your employment setting.
- Look for opportunities to participate in the research process specific to your learning needs which can include: involvement in quality improvement projects (e.g., nursing management of older adults), community needs assessments, and becoming a research assistant to nurse educators. These activities can improve one's appreciation of the importance of research in guiding excellence in practice (Wheeler et al., 2008; Wells and Short, 2010).
- Build networks and a sense of community (e.g., join the Canadian Association on Gerontology or the Canadian Gerontological Nurses Association). Attend conferences or join social networking sites that focus on gerontological nursing.
- Join a geriatric interest group which may open the door to peer mentoring opportunities. Consider starting one if one does not exist in your area. Examining one's own practice and comparing it with those of a group of peers is an important factor that facilitates learning and retention (Bourduas, 2001; CNA, 2004; Scott, 2005; White, Buhr and Pinheiro, 2009; Lee et al., 2009; Stewart and Carpenter, 2009).
- Take advantage of electronic learning opportunities as they relate to areas of clinical interest (Miller et al., 2008; Blake, 2009), including the following:
 - E-Nursing-Strategy for Canada: <cna-aiic.ca/CNA/documents/pdf/publications/E-Nursing-Strategy-2006-e.pdf>.
 - CNA's NURSEONE: <www.nurseone.ca>.
- Consider obtaining voluntary national certification in gerontology from the CNA. See: <www.cna-aiic.ca/CNA/nursing/certification/default_e.aspx>; Also, the CNA Specialties/Areas of Nursing Practice: <www.cna-aiic.ca/CNA/nursing/certification/specialties/default_e.aspx>.
- Seize the opportunity to serve as a mentor to new nurses/students. Consider becoming involved with the Canadian Association on Gerontology Student Mentorship Program. Benefits include: personal and professional development via shared learning and caring (Owens and Patton, 2003); professional renewal, enhanced professional image and potential development of new knowledge via collaboration (Brey and Ogletree, 1999; Scott, 2005, White et al., 2009; Lee et al., 2009; Stewart and Carpenter, 2009), and reducing the stigma associated with specialty areas of nursing practice (Menninger Clinic, 2008).
- Consider electronic (i.e. web-based) mentoring opportunities in nursing.

This format offers the following:

- a forum for knowledge exchange;
- skill building and access to unfamiliar resources;

- improves communication skills;
- requires less time and money than traditional face-to-face mentoring;
- expands one's network of colleagues;
- breaks down geographical and time zone barriers;
- pairs experts with novices based on learning needs;
- enhances critical thinking skills due to reflection on multiple perspectives from a global context and increases nursing knowledge of research and culture in international settings (Cahill and Payne, 2006; Rodriguez and Brown, 2000; Scott, 2005; Miller et al., 2008; O'Keefe and Forrester, 2009; Stewart and Carpenter, 2009).

Strategy #3 Make a plan

Although barriers exist (such as difficulty in obtaining time away from work to pursue educational goals, the sense of isolation when seeking to apply learning to practice, and life events such as relationships, children/family commitments and financial issues), for many nurse learners, it is important to focus on what you want to achieve in terms of professional learning and how this goal can be achieved (Melrose and Gordon, 2010).

Humanistic theorists, such as Maslow and Rogers, believed that individuals grow and develop throughout their life span. These theorists stress that adult learners are capable of identifying their own learning needs and solving their own problems (Herrick, Jenkins and Carlson, 1998; Knowles, 1990).

Allen Tough's seminal work on self-teaching and self-directed learning emphasized that learners were more likely to retain information if they were actively involved in the learning process (Tough, 1967; 1971; 1982). The self-mentoring strategies offered herein follow this same premise.

Professional satisfaction

Nurses are required to become active learners in modern health care environments, adhering to their institutional policies and mission, the provincial and territorial standards, as well as professional codes of ethics (CNA, 2008). Further, the CNA (2004) recommends the following steps be taken to enhance professional satisfaction and implement successful mentoring strategies:

- assess learning needs (i.e., think about what is important to you in your work life and write it down);
- identify personal philosophy (i.e., core values that help guide your decision making and your life);
- create a plan (i.e., learning contract);
- organize (i.e., learning goals, priorities and objectives that address your identified learning needs); and
- implement and evaluate (i.e., assess and quantify the outcome of your plan).

Initial learning areas to consider are:

- knowledge of one's organization and its' culture;
- the concept of mentoring and its' benefits and limitations;
- principles of adult learning theory;
- personal competency assessment (that is, analysis of personal strengths and limitations);
- goal setting;
- one's personal learning style (e.g., read and reflect, group discussion, hands on practice, etc.);
- identifying, choosing and practicing learning strategies;

- identifying opportunities to obtain meaningful feedback and recognizing and utilizing available resources to meet one's learning objectives (CNA, 2004).

Strategy #4 Volunteer

Participation in a special interest committee, task force, or one's professional nursing association benefits both nurses and patients. Involvement in these organizations offers opportunities for networking, knowledge sharing, staying current with best practices, promotion of the nursing profession, (provincially and nationally), and development of leadership skills and visible support of the nursing discipline and the group's mission (Hill, 2008; Felton and Van Slyck, 2008).

Volunteering and getting involved professionally enhances one's knowledge of health care organizations and their structure, the nurses' individual and collective ability to affect health care policy and direction, as well as impact client outcomes as a result of nursing actions. Volunteering also furnishes opportunities to give back to the profession (Hill, 2008; Felton and Van Slyck, 2008). In short, volunteering offers long-term care nurses' significant personal and professional rewards and a legitimate venue to learn and remain actively engaged in their work.

Strategy #5 Communicate

The final strategy is taking the opportunity to share one's experiences and stories with colleagues, and encouraging them to do the same. Each nurse has a unique story with respect to what brought them into nursing, and into aged care specifically, and each deserves respect and thoughtful consideration.

When engaging in collegial discussions, endeavour to recognize the inherent diversity of Canadian nurses and acknowledge their different needs, challenges, desires and goals.

Peers and co-workers contribute to each other's learning (Dixon, 1993; Hurst and Koplin-Baucum, 2003; Scott, 2005; White et al., 2009; Lee et al., 2009; Stewart and Carpenter, 2009). The generous sharing of personal insights, experience and knowledge could inspire the development of innovative venues for ongoing dialogue in which to contribute ideas, learning and resources with others who are committed to life-long learning in gerontology.

Lastly, speak of the values that have been integrated during professional growth and development such as: openness to new ideas, willingness to submit one's ideas and beliefs to critical reflection, and a confidence in the power of collaborative learning, essential for today's long-term care nurses when addressing the complex challenges in contemporary health care.

Conclusion

This article presents five self-mentoring strategies for nurses to consider:

1. reflection
2. committing to continuous learning
3. making a plan
4. volunteering, and
5. communicating

These strategies offer an economical and effective tool for long-term care staff to enhance recognition of their valuable contributions and commitment to a culture of excellence in resident care. They also provide tangible personal and professional development and “caring” in all stages of one’s nursing career. Health care organizations also benefit.

Although challenges exist in the implementation of these strategies (e.g., time demands, cost, etc.) much can be done by committed staff to ensure nurse retention and the continued provision of safe, high quality elderly care.

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Immunizing Children Who Fear and Resist Needles: Is it a Problem for Nurses?



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Abstract

Despite increasing evidence that immunization procedures can be stressful for children, little is known about what the experience of immunizing frightened and needle resistant children can be like for nurses. This article presents findings from a qualitative research project designed to explore public health nurses' feelings towards immunizing needle resistant children. A constructivist theoretical perspective and an action research approach framed the study. Data sources included two survey questions and audio recorded transcribed data from three focus groups. Participants included 35 public health nurses from five different health units in one Canadian province. The data was analyzed for themes and confirmed with participants through ongoing member checking. The following four overarching themes were identified and are used to explain and describe significant features of the immunization experience that were stressful and problematic for nurses: 1) Nurses experience stress when immunizing children who fear and resist needle injection; 2) the strength of child resistance and some adult behaviour creates an ethical

dilemma for nurses; 3) some adult responses make immunizing difficult and unsafe; 4) resources to help nurses cope with these situations are inconsistent.

Keywords: immunization, fear of needles, resistance to needles, nurse stress

This article describes findings from a qualitative research project that investigated the experiences, reflections and feelings of public health nurses who immunize fearful and needle resistant children. While the main purpose of the study was to explore nurses' ideas about the experience of immunizing children who are frightened of needles, a secondary purpose was to consider approaches that are helpful in decreasing nurse stress. The research was guided by the question: *What is it about immunizing children who strongly resist needle injection that is a problem for public health nurses?*

Literature Review

A literature review revealed that a significant number of children and adults are frightened of procedures involving needle injections. Considerable research has been undertaken to investigate adult responses that are both non-helpful and helpful in easing children's distress during these procedures (Duff, 2003; Cohen, Manimala and Blount, 2000; Smalley, 1999; Milgrom, Coldwell, Getz, Weinstein and Ramsay, 1997; Frank, Blount, Smith, Manimala and Martin, 1995; French Painter and Coury, 1994; Schecter, N.L., Bernstein, B.A., Beck, A., Hart, L. & Scherzer, L. (1991). Yet few resources are available to help nurses understand their own responses or to cope with their feelings of stress. Ives (2007) emphasized how health care agencies can begin to address the problem by creating a culture of empathy and respect and outlining clear policies on the use of force during immunizations. There is a "gap," however, in our understanding of how nurses themselves perceive the experience of immunizing frightened and resistive children.

Fear of Needles

Literature from the fields of psychology, nursing, pharmacology, medicine, and dentistry reveal fear of needles as one of children's greatest fears with claims that up to 93% of some groups of children experience serious immunization associated stress (Gaskel, Binns, Heyhoe & Jackson, 2005; Uman, Chambers, McGrath & Kisely, 2005; Jacobson et al., 2001; Peretz & Efrat, 2000; Bowen & Dammeyer, 1999; Smalley, 1999; Polillio & Kiley, 1997; Marten, Ramsay, Whitney, Fiset & Weinstein, 1994). Research reflects that as many as 10% of adults experience needle phobia (Bowen and Dammeyer, 1999; Smalley, 1999; Polillo and Keley, 1997; Hamilton, 1995). Clearly, nurses can expect to encounter both children who are frightened and resistant to needles as well as parents or caregivers who are also fearful.

In his seminal work exploring needle phobia, Hamilton (1995) hypothesized that needle phobia is learned as well as inherited. He noted how negative experiences associated with immunization, lab work, dental visits and other medical procedures can condition children and even those who witness the events towards becoming fearful of needles. Physical restraint and verbal abuse by health care personnel during children's medical procedures can lead to life-long fears of situations associated with needles, such as physicians, nurses, examination rooms and even antiseptic smells (Hamilton, 1995). Later, Duff (2003) argued that needle fear centers on anticipatory and procedural stress and advocated for inclusion of psychological approaches to help children actively gain a sense of control over their reactions.

Non-helpful and Helpful Adult Responses

Parent and caregiver responses, particularly anxiety related behaviors, influence how children can reduce stress, gain control and cope with immunization. Some adult responses have been found to be non-helpful. Parents or caregivers who overly reassured, overly empathized, apologized, criticized or gave children control of the procedure at the beginning increased children's stress (Cohen, Manimala & Blount, 2000; Frank, Blount, Smith, Manimala & Martin, 1995). Further, parents and caregivers who criticized or asked the child to indicate readiness to receive the needle also increased children's stress (Devine, Benoit, Simons, Cheng, Seri & Blount, 2004). Children coped best when their mothers were present but 'watched only' and remained minimally involved. Most children found the presence of their parents during a needle procedure to be helpful (Duff, 2003; O'Laughlin & Ridley-Johnson, 1995).

Distraction strategies were consistently identified as helpful for short-lived pain (Gaskel, Binns, Heyhoe & Jackson, 2005; Duff, 2003; Lawton & Rose, 2003; Sparks, 2001). With infants, playing with an object, sucking, belly-to-belly contact and nonprocedural talk were helpful (Blount, Devine, Cheng, Simons, Hayutin, 2008). Similarly, with infants, adult verbalizations associated with better pain outcomes reduced crying (Bustos, Jaaniste, Salmon, Champion, 2008). With children ages 4 to 6, watching cartoons and being coached to attend to the movie helped (Cohen, Blount & Panopoulos, 1997). With children ages 5 to 18, bubbles, books, music table, virtual reality glasses, or handheld video games helped (Sjoberg, Dale, Eshelman & Guzzetta, 2007). With most children, preparing ahead (Duff, 2003), offering limited choices (Ellis, Sharp, Newhook & Cohen, 2004) and giving permission to cry (Cohen et al 2000) reduced stress. Deferring the procedure or referral to an alternate source such as play therapy helped to avoid conflict and coercion (Duff, 2003; Smalley, 1999; Milgrom, Coldwell, Getz, Weinstein and Ramsay, 1997; French, Painter and Coury, 1994). Distinguishing among adult responses that are helpful and those that are non-helpful offers important guidance to nurses when they work with children who resist needles. However, responses to nurse stress are not as clearly defined.

Nurse Stress

Stress can be experienced when demands exceed the personal and social resources an individual is able to mobilize (Lazarus & Folkman, 1984). While it is beyond the scope of this article to present a detailed literature review of nurse stress, a snapshot of current work in the area reveals limited attention to nurses immunizing frightened and resistant children. The apparent need to "force" an immunization has been identified as an ethical dilemma for nurses, even constituting "a human rights burden" (Hodges, Svoboda & Van Howe, 2002, p. 12). Nurses remembered moral dilemmas, when they were left to wonder 'Could I have done anything else?' even years later, continuing to justify and absolve themselves from blame (Gunther & Thomas, 2006).

Nurses felt powerlessness, angry, exhausted and even burned out following their participation in situations they believed were ethical and moral dilemmas (Thomas, 2009). Coping with the emotional needs of patients and families has consistently been highly stressful for nurses (McVicar, 2003; Sherman, 2004). Avoiding coping rather than identifying that a problem exists and focusing on coping with it were found to be significant predictors of mood disturbance for nurses (Healy & McKay, 2000). Given our limited understanding of links that may exist between negative immunization experiences and nurse stress, it is essential to explore the problem.

The Research Approach

This project was framed from a constructivist theoretical perspective (Appleton and King, 2002) and a naturalistic action research design (Kemmis & McTaggart, 1988; Kemmis & McTaggart, 1990; Stringer & Genat, 2004). Action research is a reflective, spiral process where nurses use research techniques to examine their own practice carefully, systematically and

with the intention of applying their findings directly to their own and other nurses' every day practice. Kemmis and McTaggart (1988) offered the seminal explanation that action research is deliberate, solution-oriented investigation that is group or personally owned and conducted. It is characterized by spiralling cycles of problem identification, systematic data collection, reflection, analysis, data-driven action taken, and, finally, problem redefinition. The linking of the terms "action" and "research" highlights the essential features of this method: trying out ideas in practice as a means of increasing knowledge (Kemmis and McTaggart, 1988). Kemmis and McTaggart (1990) also suggested that the participatory nature of action research, where researchers collaborate with participants in order to understand and improve practice, can reduce the distance between researchers and participants and the "... problems they intend to solve, or the lived experience they intend to interpret" (p. 28).

Data sources included two survey questions and audio recorded transcribed data from three focus groups. The survey was distributed anonymously via employee e-mail to 58 nurses from five different health units in one Canadian province. Survey Question One: Does your practice involve immunizing children? Survey Question Two: "Sometimes children who present for immunization strongly resist needle injection. Based on your experience, what is it about this situation that is a problem for you?" This survey generated 35 (60%) responses, all of whom confirmed that their practice did include immunizing children.

The survey was followed by three audio taped and transcribed focus groups. The focus groups were two weeks apart, each with five to six female, English speaking, Caucasian and Indo Canadian nurses, from five different health units in one Canadian province. The participants were those who had responded to the survey and their experience ranged from novice (less than one year experience) to expert (up to 25 years experience) in two groups. The third group had no novice participants. Focus groups are flexible, cost efficient, generate rich data and tend to have high face validity (Krueger & Casey, 2009; Morrison-Beedy, Cote-Arsenault, Feinstein, 2001; Speziale & Carpenter, 2001; Webb & Kevern, 2000). The following questions guided the discussion:

1. When you hear the phrase, "a child who is strongly resistant to needle injection," what comes to mind?
2. What is it about these situations that is challenging for you?
3. What sorts of things have made it easier for you to immunize children who resist the needle injection?
4. What sorts of things have made it harder?
5. Do you have any thoughts on how these situations can be improved?

Content from these data sources were analyzed for themes. The transcripts were thoroughly read and re-read and a systematic process of content analysis was developed (Loiselle, Profetto-McGrath, Polit, & Beck, 2007; Speziale & Carpenter, 2003) to create the categorization and coding scheme that led to the themes. Trustworthiness was established through ongoing interaction and member checking with participants to confirm authenticity. Full ethical approval was granted by a university and a health authority.

The following four themes emerged from analyzing the survey and focus group data collected from and confirmed with nurses who routinely immunized children. The themes represent nurses' perceptions of what it was about immunizing frightened and resistant children that was a problem for them. Verbatim comments are italicized. The themes are: 1) nurses experience stress when immunizing children who fear and resist needle injection; 2) the strength of child resistance and some adult behaviour creates an ethical dilemma for nurses; 3) some adult responses make immunizing difficult and unsafe; and 4) resources to help nurses cope with these situations are inconsistent.

Theme One: Nurses experience stress when immunizing children who fear and resist needle injection.

Nurses used the word "*dread*" in all three focus groups to describe their apprehension about immunizing needle resistant children, especially as a new practitioner. They described the situations as awkward, difficult and complex, with "*too many pieces*" or variables. Nurses frequently recounted actual experiences to illustrate specific points. Feeling "*flustered*" and fearful

of making a medication error or harming the child, as well as fear for the nurses' own safety was reported in the survey and across all groups. Empathy for the child's *"incredible panic and fear"* was articulated, noting the child's *"terror"* and *"screaming, kicking, and biting"* behaviours as very disturbing. *"I think of how hard it is to be scared. Like that's so much work on the child's part. It takes so much energy."*

Crying was not seen as particularly difficult, but *"acting out"* behaviours, *"struggling to get away, to get out of the room"* were problems. *"The child's terror, that's what gets to me."* *"I feel really badly for the child because they're embarrassed...and they're kind of shamed."* The nurses felt *"torn"* about the process. They found it *"very disturbing"* to witness the child's distress and felt *"complicit in an assault."* They described feelings of helplessness and uncertainty, wondering how *"it might have been done differently."* One nurse wrote, *"I don't know how to make these situations more comfortable."* Nurses felt *"...pressured to just finish the job, no matter how much the child resists."* Novice practitioners were more likely to feel pressured. *"Throughout my orientation it was very heavily implied, it does not matter the situation, you always vaccinate children for as many vaccines as they're eligible for. And I just feel a lot of pressure to do that during that clinic visit."* Sometimes, the pressure comes from parents. *"I've had two, three different scenarios where...the anger from the parents like, 'Whaddya mean... And they're going to argue with you. 'I (parent) will hold them down and you **will** do it.'"*

The nurses reported feeling drained, emotionally exhausted, fatigued and unsupported. A sense of failure, guilt, *"heavy heartedness"* and frustration was expressed, as well as a *"scary"* feeling of being *"out of control."* One group likened the situation to *"a circus"* with *"moms chasing (children) around to try to get them in and there is a waiting room full of people."* Nurses described feeling hurt and annoyed when parents blamed and labelled them *"the mean nurse"* or *"the stabber"*. Nurses were troubled by the potential for *"emotional scarring"* and serious erosion of trust in the child's relationship with health professionals. They suspected that past experiences strongly influenced the present and believed children deserve to be better prepared for immunization.

Theme Two: The strength of child resistance as well as some adult behaviour creates an ethical dilemma for nurses.

A major theme that emerged was the conflict around the child's right to refuse versus the right to be protected from preventable disease. *"I think as a nurse, the challenge is combining that gentle persuasion but with letting them make their own decision."* *"And we're taught in our profession you know, do no harm. So you feel like you're doing harm when you encounter situations where there's such strong resistance."* A nurse wanted to find *"a balance between helping the child find courage and protecting him from very dangerous diseases."* Another stated the problem as:

"...the lack of respect it demonstrates to a child. In deciding on their behalf what is best for them I don't understand what makes that okay and at what age we give the child the control to make that decision. A problem for me is the subjectivity of deciding what's in the child's best interest; subjectivity in assessing potential harm to child versus benefit of vaccine."

Within each group, two or more nurses recounted stories of especially challenging situations they thought had been handled poorly and felt regret about their involvement in the process. *"There's some where you're going – oh that was awful! That didn't feel right. I don't feel good about that."* Children kindergarten age and older were viewed as the most challenging although some nurses also identified *"strong toddlers"* as difficult.

Nurses wondered, *"How much restraint is too much?"* A survey responder stated:

"The problem becomes one of the child's right to object and refuse... some parents like to talk their children into shots; this takes quite a bit of time. Others are quite physical in their restraint methods and I don't know exactly when to step in and say – that's enough!"

One nurse remarked:

"I don't think the end always justifies the means. Because I had a father who came in with a son and he was really quite brutal with him. And we were really part of that because, you know, it was our end that we wanted to go to and that was the reason why. And I thought, I'm never doing that again. I'm just going to say, 'I'm sorry, I can't do this. This is beyond what I can be part of.'"

Another recalled *"... a mother actually physically sat on her child and restrained him and slapped his face and told him how much she loved him and told him to just do it. Okay, and that's always going to come to my mind. It was like an assault, us actually harassing him."*

A colleague added:

Right, and then being torn between, Do I follow through, give it to him, get it over with for him? Will he have to go through this again? Or do I hold back and say, "Not under these circumstances." ...It was a very awkward situation. And we...you had said, "What do I do?" And I thought, "Let's get it over with for him. He'll have to go through that all over again or be bullied at home." But somehow we were then part of that.

*"It almost kind of reminds you, you know, of **One Flew over the Cuckoo's Nest**, where they have to bind them down and they give them the electrical shock treatments and they don't want it."*

A survey responder commented: *"Immunization of children is recommended, not mandatory, therefore children may have the right to refuse."* Another wrote:

"The problem I have is with the three to five year olds who clearly verbalize they don't want the shot. We hold them down and do it anyways. From a young age we teach children to use their words. We teach them to say "no" to a stranger who offers candy, rides etc. We teach them to kick, scream, and run when a stranger touches them or they feel threatened by them, yet I am a stranger to this child who is saying "no" to me and I proceed and hurt the child. What message are we sending these children?"

Children with developmental delays were particularly challenging. A nurse recalled immunizing a grade six boy with developmental delays, *"It was really hard, because he wasn't going to sit still on his own. So we had a lot of hard decisions to make with that and mom held him down. It was awful."*

In one group, a few of the more experienced nurses initially seemed somewhat dismissive of the issue as a sort of necessary evil; yet even these nurses acknowledged with some surprise after the group *"how much there was to talk about"* on the topic. Challenging variables included: *"sheer number"* of vaccines, complexities of vaccine administration, language barriers, lack of privacy in mass immunization clinics, circulating myths about needles getting stuck or breaking off in people's arms, unpredictability of some resistance, noise levels, too many people involved, and lack of time.

Theme Three: Some adult responses make immunizing more difficult and unsafe.

Non-helpful responses by adults such as parents, school staff or other caregivers were defined across all data sources as a burden to nurses. *"So often what I find makes it really difficult, because I don't know so much that I lose patience, but I'm not quite sure where to go with it when the parenting responses are so inappropriate."*

Most frequently cited non-helpful responses were: either inadequate or overly forceful restraint by the parent; shaming, threatening, yelling, slapping, lying; or alternatively, pitying, placating, bribing, wishy-washy, and helpless parental behaviours. Nurses complained of getting kicked and hit by a struggling child and expressed frustration with parents who have not explained the purpose of the visit to the child.

In school situations, nurses felt frustrated when well-meaning adults interfered with the process by attempting to take control.

It isn't suddenly about being poked anymore. There's a bunch of family dynamics there as well and they get the power stuff going, and you put the child in the school situations, sometimes it's with the classroom teacher, you know, that's involved as well, and you think, 'Oh boy, how many do we need involved in this really?' We sort of bring in all the skills you have, not just the needle part, but the kind of group skills too.

"It's tough for the nurse because, ultimately... we are in charge." Nurses reported that adults sometimes tease students in a way that increases anxiety, and that students often "rile up" each other.

Nurses disliked having competitive elements introduced into the situation. For example, parents may complain if the nurse chooses not to proceed with the immunization with comments such as: *"She couldn't do it so I need another nurse."* One nurse described her dismay if a parent would tell her, *"my baby didn't cry at all last time... with the other nurse she didn't cry at all."* I don't know why they say that to me because it hurts, it jinxes me." And finally, nurses were frustrated with parents who project their own fears onto the child or communicate to the child expectations of resistant behaviour thus generating a self-fulfilling prophecy.

Theme Four: Resources to help nurses cope effectively with these situations are inconsistent and inadequate.

Nurses voiced how existing strategies and resources to consistently support a positive immunization outcome were inadequate, inconsistently available and poorly disseminated. Nurses described strategies they used to help in these situations with mixed results. Most of the strategies were learned through trial and error or direct observation. A nurse with more than ten years of immunization experience stated: *"In a school setting, I see it as a learning opportunity of just sitting back and seeing how somebody else handles it. I'm thinking, Thank God, I'm not the one who has to deal with it."*

Nurses reported that crude forcible restraint is no longer as common as it once was. Linda related: *"I remember a principal holding a kid against the wall actually, believe that?"*

"I think we're better at saying we can't do it than, let's say, fifteen years ago. I think we used to sit on kids more than we do now. I certainly, more now than I used to, just will say, 'I can't do this'...whereas before... we used to get a couple of us in there and really, with the parent's permission of course, but were more forceful."

Several nurses described how they learned, sometimes through bitter experience, where to set boundaries.

"And also, the holding down or the forcing, I think... I do not have to give that, force that on that child. So I think that's something I've come to in my practice is that the child does not have to have it. We will not force this child to have it... and so that, yes, it is in your best interest to have this. So let's work together with parents and help them to do this. But as far as the forcing, I will not be a party to this."

"We sort of learn like where we draw the line too, and that's hard sometimes." A nurse with less than two years experience said: *"It's different in different places... like its okay for me here, to say we don't do that and I'm comfortable with that. But in another environment there might be more pressure I think, to get the thing done in a time frame."*

The nurses described being supported in choosing to defer a vaccine as very important. A novice practitioner, stated, *"I don't think it's made clear to us that we can say no, that we don't have to do it."* One survey response stated:

"Trying to put the child at ease who has become very anxious. This can be very draining and it can be difficult to know when to call it off. If you call it off, then the parent (if a kindergarten immunization) is then quite often angry. Sometimes it seems like there should be a policy or a sign that backs this up. The sign or policy stating we will not use force to immunize."

Collaborating with colleagues and being able to debrief were highly valued. Occasionally nurses recruited each other to assist

with restraint, yet as one nurse pointed out, “It’s the same thing again, like if you’re getting another nurse. And then there are two of you holding the kid down.”

Another agreed, “Yeah, it makes it like a gang mentality.” You know, we’re all ganging up on him.”

The nurses discussed what sorts of things could make it easier for them to effectively manage situations with resistant children. They recommended combination vaccines, labelled trays to hold pre-filled syringes, well-ventilated, soundproof clinic rooms, separate waiting rooms for before and after, and time to debrief after a difficult session. Strategies identified as helpful included: giving limited choices, using a calm voice, preparing parents for crying and giving children permission to cry, remaining firm but not threatening, using stickers to celebrate effort and having distraction and calming tools such as puppets, bubbles, comfort dolls and cartoon videos in waiting areas. Giving children time to express themselves but without engaging in endless negotiation is also important. Anaesthesia was not discussed except in one survey response suggesting pre-procedural child sedation.

Nurses desire skills to effectively manage immunization procedures. “I don’t have enough skills to know what the best response or techniques are to get the immunization done in a way that is most positive for everyone involved.”

“I must admit, I’m better... more compassionate with kids that I perceive as being truly afraid (than with) those that I think are... just being smart alecks. Sometimes you get a child where you think, ‘Oh, you’re just trying to pull my chain and get things riled up here. Or you see a child that is truly just terrified and I’m better with the kids that are (truly terrified), and maybe I might not even be reading it right.”

“(I)... would like to learn about more techniques for self-calming;” Another wrote, “Parents are often unaware of their child’s ability to learn some of these skills and at how young an age it can be taught.” Nurses viewed the clinic visit as an opportunity for children to acquire adaptive coping skills and experience mastery in an honest, respectful, supportive environment.

Having enough time to prepare and also to debrief with parent and child was seen as important.

“There has been no time to prepare them in anticipation of them being that way (so wound up, not being able to focus and calm down). We have nothing to offer these families. No opportunity to teach the parents... we’re rushed and the parents are in a hurry and there’s nothing else in place in another time to prepare them. We wind up being a part of it.”

They identified a need to provide parents with clear direction about positioning, secure hold and what not to say to their child, e.g., limit bribes and threats, and avoid projecting parent fears onto the child. Referral to parent education sessions was a strategy employed where available. One nurse identified the focus group session itself as a useful opportunity to “troubleshoot” and “brainstorm ideas.” Another talked about “building up your repertoire of tools” and explained how she benefited by learning strategies from other nurses that would have “never occurred to me.” The nurses expressed strong interest in educational materials that could be used by parents and children to better prepare for an immunization appointment.

Discussion

These four themes, developed from discussions with nurses who routinely immunize children who fear and resist needles, illustrate how this procedure is problematic and stressful for nurses. The intensity of nurse stress is reflected in the language participants used to describe their experiences and the vividness of their memories. The words “dread,” “awful,” “traumatizing,” “failure,” “assault,” “terror,” “fear,” and “shame” appeared frequently in the data. Casting this response against Lazarus and Folkman’s (1984) classic explanation that stress results when ‘demands exceed the personal and social resources an individual is able to mobilize’ – study findings lead us to question whether other nurses are also feeling that the demands of immunizing needle resistant children exceed their ability to cope.

The comments reflect how the experience of forcing compliance from children generates ethical and moral dilemmas for nurses. Bioethicists Hodges, Svoboda & Van Howe (2002) emphasized how heightened scrutiny is essential in situations where children, who are unlikely to be able to provide meaningful consent, are subjected to prophylactic interventions such as immunization. And yet, the issue may not be formally addressed with explicit policies and procedures in the practice arena. With the exception of the present study, the literature has not yet begun to acknowledge that a problem exists.

Nurses' descriptions of their memories of immunizing needle resistant children were consistent with the moral distress Gunther and Thomas (2006) described in their exploration of patient care events that were unforgettable to nurses. In both studies, nurses wondered whether they could or should have done things differently even years later. Descriptions of their memories in the present study also reflected a sense of powerlessness. Feelings of moral distress, powerlessness, anxiety and anger all contribute to the stress and burnout Thomas (2009) identified as a persistent issue among nurses. However, nurses' stress related to immunizing needle resistant children has not previously been included in discussions of moral distress.

Conclusion

This article presented findings from a naturalistic action research study that explored nurses' perceptions of immunizing frightened and resistant children. In contrast to other studies that focused mainly on recipients of vaccines, this project extends existing knowledge by describing nurses' reflections on their own experiences with immunizing by identifying four overarching themes. This research found nurses experience stress when immunizing children who fear and resist needle injection, the strength of child resistance and some adult behaviour creates an ethical dilemma for nurses, some adult responses make immunizing difficult and unsafe and resources to help nurses cope with these situations are inconsistent. This article calls for the creation of more opportunities to explore whether or not immunizing needle resistant children is a problem for other nurses. Articulating that a problem exists, that needle procedures are often stressful and that the experience can leave nurses feeling morally and ethically conflicted is an important first step. Further study could lead to more consistent support for nurses who are responsible for immunizing children and to more positive outcomes for all.

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Malawian Health Care Workers' Perceptions of Western Midwives: Towards Becoming a Welcome Guest



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Abstract

This article discusses a qualitative research project that explored Malawian health care workers' feelings towards western trained volunteer midwives. The project was framed from a constructivist theoretical perspective and utilized a descriptive research design. Participants included midwives, patient attendants, nurses and physicians working at the Embangweni Hospital in Malawi, Africa. Fourteen individual interviews were conducted over a three-month period. The data was analyzed for themes by two researchers and confirmed with participants through ongoing member checking. The first theme was that western midwives offer important contributions to health care services in Malawi. The second theme was that western midwives' limited knowledge of Malawian culture was problematic. The third theme was that thoughtful preparation before arriving in Malawi was valued.

KEY WORDS

Volunteer midwife contributions, Malawi

Cet article fait état d'un projet de recherche qualitative qui traite des sentiments des travailleurs de la santé du Malawi à l'égard des sages-femmes bénévoles formées en occident. Le projet a été formulé selon une perspective théorique constructiviste et un modèle de recherche descriptive. Le groupe de participants était composé de sages-femmes, de préposés aux malades, d'infirmières et de médecins de l'hôpital d'Embangweni, situé au Malawi, en Afrique. Au cours du projet d'une durée de trois mois, quatorze personnes ont été interviewées. Les données ont été analysées par thèmes, par deux chercheurs et ont été confirmées auprès des participants au moyen de vérifications continues avec ces derniers. Les trois thèmes abordés étaient les suivants : l'importance de la contribution des sages-femmes occidentales aux services de soins de santé du Malawi, la problématique posée par les connaissances limitées des sages-femmes occidentales envers la culture malawienne et l'importance d'une préparation judicieuse avant l'arrivée au Malawi.

MOTS CLÉS

Contributions des sages-femmes bénévoles, Malawi

Despite beliefs among midwives from Canada and other western nations that volunteering in developing countries can strengthen maternal care, little is known about what the experience of integrating these volunteers can look like to the health care workers who will actually practice with them. This article describes findings from a qualitative research project that investigated midwives¹ and other health care workers' perceptions of western trained midwives who travel to Malawi to volunteer at the Embangweni Hospital for a three-month period.

Malawi is a small country in sub-Saharan Africa with a population of approximately 12,000,000 people. The Embangweni Hospital was founded in the early 1900s by the Free Church of Scotland and is now operated by the Central Church of Africa Presbyterian. The hospital has 130 beds, runs an operating theatre, serves a rural population of about 100,000 and manages four health centres and sixteen mobile clinics.¹

Demographic and Health Survey data identified that the incidence of maternal mortality in Malawi was 1,120 per 100,000 live births, one of the highest in the world.²⁻³ There were 28.6 nurses (including midwives) per 100,000 people.²⁻³ Skilled birth attendants, also known as accredited midwives, were available for 55% of births.² Although traditional birth attendants or non-accredited care providers are present at many village births, it is unclear whether their presence has significantly reduced maternal mortality.⁴⁻⁵ Given that the presence of a skilled birth attendant at a birth can reduce the number of women who die in childbirth,⁵⁻⁸ if foreign midwives volunteering in hospitals such as Embangweni are perceived as welcome guests, they may be able to contribute to an immediate and urgent need to reduce maternal mortality.

THE RESEARCH APPROACH

This project was framed from a constructivist theoretical perspective,⁹ where knowledge is believed to be constructed through an individual's interactions with social processes and contexts. The design was descriptive and the findings a case study representation of one Malawian health care facility.

Robin Stott, an African-born British medical researcher, championed an investigative process of actively listening to the voices of the African people themselves. "The west is belatedly recognizing that much health research has little relevance to the world's most unhealthy people. ... We do not yet listen and learn from the people who suffer, even though they may have better solutions than we do."¹⁰

The purpose of the research was to listen to and explore health care workers' perceptions of western trained midwife volunteers. A secondary purpose of the study was to begin to consider strategies that would respond to these health care workers' needs. The research was guided by the question: "What foreign midwife contributions do workers at the hospital believe are meaningful?"

The participants in the study all worked at Embangweni Hospital in Malawi. They included each of the six staff midwives, the head nurse, a clinical officer, two patient attendants, and four American visitors (one of whom was a nurse, another was a midwife and two were physicians).

The data was collected during guided interviews with these fourteen health care workers over a three-month period. All of the participants invited the primary researcher to their homes to conduct the interviews. In keeping with Malawian customs, participants offered customary greetings and served *nsima* or traditional food during the research discussions. Typically, these in-home interviews were conducted in small brick houses across hand crafted wooden tables and with candles as the only source of light. Each interview was approximately two hours long and was initiated with the question: "How do you feel about western trained midwives coming to volunteer in the Embangweni Hospital?"

Participant responses were written down verbatim throughout the interviews.

Content from these data sources were analyzed first independently and then collaboratively by the researchers. The transcripts were thoroughly read and re-read and a systematic process of content analysis was developed to create a categorization and coding scheme leading to themes.¹¹ Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity. To ensure anonymity, pseudonyms were used when participants' comments were reported verbatim. Approval was granted from the Embangweni Hospital and all participants gave informed consent.

The following three overarching themes emerged from analyzing the data and are used to explain and describe significant features of Malawian staff members' experiences with western trained midwife volunteers. The first theme was that western midwives offer important contributions to health care services. The second theme was that western midwives' limited knowledge of Malawian culture was problematic. The third theme was that thoughtful preparation before arriving in Malawi was valued.

"Your encouragement is good. After the birth the congratulations is good."

Asmaa, Malawian mother

Theme One: Western Midwives Offer Important Contributions to Health Care Services in Malawi

Without exception, all of the staff members who were eligible volunteered to participate in the study. And, participants' comments all reflected an overwhelmingly positive attitude toward visiting midwives. However, as Jane, a visiting midwife from the United States explained: "*Sometimes people don't tell you that you may not be doing something right, Malawians are too polite. This is not a blame society.*" Sara, a visiting physician from the United States added: "*Even forthright educated Malawians may not criticize. After a long time people will tell you things, [there is a] fear of offending.*"

During research discussions with the six Malawian midwives, comments such as the following emerged: "*We ask Questions about your country, about how you manage patients. We can learn more.*" "*We share experiences.*" "*It is good, encouragement and assistance.*" Marita, a Malawian midwife, believed the relationship with foreign trained midwives was "*hand in hand.*" Similarly, the patient attendants expressed that: "*If hard workers come it is good.*" "*[It can] make the work lighter.*"

The specific midwife contributions that Malawian health care workers believed were important included an exchange of knowledge and practices, ideas about patient care in other countries and assistance with a heavy workload. Khetase, a clinical officer trained in obstetrics commented: "*Work wise, [western midwives are] strict on what you do, and [you offer]*

encouragement. We learn at school, for example, palpations, not always the way we are taught, but you do exactly as we were taught, no shortcuts.” Since little is said to new mothers immediately following birth in Malawi, Asmaa felt that: “Your encouragement is good. After the birth the congratulations is good.”

Theme Two: Western Midwives’ Limited knowledge of Culture was Problematic

By count, a lack of understanding the Malawian language and cultural practices was the most frequently identified problem in the present project. Visiting staff members urged volunteering midwives to “insist on interpreters” but cautioned “translation may not always be exact.” Through the eyes of the Malawian health care workers, volunteers’ limited command of their language resulted in difficulties communicating with patients and taking their histories. For Khetase, “[the] language [is a] problem, especially the first days. When you are just new I have to spare my time to teach.” When western trained midwives attempted to learn the language through strategies such as definition and lists of common phrases in English and Chitumbuka, they were perceived as interested and having “the heart” to learn.

Greetings in Malawi are important. Individuals routinely greet one another and have an elaborate system of words and phrases that are used at different times of the day. It was a mark of courtesy to be familiar with and to use these greetings.

Also, perceptions of time can be different in Malawi. Anne, a visiting nurse from the US explained: “Punctuality is not an issue for Malawians. The wheels go slowly. Forget western preoccupations. Relax, observe, and get to know people.” Khetase added: “Timing is a big difference. Our friends are strict on this.”

Visiting midwives perceived further differences in working conditions. Anne, discussed how .. chickens, lizards, insects and sometimes snakes are common. The food is different. Be prepared to eat what is put in front of you. [There are] transportation issues, isolation, be patient.” Mesi articulated: “The midwife from the West has a lot to learn to fit in here. Have to use your head here, improvise here. A lot of work is done by the midwives responsible for more areas of care – become a ‘small doctor’¹.”

Patient approaches, such as nursing women while they sat on the hospital floor, using strips of chitenjis or sarongs for sanitary napkins and doing without medication because of shortages made adjusting to the experience challenging for visiting health care workers. Likewise, visitors expressed their observations of Malawian attitudes towards high risk cases with comments such as: “[It is] not like North American practices with well-nourished women. [Labour is a] lonely experience for women [here], the lack of labour support is different – not a bad thing – just different. People are calm around birth [there is] faith that the woman will give birth. I appreciate the attitude to life and death here. [There is] an acceptance that things happen. Death is more accepted.” Mphatso, a Malawian midwife, commented on her concern about “missing, if we are too busy postnatal checks and counselling . ..we have to concentrate on the labour ward forgetting about the postpartum mothers.”

Theme Three: Thoughtful Preparation Before Arriving in Malawi Was Valued

Procedural considerations such as communicating through postal rather than e-mail letters with hospital administrators, obtaining relevant vaccinations and malaria prevention medication and bringing all professional certification documents were identified as important. Visiting midwives advised: “If you have a medical condition.- consider not coming, bring all meds, [there are] no facilities here for major surgery. [This is a] dry station, a Christian mission: people who are employed on the station must be Christian, guests must respect Christianity.” In order to match volunteers with fitting work placements and accommodation, hospital administrators expressed interest in knowing volunteers’ reasons for coming – was it to travel, to serve as a missionary or in the role of student?

On the other hand, emotional preparation was equally important. Visitors described feeling “drained emotionally,” “unsure if people will tell you if you are messing up,” and “needing to chat but there may not be other people to connect with for debriefing.” Comments such as “[there is] more tragedy here, no matter what we do” and “feeling like a failure [at times]” reflect the intense

nature of professional volunteer work. Knowing that self-care will be an ongoing consideration, participants in the present project encouraged volunteers to pay careful attention and to look after themselves as well as the patients they came to help. Suggestions such as not attending work when sick and “*take time to enjoy the place*” were offered.

However, the genuine support and willingness to nurture their guests were reflected in Malawian workers' statements such as: “*Teaching, we are ready to do that to anyone interested to come here. I will teach whoever comes as I have done with you.*” And another worker commented: “[*We value a*] *spirit of wanting to learn more things.*” Further, one worker appreciated: “*Being able to ask when you have a problem. Someone asking for something, it showed me the interest. If she asks, it means she has interest in that so, because of that we were encouraged to tell you more because you asked.*”

Some donated equipment items were valued while others were not. Sara advised: “*Bring equipment, things to share, doing continuing education. Bring something worth sharing, something to give back physical, equipment, books or information.*” And, Mesi cautioned: “*When we ask for things, please do not bring expired, they will not be used.*”

DISCUSSION

The aforementioned three themes, developed from discussions with practitioners who were either employees or visitors at the Embangweni Hospital in Malawi, begins to illustrate how volunteering midwives can work towards becoming welcome guests in this small African country. Clearly, health professionals cannot simply travel to developing countries and assume they will be welcomed and readily integrated. Listening attentively as participants in this project shared their personal perceptions, suggestions and beliefs of local hospital staff revealed useful ways of looking at how culturally different professionals might work together on possibilities in order to reduce maternal mortality in this area.

Important contributions that volunteer midwives can make centre on exchanging knowledge and practices. A willingness to offer culturally competent professional services and to accept new and different ways of providing care were perceived as invaluable. Defining culturally competent care, nurse scholar Alaf Meleis articulated: “*Ultimately, culturally competent care is about acknowledgment of differences, advocacy for the marginalized, and intolerance of inequity and stereotyping.*”¹²

“Bring equipment, things to share, doing continuing education. Bring something worth sharing, something to give back...

Sara, Malawian midwife

Given that language barriers are well known to impact care that practitioners offer to their culturally different patients,^{13 14} findings from this project indicate that language issues in Malawi can be addressed in part by using interpreters and creating lists of English definitions or commonly used midwifery assessment questions translated to Chitumbuka. Similarly, understanding nuances associated with exchanging greetings, perceptions of time and a seemingly overwhelming workload can help manage this limitation.

Preparing for a volunteer experience includes thoughtful attention to bringing required documents, vaccinations and certification. Sharing educational materials, working equipment and non-expired supplies was appreciated. And, intentionally planning to attend to self-care must not be neglected. The needs of bereaved nurses and midwives in developed countries' hospitals have not been studied extensively,^{15 16} and, with the high maternal mortality rate in Malawi, conditions are even more dispiriting. Anticipating that these conditions may trigger emotional responses is critical.

CONCLUSION

This article presented findings from a naturalistic descriptive research study that explored the perceptions of Malawian

health care workers towards midwives who volunteer at the Embangweni Hospital. This project found that visiting midwives offer important contributions to health care services, that limited knowledge of the language can be problematic and that thoughtful preparation before arriving in Malawi is valued. The article calls for the creation of more opportunities to view the experience of serving as a visiting health care professional through the eyes of practitioners in the field and to construct culturally sensitive approaches that help us become welcome guests.

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Mandatory Practice Hours



[PDF – 2.5 MB]

Citation

Melrose, S. and Kirby, D. (1996). Mandatory practice hours. *The Canadian Nurse* 92(3), 51–52.

In the whirlwind of health care reform and underemployment, using traditional practice requirements as a measure of professional competency serves neither the public nor the profession's best interest

Rather than protecting the public from incompetence, limiting practice requirements to paid hours and continuing nursing education merely silences, and excludes, gifted and energetic nurses, who, through no inherent fault, find themselves underemployed. Reclaiming their voices, their vigor, and their potential contribution to the profession, as well as reconstructing the practice requirement is now essential.

Feminist thinking, which advocates confronting rather than submissively internalizing oppression, has opened the possibility of restructuring traditional concepts of professionalism. As a profession predominantly made up of women, many of whom must balance family responsibilities and career obligations, nurses are uniquely positioned to accomplish a feminist restructuring of their profession.

Childbearing, childrearing, family crises and part-time employment are apparently enduring aspects of nurses' and women's lives. These obstacles to accumulating paid hours, combined with pervasive unemployment caused by budget cutbacks, have created, for many, an insurmountable barrier to meeting the practice requirements of the profession. For three Calgary nurses we met in a graduate study project, loss of professional affiliation because of insufficient practice hours was much more devastating than loss of employment. The stories of these nurses show us the human faces behind the health care reform.

Lynn. Shortly after Lynn completed her RN at a hospital, she obtained her BScN. Equipped with strong medical and surgical practice skills, as well as a university education, Lynn soon obtained an administrative position. In her role as head nurse, Lynn developed various position papers promoting nursing's unique contributions to health care. Later, she worked for several years in nursing education and eventually moved into a public health agency.

As her agency struggled to adapt to increased demands following hospital bed closures, Lynn's part-time position was eliminated. She was invited to compete for a full-time position that she knew at least six other nurses within the agency hoped to obtain. With two school-age children at home, Lynn wondered how she could continue to be there for her family if she did obtain the coveted fulltime position. No other part-time positions seemed available. As time passed Lynn lost touch with life at the agency and with other nurses. For the first time in 23 years, Lynn did not have enough practice hours to renew her membership with her professional association.

While volunteering at a seniors' lodge, Lynn automatically formed a plan for implementing a blood pressure clinic. Then she remembered she wasn't a nurse any more. She didn't have the practice hours to be a professional and without her professional association she wasn't employable. Without association membership, Lynn couldn't see herself as an entrepreneur or an independent practitioner with marketable skills.

Kathy. Like Lynn, Kathy spent three years as a student living in the hospital where she trained to be a nurse. She stood when physicians or nursing supervisors entered the room. Her nursing instructors often emphasized the importance of polishing her shoes and hiding her hair under her cap. She was trained to be a "professional."

After graduating, Kathy worked on a number of different hospital wards for several years. She also returned to university as an adult student and earned her BScN. Kathy then worked at her original training hospital — first as infection control nurse and later as a nursing instructor. Kathy taught her students that professionalism was more than polished shoes and covered hair. "Nursing isn't like putting a sheet of paper into a typewriter," she often told her students, "you can't just rip the page out and start again."

Kathy worked for 14 years as a nursing instructor, mostly part-time. She also had a young family at home, but often found herself at the hospital on her own time. Kathy's part-time work came to an abrupt halt when her seven-year-old daughter became critically ill. As she nursed her child through crisis after crisis, Kathy knew she couldn't leave her for eight- or 12-hour nursing shifts.

A year passed and Kathy's daughter was finally able to attend school for the full day. With her child out of danger, Kathy felt she could return to her nursing career but she was not eligible to practice. Working part-time, and then not at all, meant that Kathy, like Lynn, didn't have the required practice hours. She described her inability to renew membership with her professional association as "cutting the cord." "I've been in nursing since I was 17 years old, but I can no longer practice as a registered nurse. It's the worst thing I ever had to do." Kathy saw her only continuing education option as a costly refresher program she had helped to develop as a nursing instructor.

Marg. Marg described herself as a "trailing spouse." When her husband lost his job in the East, the family moved to Calgary. Marg had trained as an RN, and later earned her BScN and a master's degree in adult and community education. As a newcomer to Calgary, Marg quickly exhausted all her job-hunting strategies. She tried to network with fellow nurses, but often found her telephone calls and letters went unanswered. She joined a job-finding club, but felt they "weren't really set up for nurses." Like Lynn, Marg also worked as a volunteer. She tried to adapt to taking direction from the staff member she was assigned to help, but she ached to develop a program of her own. Sometimes she'd just make it out the door of the volunteer job before the tears came.

The hours of practice Marg accumulated before moving are running out. Marg's husband has a heart condition that seems worse since the move. He's been laid off once already and Marg knows what it's like to feed three teenagers when that happens, but this time she doesn't have her nursing to fall back on.

While Lynn, Kathy and Marg are not their real names, these are the real stories of nurses in crisis. These nurses lack the practice requirement that would enable them to weather the challenge of underemployment in community with their

profession. Their anguish should move us to reconsider the value of a mandatory practice requirement based exclusively on employment and continuing nursing education.

Of course a practice requirement is clearly necessary: it offers reasonable guidelines for professional nursing associations to maintain their responsibility to the public in providing safe, ethical and competent care. However, alternative assessments of nurses' capacity to practice competently are equally necessary.

Provincial nursing associations can no longer afford to withhold recognition for volunteer work. As accountable, autonomous professionals, registered nurses involved in unpaid endeavors must be respected for this work. Accepting volunteer hours toward a practice requirement would offer a lifeline to isolated, underemployed nurses. Rather than casting aside and alienating nurses without paid employment, proactive provincial associations who recognize nurses' unpaid contributions will support and nurture the initiative so vital to the survival of nursing as a profession.

Professional associations should also be more receptive to recognizing other types of education. Continuing education courses in nursing are clearly the most viable learning option for underemployed nurses. However, supplementing these courses with non-nursing courses can be just as worthwhile for the nurse and the profession. What better way to positively promote nursing as a profession than by sharing information and articles from nursing's extensive literature base in a variety of educational settings? While many nurses are aware of theories from other disciplines, few scholars from those disciplines have accessed nursing's unique body of knowledge. Expanding one's educational horizons through non-nursing courses should not be so readily dismissed. Individual portfolios, outlining how relevant courses, workshops and even life experiences have contributed to professional development, deserve recognition.

As knowledge creators, nurses must go beyond demonstrating professional competence through the accumulation of paid hours or continuing nursing education. Nurses must transcend the rigid thinking that denies professional affiliation to gifted and energetic colleagues because they are unable to demonstrate competence in the prescribed way. The profession is best served if we acknowledge the reality of both exclusively female obstacles to full-time employment and cutback-induced underemployment, and alter the practice requirement accordingly. By listening to the grieving voices of alienated nurses we may be moved to rethink some dearly held traditions. This is both a challenge and an opportunity for nursing.

Professional Development Needs of Non-Radiology Nurses: An Exploration of Nurses' Experiences Caring for Interventional Radiology Patients



[PDF – 211 KB]

Citation

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Abstract

Nursing in interventional radiology is diverse and multifaceted. This area of specialty nursing has not yet been acknowledged as such or embraced in Canada. Professional development for interventional radiology nurses is lacking with even fewer educational opportunities for non-radiology nurses who care for interventional radiology patients throughout the hospital to develop needed interventional radiology knowledge and related skills. This qualitative descriptive study explored the experiences non-radiology nurses have caring for interventional radiology patients. Interviews with ten non-radiology nurses in a Canadian hospital provided rich data for analysis. Thematic analysis revealed that these nurses did not receive formal IR education in their nursing curriculum; acquired their knowledge through self-teaching; lacked knowledge about imaging modalities and IR procedures; were impeded to build trusting

nurse-patient relationships; and felt ineffective communication disrupted the continuity of care they provided. Addressing professional development needs related to creating interventional radiology education; increasing awareness of the specialty of interventional radiology nursing; and enhancing clinical collaboration is a key recommendation.

Keywords: IR nursing, interventional radiology education, non-radiology nurse

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Introduction

Interventional radiology (IR) is a medical specialty within radiology that differs from diagnostic radiology, in that minimally invasive procedures are performed for diagnostic, therapeutic, curative and palliative purposes using the imaging guidance of ultrasound, fluoroscopy, and computed tomography (CT) (Canadian Association of Interventional Radiology (CAIR), 2018). This innovative practice with the use of local and conscious sedation in IR facilities has become an alternative to traditional surgery with general anesthesia in operating rooms. The multipurpose nature of these IR procedures combined with the significant benefits of shorter hospital stays, improved patient outcomes and hospital cost savings has resulted in an increased demand for IR services (Foo, 2018; Zeidenberg, 2007).

The role of IR is officially recognized as a medical subspecialty of radiology in Canada, the United States, Australia and some regions of the United Kingdom and Europe. In Canada, the CAIR is a multidisciplinary group geared to interventional radiologists, registered nurses (RNs), and medical radiation technologists (MRTs). Their mission is to help Canadians achieve optimal health and quality of life using IR procedures (CAIR, n.d.). In the United States, the Association of Radiology and Imaging Nursing (ARIN) exists to lead, educate, promote, and advance awareness and professional development for this

nursing specialty (ARIN, n.d.). In Australia, the Medical Imaging Nurses Association of Australia (MINA) promotes the nursing speciality (MINA, n.d.) However, there are no nursing organizations in Canada that do the same.

IR procedures are performed in IR suites within acute care facilities with a dedicated team of interventional radiologists, MRTs and RNs. Nursing in IR is diverse and multifaceted. Nursing care for IR patients in the hospital extends beyond the IR department to the inpatient wards and is provided by nurses who do not share the same familiarity with the specialty of IR. Yet, research examining the experiences and professional development needs of the nurses providing this care, particularly those who do not have specialized IR training is limited. The purpose of this study was to explore the learning, perceptions, and experiences of non-radiology nurses who work in hospitals caring for IR patients. In this article we present findings from a qualitative research study that analyzed interview data to describe the experiences of ten non-radiology nurses at a Canadian hospital.

Methods

A constructivist conceptual framework guided the inquiry (Creswell & Poth, 2018; Guba & Lincoln, 1994; Kivunja & Kuyini, 2017). Qualitative descriptive methodology was implemented to understand and then describe the non-radiology nurses' experiences. This methodology was well suited to detail words, events and viewpoints using the participants' own words, which allows the researcher to remain close and even get closer to the data in the analysis process (Creswell & Poth, 2018; Sandelowski, 2000; Lambert & Lambert, 2012; Neergaard, Oleson, Andersen & Sondergaard, 2009; Willis, Sullivan-Bolyai, Knafel & Cohen, 2016; Aspers & Corte, 2019).

Sample and Setting

This study was implemented at a 460-inpatient bed Canadian hospital. Ten nurses with varied work experience and exposure to IR patients volunteered to participate following placement of recruitment posters on inpatient wards. Each participant met the key criteria of working outside the radiology department and having had experience caring for at least one IR patient. Qualitative research supports purposeful sampling whereby researchers choose participants who will provide rich and unique information about the experiences under investigation (Bradshaw, Atkinson & Doody, 2017; Neergaard et al, 2009; Richards & Morse, 2013; Sandelowski, 2000).

Data Collection

Official memorandums granting ethical approval were received from both the researchers' university and the hospital, and all participants signed an informed consent form. Audio-recorded, semi-structured, face-to-face interviews were conducted in quiet locations and followed the same interview guide. The first author conducted all of the interviews and opened each interview with an invitation to the following: *"Tell me about your experience providing care to IR patients?"* Probing questions were asked to encourage participants to broaden their response. For example: *Describe a situation when you cared for an IR patient?* This was followed by probes such as: *"Can you talk a bit more about that?"* Using open-ended questions and probing sub-questions during the interview invited participants to speak freely and to gain and articulate a deep, true reflection of their perspectives (Neergaard et al., 2009).

Data Analysis

Interviews were transcribed verbatim and analyzed for themes. Thematic analysis provides a description of data sets in their entirety (Braun & Clarke, 2006) and works well with qualitative descriptive methodology, the goal of which is to achieve a rich description of the participants' experiences (Creswell & Poth, 2018; Lambert & Lambert, 2012; Neergaard et al, 2009; Sandelowski, 2010). Analysis involved initial reading of the transcripts for salient aspects and re-reading the data for coding and categorizing to identify the excerpts, meanings and themes that described the non-radiology nurses' experiences. See Table 1 for a sample of significant excerpts, meanings and themes.

Table 1

A sample of significant excerpts, meanings, and themes

Significant excerpts	Meanings	Themes
“Not been any education about IR procedures” “I don’t recall learning [about IR] a lot in class” “In school there wasn’t a whole lot of education” “There isn’t very much training...in the hospital”	Lack of formal education	No formal IR education in nursing curriculum
“Purely by experience here, I have never worked there [in IR]” “I see more now in emergency...so definitely have more experience”	Learning occurs through nursing experience	Acquired knowledge through self-teaching
“I don’t think I’ve been prepped as a nurse too well about the procedures they do in angios” “I have pretty much no knowledge to what happens [in IR]” “I didn’t feel as confident cause I didn’t know all these different procedures”	Increasing knowledge helps build confidence	Lacked knowledge about imaging modalities and IR procedures
“If someone is gasping for breath that is a reason for me to call...it’s purely advocating on their behalf” “There is nothing worse than when a patient asks, and you are like ‘I don’t know’” “I don’t know what to tell patients” “They are scared too because they don’t know what’s going to happen either, so they look to us”	Lack of knowledge limits capacity to advocate and provide holistic care	IR knowledge gap prevented development of a trusted nurse-patient relationship
“You have the pre-checked order set of what you need to do” “We won’t be notified that it has or hasn’t been done” “It would be more helpful to know what they have done more in-depth” “I felt like the person there didn’t tell me anything that I needed to know but then I saw on my floor that my charge nurse was knowledgeable” “If we had any other procedure done there would be post-op orders, so they have to be there after any angio procedure, on every patient that comes, and we don’t always get that.”	Breakdowns with verbal and written communication	Incomplete handoffs and ineffective communication disrupted continuity of care

Findings

A rich description of the participants experiences resulted from a thorough analysis of the data resulting in the following five themes previously noted in Table 1: (1) no formal IR education in nursing curriculum, (2) acquired knowledge through self-teaching, (3) lacked knowledge about imaging modalities and IR procedures, (4) IR knowledge gap prevented development of a trusted nurse-patient relationship and (5) incomplete handoffs and ineffective communication disrupted continuity of care.

No Formal IR Education in Nursing Curriculum

Most participants indicated that they had no formal education or clinical opportunities to learn about IR procedures during their undergraduate nursing programs. When two nurses reflected on an IR procedure that involved the placement of a percutaneous drain, they attributed their lack of knowledge of drain care to “*not learning about it in school*” (participants 1 & 3).

Non-radiology nurses talked about working with many new graduate nurses who had no experience and no awareness of the IR procedures and “*all the risks associated, as there has not been any education about IR procedures, so we are having to do a lot of teaching*” (participant 4). This was echoed by a nurse who commented “*I think the junior nurses still need to be guided on everything. They don’t know you know, and all of our learning is experienced based, that is just the way it is pretty much*” (participant 5).

Acquired Knowledge Through Self-Teaching

There was consensus among participants that they acquired their IR knowledge through self-teaching. This was influenced by how often they cared for IR patients. “*The knowledge comes from where you work...what types of patients you see would be the types of procedures. It is all experienced based, I honestly feel*” (participant 5). Nurses in high-turnover areas, such as the emergency department, and those who had several years of experience working with IR patients commented on how this experience helped them gain the knowledge they needed. Non-radiology nurses who lacked experience caring for IR patients deferred to the nurses who had more experience. One nurse described “*relying on the assessment skills you already have and just kind of guessing what you are expecting for complications*” (participant 6). They felt IR was an area that you either had exposure to or not.

Lacked Knowledge About Imaging Modalities and IR Procedures

In the present study, non-radiology nurses did not have a clear understanding about the various imaging modalities that are used to perform IR procedures. They also lacked knowledge about the use of ionizing radiation. Radiation safety for both radiology and non-radiology nurses has been well documented in previous studies. Results indicate that non-radiology nurses are not familiar with the inherent safety protocols of radiology and IR.

Non-radiology nurses consistently commented on how they lacked confidence when implementing IR preprocedural and postprocedural care. This left them feeling confused and unsure of how to safely provide care for their IR patients. Participants voiced a strong desire to have current, written resources that provide clear direction and instruction particularly relating to preprocedural care.

The whole preprocedure on what the expectation is for us and what we need to get the patient ready is confusing, unless you have had a lot of experience with different procedures and patients and you have been here for a long time (participant 8).

I didn’t know all these different procedures and all these drains, so a little seminar beforehand would have been helpful just to boost my confidence (participant 1).

I have a very rudimentary understanding of what those procedures are...what is running through my mind is what kind of assessments do I need to do...having more knowledge about the procedure means that you can better understand to watch for complications (participant 6).

IR Knowledge Gap Prevented Development of a Trusted Nurse-Patient Relationship

Non-radiology nurses expressed difficulty building a trusting nurse-patient relationship with IR patients. Without knowing what happens to patients in the IR department, they could not explain procedures to patients and families. They felt this lack of knowledge decreased patients' trust in their abilities, limited their capacity to provide holistic care, and diminished their efforts to advocate for patients.

Holistic nursing involves alleviating patients' anxiety and providing emotional support. One nurse commented on the challenge of building a trusting relationship when *"I really don't know much about it because I never worked in an area like that before."* She felt unable to provide holistic care to her anxious patients because she did not know exactly *"what is going to happen other than the nurse down there will care for you."* (participant 7). Similarly, another nurse expressed frustration with not knowing what to tell patients and having to defer their questions until the patient could speak with staff who work in the IR department.

Furthermore, not knowing what was going on in the IR department prevented this participant from advocating for a patient. *"It was delays in getting a procedure done and the patient suffering...the patient was brought right down to the doors of IR and turned back because something else was happening"* (participant 2). Likewise, most participants described not knowing when their patients' procedures were going to happen. *"It might be a week or longer for patients to get their procedures so that affects us and our patient care...we are all connected"* (participant 7). Having to witness their patients' ongoing distress when delays in treatment occurred was difficult and led to feelings of stress and frustration.

Incomplete Handoffs and Ineffective Communication Disrupted Continuity of Care

Non-radiology nurses are responsible for the handoff and safe transition of patients between inpatient wards and IR departments. Continuity of care occurs through verbal and written reports. All of the non-radiology nurses in this study raised the point that continuity of care was disrupted due to breakdowns in verbal and written communication. Several participants echoed similar thoughts to this participant's description of limited communication about what happened in an IR procedure during handoff.

I think the information is limited when I go to pick up the patient because I don't have the knowledge base to begin with. I may know if they weren't able to stent the patient because the artery is too blocked, but it is basic. Most of the information I'm getting is just on the recovery phase...as opposed to the details of what really happened during the procedure. (participant 8)

According to participants, information shared verbally between the sending and receiving nurse varied. One participant described feeling more comfortable to ask specifics about the procedure if they knew the IR nurse personally. Another talked about how she felt the IR team made assumptions and had expectations that *"you should know what they are talking about, but you don't necessarily"* (participant 9). Without in-depth knowledge of what occurred during the procedure, non-radiology nurses were not able to focus their assessments to provide postprocedural care, observe for complications, achieve positive patient outcomes, and provide their patients with accurate information.

Breakdown in written communications also disrupted continuity of care. Non-radiology nurses in this study expected a written report of physician's orders that must be completed when receiving patients from IR departments. Participants voiced their frustration when these were not available. One nurse discussed an incident where she took time away from patient care to make repeated calls to obtain missed reports.

Discussion

The key findings of this study are that non-radiology nurses have no formal IR education in their nursing curriculum, acquire knowledge through self-teaching, lack knowledge about imaging modalities and IR procedures, are impeded to build trusting nurse-patient relationships; and felt breakdown in communication disrupted the continuity of care they provided. These findings reflect pressing professional development needs. In response, we discuss how creating IR nursing specialty education, increasing awareness of the specialty of IR nursing, and enhancing clinical collaboration can begin to support non-radiology nurses towards providing safer care.

Create IR Nursing Specialty Education

IR is leading edge for technologically advanced minimally invasive procedures. Non-

radiology nurses provide around the clock care for patients undergoing these procedures, including preprocedure and postprocedural care. However, unless their professional development need for more speciality education is met, they will continue to simply learn and improve their practice by trial and error. Nurses should not feel as though the only learning resource available to them is chance encounters with more experienced nurses. They should not practice with such a limited level of knowledge that they feel unable to build trusting relationships with patients and to safely provide optimal care.

Ideally, undergraduate nursing programs would include IR speciality education in their curriculum. An IR nursing curriculum could include content about the technical use of the various imaging modalities, such as differentiating among CT scan, fluoroscopy and ultrasound including their procedural significance and respective safety measures. A detailed understanding of the various procedures performed in IR includes the anatomy, pathophysiology and clinical indications for each with opportunities to observe procedures during clinical placement. Relevant content could also include information about the use of procedural sedation, education about the preprocedural, intraoperative and postprocedural assessments including rationale for laboratory tests, allergy identification and comorbidities, common medications and sepsis training. Additional content including discharge teaching about managing and troubleshooting equipment as well as how to handle potential complications to decrease emergency visits and readmissions to the hospital after discharge could be incorporated. We support existing literature that identifies a significant need for increasing curricula related to IR (Farrell & Halligan, 2017; Mustonen, 2016; Penzias, Cadman, Sullivan & McIntosh, 2015; Powell, 2007; Sousa, 2011). When this is not feasible, opportunities such as online learning modules provided by educational institutions and IR speciality organizations could begin to address this critical need for IR speciality education.

IR speciality education could also be delivered through in-hospital orientation sessions. This would be a valuable professional development opportunity where non-radiology nurses could increase their knowledge about the specific procedures that are performed in their individual IR facilities. In addition, written guidelines reflecting best practice that describe specific hospital policies and procedures related to IR preprocedure and postprocedural nursing care; how nurses could best implement standards of care; and how they could access personnel with IR speciality experience would also support the professional development of these nurses. Although information explaining orientation to IR departments is available, the literature is silent on programs geared to non-radiology nurses working in hospitals (Cefaratti, Benninger & Nguyen, 2013; Clark & McClain, 2004; Gill & Shanta, 2019; Vlach, 2018; Jeffery & Werthman, 2015; Penzias et al, 2015; Sousa, 2011; Vlach, 2018).

Increase Awareness of the Specialty of IR Nursing

A “mystery”, an “unknown entity” and “unfamiliar territory” are terms non-radiology nurses, community nurses and other

authors have used to describe the specialty of IR (Farrell & Halligan, 2017; Kelly, 2013; Potter, 2015; Powell, 2007). The accredited certified radiology nurse (CRN®) program recognizes nurses for achieving in-depth knowledge and a standard of competency in the specialty of radiology (Radiologic Nursing Certification Board, 2020). There are few nurses in Canada who possess this designation, which supports the need for increased awareness about this specialty area of nursing.

The non-radiology nurses in this study reported either limited or no physical contact with CRN®s or IR staff. Lack of IR nursing exposure extends from in-hospital and community to a broader invisibility through Canadian provincial and national nursing associations.

The participants agreed that the specialty of IR nursing and the skills required to care for this client population need to extend beyond the doors of the IR department throughout the entire hospital. Increased exposure and awareness of all the IR procedures performed, where they are performed, the imaging modality that is used to perform them, what they involve before, during and after the procedure, and the process of how the IR procedures are scheduled is important professional development knowledge that non-radiology nurses need.

Enhance Clinical Collaboration

Collaboration between non-radiology nurses working with inpatients on hospital wards and IR departments is essential. Non-radiology nurses cannot provide safe patient care without collaboration to increase their understanding of the IR procedures performed. When nurses do not understand the procedures patients have undergone, they simply engage in postprocedural tasks rather than implementing informed nursing assessments. As McClaran and Scarbrough (2015) asserted, hospital nurses' lack of IR knowledge directly contributes to patients' postprocedural complications. Non-radiology nurses need clear written explanations of procedures their patients have undergone and specific instructions and resources for providing nursing care.

Without collaboration to notify nurses of schedule changes (such as accommodating a high need patient), nurses cannot advocate for those patients who must subsequently endure a long and uncomfortable wait. Having notification processes in place could decrease the nurses' feelings of stress and enhance clinical collaboration.

Collaboration is needed between interventional radiologists and non-radiology nurses as well. Interventional radiologists in Canada perform procedures primarily through a referral service. The degree of clinical involvement with patients varies depending on IR personnel and hospital supports, such as an interventional radiologist having admission privileges. Zener et al. (2018) note that only 46% of interventional radiologists working in Canada have admitting privileges. This can lead to the continuity of patient care being compromised when interventional radiologists do not oversee the clinical management of their patients. Non-radiology nurses in this study stated that they did not initially think to notify the interventional radiologist about patient concerns relating to an IR procedure instead notified the most responsible physician. This lack of collaboration creates a breakdown in communication that can result in miscommunication or information not being communicated at all. As a consequence, patients are not prepared for their procedures, they may experience complications, and the efficiencies of the IR department are compromised. Clinical collaboration could be enhanced by identifying either the interventional radiologist's name and contact number on patients' charts or a clinical liaison.

Finally, collaboration is needed between hospital and community nurses when patients are discharged. Community nurses lack of education and knowledge about percutaneous drains inserted in an IR department rely on hospital nurses to inform them about IR procedures, and required nursing care (Farrell & Halligan, 2017). Lack of collaboration can result in setbacks for patients. Once again, written resources explaining IR procedures and required nursing care would enhance clinical collaboration.

Advanced nurse practice roles rooted in the nursing model, such as clinical nurse specialists (CNSs) have recently been introduced into IR to enhance clinical collaboration, provide IR specialty expertise, consult about care needs before and after procedures, and coach, educate and incorporate new and existing research (Muehlbauer, 2011; Penzias et al., 2015). CNSs in IR

serve as an essential multidisciplinary and interprofessional liaison with the rest of the hospital and have the potential to enhance efficiency, alleviate confusion and improve communication for patients and team members.

Limitations

The limitations of this study include the sole use of interviews for data collection restricting triangulation of data sources and a small, non-diverse sample with low-inference analysis inhibiting the generalization of the findings.

Future Development

Further research exploring non-radiology nurses' experiences using a larger, more diverse sample within an urban, academic setting, investigating discharge planning practices specific to IR procedures, and examining how the role of an APN influences patient safety and the efficiencies of an IR department is needed.

Conclusion

IR is a specialty that will continue expanding with the development and application of advanced technology and an ongoing valuing of minimally invasive procedures. This research provided non-radiology nurses with the opportunity to express, in their own words, their experiences caring for hospitalized IR patients. As a result, we now have a deeper understanding of the professional development needs of this group of nurses.

As non-radiology nurses strive to provide safe and informed preprocedure and post procedure care to their IR patients, they do so with few available resources. Gaps in their undergraduate nursing curriculum did not equip them for IR practice. Once in practice, they acquired their knowledge mainly through self-teaching and frequently relied on informal exchanges of information with more experienced nurses. Addressing non-radiology nurses' professional development needs centers on providing them with the information they need to care for IR patients. We recommend beginning this process by creating opportunities for IR education. Educational institutions and professional associations are well positioned to host learning modules and they can be accessed by both pre-service and in-service learners. In-hospital orientation sessions are also a practical venue for IR education.

In addition, we recommend increasing awareness of the speciality of IR nursing. When specialists in IR departments actively seek out opportunities to share information, non-radiology nurses can provide safer, more informed care in hospitals as well as community settings. Knowing that lack of collaboration among IR departments, hospital and community nurses can impact the provision of safe holistic care, the need for professional development opportunities that enhance interdepartmental collaboration becomes clear. In sum, there is a pressing need to develop resources that non-radiology nurses can use to deepen their understanding of IR. This is both a challenge and an opportunity for the field.

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EDUCATION (LPN TO BN LEARNERS)

Asynchronous online peer assistance: Telephone messages of encouragement in post licensure nursing programs



[PDF – 186 KB]

Citation

Melrose, S. & Swettenham, S. (2012) Asynchronous online peer assistance: Telephone messages of encouragement in post licensure nursing programs. *Journal of Peer Learning*, 5(1), 1–5. Available at: <http://ro.uow.edu.au/ajpl/vol5/iss1/4>

Abstract

Peer assistance activities can strengthen online learning environments. And yet, like other professional adult learners, working post licensure nurses attending university part time to upgrade their credentials may have limited interest in student-to-student interaction. Some intentionally choose asynchronous self-paced courses so they can work on their own. This Telephone Messages of Encouragement educational innovation illustrates a peer assistance activity suitable for asynchronous courses in both undergraduate and graduate programs. Students' recorded messages of encouragement to their peers are collected on a telephone answering machine as MP 3 files and then embedded in courses. The activity provides an option for students to 'hear' from other students at any time.

INTRODUCTION

Learning can be profoundly influenced by peer interaction (Vygotsky, 1978), peer collaboration (Slavin, 1985) and peer assistance (Topping & Ehly, 1998; Topping, 2005). In online learning environments, peer assistance can promote a sense of community (Huijser et al, 2008; Shackelford & Maxwell, 2012) and strengthen reflective practice (Ladyshewsky & Gardner, 2008).

Nursing education programs have a rich tradition of incorporating peer assistance activities (Gill et al, 2006; Secomb, 2008) and continue to do so as courses move online. In online nursing courses peer assistance activities can help students solve complex problems (White, et al, 2012) and invite interprofessional collaboration (McLelland, 2012).

However, in virtual learning environments, particularly asynchronous platforms, requiring working professional students to interact, collaborate and assist peers can leave them feeling increasingly frustrated (Shackelford & Maxwell, 2012), indifferent and even negative toward student-to-student interaction activities (Kellog & Smith, 2009). Some learners are simply not interested in collaboration and intentionally select self-paced courses so they can work on their own (Poellhuber et al, 2011).

When busy post licensure nurses enroll in asynchronous self-paced online courses to upgrade their credentials, their time is stretched. The *Telephone Messages of Encouragement* activity described in this article is an innovative practice that provides these nurses with an opportunity to literally 'hear' assistance from the voices of their peers at any time their own schedule permits.

THE INNOVATION

The Research Project

This educational innovation collected and then embedded telephone messages of encouragement from two different groups of post licensure nursing students into their online courses. Post licensure nurses are those who have completed a basic nursing program, have practiced in their field and are upgrading their credentials at university part time as either undergraduate or graduate students.

The first group were vocationally educated Licensed Practical Nurses enrolled in a Bachelor of Nursing program (Post LPN to BN). The second group were university educated Registered Nurses enrolled in a Master of Nursing program (BN to MN). Both groups of nurses were predominantly female, ranged in age from early twenties through to late fifties, worked two or more jobs and often found it challenging to balance course requirements with work and family commitments.

Some non-clinical courses in both the Post LPN to BN and BN to MN programs are delivered online through self-paced, asynchronous text-based threaded discussions within a MOODLE (Modular Object-Oriented Dynamic Learning Environment) environment. Students live in different geographic locations and they may never meet face-to-face with peers in their program. They work individually at their own pace through a Study Guide and receive tutor feedback on submitted assignments. While optional online activities for student-to-student interaction are available, participation can be limited.

This educational innovation was framed as an action research project (Kemmis & McTaggart, 1988; 1990) and received ethical approval from the university. Action research is defined as "research conducted by classroom teachers, often concurrent with their teaching" (Centre for Research on Education, Diversity and Excellence, n.d.) where educators gather information about how they teach and how their students learn in order to gain insight, develop reflective practice, effect positive changes in the learning environment and improve student outcomes (Donato, 2003). The purpose of the project was to gain insight into

how relevant peer assistance activities could be incorporated into asynchronous online courses with professional working nurses who have little interest in student-to-student interaction.

22 participants offered their peer assistance in the form of telephone messages of encouragement. With each of the two groups of nurses, participants were recruited by sending an e-mailed Letter of Invitation to students nearing completion of their programs.

The Letter of Invitation invited these more senior students to call a toll free number, any time of the day or night and leave a message of encouragement to students just beginning their program. They were asked to offer peer assistance by sharing strategies that helped them succeed and to talk about “what worked for me.”

The messages were recorded on a telephone answering machine and audio digital recorder. When the peer assistants telephoned the toll free number, they were prompted by the answering machine to verbalize their consent to having their voices recorded and then to briefly share their message of encouragement. Messages on the answering machine from both groups of students were collected on a digital voice recorder over two different three week time frames.

The digital recorder created MP3 audio files that were transferred via cable to a computer and played using Windows media player. The audio file messages were embedded into courses in the MOODLE environment as podcasts.

The Messages of Encouragement

The recorded messages of encouragement that students shared did not differ significantly between the undergraduate and graduate groups. In essence, the assistance nurses offered one another related to balancing existing family and work commitments as they returned to a student role.

For many of the undergraduate group of vocationally educated Licensed Practical Nurses, attending university was a new experience. Several of their messages assistant expressed: “This is not on the same level of studying as the LPN program. Do not underestimate the amount of work required.” Examples of specific advice included suggestions to make use of tutors’ availability hours, to use writing help centres at the university and to create schedules.

Although the graduate group of nurses had previous higher education experience, they also experienced challenges as they readjusted to the requirements of returning to university and to learning online. Examples of specific advice included suggestions to plan ways of celebrating milestone accomplishments. “Dinner out with the family after submitting an assignment” was suggested. Knowing that traditional student group celebrations were not as likely to occur in online classes, the nurses urged peers to find alternatives.

Anecdotally, students reported that the peer assistance they received from the messages did help them feel connected to like-minded others “without having to spend time I don’t have” on student-to-student interaction. Unfortunately, as students seldom complete their course evaluation forms, empirical data on the effectiveness of the educational innovation is not available. The following figure illustrates a screen capture of how messages are presented in a graduate class.

Messages of Encouragement

If you are interested in hearing about strategies that have worked for other students in the Centre for Nursing and Health Studies, here are some messages of encouragement.



Seek help with writing



Keep in touch with classmates



Dedicate time each week



Establish a quiet workspace



Set up a personal calendar



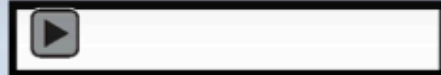
Reach out to your instructor



Connect with a classmate



Do 'make-ahead' meals



Consult a librarian



Post early in the week



Work on your course everyday



Link course topics to workplace issues



Figure 1. Clicking on each play button activated the embedded MP3 file.

CONCLUSION

This article described *Telephone Messages of Encouragement*, an online asynchronous peer assistance activity suitable for post licensure nurses attending university part time to upgrade their credentials. The activity is an educational innovation that is simple to implement in that students messages to their peers can be recorded on an answering machine, transferred to a digital recorder and then embedded into a course management system. The activity can be adapted to both undergraduate and graduate learners and may be of interest to other educators who teach working professionals.

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DEMONSTRATION



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Resisting, Reaching Out and Re-imagining to Independence: LPN's Transitioning towards BNs and Beyond



[PDF – 276 KB]

Citation

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Abstract

Little is known about the process of how nurses transition between vocational training and institutions of higher education. Understanding this process provides educators with the knowledge to support new groups of university students making this transition. Grounded theory (GT) was used to explore and understand this process. Three studies from a 7-year research program were used as data. The analysis led to the generation of a GT illuminating the process of students transitioning from post-LPN to BN. This GT illustrates how students overcome difficulties encountered moving to a more complex nursing role. The students' main concern was a lack of independence. The core variable, which resolves this main concern, and which emerged from the analysis of the data is developing independence. There are three sub-core variables, resisting, reaching out and re-imagining which support this core variable of developing independence.

Keywords

LPN to BN learning, independence, grounded theory

Licensed practical nurses (LPN) have usually earned their nursing credential in vocational institutions and are seldom awarded recognition in university bachelor of nursing (BN) degree programs for their prior learning. Vocational programs focus on procedural knowledge and occupation-specific training, whereas universities focus on conceptual knowledge and theoretical understanding (Karmel, 2011). Some registered nurse (RN) programs at community colleges offer LPN to RN diploma bridging programs and acknowledge the LPN credential. In most Canadian provinces, RNs are required to complete a university nursing degree. More opportunities for LPNs to transition to RNs are becoming available, but the literature addressing their experiences is mainly descriptive. A deeper theoretical understanding of the transitioning process these nurses follow, their concerns and the strategies they use to resolve them is needed. To address this lack of understanding, three studies from a 7-year program of research were used as data for a grounded theory (GT) analysis.

Background

In Canada, nursing education opportunities are available in vocational, college and higher education institutions. The majority of entry-level nursing students earn an LPN credential from a 2-year program or a BN degree from a 4-year university program. When credit for prior learning is awarded, LPN students may be able to earn a BN degree in 2 years. With the exception of the post-LPN to BN group, students awarded credit for prior learning have previous exposure to the demands of university. However, nurses who transition from one post-secondary system to another and have to adjust to the university system face unique challenges.

Making the transition from vocational training to university programs is not easy. Sharp differences exist. In school, students are often selected at an early age for either a vocational or an academic track (Moodie, 2008). Named “the Cinderella of tertiary education,” vocational education continues to be viewed by some as a second, less glamorous post-secondary educational choice (Institutional Management in Higher Education [IMHE], 2012, p. 1). Despite international efforts to promote vocational education, “parity of esteem between vocational and academic qualifications remains a myth” (Hayward, Dunbar-Goddet, Ertl, & Hoelscher, 2008, p. 1). Consequently, determining equivalence between qualifications among vocational programs is difficult and in turn also makes awarding credit for prior learning difficult (Hoelscher, Hayward, Ertl, & Dunbar-Goddet, 2008; Langworthy & Johns, 2012; Moodie, 2008).

Generally, students transitioning between post-secondary institutions can expect to face challenges. Vocational programs are more likely to provide considerable individual guidance and encourage instrumentality, making the more anonymous impersonal university environment difficult to comprehend (Crabtree, Roberts, & Tyler, 2007). Students in a Faculty of Business who upgraded from vocational training to an institution of higher education were unaware that independent learning was a requirement for success in higher education. They also lacked many of the skills necessary for effective independent study (Crabtree et al., 2007). College-prepared Social Work students found that the transition to a research-led university was not easy (Cree, Hounsell, Christie, McCune, & Tett, 2009). Students at five different universities transitioning from vocational training programs experienced difficulties understanding expectations of them, particularly in the areas of essay writing and mathematics (Hayward et al., 2008).

LPNs transitioning between institutions face unique challenges. LPNs may enter RN programs with unrealistic expectations regarding program rigor and flexibility (Brown, 2005). Often, they feel shocked by the magnitude of work (Claywell, 2003), which may lead to struggles assimilating into the academic learning environment (Hutchinson, Mitchell, & St John, 2011). Previous learning experiences may not have prepared them for RN level study (Hylton, 2005). They struggle to overcome role ambiguity (Cubit & Leeson, 2009) and grapple with their dual identity (Hutchinson et al., 2011). Some find the working role of

an RN is more complex, broad and mentally and physically trying than expected (Kilstof & Rochester, 2004). They may experience a cultural transition requiring they question traditionally held values and adopt a more critical stance to their professional practice (Milligan, 2007). Arranging employment leaves and travel away from home to complete practica is often problematic (Rapley, Nathan, & Davidson, 2006). In some instances, post-LPN to BN students found they had to terminate their full time employment to continue their studies (Melrose & Gordon, 2011). Students described how expectations placed on them by clinicians and managers exceeded their level of expertise, resulting in increased levels of anxiety (Nayda & Cheri, 2008). They may even associate gains from their new university education with some loss of their hands on bedside nursing role (Melrose & Gordon, 2008).

A final challenge, unique to this group of nurses, is the apparent task similarity that exists within both the LPN and RN roles. Appreciating differences between LPN and RN responsibilities is complex. Both groups study similar foundational knowledge, are governed by regulatory colleges and are guided by distinct standards. However, RNs study longer, have a wider, more indepth scope of practice and earn higher salaries. In most instances, LPNs collect client data and report findings, while RNs synthesize the data and make independent decisions (Kearney-Nunnery, 2010). Workplace policies differ significantly: LPN tasks often focus on collecting quantifiable data such as vital signs; RNs incorporate data into more holistic assessments, coordinate care and identify the need for involvement of other health professionals (White et al., 2008).

Although both LPNs and RNs strive to provide exemplary care to their clients and nursing leaders strive to deploy all nurses efficiently (Harris & McGillis Hall, 2012), relationships between the two groups can be strained. LPN's may feel that they are not respected, that their nursing knowledge as LPN's is not acknowledged and that they are undervalued within the RN community (Melrose & Gordon, 2008). LPNs invest considerable emotional labor into their interactions with RNs. This investment often goes unrecognized (Huynh, Alderson, Nadon, & Kershaw-Rousseau, 2011). Over the past decade, with LPN programs lengthening, the scope of practice increasing and the patient care tasks they implement seeming very similar, LPNs often view the two roles as interchangeable (Huynh et al., 2011).

The research approach

This study investigated the experiences of post-LPN nurses transitioning to BN students to understand how post-LPN nurses overcome difficulties associated with the transition from vocational to institutions of higher education and learning a more complex nursing role. Classic GT (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967) was used for the analysis. Two key components of the methodology of GT were emphasized, constant comparison and memoing, to maximize the probability of generating theory that is relevant to the action in the area studied (Glaser, 1978). Constant comparison and memoing facilitate and cultivate conceptualization and emergence of a relevant GT of what is going on in the data.

Data collection

Three studies that formed part of a 7-year research program were used as data. Participants were all students in a post-LPN to BN program at a Canadian university. In the first study, from 2006 to 2009, 10 students were individually interviewed three times: at the beginning (Melrose & Gordon, 2008), middle (Melrose & Gordon, 2011) and end or post-graduation (Gordon & Melrose, 2011a) of their program. These 30 interviews provided snapshots of how their views changed and remained the same.

In the second study, from 2010 to 2011, 27 students participated in four focus groups held in different geographic locations (Melrose, Miller, Gordon, & Janzen, 2012). The focus groups were held during non-course hours when students were completing clinical practica on acute medical-surgical hospital units.

In the third study, in 2011, 16 students podcast audio messages of encouragement to their peers (Gordon & Melrose, 2011b).

Students were invited to leave telephone messages sharing strategies that worked for them, as they faced the challenges of attending university and learning a more complex nursing role. The collection of messages added important insight to theory generation as students commented on the practical ways they resolved the everyday problems they encountered. This provided information on the difficulties they encountered and how they were resolved.

Separately, in each of these three descriptive studies, ethical approval was obtained from the university; new participants were recruited and new researchers were added to the team. None of the researchers had teaching responsibilities in the post-LPN to BN program. In these previous studies, data (transcripts of recorded interviews, focus groups or telephone messages) were analyzed using line by line coding to create categories that led to themes. In the present study, GT was used to conceptualize, link and extend the cumulative data from the studies.

Data analysis

Constant comparison and memoing were emphasized in the data analysis to facilitate the generation of GT, illuminating the transition process of post-LPN to BN students. Interview, focus group and telephone message data previously analyzed and presented at a descriptive level were re-analyzed using GT. Applying GT moved the analysis beyond the descriptive to understand and conceptualize the transition process. New concepts and categories emerged which upon constant comparison and memoing, led to the identification of the main concern of the participants, and the core variable, how this main concern of the participants in the study was being resolved.

The theory generated was evaluated using Glaser's (1978, 2001) criteria for a generated GT. These criteria are that the theory must be relevant. It also must grab, fit and work with the data from which it was derived. Lastly, the theory is modifiable. The theory transcends a descriptive focus on individuals to generate the process of nurses transitioning between vocational and institutions of higher education. Generating this GT increases resonance with learners who are making transitions. The theory illustrates how students overcame difficulties they encountered moving to their more complex nursing roles.

The theory

The students' main concern was a lack of independence. The core variable, which resolves this main concern, emerged from the analysis of the data. The core variable is *developing independence*. Three sub-core variables supporting this process of developing independence were *resisting*, *reaching out* and *re-imagining*. The process of *developing independence* and the three sub-core variables supporting nurses' *developing independence* are illustrated in Figure 1.

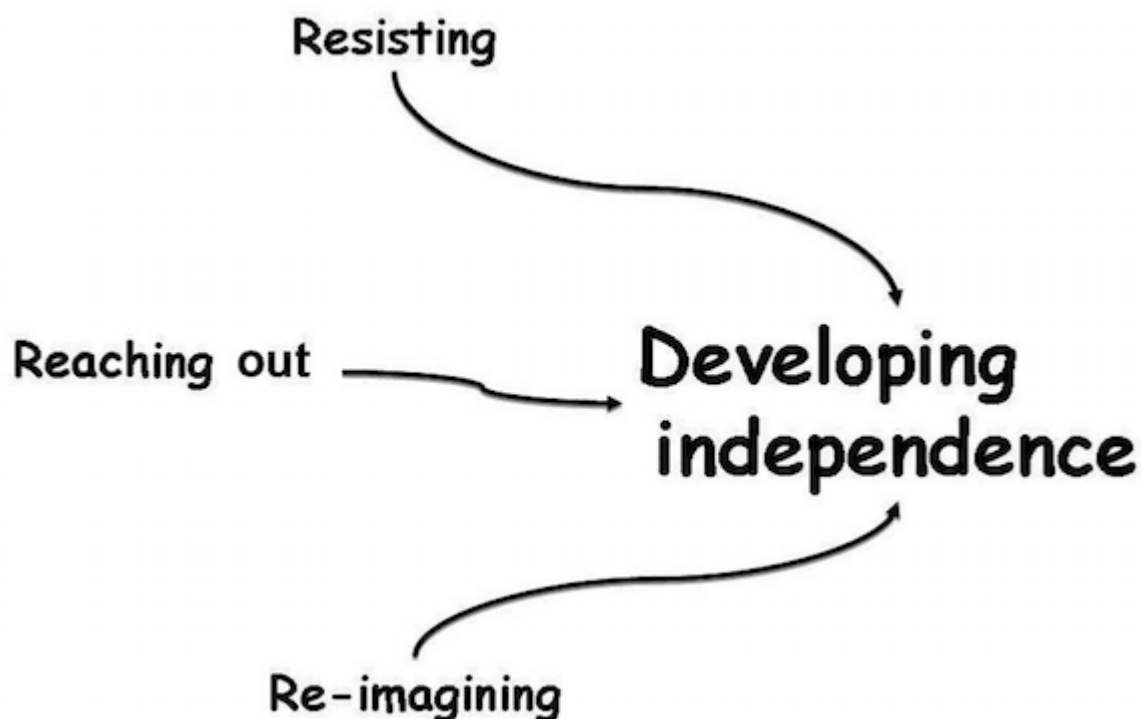


Figure 1 Resisting, reaching out and re-imagining to independence.

Findings

Resisting

I'm a nurse already – what's new? Throughout all three studies, post-LPN to BN students emphasized that they were “already nurses.” They consistently resisted the notion that they were “becoming” nurses or being “socialized into” the nursing profession. Many felt “insulted” when others posed questions such as “when will you finish and be a nurse?” When researchers referred to the post-LPN to BN program as “upgrading education,” one nurse adamantly explained that this term was pejorative and urged us to say “continuing education” instead. Participants repeatedly expressed how they saw little or no difference between the LPN and RN roles. Comments such “we already think critically” and “we do the same things – RNs are just paid more” were common, particularly in the beginning and middle individual interviews and in the focus group discussions. LPNs were proud of the nursing knowledge they already had but expressed that “RNs always have more authority.”

Our participants often told us that they did not feel respected in their LPN role and this lack of respect was a key motivator in their decision to earn their RN credential. They shared workplace incidents where their knowledge as LPNs was not valued or even acknowledged. For example, one participant described how she was required to remain outside the door of a multidisciplinary conference while an RN presented client data this participant had collected and “written up.” Another participant spoke about how “just LPNs” can be “good enough” when RNs were not available to “desperate” employers. In two of the focus groups, students discussed how “RN stands for Real Nurse and LPN stands for Little Pretend Nurse.” These

perceptions of being disrespected, devalued and excluded from the nursing community persisted as they completed courses and practica in their post-LPN to BN program.

Hurting: Seems I'm leaving bedside nursing behind – this hurts! We heard considerable hurt and expressions of loss in the nurses' voices as they discussed leaving their role as LPN. In an early interview, a participant expressed how she viewed the RN role as "sitting behind the desk" while the LPN role involved "looking after patients at the bedside." Despite their comments explaining the inherent limitations of the role, LPNs loved the hands-on connections with patients their role provided. They did not want to abandon bedside nursing, remaining protective of their LPN credential throughout their program, even after they graduated. Relating an incident that occurred during an interview for a new job as an RN, a participant wondered why the employer required her to "choose between LPN and RN on my nametag – I want both on there." Knowing that these feelings of hurt and abandonment are occurring within the transition process, it is not surprising that post-LPN to BN students respond with resistance.

Reaching out

Am I doing OK? During their practica on acute hospital units, many LPN to BN students still did not recognize the significant differences between the LPN and RN role. However, most became less resistant and more open to actively seeking answers from others when they reached the point in their program where they attended clinical sites. Students did not see themselves as "doing anything differently"; it was others' affirmations that they were that made a difference. When workplace or practica mentors shared how students thinking or actions "fit" the RN role more than the LPN role, this feedback legitimized their learning and indicated that change was actually happening.

As students risked letting go of their resistance and began tentatively reaching out for help, feedback from instructors and preceptors was strikingly important. For example, one participant "kept every set of comments I've ever gotten from preceptors and instructors." Another tearfully recounted a failed clinical experience. Although nearly 2 years had passed since this failure, she remained deeply affected by the feedback. She responded to the challenge of failing by repeating the course and seeking out evaluators who "did know I'm a good nurse."

Sacrificing: Sold my home, gave up my job – Costs are more than money. Post-LPN to BN students made substantial sacrifices to continue their education. Two participants told us they had sold their homes to pay for their program. Of the ten students interviewed at the beginning, middle and end or post-graduation, five had either terminated their full time employment or changed to jobs with reduced hours to attend practica and finish their degrees. Focus group discussions frequently included comments related to giving up time with family and friends.

The telephone messages of encouragement participants shared with peers centered on strategies to reduce stress, manage time more efficiently and persist "no matter what." As these nurses "put life on hold," they expected academic and clinical learning events that would make these sacrifices "worthwhile."

Challenges occurred when learning events did not seem worthwhile or when instructors and preceptors did not seem to understand the depth of their sacrifice. In the words of one participant: "the costs are more than money." Another commented angrily on how one university course "had the same textbook" used in her LPN program. In her practicum, a participant felt frustrated when she was "buddied with an LPN when I'm supposed to be learning to be an RN." Comments about not wanting to "waste time and tuition money to work on a unit I'd get paid to work on as an LPN" were common.

In order for the post-LPN to BN students to resolve these difficulties and become more independent, they needed help from others. Unfortunately, when they communicated their feelings of frustration and anger with the intention of reaching out for help, they found their intentions were misunderstood and they were viewed as "complaining." Time and again our participants iterated how valuable it was that others could see and would respond when they were reaching out for the help and direction they needed.

Re-imagining

I see the difference now – I want to lead with this new vision. Two years after graduating from her program, one participant discussed how she views the RN role very differently now. She spoke about how her thinking changed, how her perspective shifted and how she gained “a new depth of knowledge,” particularly once she was employed as an RN. When this same participant was previously interviewed during the middle of her program, she commented on her belief that “LPNs could work in speciality areas – they have as much to offer as RN’s.” But, when the interviewer revisited this comment in her final interview, she no longer felt it was true. She continued to champion LPN nurses, but “when it comes to the difference between the roles, you don’t really know until you get there.” Reflecting on what stood out for her most during her transition from LPN to RN, she reported how much more “confident and comfortable” she felt both personally and professionally. She shared how the ritual of clasping her RN pin to her uniform was very meaningful. This action reminded her that she “used to feel that maybe I’m not correct – maybe I’m wrong. But as an RN, I have more confidence. When people look at this pin, I feel I do get more respect.” Like this participant, as other post-LPN to BN students and graduates began to feel more confident and respected in their new role, they also began to re-imagine how they could contribute to their profession. In their telephone messages of encouragement, students urged peers to participate in the professional development activities now becoming available to them. Suggestions such as “try joining committees or projects that are going on – as RNs we can” were made. A process of re-imagining professional possibilities subtly took on greater importance than resisting the idea that differences between the roles existed. Similarly, as the nurses cautiously began envisioning themselves in their new nursing role, they had less need to reach out for affirming feedback from others. One focus group participant named this process “nurse life changing.” When the nurses began their transition to a new and more complex nursing role, they were motivated in part by a desire to move beyond the dependencies associated with the LPN role. They shared ideas about how they could support other LPNs to continue their education and how as RNs, they could now become leaders initiating meaningful change.

Core variable: developing independence

I’m no longer in someone’s shadow. Developing independence is the core variable for post-LPN to BN students as they transitioned towards the more complex nursing role of an RN. Both during their program and beyond their formal studies, this group of nurses struggled towards developing independence. As LPNs, they were required to collect and report data rather than make significant client care decisions. As vocational students, they were provided more instrumental guidance than opportunities for self-direction. Although they viewed themselves as an integral part of the professional nursing community, they often felt disrespected and excluded by RNs. At the outset of their transition, they saw little difference between the LPN and RN role, and many entered their university program without previous university experience.

Discussion

The process and strategies that learners undertake to develop and support independence as RNs are inherently difficult to understand, yet university programs consistently expect and require students to think and act independently. A key element in developing independence in any educational activity is for students to take responsibility for their learning above and beyond responding to instructions (Boud, 1988; Knowles, 1975). Becoming independent requires students to choose fitting learning activities, reflect on their effectiveness and initiate any needed changes (Holec, 1981; Little, 1991).

Vygotsky’s (1978) seminal term “zone of proximal development” is the “distance between the actual development level as determined by independent problem solving and the level of potential development as determined through problem solving under ... guidance” (p. 86). In essence, this developmental zone encompasses the discrepancies between what learners can accomplish with support and what they can accomplish independently. Post-LPN to BN learners with limited previous

university experience enter their program with a wide zone of proximal development, and they require considerable guidance and support before they can achieve independence.

Unrelenting expectations of independence associated with their new role was the main concern this group of adult learners encountered. Given that LPNs have consistently been denied opportunities to venture beyond responding to direction from others, the challenge of developing their independence becomes clear. Developing independence, the core variable, is supported by a spiralling process of resisting, reaching out and re-imagining.

Resisting the idea that differences actually existed between the roles helped narrow the gap between what they already knew and what they still needed to learn. Reaching out for help and affirmation that what they were doing was on track was a familiar strategy that worked well for them in previous learning and practice settings. Re-imagining the professional as well as personal opportunities that the RN role offered motivated and sustained them throughout their journey of developing independence. After working as an RN for 8 months, a participant reflected on the independence she had developed with the comment “I’m no longer in someone’s shadow, no one is watching over my shoulder.” As LPNs integrate the new knowledge, skills and attitudes they need to practice and develop as RNs, the heart of their learning is building up their independence.

Conclusions

The grounded theory of developing independence explains how learners progress to independence through resisting, reaching out and re-imagining. This grounded theory provides a glimpse into what nurses are doing to develop independence, highlighting what post-LPN to BN students and their teachers can expect in this transition. The grounded theory also provides insight into how this group of nurses resolve difficulties they encounter.

LPNs attending university initially demonstrate considerable resistance. Beneath the surface of this resistance is an enduring pride in an existing professional identity. As nurses already, it is what is different and new that is most important. As LPN to BN students reach out for the help they need, affirmation from others that they are “doing OK” is critically important. Knowing that these learners have made appreciable sacrifices, even selling homes or resigning from career jobs, the significance of others’ affirmations, particularly those others who are in positions of determining student success or failure, becomes evident.

As the nurses have opportunities to actually practice as RNs, differences between the roles become apparent to them and they begin to re-imagine their profession and the possibilities for helping and leading that are now available. Central to all of these processes is moving away from being “in someone’s shadow” and towards thinking and acting more independently.

While existing literature describes students’ experiences at different points in time, the present research presents a deeper and more abstract theoretical explanation that may also resonate with learners who are not nurses. The theoretical explanation of the process nurses implement during their transition from LPN to BN and beyond generated through this study offers insights to educators developing curriculum and instruction. The theory is practical, relevant and fitting for a group of nurses who are continuing rather than beginning their professional education.

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Licensed Practical Nurses becoming Registered Nurses: Conflicts and responses that can help



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Abstract

This article describes findings from a qualitative research project designed to understand the professional socialization experiences of Licensed Practical Nurses attending university to transition to the role of Registered Nurse. Findings revealed that this group of nursing students believed (Licensed Practical Nurse) LPN's were not respected, that their nursing knowledge as LPN's was not acknowledged and that it was challenging for them to feel a sense of belonging with the RN community. These insights have implications for practicing (Registered Nurse) RN's as student nurse groups are now including more Licensed Practical Nurses. Responding with reflection, communication and collegiality can offer important help to LPN to RN students.

Key words

(Licensed Practical Nurse) LPN to (Registered Nurse) RN transition, Nurse conflict, Responses to nurse conflict

I Introduction

The transition from LPN to RN can be a difficult process. When Registered Nurse students are also practising Licensed Practical Nurses, nursing teams may not know how to best support and include these unique learners. All too often, LPN to RN students' feelings of inner conflict and ambivalence are overlooked during their clinical learning experiences. In our research exploring the professional socialization experiences of LPNs as they transitioned into the role of Registered Nurse, we conducted four focus groups with nurses advancing their nursing role. During discussions with these LPN colleagues currently in the role of student RNs, we learned that this group of nursing students believed LPNs were not respected, that their nursing knowledge as LPNs was not acknowledged, and that it was challenging for them to feel a sense of belonging with the RN community. Our findings have implications for practicing RNs, particularly preceptors, as student nurse groups are now including more LPNs. In this article, we discuss conflicts that can emerge as LPNs continue their education in nursing. Responding with reflection, communication, and collegiality will not only help support this group of learners, it will strengthen teamwork among all nurses.

1.1 Background and significance

The experience of socializing into a new and more complex professional nursing role is seldom straightforward. Traditionally, LPN to RN bridging programs were not widely available. However, today a variety of opportunities exist where LPNs can advance their nursing education. And yet, little has been written about the professional socialization experiences of this new group of learners.

Our research project was framed from a constructivist conceptual framework. Constructivist epistemology suggests that individuals approach learning by actively collaborating and engaging with others in their environment to build on what they already know [1-3]. In clinical learning environments, collaboration and engagement with practicing nurses is particularly important to student nurses as they construct knowledge and seek to make sense of the world in their chosen profession. As practicing RNs interact with LPN to RN students to help them build on their existing knowledge, an understanding of what the concepts of both conflict and collegiality can look like through the students' eyes offers valuable guidance.

Conflict. Conflict is not unexpected when LPNs transition to the more complex role of RN [4-6]. The RN role involves more independence and accountability for client outcomes. As Kearney-Nunnery explained, LPNs collect client data and decide who needs to be informed while RN's synthesize client data and make independent decisions [5]. As LPN to RN students tentatively move away from a role where they were taught to inform others rather than make independent decisions, the idea that conflict could emerge for them becomes plausible.

LPN to RN students can feel a sense of loss as they move away from their familiar bedside nursing role [7]. Developing the independence needed to function as an RN is particularly difficult [8]. This "internal strain creates a state of ambivalence, conflicting internal dialogue or lack of resolution in one's thinking and feeling," known as *intrapersonal conflict* [9]. If left unresolved, *interpersonal conflict* (between members of a team) may result [10]. In turn, nurse communication and collegiality may be threatened, issues known to negatively impact patient care, teamwork, nurse satisfaction, and retention [11-14]. While conflict is an expected element in any transition [15-17], the way we respond to colleagues experiencing conflict can help make the experience a more positive one.

Collegiality. Nursing literature increasingly recognizes the impact of nurse group cohesion/collegiality as important to nurse job satisfaction, retention, and quality of patient outcomes. A connection between quality of work life, role identity, and a sense of belonging has been acknowledged [18]. Higher levels of job satisfaction have been associated with teamwork [19]. Nurses' thoughts, behaviours, and attitudes are also considered central to effective teamwork; these skills can be learned and developed [20]. Optimizing communication between nurses has been acknowledged as necessary for patient safety [21].

However, collegiality may not always exist between LPNs and RNs. Although LPNs invest considerable emotional labour into their interactions with RNs, this investment often goes unrecognized [22].

Knowing that employment of RNs is expected to grow 26 percent from 2010 to 2020 [23] and that 13% of new nurses will consider leaving their jobs in their first year, [24] it is critically important for practicing nurses to “extend a hand of welcome” to our experienced LPN colleagues. When LPNs advance their nursing education, they are not new nurses and they are expected to stay in nursing. A deeper understanding of LPN to RN students’ experiences in both their LPN role and their student RN role offers important insight into creating inclusive nursing teams.

1.2 Purpose

The main purpose of the study was to describe LPN to RN student nurses’ experiences with professional socialization as they learned a more complex nursing role. A secondary purpose of the research was to begin to understand how practicing nurses can best respond and support these students’ learning.

2 Method

This qualitative project, framed from a constructivist worldview, is part of an overarching program of research exploring the transitions LPNs experience when they advance their education to become RNs. Participants were 27 LPNs enrolled in a baccalaureate nursing program, who were currently attending a practicum on an acute hospital unit.

Participants. The participants’ LPN to RN bridging program is unique in that LPNs are awarded approximately two years prior academic credit towards their four year program. In Canada, a baccalaureate nursing degree is required in order to write the RN qualifying exam. Historically, university programs have not offered LPNs credit for their previous nursing credential. The bridging program is also unique in that all courses except the clinical practicums are delivered online.

Students come from across Canada and the only time they met in person was during practicums. In most instances, students left their families and full time employment and had to find accommodation in a new city in order to complete their month long practicums. Thus, in order to access students when they were in groups, the research was conducted when they were attending practicums.

Recruiting was done by emailing a Letter of Invitation to four groups of students scheduled to attend practicums on acute medical surgical units. The Facilitators collected the names and arranged meetings at times when clinical shifts were over for the day. All recruitment and facilitation was implemented by researchers who were not known to participants and who had no teaching or evaluation responsibilities in their program. Interestingly, all the students who received the invitation participated. We reasoned that this was in part related to the fact that most were from out of town, that few other non-program opportunities were available and that the timing was convenient.

Participants were adult learners with diverse demographics. They included two males and twenty five females with ages ranging from early twenties through to late forties. Their practice areas included acute hospital units such as medicine and surgery, urban and rural community clinics and care homes for the aged. While some participants had practiced as LPNs for two years, others had practiced for over twenty years. Some had practiced on acute hospital units very similar to the practicum placements and others had no previous practice experience on acute hospital units. They brought a range of existing nursing knowledge to their learning and had varied learning needs.

Practicums. The two hospital units where the four groups of participants completed their practicums were located in different cities. As clinical placements for all RN students throughout the province were centrally coordinated, LPN to RN students were assigned to the same units as traditional RN students. Patients on these units were acutely ill, remained only

for short periods and required a high level of nursing care. Nursing staff on the units included a mix of LPNs and RNs and informal student and instructor evaluations of these units as practicum placements were very positive.

Data Sources. Data sources were four face-to-face digitally recorded, transcribed focus group discussions. The focus groups were conducted in different cities with different participants over a period of two university terms.

A semi structured interview guide, framed around questions related to professional socialization was used. For example, participants were invited to discuss their perceptions of the concept of “professional socialization”. They were encouraged to discuss the formal academic and clinical experiences that supported or distracted from their learning. And they were invited to discuss the informal experiences that supported or distracted from their learning. In all four groups, discussions became particularly animated during discussions of learning distractions.

At the beginning of each session, the facilitators identified group ground rules which included an expectation that all comments would remain confidential. They used pseudonyms when entering data, ensured consent forms were signed and emphasized that participants were free to discontinue their involvement at any time.

Data Analysis. QSR International's NVIVO 10 [25] was implemented to organize thematic analysis of the focus group transcripts. Line by line coding was used to group participants' phrases and conversations (indicators) into meaningful qualitative units or categories of concepts [26] In keeping with naturalistic inquiry, these categorizations in turn led to the development of overarching themes [2]. The transcripts were thoroughly read and re-read and the research team met regularly to discuss our interpretations and develop a systematic process of thematic analysis. Investigator triangulation and member checking with participants ensured trustworthiness and authenticity of the findings. Full ethical approval was granted by the university's Ethics Review Board.

In this article, we discuss three themes that begin to illustrate some of the conflicts that this group of learners expressed as they continued their education as nurses. First, this group of nursing students believed LPNs were not respected. Second, they felt that their nursing knowledge as LPNs was not acknowledged. Third, they expressed that it was challenging for them to feel a sense of belonging within the RN community.

3 Results

Theme 1: LPNs are not respected. Participants frequently commented on their belief that LPNs were not respected by other members of the healthcare team. In particular, they did not feel that the LPN role was as respected as the RN role. They mentioned that while people often don't know what LPNs do, the role of the RN is more familiar. One participant remarked that “people look at LPNs differently, kind of like a nursing attendant or something, because that's kind of what we've been historically.” For some of our participants, their motivation to advance from the role of LPN to RN centered on a belief that the LPN role was less respected.

They talked about how they felt undervalued when they practiced as LPNs. The LPN to RN students spoke positively about many of their new experiences as student RNs as they were beginning to sense the additional collegiality and respect they would experience when they finished their program. They wondered why this same sense of cohesion and respect had not been possible in their LPN role. The following excerpt reflects this perceived interpersonal conflict among nurses and a desire for change.

I know the respect will be different [as an RN]. I find this kind of frustrating. I've taken this last year off to go to school full-time and complete my degree and [now] all the doctors and all my co-workers are like “Good for you!” They're so excited for me! But then it makes me sad that I'm giving up LPN. Yeah, like I'm getting all that extra respect, but why couldn't I have had that before when I was doing my job so well?

Theme 2: LPN nursing knowledge is not acknowledged. Similarly, LPN to RN students felt that their LPN knowledge was not

acknowledged by other members of the healthcare team. As one participant explained: “You get that stigma, people see you as somebody who is maybe not what an RN is, even though you’re all members of the team.”

Nurses in this study were largely female, over 30, culturally diverse, with considerable work experience. As mature learners, many were employed with family commitments and other responsibilities. They had established their identities as nurses before returning to the role of student. During the focus group discussions, they often mentioned how a seeming lack of consideration for their existing knowledge left them feeling hurt and longing for acknowledgement of the important contributions LPNs bring to the nursing profession.

When discussing how an instructor required a return demonstration of a skill she mastered as an LPN, one nurse commented:

It’s almost like there’s no recognition for what we’ve done in our careers and that is extremely frustrating because it’s like none of that mattered. Do you know what I mean? Supposedly it’s this LPN to RN [new knowledge] thing. But it’s like [no one] really cares that you’re an LPN. You’re starting from scratch

Further, when discussing her perceptions that RNs did not acknowledge LPNs as nurses who could think critically, one student stated: *I’ve had a lot of RN’s talk to me and say LPN’s don’t know how to think critically.*” Another participant also expressed: “Obviously I have some skills and some critical thinking ... enough to pass as someone who is knowledgeable in my job, in my profession. I’m sick of being undervalued [in the LPN role].”

Theme 3: Desire to belong. LPN to RN students expressed that it was challenging for them to feel a sense of belonging with the RN community as they tried to learn the RN role. In clinical practicums, when they were assigned tasks they had already mastered as LPNs or were partnered with practicing LPNs, they struggled to understand their future role. Practicing RNs were often unaccustomed to students who brought such a wealth of existing nursing knowledge to their learning experiences. This limited understanding was at times viewed as exclusionary. However inadvertent, by being excluded from learning opportunities only available to practicing RNs, they were not always able to fulfill their desire to belong. The following quote illustrates one student’s need to belong to an RN community versus continuing to identify with her LPN peers.

I found it kind of ironic, though. It was weird. Like we didn’t team up all the time with RNs. So you’re trying to create this [new identity] and appreciate the difference between [LPNs and RNs]. But your buddy’s an LPN and so you’re trying to think, “Okay, am I thinking like an LPN or am I thinking like an RN?” And so that was a little difficult because then you still related on an LPN kind of level. So I found that a little difficult. Like it would have been more interesting if we could have maybe like sat with, like been with the charge nurse, like you know, because that’s a role that you would do.

4 Discussion and implications

After listening carefully to the experiences of LPN colleagues as they shared their experiences transitioning to the RN role, our research team reflected on how nurses could best respond and help this group of nurse learners. A change in one’s job is a well-known stressful life event [27]. Transitioning from one nursing role to another can evoke differing emotions and might precipitate intra- and potentially interpersonal conflict between nurse colleagues. LPN to RN learners seek help from workplace mentors to apply their learning [28]. And yet, when they feel other nurses do not respect the LPN role as much as the RN role, do not adequately acknowledge LPN knowledge, and they aren’t exposed to RN experiences that help them become part of the RN community, seeking help becomes difficult.

Viewing the process of entering the RN community through the eyes of LPN to RN students, the conflict with both self and others can seem overwhelming. Practicing RNs, particularly preceptors, play a pivotal role in the professional socialization and successful transition of these experienced nurse learners. The following suggestions, grounded in the concepts of

reflection, communication, and collegiality, are offered for responding and helping LPN colleagues as they adjust to their new roles.

4.1 Reflection

As practicing RNs we often encounter new and difficult situations which have the potential to precipitate both intra- and interpersonal conflict. Reflection offers us the opportunity to apply active, focused thought to an experience in order to gain insight into that experience, leading to new perspectives, learning, and a change in future action. Various models of reflection have been identified in the nursing literature. Johns' structured model of self-reflection [29] is considered easy to use as it provides a series of steps that prompt consideration of an event. [29-31] This model acknowledges the influence of past experience on the present and enables nurses to probe these experiences on a deeper level. Reflecting upon the following six questions could help practicing RNs consider ways to improve transition experiences, and their associated conflicts, giving rise to practice changes which enhance teamwork amongst all nurses: [29]

1. How does this situation relate to previous experiences?
2. Could I handle this better in similar situations?
3. What would be the consequences of alternative actions for the patient, others, or myself?
4. How do I feel *now* about this experience?
5. Can I support myself and others better as a consequence?
6. Has this changed my ways of knowing?

4.2 Communication

Communication (verbal and nonverbal) is part of everything we do as nurses and it influences all we come into contact with. As the provision of safe, quality patient care is a common goal of both LPNs and RNs; our ability to effectively communicate with each other becomes increasingly important in today's complex and hectic healthcare environments.

Communication can be strengthened and potential misunderstandings can be reduced when nurses intentionally engage in positive interactions with colleagues (e.g. communicate openly and directly; validate their professional expertise and importance in patient care). These reflect the respect so essential to effective collaboration [32-35]. Whether their credential is LPN or RN, it is important for all nurses to discuss their common interests and clarify areas of positive interdependence (e.g. values, shared goals) [36-38]. Knowing that words can inadvertently be hurtful, nurses can make a point of rectifying language patterns which could exclude or demean [39] any nurse group. Avoiding and not acknowledging that conflicts exist can keep nursing groups from communicating effectively [40].

The simple process of listening to others' viewpoints can be the heart of effective communication. Sometimes no response is required, just a listening ear and a sense of support and understanding is all that's needed [41]. Once individuals genuinely feel they have been heard and their concerns acknowledged, it is possible to progress towards seeking further information and eventually arriving at a joint understanding of problems. Being willing to discuss ways of working together leads to the development of joint solutions [42]. As with any team, when LPNs and RNs engage in meaningful discussions about dealing with issues, the outcomes can lead to optimism, change, and growth in the nursing profession [42].

4.3 Collegiality

Work environments which offer members a sense of acceptance and connectedness positively impact patient care and nurse

retention rates [43-45]. Building communities which emphasize these elements can help promote a cooperative orientation which encourages constructive conflict management when issues do arise. Welcoming LPN to RN learners into the RN nursing community can begin by expressing a willingness and commitment to serving as an RN role model.

Acknowledging and respecting the differences that exist between nurse colleagues is important [46]. If LPNs are not usually included in team meetings, consider inviting them whenever possible. Regular meetings enhance communication amongst team members, help resolve interpersonal conflict and promote positive interpersonal relations [47]. When workshops on conflict management become available, LPNs and RN's attending together can shed light on LPN issues that RNs may not be aware of. Conflict management helps develop effective communication and coping skills [44]. Similarly, positive team building will evolve when conflict is managed effectively.

5 Conclusion

This article presented findings from a qualitative study that explored Licensed Practical Nurses' perceptions of becoming socialized into the role of Registered Nurse. Unlike other studies that focused on traditional student nurses, this project offers new information about a unique group of nurse learners. This research found that LPN to RN students believed that LPNs were not respected, that their nursing knowledge as LPNs was not acknowledged, and that it was challenging for them to feel a sense of belonging within the RN community. The limited sample is not intended to represent all LPN to RN students and further research is needed to extend our findings. We call on practicing RNs, particularly preceptors, to respond with reflection, communication, and collegiality to our LPN colleagues as they work through the intra- and interpersonal conflicts associated with transitioning to a new and more complex nursing role. We applaud their efforts and invite continued dialogue about ways to welcome and include LPNs on our teams and in our learning opportunities.

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Declarations of interest

The authors declared no conflict of interest.

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Becoming Socialized into a New Professional Role: LPN to BN Student Nurses' Experiences with Legitimation



[PDF – 496 KB]

Citation

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Abstract

This paper presents findings from a qualitative descriptive study that explored the professional socialization experiences of Licensed Practical Nurses (LPNs) who attended an online university to earn a Baccalaureate degree in nursing (BN), a prerequisite to writing the Canadian Registered Nurse (RN) qualifying exam. The project was framed from a constructivist worldview and Haas and Shaffir's theory of legitimation. Participants were 27 nurses in a Post-LPN to BN program who came from across Canada to complete required practicums. Data was collected from digital recordings of four focus groups held in different cities. Transcripts were analyzed for themes and confirmed with participants through member checking. Two overarching themes were identified and are presented to explain how these unique adult learners sought to legitimize their emerging identity as Registered Nurses (RNs). First, Post-LPN to BN students need little, if any, further legitimation to affirm their identities as "nurse." Second, practicum interactions with instructors and new clinical experiences are key socializing agents.

1. Introduction

Vocationally educated Licensed Practical Nurses (LPNs) who enter an online university to upgrade their credentials by earning a Bachelor of Nursing (BN) degree can find the experience of socializing into a new and more complex professional role challenging [1, 2]. Professional socialization is the process of learning a professional role and emerging as a member of an occupational culture [3]. A key element within the overarching process of professional socialization is legitimation or the experience of gaining a sense of affirmation from socializing agents [4, 5].

Traditionally, opportunities for transitioning between vocational colleges and universities were limited [6–8]. Although few universities offer bridging programs for Licensed Practical Nurses, participants in the present study attended a new program where they were awarded prior academic credit for their previous nursing credential. Graduates of the bridging program go on to write the Canadian Registered Nurse (RN) qualifying exam. To date, educational research examining this group of nurses is limited.

This paper describes findings from a qualitative descriptive study that investigated the professional socialization experiences of 27 Post-LPN to BN students. Although most of the nurses' courses are offered online and are completed independently at their own pace, small groups of LPN to BN students do meet face to face for required practicum experiences. The practicum experiences are only offered in two Canadian cities, and students are required to travel to these locations for four-week periods. Over a period of two university terms, our project facilitators conducted focus group discussions with four different groups of students attending practicums. Post-LPN to BN students are required to complete one year of full-time experience as LPNs before they are admitted to the program. Participants in our focus groups were in their final cluster of required courses. By explaining students' perceptions of the legitimation experiences and socializing agents that helped them feel as though they were becoming Registered Nurses, we offer important insights for university educators who teach this new group of adult learners. Insights into the experiences that Post LPN to BN students themselves believe are affirming to their professional socialization can help educators facilitate clinical learning experiences that are relevant and meaningful.

2. Literature Review

2.1. Professional Socialization.

Defining professional socialization is not straightforward. Socialization is a process where individuals acquire a personal identity and learn the values, norms, behaviors, and social skills appropriate to their social positions [9]. Professional socialization is a “process by which persons acquire the knowledge, skills and disposition that makes them more or less effective members (of a profession) ... and a subconscious process whereby persons internalize behavioral norms and standards and form a sense of identity and commitment to a professional field” [10] (page 6). It includes the formation of an individual professional identity, where students come to view themselves as members of a profession with the knowledge and responsibilities which attend membership. It is thus an inherently social process [11].

In health care education, previous research has expanded our understanding of professional socialization. In medicine, the process includes both the intended and unintended consequences of an educational program [12], the informal implicit aspects of a “hidden curriculum” that can be more powerful than the “manifest” or official curriculum [13], and the preprogram attitudes that are important agents of socialization [14]. In social work, the process can include only limited changes in students' preprogram preferences [15] and the value and attitude dimensions have been identified as difficult to measure [16]. In physical therapy, the process is highly influenced by interactions with peers and faculty [17], by legitimation from socializing agents such as patients and clinical instructors [5], and by communication with practitioners [18].

In nursing education, previous research has examined professional socialization among select groups of student nurses, for

example, traditional undergraduate nursing students [19, 20], undergraduate students specializing in community nursing [21], accelerated after degree students [22], male students [23], and students in distance programs [24]. Further, the experiences of select groups of Registered Nurses who upgrade their credentials have been explored. For example, upgrading to Nurse Anaesthetist [25]; to Nurse Practitioner [26, 27], and to Advanced Practice Nurse [28]. Finally, the legitimacy of nursing as an academic discipline has been examined [29].

Although an abundance of literature on professional socialization exists, there is a gap in our understanding of the experiences of vocationally educated nurses who attend university to earn their Registered Nurse (RN) credential. Kearney-Nunnery [30] explained that Licensed Practical Nurses are socialized to “collect client data and decide who needs to be informed,” while university educated Registered Nurses are socialized to “synthesize client data and make independent decisions” (page 19). Given the differences in role socialization between these two groups of nurses, when LPN to BN students undertake a mainly self-paced online curriculum, it is particularly important to examine the socializing agents that strengthen their feelings of legitimation when they meet faculty, peers, and patients face to face.

2.2. Legitimation.

Legitimation, a critical element within the process of professional socialization, occurs when those around learners affirm that they are actually developing an identity as a member of their chosen profession [3]. Symbols, benchmarks, or “ritual ordeals” and people can all serve as valuable socializing agents during learners’ experiences of legitimation [4].

As students are professionalized, they are initiated into a new culture wherein they gradually adopt those symbols which represent the profession and its generally accepted authority. These symbols (language, tools, clothing and demeanour) establish, identify and separate the bearer from the outsider, particularly from the client and the paraprofessional audience [4] (page 54).

In Haas and Shaffir’s [4] view, early manipulation of these symbols of legitimization “heightens identification and commitment to the profession” (page 70) and more importantly “actually changes the neophytes’ own perception of (self)” (page 72). Traditional symbols of legitimization in health care fields included white laboratory coats for medical students [13] and white caps for nursing students [3]. Today, name badges remain one of the few symbols of authority and legitimation that health care professionals continue to use as socializing agents. It is important to note that in the Post LPN to BN program, students’ name badges do not include the identifier of “Registered Nurse.” Practitioners and patients who are not familiar with the program may not understand that Post LPN to BN students are experienced Licensed Practical Nurses developing new professional identities as Registered Nurses.

Additionally, benchmarks or “ritual ordeals” such as personal admission interviews, semester-based courses, and scheduled examinations for cohort groups also serve as socializing agents that bolster feelings of legitimation among learners in the health care fields [4]. Here again, students in the Post LPN to BN program do not participate in these benchmarking rituals. Their admission process did not include interviews, and they completed courses and examinations online at their own pace. Their only opportunity to meet faculty in person and join a cohort group was during their clinical practicums.

Finally, people such as faculty, peers, patients, and practitioners are important socializing agents that reinforce legitimation [4, 5, 17, 18]. Faculty evaluations of student progress and learning experiences that are new and different provide students with affirmation that they are progressing towards being granted professional legitimation and status. As Dall’Alba [31] emphasized “Learning to become a professional involves not only what we know and can do, but also who we are becoming” (page 34).

As part of an overarching program of research examining Post LPN to BN transitions, our research team questioned how Post LPN to BN students perceived their own processes of professional socialization and the kinds of formal and informal socializing agents of legitimation that contributed to or distracted from their growing identity as Registered Nurses.

3. Research Approach

This qualitative descriptive project was framed from a constructivist worldview [32–34] and Haas and Shaffir's [4] sociological theory of professionalization. Haas and Shaffir theorized that legitimation is a central concept in healthcare professionals' process of socialization. Participants were 27 Post LPN to BN students from a Canadian university who attended a practicum on an acute hospital unit. The main purpose of the research was to describe Post LPN to BN student nurses' experiences with professional socialization as they transitioned into a more complex nursing role. A secondary purpose of the research was to begin to understand how university faculty can best support and facilitate these students' professional socialization as they learn to become Registered Nurses (RNs). Data sources included four face-to-face digitally recorded, transcribed focus group discussions which were analyzed for themes.

Our rationale for collecting and analyzing focus group data centered on our intention to invite our participants to converse and interact in ways that stimulated new insights. Focus group methodology, with its emphasis on group interaction [35–39] and goal of collaborative discussion [40, 41], allowed us to draw out participants' views and to explore their ideas and conversational exchanges with one another in depth. Focus groups are a rich source of information [42] and a valid method of generating data within a constructionist epistemology where "knowledge is created in situated, [collective] encounters" [43] (page 496). They are a useful method for gaining insight into phenomena where little is known [44]. When focus group data has been collected from multiple groups and multiple sites, researchers can have increased confidence in the reliability and validity of the findings [45].

The focus groups were guided by following questions.

(1) Perceptions of Professional Socialization.

- (a) *What comes to mind when you hear the phrase "professional socialization"?*
- (b) *Share memories of your experiences becoming socialized into the role of Licensed Practical Nurse and developing your identity in this role.*
- (c) *How is the experience of developing your new role and identity as a Registered Nurse the same? How is it different?*

(2) Formal Academic Experiences: Online Classes and Clinical Practicums.

- (a) *Talk about experiences you have had so far in your online university classes where you "felt like" a Registered Nurse and not a Licensed Practical Nurse? Have there been times in your online university classes where you haven't been sure about what it "feels like" to be a Registered Nurse?*
- (b) *Talk about experiences you have had so far in your practicums where you "felt like" a Registered Nurse and not a Licensed Practical Nurse? Have there been times in your practicums where you haven't been sure about what it "feels like" to be a Registered Nurse?*

(3) Informal experiences (Employer Requirements, Workplace Interactions, and Existing Professional LPN Commitments).

- (a) *What have employers and colleagues at your workplace said or done that contributed to your "feeling like" a Registered Nurse? What distracted?*
- (b) *How do your existing professional Licensed Practical Nurse commitments contribute to your process of becoming socialized into the role of Registered Nurse? How do they distract?*
- (c) *Talk about the sorts of things that are going on in your life with family and friends that impact your changing role and professional identity.*

Transcripts from the focus group discussions were analysed for themes [46–48]. Our research team thoroughly read and reread the transcripts and met regularly to develop a systematic process of thematic analysis. We used investigator triangulation [49, 50] to create and agree upon the categorizations and coding schemes that led to our themes. Our themes

appeared consistently in each of the four focus groups. Trustworthiness was established by member checking with participants to ensure authenticity.

Several strategies were utilized to increase rigor [45, 51]. Stability was enhanced through the use of multiple focus groups in geographically different areas. Equivalence was achieved through the use of two experienced moderators with complementary styles to achieve “flow, texture and context” and to promote construct validity [51] (page 302). Credibility was strengthened through sustained engagement and observation over the course of four focus groups, researcher triangulation, debriefing as a research team, and member checking. Reflexivity, where researchers strive to understand their own experiences as well as the research question, in order to remain objective, neutral, and nonbiased, was supported through regular face-to-face and teleconference meetings. Transferability was enriched through dense sample description and rich description of the data. Confirmability was heightened through peer debriefing and maintaining our audit trail. Dependability was attained by recording a log of our plans, meetings, and ongoing interpretations. Using annotation and memo functions, NVIVO 9 [52] maintained a permanent record of our work. Tracking individual responses in addition to the group account [53] assisted us in avoiding the risk of analyzing data from only vocally dominant members of the groups. Field notes or “descriptions of participants, impressions related to the discussion (and) observations related to group dynamics” [54] (page 85) maintained by both moderators during and immediately following the sessions further increased the dependability of our findings.

Practical issues such as organizing groups at a time and place to minimize disruption and avoiding power differential dynamics [55] were addressed. The groups were held when participants, who were normally separated by distance, were together in the same city for a required practicum experience. They were held at change of shift in lieu of a post conference. Knowing the power differential between students and teachers, moderators who did not have teaching responsibilities in the Post LPN to BN program were chosen to facilitate the focus groups. Instructors were not present during any of the discussions and had no involvement with the transcript data. Participants were recruited through a Letter of Invitation sent via email by a Research Assistant who was also not involved with the program. Four focus groups were held with 5 to 9 participants each. All the students who were invited chose to participate. We reasoned that this may have been because they were all from out of town and appreciated an opportunity to interact and share their views. Pseudonyms ensured participant confidentiality. Full ethical approval was granted by the university. The following two overarching themes emerged from analyzing the data. First, Post LPN to BN students need little, if any, further legitimation to affirm their identities as “nurse.” Second, practicum interactions with instructors and new clinical experiences are key socializing agents.

4. Results

4.1. Theme One: Post LPN to BN Students Need Little, If Any, Further Legitimation to Affirm Their Identities as “Nurse.”

Without exception, participants in this project all commented on how they felt as though their identity as a “nurse” was well established before they entered the Post LPN to BN program. When invited to discuss memories of times when they felt affirmed in their identity as a “nurse,” several participants commented on skills they mastered in their practice as LPNs, for example:

“When I gave my first injection—that was like— I’m a nurse!”

“I know it’s the silliest thing, but doing the hospital corners for me was ... very sentimental—I felt very nursy.”

“The gross stuff-wounds.”

Participants discussed how others’ expressions of trust in their knowledge also legitimized their identity as “nurse”:

“Collaborating with the physicians. At my work, I would say I need this ordered, Dr ... and he’ll just say, okay, it’s ordered. And then it seems like I make the decision and I just need his signature.”

“When the client would appreciate the care that you provide them, and also the family. They will speak with you and then thank you for whatever you did.”

They talked about opportunities where demonstrating professional authority in their workplace further established their identity as “nurse”:

“Working your first night shift ... in your new role. The culture of night shift—it’s different.”

“The first time I cared for a palliative patient and was there when they passed. Talking with the family. My first job that I had as an LPN, I was alone on the floor as the only official nurse for more than half of my shift. I had the full responsibility of all 60 residents in my care ... that all happened as an LPN.”

From the Post LPN to BN students’ perspective, the notion that socialization into the role of “nurse” would occur for them at this point in their career was insulting:

“I almost feel a little bit insulted to think that I would feel any less professional as an LPN than I do as an RN. I feel equally professional in both roles.”

“My buddy nurse actually asked me if I (implemented treatment) and I was like, I have done this before! It was a little like patronizing. I did not like being patronized in that sense. We are not newbies. We have been around.”

“We aren’t newbie’s. We do bring experience ... I’m still very proud of the work I do as an LPN. I already feel I do think like an RN. (It’s) very frustrating and almost devalues the work that I’ve already put into the profession.”

“(In one course) the textbook was the exact same textbook that I used in my LPN course. Same cover, same everything. I found that so frustrating because I thought, I’ve read this textbook already.”

In sum, Post LPN to BN students in our study expressed that they already viewed themselves as professional nurses. They were not “becoming nurses” by attending a university. One nurse offered this advice to those involved with educating this group of learners: “It’s extremely important when you are an adult learner to be treated as such. When you disregard our previous skill and knowledge, it’s a blow to our ego, it’s degrading.”

4.2. Theme Two: Practicum Interactions with Instructors and New Clinical Experiences Are Key Socializing Agents.

When participants in this study reflected on changes and growth in their professional identity, it was the practicum interactions with instructors and the opportunities for new experiences that stood out for them as particularly meaningful. Students consistently emphasized that they viewed the LPN and RN roles as similar during the focus group discussions. During the practical components of their program, it was especially important to receive legitimation from others that they were truly extending their existing “nurse” identity. Many students expressed that they did not feel different:

“I think what’s changing is how other people look at you more than how I feel, how other people treat you and how willing they are to give you responsibility versus how I ever felt.”

“I do not feel different myself. But people react to you differently. People are willing to give you more responsibility because you are going through the RN program.”

“I’ve noticed it’s more external in how people treat you versus how you feel.”

"I do not feel different myself. But people react to you differently. People give you more responsibility."

Instructors expected students to demonstrate a capacity to seek out new and relevant information and frequently questioned them about their patients. This evaluation process was a familiar ritual to Post LPN students. When our participants felt that they responded well, they expressed a tentative willingness to risk identifying more with the RN role:

"I find coming into this program, you need to justify everything that you're doing and explain the reason for it. It makes you think more about your reasons for doing something and whether you can justify them well enough to, you know, proceed to doing care. And I think maybe that's because you have somebody who's constantly challenging you to prepare. So if you can give a good answer, you know okay, I'm on the way. What can I do better? If you cannot answer the questions, then you're challenged to go and maybe research a little bit better so you do not feel, oh, I did not answer that question very well."

"I think one thing that I find myself doing more just in this role is just researching because they put such an emphasis on that that I find myself looking everything up, so that's one thing that I've changed in my practice is I look things up more."

"Well, as an LPN and an RN, it's our professional responsibility to have continuing competence and learning, so has taking the RN program taken me farther than I would have taken myself as an LPN? I do not know, because that was my responsibility to continue to learn ... oh, I do not understand what this blood work means. Maybe I should look it up. I still should have and would have been doing that as an LPN. Going through this program has forced me to [research patient conditions] because we have homework every night to do, so maybe it's a little bit more forced learning but"

"Instructors have been really good about asking you questions and getting you to think or why is this being done, and why would you think that you would do this? And what would you do if this happened? (They) kind of encourage and draw out of me that way of looking at the whole picture."

Opportunities for new experiences supported participants' sense of gaining a more complex nursing identity. They identified the topic areas where they gained the most new knowledge as acute care, research, leadership, psychiatric mental health, and community nursing. Describing her opportunity to attend an Intensive Care Unit (ICU), one participant described how the prospect of interacting more with this patient group contributed to her growing identity as an RN: *"I went to ICU today, and like the whole day I was like Wow! This is awesome. I already work and feel confident in (acute care) I would have loved to (complete the practicum in ICU)."*

Similarly, another participant described how she learned of a community resource which distributed milk to the needy and was able to refer her patient: *"After seeing what's out in the community ... I was never aware (of these programs.) Another added: "It's nice to see that nursing is the (profession) that does that! I get excited about it! There's so many things that we can do. (In hospital nursing) it's one on one. You help one person, but in community nursing, you're talking whole communities and populations, and like a long life span too right? They're going to teach their kids, and their children's children. That was interesting."*

Participants consistently identified that the new experience of working alongside a Registered Nurse was also a powerful experience of legitimization: *"A good example today was (procedure). I did (procedure) so I got to sort of walk through that with my RN that I was working with. She was really, really open to sharing what she knew about it. (This opportunity was) definitely a new skill."*

Where problems occurred in seeking new clinical experiences for Post LPN to BN students was the variance in their previous experience. It was during these discussions that the interactive nature of our focus groups was most apparent. Participants were interested in one another's perspective, but they did not agree on what actually constituted a "new" experience. Students who worked on acute care hospital units did not view some aspects of their university practicum as "new." On the other hand, those who worked in long term care found the practicum "very challenging." Problems also occurred when institutional policies for undergraduate nursing students did not take into account that Licensed Practical Nurses could also be members of this student group. Participants mentioned instances where "my buddy nurse was an LPN with less experience

than me” and “I cannot actually do some of the skills that I’ve been trained to do as an LPN in this practicum so it’s kind of holding me back.”

5. Discussion

The aforementioned two themes, developed from focus group discussions with Licensed Practical Nurses attending university to become Registered Nurses, begin to illustrate the experience of legitimization among this group of learners.

Listening attentively as students described their experiences revealed useful ways to acknowledge their existing identity as nurses, to understand how important instructors’ questions were to them and to conceptualize the notion of “new” experiences through their eyes.

Consistent with MacLellan et al.’s [56] research with dietetic students and Klossner’s [5] research with student athletic trainers, our project also revealed that professional socialization begins when instructors and patients accept students in their new professional role. This acceptance and acknowledgement by others generates confidence and a willingness to risk behaviours expected of those in the new role. Similarly, our project echoes Spoelstra and Robbins [28] research with Registered Nurses transitioning to an advanced practice role. Like our participants, the practising nurses in Spoelstra et al.’s study identified that implementing direct patient care was an essential component in their successful role transition.

However, the experiences of legitimization that Post LPN to BN students face are unique. Traditionally, university programs did not offer bridging programs to vocationally educated nurses. In turn, questions about the legitimacy of their new program may be raised. Scales measuring values new students acquire as part of their socialization into the role of nurse, such as Weis and Schank’s [57] Nursing Professional Values Scale-Revised NPVS-R or Shinyashiki et al.’s [58] professional socialization questionnaire, are not fitting for this group of nursing students. Licensed Practical Nurses begin their program already well socialized into the identity of “nurse.” Participants in the present study felt insulted by the notion of “becoming” a nurse. Given the similarities between the LPN and RN role in their workplaces, they did not always feel that they were doing anything “different” in their practicum.

Affirmation from others that their professional identity was extending and changing was especially important to this unique group of learners. The authenticating experiences of completing courses and examinations in cohort groups that Haas and Shaffir [4] considered foundational to professional socialization were not available to these students. They completed prepracticum courses and examinations alone and online. Their employment experiences as LPNs did not usually support acting independently. On their practicum units, their name badges did not effectively communicate what their role was. In some instances, they were prevented from implementing nursing care that was part of their everyday practice. In essence, the typical legitimization agents that historically supported healthcare learners towards new professional identities are not fully available to Post LPN BN students. Therefore, both the time they spent with instructors and “new” clinical experiences were especially important.

Limitations of the study included recruiting a small homogenous sample of learners from only one program. As we were not previously acquainted with participants, group dynamics such as dominance by one or two members, power differentials, or established patterns of communication may have influenced the conversations. Despite our moderators’ attention to group process, some participants may have simply agreed with others, not expressed their views fully, or commented only superficially.

6. Conclusion

Given these findings, implications for instructing Post LPN to BN students include honoring the feelings of legitimacy they

have already developed as practising professional nurses. Educators must ensure that opportunities are available for these learners to meet with their instructors regularly and to engage them in learning topics and experiences that, in their view, are “new.”

Clearly, structured evaluation times are a priority. Students expect and need the formal acknowledgement that they are progressing or not progressing as expected. Although students may not “feel different” themselves, acknowledgement from others that they are developing a new nursing identity can be impactful. Further, the importance of encouraging students to identify individual learning goals should not be underestimated. Traditional undergraduate placements cannot be expected to accommodate all the needs of this diverse group of adult learners. It is critical for educators to recognize that “new” experiences are likely to be different for each student.

In conclusion, this paper presented findings from a descriptive study that explored Post LPN to BN students’ experiences with professional socialization. The research investigated socializing agents that impacted students’ feelings of legitimacy as they developed new identities as Registered Nurses. In contrast to other studies, this project extends our understanding of healthcare learners’ professionalization by including the voices of Licensed Practical Nurses who attended university. Knowing the value that this group of adult learners place on instructor evaluation and “new” clinical experiences, implications for educators include ensuring that one-to-one time with their teachers is available and designing practicum experiences that build on their established identities as professional nurses.

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From vocational college to university: How one group of nurses experienced the transition



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Abstract

This qualitative descriptive study explored Post LPN to BN students' perceptions of their studies at a Canadian University. Kelly's (1955/1991) Psychology of Personal Constructs was the theoretical framework for this three year longitudinal project in which 10 Post LPN to BN students were interviewed at the beginning, middle and end of their program. Transcripts from the interviews were analyzed and two key themes are presented to illustrate the experiences of one group of adult learners, Licensed Practical Nurses, as they upgraded their vocational credentials at the university. Study results found that creating opportunities for Post LPN to BN students to articulate previous accomplishments bolstered their confidence. Further, instructor encouragement supported them towards self direction and independence.

Introduction

Vocationally prepared Licensed Practical Nurses (LPN's) who enter the university to upgrade their credentials by earning a Bachelor of Nursing (BN) degree can find the experience overwhelming. And yet, educational research examining the transitions these adult learners undergo is limited. This article describes findings from a qualitative descriptive study that applied Kelly's (1955/1991) Psychology of Personal Constructs as employed to investigate the transitional experiences of 10 Post LPN to BN students who extended their nursing education by attending university. The project spanned three years and involved thematic analysis of interview data collected at the beginning, middle and end of participants' program of study. By illustrating students' views and using their own words to describe their transition over time, this longitudinal study begins to offer insight into how one group of nontraditional learners, Licensed Practical Nurses, gained confidence, self direction and independence.

Literature Review

Transitioning from Vocational to Higher Education

The experience of transitioning from vocational college to university is not straightforward. Traditionally, these students chose to attend either a vocational college or a university to prepare for their career. Further options for transitioning between the sectors have existed. In an early study of educational participation in the United States, Arum and Shavit (1993) wrote: "vocational education at the secondary level ... does inhibit students' chances of continuing on to [the university] and as such, it probably inhibits their chances of reaching the professions and most prestigious occupations" (p. 20).

Today, although more opportunities are available for such students to apply their vocational credentials towards university credit, the process is seldom seamless. In his investigation of the relationship between vocational and higher education sectors in The United States, Canada, the United Kingdom and Australia, Moodie (2008) emphasized that determining equivalence between qualifications is difficult in vocational training sectors, making awarding credit for what learners from different programs have achieved particularly difficult.

Vocational training programs that exist are generally designed to prepare graduates more for the workplace than for university entrance. Hoelscher, Hayward, Ertl & Dunbar-Goddet (2008) questioned whether participation in vocational training could provide a successful progression into higher education. In their research exploring learners' transition from vocational to higher education Hayward, Dunbar-Goddet, Ertl, & Holscher (2008, May) asserted that "parity of esteem between vocational and academic qualifications remains a myth" (p. 1).

Vocational programs are more likely to provide considerable individual guidance and encourage instrumentality; making the more anonymous impersonal university environment difficult to comprehend (Crabtree, Roberts and Tyler, 2007, September 13). Students transitioning from vocational to higher education appeared to be unaware that independent learning was a requirement for success in higher education and lacked many of the skills necessary for effective independent study (Crabtree et al). Also college prepared Social Work students found that the transition to a research-led university was not easy (Cree, Hounsell, Christie, McCune & Tett, 2009). Hayward et al (2008) found that vocational students who transitioned from training programs to university experienced difficulties understanding what was expected of them, particularly in the areas of essay writing and mathematics. Confidence, self direction and independence are key elements as adult learners transition from vocational to higher education.

Confidence.

Students are more likely to take on new and more independent behaviors confidently and efficiently if they feel their previous experience has equipped them with sufficient capabilities. Bandura's (1997) seminal work with self-efficacy, or the level of confidence individuals have in their ability to execute a course of action or attain specific performance outcomes, established a critical link between articulating previous accomplishments and raising confidence levels. Previous accomplishments, (also referred to as performance accomplishments), refer to similar activities that have been repeatedly and successfully completed in the past. Such repeated and successful completions of similar activities raise learners' confidence, whereas repeated failures in past activities lower it. In her concept analysis of self confidence in nursing students, White (2009) emphasized the importance of belief in positive achievements among both practicing and student nurses.

Self direction.

Similarly, students can be expected to demonstrate increased levels of self direction when they believe their previous accomplishments are recognized. Self directed learners are active participants who are highly motivated, make use of problem-solving skills, have the capacity to engage in independent learning activities, and autonomously manage their own learning (Brookfield, 1985; Knowles, 1975; Tough, 1979). However, as O'Shea's (2003) literature review of self direction in nursing education revealed, not all students are self directed and nurse educators have an important role to play in developing this skill.

Independence.

In his work exploring student autonomy in learning, Boud (1988) identified that the main characteristic of autonomy or independence in learning was that students take significant responsibility for their learning above and beyond responding to instructions.

Certainly, for vocational learners, who are more familiar with instrumental guidance, it is not unexpected that demonstrating independence may be particularly challenging.

Nursing Education

In Canada, two separate levels of nurse training exist. A Licensed Practical Nurse program can be completed in one or two academic years at a vocational college; and a Baccalaureate degree in nursing, which is required for entry to practice as a Registered Nurse (RN), can be completed in three or four academic years (Canadian Institute for Health Information CIHI, 2006). Keamey-Nunnery (2009) differentiated between nursing roles by explaining that LPN's "collect client data and decide who needs to be informed" while RN's "synthesize client data and make independent decisions" (p.19).

Historically, Canadian university programs have not offered nurses the opportunity to bridge between vocational and higher education sectors. However, participants in the present study attended a new university program where they were awarded prior academic credit for LPN experience. Although core nursing curriculum courses were developed specifically to build on their existing competencies, Post LPN to BN students were required to select other nursing courses and general electives from the university calendar. Therefore, their program differed from typical undergraduate or second degree programs in that they did not take introductory courses in the discipline of nursing.

A paucity of research exists to explain the transitions that Licensed Practical Nurses experience when they attend the university. The process of learning a more complex role is expected to be stressful (Brown, 2005; Claywell, 2003; Deamley, 2006; Rapley, Nathan & Davidson, 2006). Post LPN to BN students can associate gains from their university education with a loss of their hands on nursing role (Melrose & Gordon, 2008). Some LPN's approached their university education with a belief that they were "already functioning as RN's and have little to learn beyond RN-specific tasks and that they are essentially just getting the credential to support their current practice" (Porter-Wenzlaff & Froman, 2008 p. 233). Instructors noted the importance of early identification of students at academic risk (Ramsey, Merriman, Blowers, Grooms & Sullivan, 2004). Graduates may find the role more mentally and physically trying than they expected (Kilstof & Rochester, 2004) and they may not actually identify with the RN role until returning to the work setting (Shultz, 1992). Textbooks are available to articulate transitional processes and to support LPN to RN students (Claywell, 2008; Harrington & Terry, 2009; Keamey-Nunnery, 2009).

The present project, part of an overarching program of research examining Post LPN to BN transitions, explored students' perceptions of their university experiences. While the main purpose of the project was to understand how vocationally trained nurses adapted to higher education, a secondary purpose was to consider instructional strategies that support learners' own processes of adapting and coping.

Method

This three year longitudinal study collected audiotape-recorded transcribed interview data from 10 LPN to BN students at a Canadian university. From January 2007 through to December 2009, data from semi structured interviews with LPN to BN students was collected at three different times. Kelly's (1955/1991) Repertory Grid Methodology (Fransella, 2005) was used to create the structure for the interviews and has been described elsewhere (Melrose & Gordon, 2008). Full ethical approval was granted by the university. NVIVO software was used to organize the data collection and analysis. Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity.

The following two themes emerged from content analysis (Denzin & Lincoln, 1994; Lincoln & Guba, 1985; Loiselle, Profetto-McGrath, Polit & Beck, 2007; Speziale & Carpenter, 2007) of the interview data and were confirmed with participants. Verbatim comments are italicized. First, creating opportunities for Post LPN to BN students to articulate previous accomplishments bolstered their confidence. Second, instructor encouragement supported them towards self direction and independence.

Results

Theme One: Creating opportunities for Post LPN to BN students to articulate previous accomplishments bolstered their confidence

Lack of confidence. Post LPN to BN students may enter university with limited confidence. LPN programs prepare graduates to collect patient data, report that data to Registered Nurses and to act only when authorized. As one participant at the beginning of her program explained: "See, with a Licensed Practical Nurse, we're practical. We [are told] what's good, what's bad, how to do it. And you have somebody very harsh standing over you." Another participant commented on how she had always worked "in someone's shadow" and her experience with learning was that "someone told you what to do." When a participant did not complete assignments she felt she was "not supported. No one asked -how's it going, what can we do for you? When I did my LPN, they rode us hard and made us better nurses for riding us hard. And, they supported us and said that we're doing a good job." However, in the university environment, she discovered: "You don't have somebody harping on you. You don't have somebody giving you the guilt trip."

Reflecting on the lack of confidence that can be apparent in LPN practice, a participant who graduated from the Post LPN to BN program clarified: “The LPN’s are always calling me... they want to verify if it’s alright for them to do certain things. I have to tell them, OK, you can do this. You have to keep going back to them because they keep calling for assistance. I wonder if its confidence?” Another graduate commented: “when I was an LPN, I had to always go to the nurse that I’m working with to ask her what can I do in this situation?”

Further, as adults, returning to formal learning was intimidating. As one single mum expressed: “the biggest barrier for me was the actual decision of returning to school, and my own, the lack of I guess, of confidence, that yes, I can do this as a mature woman with 2 grown children. That was I think, my own sense of self and can I do this? I kept saying, no, I can’t do this. It’s too hard. There’s no way.” A practitioner who had been in the workforce for fifteen years stated: “I’m not a big reader of books, so for me getting back into reading, you know, text books was a lot harder. I had to get my mindset. I had to really focus on thinking as a student.” Another commented “I was afraid of failing. I didn’t even tell anybody at first in case I couldn’t do it.” Writing essays was challenging as illustrated in statements such as: “Handing my first assignment in to any new instructor is terrifying for me;” “Everything we write has to be quoted from somebody;” “Initially I didn’t know what APA was;” am? “[instructors] all mark differently – I don’t know what they want.” And, all of the participants described limited confidence in their mathematical abilities. Comments such as “I was terrified of statistics” and “I hate math” were common.

Participants who spoke English as a second language described feeling a lack of confidence communicating. “I think challenge is English as second language, because some feelings and attitudes need to have the right words to be used to express them without offending the other person.”

“The way the school works here is much different from back home. Maybe I didn’t ask the right question for what I was expected to have an answer. Maybe because English is my second language, I cannot formulate very precise questions. I’m trying to work on that.” “It’s hard to fit in a system that is different from what you have been used to.”

Articulating previous accomplishments.

However, when opportunities to articulate their previous accomplishments were presented, participants expressed considerably more confidence. When describing skills in the clinical area, the following remarks were typical. “I know what people are like when they’re sick and how to deal with them. I have that common sense.” It’s a practical profession and you learn right at the bedside, I’ve done that.” “Showing a human face to people– I know what that means. Take into context everything that’s affecting that person. Why they’re behaving in a certain way.”

Upgrading the knowledge, skills and attitudes Post LPN to BN students achieved in their vocational training to those required in university left participants feeling that, at times, their previous accomplishments were not really valued. One participant explained: “There’s just a sense of patronizing or condescension or oppression because it doesn’t feel like the LPN is valued in the program.” Most of the participants related incidents where their “scope of practice allowed [them] to do [a clinical task], but their instructor had to watch me.” “It was demeaning to feel that I had to reassert my ability to do something.” “We shouldn’t have to prove again that we are licensed to do [certain clinical skills].” In her workplace, a senior LPN described an incident when “a colleague came up to me and said congratulations – you’re going to be a nurse. It’s great. We really need nurses. And this is an RN talking to me who has worked with me for 8 years. I said– I am a nurse, but thanks.”

Participants were very open to instructors “having their own ways of checking us.” They acknowledged that determining equivalence among LPN qualifications is difficult. LPN programs can range in length from one to two years; and LPN admission requirements can range from work experience as a Nursing Assistance through to grade 12. But, while students accepted the inherently different evaluation requirements of their new nursing role, they felt they were not heard when they tried to say they had already mastered a task. There were few opportunities to articulate the previous accomplishments that had inspired and maintained their confidence.

Opportunities to bolster confidence.

When participants were asked what advice they would offer instructors in their program or managers orientating them to their new role, responses repeatedly related to a need to be heard in relation to what they 'can already do.' There was a need for "reaffirmation of what we bring, all through the program, in [all] the courses" and when re-entering the workplace in a new role. Throughout the three year study. Post LPN students and graduates consistently enjoyed describing instances when they had been successful. One participant's familiarity with a set of behaviors equipped her to deal with a challenging mental health client. Several participants were very proud to share how they had helped fellow students and RN staff in the clinical area as a result of their previous nursing experience. A senior LPN described herself as "not just a kid coming out of high school [but someone who] had hardships and made it through so many things that nobody even knows about." Another newly graduated participant expressed pride in helping other new RN hires as she was familiar with working in a hospital setting. Participants agreed that discussing previous accomplishments bolstered their confidence and that they wanted more opportunities to do so.

Theme Two: Instructor encouragement supported them towards self direction and independence

Throughout the research interviews, participants frequently emphasized their need for instructor encouragement. Used to health care environments where mistakes can have serious consequences, these nurses had high self expectations. In one participant's words: "I'm a perfectionist. It's bad if I get a 93% – Why not a 95%?" Comments such as "*needing the encouragement [from instructors]*" "*needing the understanding of the teachers,*" and "*wishing there was acknowledgement when we get over a barrier*" were typical. One participant emphasized: "*we need that encouragement and guidance and just that drive. You 're OK, I 'll stand beside you. I 'll walk beside you. You can do it!*"

Encouragement did not mean "*just saying everything's OK.*" For this group of nurses, knowing specifically what they needed to do to improve and excel was important. Writing papers, participants wanted concrete tangible suggestions to strengthen their submissions and not "*just tearing the paper apart.*" Feedback such as "*This is good but work on ...*" was valued. When asked to elaborate on the kind of encouragement that helped them become more confident in their writing, the following statements were common. "*One instructor told me to use more nursing journals – not magazines or even not medical journals.*" "*You've got good structure in your writing – but its choppy. Use transition words to help the flow and smooth it out.*" One participant who had graduated from the program described an incident where she read an assignment a colleague completed for another university. Describing the assignment, she questioned: "*Are you going to present this? [At our university] you go out of your way to do everything before you can get good marks.*" She seemed proud to add "*they want to create a standard which is good because I found out that they are very, very strict in their marking. You don't just get an A.*"

In practicum courses, students recounted numerous instances where the encouragement they received from instructors and preceptors supported them towards self direction and independence. Pride was apparent in voice tone and inflection when they described instructor comments such as "*[name] told me my communication skills were strong already*" and "*[name] said the way I handled [incident] showed a great strength that I had.*" They felt welcome and more willing to risk new behaviors after hearing preceptors' statements such as: "*They [Post LPN to BN students] already knew how to do blood pressures, assessments, admissions and charting,*" "*these students already know their stuff*" and "*they have the experience and the background to [complete nursing care].*" On the other hand, one graduate became tearful when relating an incident where a preceptor told she was not succeeding but did not give direction for improvement. Although the incident occurred nearly two years ago, she still felt "raw." Another graduate related how she "*kept everything – all the comments on my papers and my clinical evaluations – I don't know if they know how much we take evaluation to heart.*"

Discussion

These two previously identified themes, developed from interviews with nurses who transitioned from vocational college to

university, illustrate how important it is for this group of adult learners to articulate their previous accomplishments and to receive instructor encouragement. Post LPN to BN students were trained to seek direction before acting and can be expected to lack confidence and familiarity with the self direction required at university. While they were well prepared for health care workplaces, they anticipated instrumental guidance and felt overwhelmed when required to learn independently. Casting their transitioning experiences against Bandura's (1997) view that critical links exist between successful previous accomplishments and increased confidence levels, this study leads us to consider ways to create more opportunities where learners can share what they know.

Many of the nurses' experiences are similar to those of other learners transitioning from vocational to higher education. Like Hayward et al's (2008), findings. Post LPN to BN students found essay writing and math particularly difficult. Like the business students Crabtree et al (2009) discussed. Post LPN to BN students also initially lacked the skills needed for independent study. And, like the social work students Cree et al (2009) described. Post LPN to BN students too found adjusting to a research led university challenging.

However, some of the transitions that this group of nurses experienced are unique. Their existing knowledge of client conditions, their comfort with health care environments and their previous achievements in the area of clinical skills were strong. They brought a significant body of nursing and health care knowledge to their classes and practicums. So, requiring these professionals to reassert their proficiencies did little to increase their confidence. Nor did it inspire self direction or independent thinking. On the other hand, affirmations of their practical understandings and expertise bolstered their confidence and inspired them to go beyond simply responding to instructor direction.

In particular, participants in this study emphasized how important it was to them to read or hear words of encouragement from instructors, preceptors, managers and the staff they worked with. Perhaps more than other adult learners. Post LPN to BN students yearned for acknowledgement that their efforts to succeed and excel were recognized. And, they wanted frequent connections with the individuals who evaluated them so they could correct and improve their performance. Therefore, in both classroom and practical learning environments, scheduled opportunities for students to converse individually with instructors are needed.

Kicken, Brand-Gruwel, Merrieaboer and Slot's (2009) research with vocational learners emphasized the value of supervisory meetings in developing self direction. Simply arranging regular points of contact where learners could e-mail, telephone or meet their evaluators to discuss their strengths and areas to grow will boost confidence. Knowing how deeply these nurses integrate feedback, how they can feel "raw" remembering a non constructive evaluation even years later and how they may "keep all the comments on my papers and clinical evaluations," educators have a responsibility to ensure that time for listening and encouragement is available. Perhaps most important of all, educators cannot ignore any opportunities to formally recognize instances when students project confidence and initiate activities beyond just what they have been required to do.

Occasions for articulating accomplishments and feeling encouraged are not limited to interactions with those who formally evaluate students. Assignments can be structured to identify previous knowledge and distinguish new learning. For example, creating case studies of former patients and extending the presentation with a comprehensive literature review. Partnerships with fellow students can be developed to include peer evaluation. Staff teaching sessions can be initiated where learners provide workshops or informational materials during practicum placements. Program wide logs, journals or portfolios to record achievements will illustrate growing independence and decrease reliance on instructor directed activities. Thus, although initially more interaction with instructors and evaluators may be necessary, this can decrease once students internalize university level expectations.

Conclusion

This article presented findings from a longitudinal study that explored the experiences of Post LPN to BN students who transitioned from vocational to higher education. The research investigated how this group of nontraditional learners gained

confidence, self direction and independence. In contrast to other studies that explored the experiences of vocationally prepared individuals attending university, this project extends our knowledge of what it was like for nurses trained to practice in a dependent role adapt to university and become more autonomous. The research found that creating opportunities for Post LPN to BN students to articulate previous accomplishments bolstered their confidence and that instructor encouragement supported them towards self direction and independence. Implications for teaching include ensuring that students have regularly scheduled points of contact with their instructors, preceptors and evaluators; creating assignments that include and build on previous learning, developing peer evaluation partnerships and initiating student led staff teaching sessions. Recognizing previous accomplishments, finding ways to showcase them and offering encouragement rather than instrumental direction can have a profound impact on these learners' continued success.

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LPN to BN Nurses: Introducing a New Group of Potential Health Care Leaders



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Abstract

Vocationally educated Licensed Practical Nurses are seldom viewed as potential leaders in health care organizations. And yet, transformational leadership practices were evident as Licensed Practical Nurses graduated from a Bachelor of Nursing program and transitioned towards a new role. This article, framed from Kouzes and Posner's (2007) model of transformational leadership, presents two key themes illustrating how these nurses changed and grew as a result of their university education. First, Post LPN to BN nurses identified a changed awareness of the implications of their new role as they neared program completion. Second, following graduation, they developed confidence and a vision of the nursing profession as a result of upgrading their nursing credentials.

Transformational, confident and visionary leaders are needed more than ever in today's changing healthcare organizations. Traditionally, in the field of nursing, vocationally educated Licensed Practical Nurses had limited opportunities to grow into leadership roles (Claywell, 2008; Harrington & Terry, 2009; Kearney-Nunnery, 2009). However, when one group of nurses

upgraded their credentials from Licensed Practical Nurse (LPN) to Bachelor of Nursing (BN), their perceptions of themselves as leaders changed and evolved. This article introduces Post LPN to BN nurses as new group of potential health care leaders.

We describe findings from a qualitative descriptive study that applied Kouzes and Posner's (2007) model of transformational leadership to explore the experiences of 10 Post LPN to BN nurses. The project spanned three years and involved thematic analysis of yearly interview data collected during and after their program. Nurses' own words are used to illustrate their changing views. This longitudinal research offers important insights for health care facility administrators and managers who have the opportunity to support and encourage the continued leadership potential of this unique group of new Registered Nurses (RNs).

The Transformational Leadership Model

The transformational leadership model (Burns, 1978) describes a leader as being visionary; arguing against hierarchical management structures and purports that leaders and followers working together can achieve a higher level of morale and motivation. Transformational leaders inspire followers to perform to their full potential by influencing a change in perception and providing direction (Bass, 1985; Bass & Avolio, 1990). They are motivated by their core beliefs and impact followers in a manner which enhances positive organizational outcomes (Tickel, Brownlee, & Nailon, 2005). Environments characterized by teamwork, cooperation and limited interpersonal conflict were typically generated by transformational leaders (Bass, 1998). This model has demonstrated effectiveness in achieving improved results when utilized in rapidly changing environments (Bass, 1998). A contemporary version of the model, developed in 2007 by Jim Kouzes and Barry Posner, continues to support the view that leadership is a process, not a position; a process everyday people can utilize to bring forth the best in themselves and others.

In healthcare organizations, nurse leaders have embraced the model and found it integral to empowering their staff to perform up to their potential (Marriner-Tomey, 1993). It has positive impacts on communication and team building (Thyer, 2003) and may protect against the depersonalization associated with burnout (Kanste, Kyngas, & Nikkila, 2007). It can also assist in the preparation of nurses for their ongoing leadership roles (Tourangeau, 2003). Higher levels of nurses' job satisfaction and lower nursing turnover have been identified on units where nurse managers practiced transformational leadership (Doran, Sanchez McCutcheon, Evans, MacMillan, McGillis Hall, & Pringle *et al.*, 2004). As healthcare organizations become more inclusive, interdisciplinary and less reliant on hierarchical medical leadership, the model is viewed as particularly relevant to nursing (Aiken, Havens, & Sloane, 2000). Despite the model's growing acceptance, there remains limited evidence of its applicability to Licensed Practical Nurses who continue their education to earn a university degree.

The present study applies Kouzes and Posner's (2007) model of transformational leadership to understand how a group of nurses not usually expected to inspire others (Licensed Practical Nurses), gained leadership skills when they earned a Bachelor of Nursing degree and returned to practice as RNs. In Canada, LPNs complete a two-year vocational college program and RNs complete a four year university program. LPN's are expected to gather client data and inform team leaders while RN's are expected to lead teams (Kearney-Nunnery, 2009). Historically, LPNs have been unable to bridge into university programs and receive credit for their vocational training. As more universities develop bridging programs for LPNs, it becomes increasingly important to recognize graduates of these programs as potential health care leaders.

Kouzes and Posner (2007) asserted that transformational leadership includes observable, learnable sets of practices. Two of these practices, *modelling the way* and *inspiring a shared vision* frame our discussion of the nurses' experiences as they developed and grew as leaders.

Method

This descriptive study, the third phase of a longitudinal project exploring LPN to BN transitions, collected audiotape-recorded transcribed interview data from 10 nurses who graduated or were about to graduate from a Canadian university. From January 2007 through to December 2009, data from semi-structured interviews with LPN to BN nurses was collected. In the first phase, implemented during 2007, George Kelly's (1955/1991) Repertory Grid Methodology (Fransella, 2005) was used to create the structure for the interviews (Melrose & Gordon, 2008). In the second phase, implemented during 2008, barriers the nurses faced were described (Melrose & Gordon, 2011). Now, in this third phase, completed during 2009, the nurses' experiences with transformational leadership practices are reported.

The transcripts were analyzed for themes (Denzin & Lincoln, 1994; Lincoln & Guba, 1985; Loiselle, Profetto-McGrath, Polit, & Beck, 2010; Speziale & Carpenter, 2007). Kouzes and Posner's (2007) model of transformational leadership has been used to frame nurses' views as they completed their program and returned to practice. Full ethical approval was granted by the university. QSR International's NVivo 8 software was used to organize analysis of the data.

Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity. The following two themes emerged: First, Post LPN to BN students identified a changed awareness of the implications of their new role as they neared program completion; second, following graduation, they developed confidence and a vision of the nursing profession as a result of upgrading their nursing credentials. Verbatim comments are italicized.

Findings

Theme One: Post LPN to BN nurses identified a changed awareness of the implications of the RN role as they neared program completion

Early in their program, the nurses described feeling challenged by perceived similarity, or task overlap, between the role and function of an LPN versus that of an RN. All identified the LPN scope of practice as having evolved in their geographic region due to changes in the healthcare environment and delivery system. Varying degrees of frustration were noted as nurses described what they were allowed to do as RN students in practicum settings versus what they were licensed to do as LPNs in work environments. At the beginning of the project, participants' comments reflected their belief that the LPN role was very similar to the RN role:

"They've expanded the LPN's scope greatly, so basically when you look at two nurses and one is an RN and one is an LPN, a patient looks at them and they will see them doing the same things."

"I would have liked to have seen more practicums. There was a couple of them I'm going, as LPNs, the way our scopes of practice were at that point in time, we're like doing this already. Why do we have to be shown this again?"

However, as these nurses completed university nursing courses, they began to define their personal values and beliefs about the RN role differently. The leadership practice of *modelling the way* (Kouzes & Posner, 2007) is the process of coming to understand one's motivations and responses by defining personal values and beliefs. Kouzes and Posner (2007) posit that values influence all aspects of one's life including commitment to organizational goals, responses to others and moral judgements; they also inform decision making and serve as guides to future action. *Modelling the way* was evident in the way these nurses conversed with colleagues and modeled their new way of thinking about their profession. When comparing their practice as LPNs to the added responsibility and accountability inherent in their new practice as RN's, the nurses changing values were apparent:

"My aahaa moment...I was actually sitting in orientation for home care...and we were talking about feeding tubes...and I

remember as an LPN in home care...if I had a problem with one of those I would say oh, I'll just have the RN come out and change it. And it hit me. I don't have anybody to call anymore. I'm that person, right?" and

"I'm sad that in my practice as an LPN I missed all this that I know now. I could have been a better nurse to that patient or what did I miss that I should have caught? How better could I have helped them? So in some respects I'm sad, and in some it's like, wow...but I'm really scared...of the...responsibility because...it's the expectation that I have on myself that I can't go back to that...narrow thinking. I have to think huge...put it all together. Make sense of it all."

[When LPN's say]...we do the same work as RNs with a degree and how come we don't get paid the same? I always tell them, when I was in their position as an LPN, I said the same thing until actually I went and took my RN degree. Now I realize it is so different in the depth of the skills that you're doing and the leadership. You actually are doing a lot more. Utilizing your job knowledge, using evidence from research...trying to...apply them to what you are actually doing. As an LPN, that isn't so much into play."

"As an LPN I thought what more is there to learn? ...I was thinking in the hospital I do the same as an RN and now it's like yes, but how can I think differently? ...I can do the same skills but I have to take my thinking beyond that and I have to be more than just the title RN. **It means I have to be a leader.**

Theme Two: Following graduation, Post LPN to BN students develop confidence and a vision of the nursing profession as a result of upgrading their nursing credentials

Nurses in this study were largely female, older than 35 and with dependents. Many had significant life and healthcare experience. Limited confidence as well as feeling restricted and conflicted in their LPN role was initially identified as motivators to upgrade their nursing credential. Comments such as the following were common:

"I always wanted to go back to school...but as the years went by...I think my frustration levels went up...and I think the motivation...when I actually started...was more, I don't know, anger...frustration. At the end the motivation was more a negative because I was just frustrated...so many years of not feeling good about myself and lack of respect [for the LPN role]."

However, as they upgraded their nursing credentials and began to align more with the RN role than with the LPN role, the nurses expressed enhanced confidence and a commitment to making a difference within their profession. Kouzes and Posner (2007) speak of the transformational leadership practice of *inspiring a shared vision*; suggesting leaders need to develop confidence and a sufficiently engaging vision to prepare them to make a difference in their profession by appealing to values, hopes, interests and dreams. The following statements highlight participants' growing confidence and dreams for their profession:

"I have confidence now. Now I have the credentials. When I speak, when I give an opinion, or when I make a decision, I feel like I have the credentials to back me up... I...believe that I have the authority to make that decision, so I don't apologize."

"I just feel totally better about myself. I feel more comfortable with the knowledge I have even though I had a lot of the same knowledge as an LPN. I just never felt comfortable. Like, am I right? Should I ask? Like it was just sort of the fear of being wrong whereas [now] as an RN I have more confidence."

"It's not just [a job] anymore. It's about life...I can't waste my life anymore...**I have to help** [the nursing profession]. I've been given a life for a reason.... I think...the LPN hasn't been given the opportunity to experience what a degree gives you...It's like piano lessons or something. If you've never been exposed then you don't know the joy of it. Once you've been exposed, you keep going and you want to get better and better and better."

[when discussing plans to pursue leadership opportunities] "... to be more fulfilled in my chosen career, I don't have to be in the middle, I have to go above and beyond."

"I have this broader knowledge...and I want to use it...I don't want to do the minimum anymore."

Discussion

These two themes, discussed in relation to Kouzes and Posner (2007) model of transformational leadership, illustrate how Post LPN to BN nurses gain both an increased awareness of their new role and the confidence to begin envisioning themselves as leaders who can make a difference in their profession. Some of the experiences nurses described in this study are consistent with those expressed by other LPNs upgrading their credentials. Like Claywell's (2003) examination of LPNs upgrading to a nursing diploma, conflict within their role as an LPN was an impetus for LPNs returning to school. Like Brown's (2005) exploration of LPNs upgrading to a nursing diploma, leadership roles were believed to be more available to RNs than to LPNs. Like Porter- Wenzlaff & Froman's (2008) description of participants in an accelerated LVN to BN program, some LPN's initially believed that they were "already functioning as RN's and have little to learn beyond RN-specific tasks and that they are essentially just getting the credential to support their current practice" (p. 233). And, as White, Oelke, Besner, Doran, McGillis Hall, and Giovanetti (2008) explained, the skill sets of LPNs and RNs often overlap, making it challenging to see the difference between the two roles.

However, some of the experiences that this group of nurses expressed are unique. Given that universities have previously not offered bridging programs for LPNs and that opportunities for leadership have been limited, insights from our participants offer important direction. Their values and beliefs about the RN role changed significantly as they completed their program. Although they initially saw little difference between the two nursing roles, once they graduated, they viewed the RN role as one requiring them to '*put it all together*,' to model '*depth*' in their practice; and to allow them to '*be leader(s)*.'

This change in awareness of the implications of the RN role has not been reported elsewhere and has implications for health care facility administrators and managers. Post LPN to BN graduates no longer view their university degree as a credential to support their LPN practice; they feel that now they can '*be better nurses*,' they '*expect more*' from themselves than '*narrow thinking*,' and

they '*think differently*' even though doing '*some of the same skills*.' Therefore, opportunities in both classrooms and workplaces where these experienced nurses can talk about how their thinking has changed are needed. The process of discussing their commitment to nursing, their passion for their profession and their excitement about the possibilities available in their new career can model the behaviour to others, once again reflecting Kouzes and Posner (2007) leadership practice of *modeling the way*.

Similarly, knowing that Post LPN BN graduates bring confidence and a vision of nursing that seeks to '*go above and beyond*,' guidance towards developing leadership action plans is also needed. DeGroot (2005) suggests that although vision is value and future directed, action plans are required to translate that vision into reality. Perhaps most important of all, Post LPN BN nurses need encouragement to risk leading initiatives within their organization. Here, the Kouzes and Posner (2007) leadership practice of *inspiring a shared vision* that emerged during their university education can be extended and fostered.

Conclusion

This article introduced Post LPN to BN nursing graduates as potential health care leaders. The project explored how a non-traditional group of nurses tentatively initiated the transformational leadership practices that Kouzes and Posner's (2007) named *modeling the way* and *inspiring a shared vision*. Unlike other research that explored the continuing education experiences of Licensed Practical Nurses, this study provided a glimpse into how LPNs began to define their personal values and beliefs differently, how they embraced the possibility of leadership and how they dreamed about a vision for the future of their profession. Implications for educators and employers include recognizing that Post LPN to BN graduates have leadership aspirations, creating opportunities for them to discuss and model their new way of thinking, guiding them towards developing leadership action plans and encouraging them to risk leading initiatives within their organization.

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Overcoming barriers to role transition during an online post LPN to BN program



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Citation

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Abstract

Canadian Licensed Practical Nurses continuing their education in an online Bachelor of Nursing program face unique barriers as they transition towards a new and more complex nursing role. This qualitative descriptive study explored Post Licensed Practical Nurse to Bachelor of Nursing (Post LPN to BN) students' perceptions of their experiences during their education. George Kelly's (1955/1991) psychology of personal constructs, which seeks to understand how individuals perceive the world around them, was the theoretical framework for this three year longitudinal project in which 10 Post LPN to BN students were interviewed at the beginning, middle and end of their program. Transcripts from the interviews were analyzed and three key themes are presented to illustrate barriers that Post LPN to BN students faced and the strategies they implemented to overcome them. First, workplace mentors helped Post LPN to BN students apply their learning. Second, personal learning goals sustained their motivation. Third, time management strategies included terminating full time employment.

Introduction

Vocationally prepared Licensed Practical Nurses (LPN's) who enter an online university to continue their education by earning a Bachelor of Nursing (BN) degree face unique challenges (Melrose and Gordon, 2008; Porter-Wenzlaff and Froman, 2008; Ramsey et al., 2004). And yet, educational research examining both the barriers that these adult learners face and the strategies they implement to overcome them is limited. In Canada, two separate levels of nurse training exist. A Licensed Practical Nurse program can be completed in one or two academic years at a vocational college; and a Baccalaureate degree in nursing, which is required for entry to practice as a Registered Nurse (RN), can be completed in three or four academic years or two years in an advanced standing accelerated program (Canadian Institute for Health Information CIHI, 2006). Traditionally, university programs have not offered nurses the opportunity to bridge between vocational and higher education sectors.

This article describes findings from a qualitative descriptive study that applied Kelly's (1955/1991) psychology of personal constructs to investigate the transitional experiences of 10 Canadian Post LPN to BN students during their education. The project spanned three years and involved thematic analysis of interview data collected at the beginning, middle and end of participants' program of study. By illustrating students' views and using their own words to describe their transition over time, this longitudinal study begins to offer insight into an emerging group of non-traditional learners.

Background/literature

Strategies that LPN's or Enrolled Nurses (EN's) implement to cope with the challenges they encounter during their process of upgrading their nursing credentials have been understudied. Existing literature begins to describe some of the difficulties they can expect to encounter. However, few studies are available to illustrate the personal efforts that Post LPN or Post EN learners are making to overcome barriers.

The initial time of transitioning to student status has been identified as stressful for LPN's (Rapley et al., 2006). They may perceive that their previous experience as qualified nurses has not been acknowledged (Allan and McLafferty, 2001; Kenny and Duckett, 2005). They may begin their studies with unrealistic expectations regarding program rigor and flexibility (Brown, 2005). The magnitude of academic studies can be shocking (Claywell, 2003). Post LPN to BN students can associate gains from their university education with a loss of their hands on nursing role (Melrose and Gordon, 2008). Some LPN's seem to have approached their university education with a belief that they were "already functioning as RN's and have little to learn beyond RN-specific tasks and that they are essentially just getting the credential to support their current practice" (Porter-Wenzlaff and Froman, 2008, p. 233).

During their program, arranging employment leaves and traveling away from home to complete clinical practicums were problematic for LPN's (Rapley et al., 2006). Participating in upgrading courses was associated with changes in home and work life (Dowswell et al., 1998). LPN's experienced negative peer pressure and sabotage from co-workers occurred (Claywell, 2003). The experience involved a cultural transition and required learners to question traditionally held values and adopt a critical stance to professional practice (Milligan, 2007). Students appreciated recognition for their previous accomplishments (Melrose and Gordon, 2008) and they valued opportunities to reflect on their wealth of experience (Dearnley, 2006). Instructors noted the importance of early identification of students at academic risk (Ramsey et al., 2004). Textbooks are

available to articulate transitional processes and to support LPN to RN students (Claywell, 2008; Harrington and Terry, 2009; Kearney-Nunnery, 2009).

After graduating, Post LPN students found the working role of the RN was more complex, broad and mentally and physically trying than they expected (Kilstof and Rochester, 2004). An early study concluded that the actual process of identifying with the RN role did not occur until graduates returned to the work setting (Schultz, 1992).

The present project, part of an overarching program of research examining Post LPN to BN transitions, explored the following questions: What barriers do Licensed Practical Nurse students transitioning to the role of Registered Nurse encounter during their university education? What strategies help overcome these barriers?

Method

This longitudinal study was framed from George Kelly's (1955/ 1991) psychology of personal constructs. Personal construct theory seeks to understand how individuals perceive the world around them, what their experiences have been and how these experiences influence their beliefs and actions. The theory, and the methodology which extends from it, repertory grid methodology, invites research participants to use their own words to illustrate unique interpretations of events and personal ways of constructing knowledge. This approach, with its underlying assumption that individuals have their own personal ways of construing meaning, was chosen for its relevance to adult learners who bring practical nursing experience to their academic studies.

Researchers collected audiotape – recorded transcribed interview data from 10 Post LPN to BN students in a Canadian online university at the beginning, middle and end of their program. The study included three phases. Phase One reported students' views of transitioning to a new nursing role at the beginning of their program and explained how George Kelly's (1955/1991) Repertory Grid Methodology (Fransella, 2005) was used to establish a baseline interviewing guide (Melrose and Gordon, 2008). Phase Two, the present study, analyzed transcripts from the interviews for themes and reports on students' views in the middle of their program. Specifically, both the barriers students encounter and the strategies that help overcome these barriers are discussed. Phase Three is in progress and will report students' experiences at the end of their program. Full ethical approval was granted by the university's Research Ethics Board. Participants signed a consent form and were free to refuse to participate or withdraw from the study at any time. QSR International's NVivo 8 software was used to organize the data collection and analysis. Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity.

The following three themes emerged from thematic analysis (Denzin and Lincoln, 1994; Lincoln and Guba, 1985; Loiselle et al., 2007; Speziale and Carpenter, 2007) of the interview data and they were confirmed with participants. Verbatim comments are italicized. First, workplace mentors helped Post LPN to BN students apply their learning. Second, personal learning goals sustained their motivation. Third, time management strategies included terminating full time employment.

Results

Theme one: workplace mentors helped Post LPN to BN students apply their learning

Participants viewed isolation as a barrier as they sought to apply their learning to practice. They often felt they had “no one to talk to about the courses” or to answer their questions about “how [course information] was relevant to practice.” Their program offered prior academic credit for LPN experience and required completion of elective and non-clinical nursing

courses in an asynchronous online environment where they worked individually and at their own pace. This method of course delivery made the program accessible to students from across Canada and allowed them to remain in their own communities until they joined a clinical group for their in-person practicum experiences. While optional opportunities for peer and instructor interactions such as e-mail, forum discussions and chat room were built into all their online courses, in-person discussion was limited. However, as these students were employed, they did have occasion to meet RN's or other university educated health care professionals in their workplace.

Unlike either traditional undergraduate nursing students or after degree nursing students, Post LPN to BN students brought professional skills and competencies to their learning process. But, when academic credit for this prior practical learning was allocated, as it was in these participants' program, LPN's may face the barrier of participating in senior level university classes with only limited opportunities to complete introductory undergraduate courses. As one participant explained *"I did a 14 month bridging program from Health Care Aid to Licensed Practical Nurse before I came to the Post LPN to BN program, so I didn't have the [introductory] undergraduate time that some university students have."* In this study, although three participants had earned degrees in other countries, four bridged from Health Care Aid programs.

When elective and non-clinical nursing courses are completed asynchronously online, informal dialogue among teachers and peers may be limited. Lack of opportunity to discuss application of theory to practice can be a barrier to transitioning beyond the LPN role and towards the more complex role of RN. In this project, students created opportunities to talk about what they were learning and how it applied to practice by discussing course material with colleagues at work and by seeking out workplace mentors. Some students found their supervisors were a valuable resource.

"What helped me bring book smarts [theory] to life – mentors-leaders in [my] department. I've got a couple of mentors that are RN's who really encourage me and support me in that role of transitioning, you know, verbally, and saying that they would like to see me take on that role. Mostly the mentorship, you know."

"My manager has been really supportive. Sometimes she even read over my papers. She went back to school to do her masters so she knows what the pros want."

"My boss helped me look for information and also guided me through some of the more theoretical work."

Other students turned to co-workers.

"Co-workers at my current job were supporting and encouraging me to continue. Even though it's difficult, you need to complete. You need to go through. And eventually after awhile, the support that you have there, the people encouraging you to do it – helps."

"I had the chance to work with a very qualified RN that I learned a lot from. Talking to her made some things more clear than just reading them."

"I think about some [RN co-workers] like role models, I want to be where they are, so I can mentor other LPN's. The encouragement when somebody else says that you can do it, you can do it."

One participant felt her colleagues believed in the value of her assignments and reading when *"they would say e take this opportunity e get your homework done. Let me look after a couple of your patients."*

Theme two: personal learning goals sustained their motivation

Participants consistently expressed the same individual goals during the three year data collection period. Each student had personal reasons for undertaking their university education and they reiterated these goals during the research interviews. Five participants discussed how they had "always wanted to be an RN," but explained that difficulties completing RN programs, life events such as relationships, children/family commitments and financial issues "got in the way." One participant chose to become an RN by attending a vocational program, "practicing the one year needed for this program" and then enrolling immediately. Three participants earned university degrees in other countries and always intended to undertake university studies in Canada. The remaining participant had also always planned to attend university for "career

advancement, I wanted to improve my own knowledge and go further.” While all of the participants commented on the financial gains associated with transitioning from LPN to BN, they also all emphasized time and again that this was not their primary motivation. Rather, they were continuing their education to fulfill personal learning goals.

These individual personal learning goals sustained students during times when they felt their motivation waning. Isolation was a barrier they frequently commented on.

“I find [the pre-clinical asynchronous courses] very hard. I felt disconnected from [the program], from camaraderie with other people that are going through and struggling, who are having outside life interfere with school life.”

“When I failed an exam, I felt like nobody really cared whether I passed it or didn’t pass it. I didn’t feel that personal connection where you’re seeing somebody everyday in a classroom, they get to know you as a person. I felt like I was just a number.” “When I was inactive for a year and a half, no one even called or sent me an e-mail.”

Family and workplace demands left some participants with little time to take advantage of opportunities the program offered for establishing connections among classmates and teachers.

“I don’t use the communication part much. I don’t communicate with my tutor. I don’t go on the chat sites or the discussion boards. If I don’t have to do it, I’d rather not talk to anybody. I don’t have time. I try to do the minimum amount of work that I have to do to be able to pass the courses. I know I’m not taking full advantage of the course work.”

“I missed the socialization. But, there were times when I’m like – I just don’t care. I don’t want to make friends. I’m here to work. I’m here to get this job done – just leave me be.”

“There were days when I missed having interactions. There was help but we have to do things by ourselves.”

In the absence of motivational support from fellow students, participants drew strength from the personal goals that led them to university.

“I have a clear goal. Whatever mountains are in my way, whatever clogs in my wheel, I know they are temporary – I want to get this done.”

“This is my degree, my goal – I want this.”

“I will finish to prove to my son that I can do it, even if I am older, so he can do it too.”

“I look to my goal; I’m trying to achieve something better.”

Theme three: time management strategies included terminating full time employment

Balancing full time employment with required attendance at practicums that extended from two through to ten weeks and taking needed time for completing assignments presented a particularly difficult challenge. Employers may not grant educational leave to LPN’s. In one participant’s words: “*I can get leave for stress, I can get leave to get married or have a baby – but I can’t get leave for education.*” While many individuals who students worked with were an invaluable source of help, workplace policies and agency requirements often prohibited staff absences. Five of the ten participants in the present study were unable to acquire leaves and chose to terminate their full time employment in order to continue their program.

Loss of full time employment was a significant sacrifice.

“Leaving my job and selling my home so I could get my last year done was one of the scariest things I’ve ever done.”

“I was kind of forced to leave my position. The employer was very happy with my performance, but for the comfort of the bosses, they wanted me in the building all the time. So they didn’t approve the one month off for my practicum. I left. There are a lot of jobs, school has to be finished first.”

“I was working full time and then I switched to part time, and then eventually I had to go to casual because I wanted to complete the courses.”

“My barrier was my employer not giving me the time off, making me choose between keeping my job or giving up my line.”

“I had to stop working; I just figured I couldn’t combine my children, my home, and my schooling. My husband’s salary is enough to keep the home going so we decided I should just stop at that point, because it was becoming too stressful for me. The last two years of my program have been so critical for me.”

Relinquishing employment to continue her education was not an option for one participant and as a consequence, she was not active in her program for nearly two years.

“I found the biggest challenge was financial. Especially when I completed some of the practicum courses, it required me to be away from work and I needed my full time income. And also my husband was laid off you know, during this economy, and so I had to go back to work full time then. I couldn’t continue keeping up with my studies.”

Of the five participants who terminated their full time employment, three graduated during the data collection period and one expected to graduate the following term. None of the participants who graduated remained in the workplaces they were employed in as LPN’s. One of the graduates remained with the same employer but changed departments. Clearly, maintaining full time employment while continuing their nursing education through an online university was a barrier for LPN’s. In this very small sample, half of the study participants identified that terminating their full time employment was the only viable strategy available to them.

Discussion

The aforementioned three themes, developed from interviews with Post LPN to BN students at the beginning, middle and end of their program, begin to illustrate how this group of adult learners are overcoming the barriers they face. Listening attentively as students discussed their experiences revealed useful ways of looking at the issues of how asynchronous, self paced courses may limit opportunities to discuss the application of theory to practice; how online learning can incite feelings of isolation among students; and how combining full time employment and university studies can put some adult learners in the position of having to terminate one or the other.

Some of the barriers that this group of students described are consistent with those experienced by other LPN’s who attended university to continue their education. Porter-Wenzlaff and Froman (2008) also noted how Licensed Vocational Nurses (LVN) to BSN students can be challenged by disadvantaged academic backgrounds and life responsibilities. Similarly, Rapley et al. (2006) described how some EN to BN students also felt isolated and chose not to use the online tools that were available for communicating with fellow students. Further, the difficulties students experienced when they requested work release to study or attend practicums have been documented consistently (Dowswell et al., 1998; Kenny and Duckett, 2005; Rapley et al., 2006).

However, some of the challenges that this group of vocationally prepared nurses faced when they completed a university degree are unique. Undergraduate academic skills, such as reading professional literature and writing papers may be underdeveloped. Time management skills were carefully balanced to target priorities and eliminate course activities not directly identified with earning marks. So, optional conversations among classmates and teachers in pre-clinical and elective courses may be minimal. Therefore, supplemental opportunities for students to talk about how theory can be applied and viewed as relevant to actual workplace practice are needed. Motivation can be impacted by relentless family and workplace demands, living through previous efforts to complete an RN program and battling lack of recognition for an out of country degree. Feelings of isolation and abandonment can occur when university programs, unlike vocational programs, may seem ‘not to care’ when students fail or leave. Here, integrating opportunities to create and re-visit students’ own personal learning goals into different courses and at different times throughout the program are needed to sustain motivation. And, perhaps most important of all, this group of nurses had considerably less employment flexibility than full time university students. As a result, this restriction must be taken into consideration when scheduling practicums.

The present investigation suggests expanding our ideas about facilitating learning with online Post LPN to BN students to include acknowledging the barriers they face and the strategies they may already be engaged in to overcome them. In turn, this acknowledgment can guide us toward a deeper understanding of how best to support this new group of learners and to create meaningful and relevant learning activities in their courses and programs. Knowing that their workplace can be expected to provide Post LPN to BN students with access to RN's, assignments can be created that require inclusion of interview comments from these colleagues. Thus, although online interaction may not be occurring with classmates and teachers, students could demonstrate aspects of their application of theoretical course content by submitting a record of their workplace conversations. Further, knowing that reflecting on the individual personal goals that led them to university can help Post LPN to BN students sustain their motivation throughout their program, course objectives can expect learners to maintain an ongoing Learning Plan that articulates these personal goals as well as course specific goals. Despite feeling unable to take advantage of optional course activities designed to reduce isolation and sustain motivation, students can find that much needed motivation internally. Finally, knowing that some students must terminate full time employment in order to complete their studies, program schedules must recognize the restrictions that LPN employers impose.

Conclusions

This article presented findings from a longitudinal study that explored online Post LPN to BN students' transitional experiences during their university education. The research investigated barriers that this group of non-traditional learners faced and the strategies they implemented to overcome these barriers. In contrast to other studies that identified the experiences of LPN's and EN's when they continue their education in nursing, this project extends our knowledge of how learners themselves are coping with the challenges they encounter. The research found that students turned to workplace mentors for help applying their learning, that they reflected on personal learning goals to sustain their motivation and that they could even terminate their full time employment as a time management strategy. Implications for teaching include creating assignments that require workplace interaction with RN's or other university educated professionals, course objectives that expect articulation of personal goals and schedules that accommodate employment. The article calls for the creation of more opportunities to understand the barriers these students face and continued attention to constructing teaching approaches that support and encourage students' own solutions.

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Online Post LPN to BN Students' Views of Transitioning to a New Nursing Role



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Abstract

Vocationally prepared nurses, most of whom are women, experience unique challenges when they enter an online university. And yet, educational research examining their perceptions about transitioning into a new professional role is limited. This qualitative descriptive study investigated beginning Post LPN to BN students' views of role differences among nurses and the process of transitioning between those roles. The project was framed from a constructivist theoretical perspective and applied repertory grid methodology from the field of personal construct psychology. Ten students from a Canadian online university were interviewed. Interview transcripts were analyzed for themes. Findings revealed that students appreciated recognition for their previous accomplishments. They valued affirmation of the unique challenges they faced. And, they associated gains from their new university education with some loss of their hands on bedside nursing role.

KEYWORDS

This article describes findings from a qualitative research project that applied personal construct psychology to investigate the transitional experiences of vocationally educated Licensed Practical Nurses (LPN) as they entered an online university program to earn their Bachelor of Nursing (BN) degree. While the main purpose of the project was to explore learners' ideas about transitioning into a different and more complex nursing role, a secondary purpose was to begin to consider instructional strategies that respond to learners' needs. The research was guided by the question: how do beginning Post LPN to BN students view the experience of transitioning to a new role in an online university?

Participants in the study were Licensed Practical Nurses who had completed their first cluster of required courses in an online Post LPN to BN program offered through a Canadian university. Responding to a critical shortage of Registered Nurses, the university offers a Post LPN to BN program where Licensed Practical Nurses from across Canada complete their Baccalaureate degree in nursing while remaining in their home communities. Although most of the course work is completed online, students are also required to travel to attend clinical practicums supervised by instructors or preceptors.

These adult learners are predominantly female, are from both urban and rural geographical areas, and are prepared for licensure at a vocational college. They are employed in often over-burdened health care settings and are required to continue caring for their families. Familiar with contemporary health care environments, these practitioners will bring their previous experience as well as their new Baccalaureate learning to their practice as Registered Nurses. Three key areas of theoretical understanding provide background for this study: transitioning from LPN to BN; differentiating between the LPN and BN role; and situating LPN to BN students as adult women entering online university programs.

LITERATURE REVIEW

Transitioning from LPN to BN

A plethora of literature exists to explain the transitional experiences of Registered Nurses when they have recently graduated from traditional undergraduate programs (Ellerton & Gregor, 2003; Halfer & Graf, 2006; Kamphuis, 2004; Kramer, 1974; Kelly, 1996; Whitehead, 2001), and when they earn further professional credentials (Benner, 1984; Forbes & Jessup, 2004; Heitz, Steiner & Burman, 2004). However, fewer studies are available to illustrate the experiences of Licensed Practical Nurses. Most post graduate programs for Licensed Practical Nurses offer a Registered Nurse diploma, not a Bachelor of Nursing degree.

In the United States, findings from dissertations examining transitions into diploma programs offer important insights. Shultz (1992) noted that the actual process of identifying with the Registered Nurse role did not occur until Post LPN students returned to the work setting. Claywell (2003a) identified that LPN's felt negative peer pressure or sabotage from co-workers and they were shocked by the magnitude of nursing school work. Similarly, Brown (2005) suggested that students began their studies, which were online, with some unrealistic expectations regarding the program's rigor and flexibility. Anecdotally, Ramsey, Merriman, Blowers, Grooms and Sullivan (2004) stated that regularly scheduled role transition seminars were needed in their LPN to RN program and that early identification of students at academic risk was important. Texts are available for facilitating these kinds of seminars (Claywell, 2003b; Duncan & DePew, 2005; Ham, 2001; Harrington & Terry, 2003).

In Australia, studies examining enrolled nurses (EN's), who work in a similar capacity to LPN's, sketches in additional information about transitioning into diploma programs. Kilstof and Rochester (2004) concluded that the transition experience was stressful and that the working role of the RN was more complex, broad, and mentally and physically trying than students expected. Rapley, Nathan and Davidson (2006) emphasized that it was the initial time of transitioning to student status that

was especially stressful, and that arranging employment leaves and travel away from home to complete practicums was problematic.

In the United Kingdom, researchers such as Dearnley (2005) highlight the importance of supporting students' reflections on their wealth of experience as they transition into diploma programs. Once enrolled nurses completed their course, Allan and McLafferty (2001) found that 90% of the respondents in their small study did consider further education. In Canada, since bridging programs for Licensed Practical Nurses are limited and diploma credentials may no longer be offered, little is known about how this group of adult women experience transition, particularly during the formative time of entering an online university.

Differentiating between the LPN and BN Role

Clearly, articulating the experience of transitioning from LPN to BN is not straightforward – nor is the task of differentiating between the two roles. Beverage (2004) posited that distinctions are based on levels of education and independence of practice. Regarding education, while an LPN program may be completed in one or two academic years (Canadian Institute for Health Information CIHI, 2006), an RN program – where a Baccalaureate degree in nursing is required for entry to practice – may take three or four academic years (Jeans, Hadley, Green, & DaPratt, 2005). Higher levels of nursing education have been associated with lower patient mortality and job satisfaction (Blegen, Vaughn, & Goode, 2001; Ellis, Priest, MacPhee, & Sanchez McCutcheon on behalf of CHSRF & partners, 2006; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti; Hickam, Severance, Feldstein, Ray, Gorman, Schuldheis, et al. 2003).

With independence, in delineating scope of practice in Alberta, Canada, collaboration between LPN and RN Alberta regulatory bodies determined that all nurses are expected to demonstrate competency in clinical practice, decision making and critical thinking (AARN/CARNA, 2003). However, Registered Nurses are expected to demonstrate additional competencies related to leadership, research utilization and resource management (AARN/CARNA, 2003).

While regulatory bodies have initiated policies to differentiate these professional competencies, there is a “gap” in our understanding of what the differences between the role of RN and LPN actually look like in practice. Besner, Doran, McGillis, Hall, Giovannetti, Gerard and Hill et al's (2006) research examining differences in scope of practice among LPN's, RN's, and RPN's in three Canadian cities revealed “substantial role confusion in nursing” (p. 2) and called for further examination of role clarification. Given this role confusion in nurses' work environments; online educators have few resources available from practice settings to guide students' transitional processes.

Situating LPN to BN Students as Adult Women Entering Online University

Viewing Post LPN to BN students as adult women who are entering online university programs begins to offer educators some direction. In 2005, 93% of Canada's 65,000 LPN's were women (Canadian Institute for Health Information CIHI). Adult women who attend university are often motivated by a desire to advance in their jobs and choose an online delivery program for the flexibility of not having to leave their families and employment commitments (Furst-Bowe & Dittmann, 2001). Barriers include time constraints as they seek to balance multiple commitments, and problems obtaining time off from employers to complete assignments (Furst-Bowe & Dittmann, 2001). In nursing, distance education is believed to be a solution to educating more nurses to eventually decrease an international nursing shortage. Mancuso-Murphy's (2007) literature review reflected that students' experiences with technology-delivered instruction have been generally positive.

Examining the specific experiences of nurses as women in distance education, Care and Udod (2000) noted that they valued caring, collaborative educational approaches that combined feminist pedagogy with advanced technology. Home (1998)

revealed that their lower income increased their vulnerability to role conflict, overload and contagion. And Atack and Rankin (2002) explained that having access to computers for course work in health care settings can be problematic.

In Canada, most provinces require a Baccalaureate degree as entry to practice. A Post LPN to BN program is now available, and significantly higher salaries are offered to university educated nurses. Therefore, more Licensed Practical Nurses are seeking higher education. However, the unique circumstances and needs of these vocationally prepared nurses entering an online university environment have not been addressed. While much has been published regarding how other groups of women and nurses experience a variety of learning transitions, a deficit exists in information related to the way vocationally educated nurses construct new professional knowledge as they transition into a more complex role and earn degrees in an online university.

THE RESEARCH APPROACH

This project was framed from a constructivist worldview (Appleton & King, 2002; Kelly, 1955/1991; Peters, 2000; Piaget, 1954; Vygotsky, 1978) in that knowledge is believed to be constructed through an individual's interactions with social processes and contexts. The project draws from the theoretical tenets of androgogy (Friere, 1984; Houle, 1992; Knowles, 1978), Bridges (1980, 1991, 2001) views of role transition and George Kelly's personal construct psychology (Kelly 1955/1991).

The tenets of androgogy (Friere, 1984; Houle, 1992; Knowles, 1978) are grounded in a belief that adults learn best when engaged in learning that is immediately relevant to their work or personal life. Adult learners may be more interested in practical, everyday applications of information than abstract illustrations of knowledge for its own sake. Adult learners bring a wealth of experience to their learning. They are self-directed and goal oriented, and appreciate being actively involved in planning and evaluating their own learning. The research approach incorporated these tenets of androgogy by inviting participants to use their own practical everyday word choices, to share their previous work and personal experiences, to be actively involved in the task of constructing repertory grids, and to confirm the trustworthiness of the findings with the researchers. Participation in the study offered Post LPN to BN students an opportunity to see firsthand what the experience of implementing a research study actually looks like.

Bridges (1980, 1991, 2001) view of role transition suggests individuals' progress through the three overarching stages of endings, neutral zone, and beginnings. The first stage, ending, can involve dealing with loss and may stimulate feelings of anxiety, blame, fear and shock. The second stage, neutral zone, is expected to be a transitional period characterized by confusion and uncertainty. The third stage, beginnings, involves setting new goals that will ultimately lead to integration and a reinvention of oneself. This research targets participants in the first stage of transition, that of ending or letting go of the professional role of Licensed Practical Nurse.

Data sources included ten audiotape-recorded transcribed interviews with Post LPN to BN students at an online Canadian university. The interviews were guided by repertory grid methodology from the field of personal construct psychology. Content from these interviews was analyzed for themes. Pseudonyms were used when participants' comments were reported verbatim. Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity. Full ethical approval was granted by the university and all participants gave informed consent.

Personal Construct Psychology

Personal construct psychology and the methodology that extends from it, including repertory grid technique (Kelly 1955/1991), provides a framework to listen credulously and to include students' own words in the project. The psychology of personal constructs honors people as knowing individuals, self-inventors and interpreters of their world (Bannister &

Fransella, 1971; Beail, 1985; Fransella, 1995, 2005; Fransella, Bell, & Bannister, 2003; Jankowicz, 2003; Pope & Shaw, 1981; Shaw, 1980).

Most applications of personal construct theory are in the area of psychotherapy. However, the approach also holds considerable promise in the fields of education (Pope & Denicolo, 2001; Shapiro, 1991) and nursing. Incorporating repertory grids to examine the experience of undertaking new roles within nursing, White (1996) researched students transitioning into the role of graduate nurse, Melrose and Shapiro (1999) researched students in the psychiatric clinical area, and Mehigan (2003) researched nurses learning to specialize in operating room practice. The framework has not, however, been used to investigate nurses bridging from one professional designation to another.

Data Collection Interviews

In this project, a personal construct psychology approach was used to guide interviews with ten Post LPN to BN participants. Nine participants were female, one was male, and their ages ranged from early twenties through to early fifties. The interviews were approximately two hours long and included three distinct segments. In segment one, opening questions were posed. In segment two, elements were used to create personal constructs and repertory grids. In segment three, participants' own words from their personal constructs and repertory grids were used to discuss their experiences with role transition.

Segment One. In the first segment, the following opening questions were used to initiate discussion: *Are you from a rural or urban area? What is your specialty area of practice? Talk about what motivated you to make the transition from the role of LPN to the role of BN? What has helped your transition? What barriers have you encountered? Comment on your experiences transitioning to a new professional role in an online environment. What stands out for you as you think about your own process of transitioning from LPN to BN?*

Segment Two. In the second segment, elements were used through a process of triadic elicitation to create a set of personal constructs. The personal constructs then formed a repertory grid. Elements are relevant people, objects, activities, or concepts in a participant's experiences (Beail, 1985). In this study, the elements included the six roles of: (1) Nurse Assistant; (2) Licensed Practical Nurse; (3) Registered Nurse; (4) Registered Nurse with Baccalaureate degree; (5) Clinical Nurse Specialist; and (6) Instructor. The elements served as prompts or cues to draw out participants own words and ways of expressing their thinking.

With the process of triadic elicitation, participants were 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 that 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). For example, when discussing the three elements of (2) Licensed Practical Nurse, (3) Registered Nurse and (5) Clinical Nurse Specialist, one participant, Jenny, described (2) and (3) as 'caring for patients,' and differentiated (5) as 'makes policies in an office.' When the interviewer probed, Jenny elaborated on how she did not view 'making policies' as important to patient care. In Jenny's view, transitioning away from the role of LPN and towards the role of BN meant that she was 'losing the chance to be with my patients.'

Personal constructs are personal bipolar descriptive dimensions that can be applied to each element. For example, in one common form of the grid, and in this study, the elements noted above were supplied by the researchers and the constructs were elicited from the participants. Constructs are abstractions, linked to fellow constructs and reflect how individuals make sense of the world (Fransella, 1977, 1997). They are not concepts or rules and will be different for each participant. There are no 'right' or 'wrong' responses when creating and discussing personal constructs.

Repertory grids were constructed once 6 sets of personal constructs were listed with the emergent (alike) poles on the left and the implicit (contrast) poles on the right. Once the grids were constructed, each of the elements was ranked on a scale of one to five using the participants' own words (their constructs). For example, using the constructs above, Jenny ranked elements (1) Nursing Assistant, (2) Licensed Practical Nurse and (3) Registered Nurse close to her construct of 'caring for

patients' on the left side of her grid. On the right side of her grid, she ranked the remaining elements (4) Registered Nurse with Baccalaureate degree, (5) Clinical Nurse Specialist and (6) Instructor closer to her construct of 'making policies in an office.'

Segment Three. In the third segment, interviewing probes were used to invite participants to elaborate further on their experiences. The probes were drawn from the words and descriptors in the personal constructs and grids.

Data Analysis

The two-hour long interviews included the three segments described above (first, opening questions; second, triadic elicitation to create personal constructs to form and then be ranked on a repertory grid; third, discussions that emerged from the interviewing probes). These three segment interviews were audiotape- recorded and transcribed verbatim. The transcripts were verified by listening carefully to the audiotape while reviewing the transcript. They were line numbered and formatted for coding. Independently, the researchers each read and re-read the transcripts of the interviews. Then, collaboratively, the researchers developed a systematic process of content analysis (Denzin & Lincoln, 1994; Lincoln & Guba, 1985; Loiselle, Profetto-McGrath, Polit, & Beck, 2007) to create the categorization and coding scheme that led to the themes. Patterns in the interviews emerged and three themes that represent common experiences among this group of Post LPN to BN students were identified. First, they appreciated recognition for their previous accomplishments. Second, they valued affirmation of their unique access challenges. Third, they may associate gains from their new university education with some loss of their hands-on bedside nursing role.

FINDINGS

Theme One: Post LPN to BN Students Appreciate Recognition for Previous Accomplishments

Varied Backgrounds. When participants in the present research discussed their backgrounds, previous employment and education, they consistently expressed a need to have those accomplishments recognized. In addition to working in a variety of hospital and long-term care settings, participants held positions such as instructor in an LPN program, manager in an elder care facility, and travel, dialysis, and cancer screening nurse. Three participants had previously initiated RN studies in diploma or degree programs but had not completed the programs. Four Canadian born participants bridged into their LPN program after working as nursing assistants. Before coming to Canada and completing an LPN program, one participant was educated as a mechanical engineer, another as a school teacher and yet another as a microbiologist. Other previous occupations participants mentioned included machine operator in a warehouse and owning a business.

Given their previous health care experience, Sara summarized: "We already know a lot of stuff!" As an experienced nurse, Anita explained: "The patients in front of me, I know what to do with them, I've dealt with them; I haven't just studied the book." Jumoke described orienting new Registered Nurses as their "buddy or resource nurse." In Derek's view, LPN's can "move into the (RN) role readily." Sara added: "It won't be as difficult for me, I have the experience, the background; I automatically think that way." Describing her existing communication skills with patients, Anita asserted: "I'll tell you how it is, I'll put you straight, but I'll also wrap my arms around you."

Entry Credits. Without exception, participants in this project all commented on how much they appreciated formally receiving credit for prior learning. Their program awarded "30 credits towards a 120 credit" nursing degree for previous non-university education. Commenting on other universities, requirements such as "needing an 85% average, going back to

get math and chemistry and set times for classes” were daunting. Oba stated: “I tried to take chemistry, but then I found this program and I could take another science – that by far benefited me more than a chemistry class.”

Feeling Undervalued. It is not unexpected that adult learners transitioning into a more independent nursing role would value receiving university credit for previous health care experience. But to these vocationally educated nurses, the unique opportunity to receive credit was particularly meaningful. Participants described numerous instances in which they did not feel that their previous experiences as nurses were recognized. Donna shared experiences where she completed patient assessment forms for Registered Nurses, but was not allowed in the conference room when her findings were reported and discussed. Jenny discussed how “I’m already teaching, I’m already mentoring, I’m already providing that autonomous care for patients.” Reflecting on how the role of the LPN may be construed as lacking in theory, Anita exclaimed, “What the heck have I been doing for six years if I don’t have theory in my practice!”

From the student perspective, participants viewed their LPN nursing role as very similar to that of an RN role, but with significantly less pay. Jumoke planned to work “part time as an RN and earn the same money as a full-time LPN.” With clinical placements, Sara wondered “why we have to pay to go and work on another unit?” In their personal constructs, participants consistently differentiated nurse roles with words such as “has more education” versus “has less education.” And yet, articulating just what was involved in the additional education required for some nurse roles was difficult.

Academic Inexperience. Recognition for previous academic as well as practice accomplishments was also very meaningful to participants. However, a key problem emerged when individuals in an online university program did not have experience with academic writing. In some instances, previous degrees had been completed in a language other than English. In other instances, participants had not taken any other university courses. Words frequently used to describe barriers included “reading ... writing papers ... doing APA.” When elaborating on “doing APA,” participants explained that they did not always know what their tutors “wanted” and they didn’t understand “what was missing.” In Magdalena’s words: “I get the feeling I’m not asking the right questions.”

Implications for instructing transitioning LPNs online become apparent as we consider how learners may feel both undervalued for their practical expertise and inexperienced with academic expectations. Six of the ten participants in this study replied that it was their “manager(s)” who they turned to for help with academic tasks such as writing papers. Others identified spouses, adult children and friends who worked in professional capacities. A fundamental need for help with “editing” papers was mentioned repeatedly.

Theme Two: Post LPN to BN Students Value Affirmation of their Unique Access Challenges

Limited Funds. Limited funds made accessing further education especially challenging for this group of predominantly female learners. By count, participants emphasized financial difficulties the most number of times during the research discussions. Two of the ten participants disclosed how they had sold or re-mortgaged their homes in order to pay for their studies. As Donna expressed: “I sold my home, got an apartment and started taking out my RRSP’s to go to school. I got sick over the decision ... it was huge and I was totally scared.” Grace, who re-mortgaged her home, clarified that LPNs may be ineligible for student loans: “I went out and borrowed \$50,000. I applied, but I can’t qualify for any student loans, because when you earn \$30,000 a year, that’s too much.”

Participants financed their education by careful budgeting and “working two jobs ... and/or working overtime.” In addition to tuition, costs included travel and accommodation to attend practicums as well as 24-hour child care expenses. During her first practicum, Oba described how “my husband had to ask [his employer] for time off work when I’m away to look after the children.” Time away from work for both students and their spouses resulted in lost income.

None of the participants reported receiving any financial support from their employers. Employers “allowed time off ... gave special permission to bank overtime hours.” While one employer did grant “educational leave,” most participants described “using holidays” to attend practicums. Grace wondered why her employer “spent thousands to recruit Registered Nurses

internationally but offered no funds” to assist upgrading LPNs. Jumoke quit her full-time job when she returned to school. She stated: “I work relief now, so that I can be the one who is flexible. I’m in control of what hours I’m working.” Participants were not aware of any available scholarships or bursaries.

Workplace Restrictions. The restrictions of health care workplaces also pose unique access challenges. With the current shortage, nurses’ requests for time off may be denied and they can be required to work overtime. Oba noted that “sometimes your employer isn’t willing to let you go.” Exhausted after long and demanding hours in the workplace, Sara exclaimed “By the time evening hits, I have maybe an hour or two of good brain time before I’m toast.” Shift work made accessing tutors difficult and by “using holidays for clinical,” Sara felt that she “didn’t have any holidays, any actual down time.”

Theme Three: Post LPN to BN Students Associate Gains from University Role with Loss of Hands-on Bedside Nurse Role

Dissonance. As they elaborated on their personal constructs and repertory grids, participants distinguished the LPN role from other, less familiar nurse roles. Participants viewed LPNs as “bedside nurses ... hands on caregivers ... learned in the war zone – the hospital ... having common sense ... getting crappy pay ... not considered a true nurse ...” On the other hand, they viewed roles, such as Registered Nurses as “getting away from the patients ... not comfortable with the patients ... having no clue what to do ... something better ... teaching ...managing ... community ... research ... administrating ... finding money ... more responsibility and accountability ... doing paperwork ... updating policies and procedures ... more education ... more pay,” and “book knowledge that doesn’t help at the bedside.” Participants valued their hands-on bedside work and did not perceive that other nurse roles offered this opportunity. Carol stated explicitly: “I do feel I am leaving bedside nursing behind.”

All of the participants expressed how transitioning to a new and more independent nursing role would offer them more money and more opportunities. Donna declared: “I’m finally going to have those RN initials that have been so out of reach for me.” However, participants also expressed dissonance, loss and a desire to retain aspects of their LPN role. Anita stated that after graduating, she “wants to keep LPN on my nametag – as well as RN.” Grace jokingly commented that she was “going over to the dark side.”

DISCUSSION

The aforementioned three themes, developed from discussions with LPNs upgrading to become RNs, offer a snapshot of how this group of learners can experience transitions as they begin an online university program. Listening attentively as students used their own words to describe personal ways of constructing knowledge about differences among nursing roles revealed useful insights.

The appreciation participants expressed when their previous accomplishments were recognized is consistent with other adult learners (Friere, 1984; Houle, 1992; Knowles, 1978). Similarly, their circumstances were consistent with access challenges other women learning in online universities face (Furst-Bowe & Dittmann, 2001) and which those other nurses encounter (Atack & Rankin, 2002; Care & Udod, 2000; Home, 1998).

Participants’ experiences with transitions were also comparable with findings from the literature. Associating gains from a new role with the loss of meaningful aspects of an existing role is consistent with Bridges (1980, 1991, 2001) theory of role transition. Bridges (2001) defined transition as “the process of letting go of the way things used to be and then taking hold of the way they subsequently become” (p. 2). In his view, the first phase of role transition is ending, which involves a process of dis-engagement, dis-identification, dis- enchantment and dis-orientation. Before a change in perspective can be expected, individuals are likely to experience feelings of loss. This feeling of loss was evident in the theme named ‘dissonance’ in the present research.

The beginning of the transitional process from LPN to RN can be expected to be an especially stressful time (Claywell, 2003b; Duncan & DePew, 2005; Ham, 2001; Harrington & Terry, 2003; Rapley, Nathan, & Davidson, 2006). Interviews with the Post LPN to BN students in this project, who were in the first cluster of courses within their program, reflected a high degree of stress. Adding new online studying requirements and attendance at out-of-town practicums to their existing family and work responsibilities was not easy.

However, some of the transitional experiences that this group of nurses revealed are unique. Previous accomplishments of traditional undergraduate nursing students have not usually included professional nursing experience. In addition to caring for acutely ill patients in hospital settings, participants worked in teaching or management positions and held non-Canadian university degrees. Here, students met or exceeded the entry to practice level RN competencies.

Conversely, these learners felt that their professional experience was undervalued and that they were inexperienced academically. English as a second language and writing academic papers were particularly difficult. Four of the ten participants had initially bridged into the LPN role from the non-regulated position of nursing assistant. Credit for their previous experience took into account both practice competencies and academic inexperience. At this Canadian university, Post LPN to BN students were not incorporated into existing undergraduate programs. Rather, required courses were written specifically for this group of learners. Students are encouraged to seek editing help with their academic writing.

Access challenges such as leaving family to relocate to different areas for several weeks at a time to complete practicums have not always been expected of traditional undergraduate nursing students. Selling or re-mortgaging homes, working two jobs and requiring spouses to take time off work to help with child care illustrate how limited funding can impact access for these students. Workplace restrictions, where the current nurse shortage may not even allow students to leave in order to attend their practicums, can further hamper access. Strategies such as banking overtime or using holidays to compensate for lack of educational leave can result in students feeling exhausted. Ledwell, Andrusyszyn and Iwasiw (2006) emphasized how Registered Nurses pursuing their degrees online needed employer support to feel empowered. And yet, with the exception of individual managers who may choose to assist with editing papers, the LPN group of nurses has little if any employer support available.

The perceived loss of an existing and very meaningful professional role is seldom considered in undergraduate nursing education approaches either. Given the role confusion between LPNs and RNs in practice (Besner et al, 2006) and the overlapping competencies between the two roles (AARN/CARNA, 2003), educators can expect dissonance as Post LPN to BN students begin their online studies. As they transition through Bridges (2001) 'ending' phase, feelings of loss of certain aspects of their LPN role may occur.

CONCLUSION

This article presented findings from a naturalistic research study that explored online Post LPN to BN students' ideas about beginning their transition toward a new and more complex role. Repertory grids from the field of personal psychology were useful in inviting participants to share their perceptions, experiences and personal ways of distinguishing among nurse roles. In contrast to other studies that explored the experiences of nurses undergoing transitions, this project extends existing understanding of what it was like for vocationally educated nurses at the beginning of their university distance education program by identifying three overarching themes. This research found that Post LPN to BN learners appreciated recognition for their previous accomplishments, valued affirmation of their unique access challenges, and may associate gains from their new university education with some loss of their hands-on bedside nursing role. Further mixed method and longitudinal research is needed to examine the transitions Post LPN to BN students' experience at later stages of their program and after graduating. The article calls for the creation of more opportunities to understand how students construe transitions and continued attention to constructing teaching strategies that respond to and collaborate with students in innovative and genuinely helpful ways.

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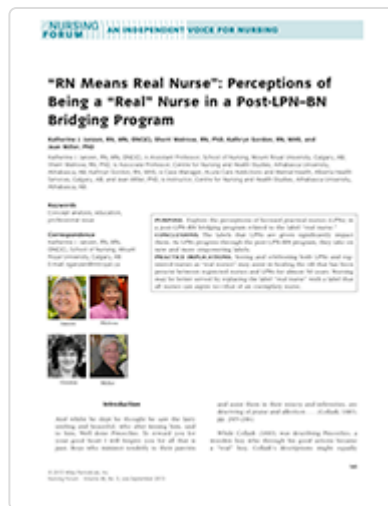
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"RN means Real Nurse": Perceptions of Being a "Real" Nurse in a Post LPN-BN Bridging Program



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Abstract

PURPOSE. Explore the perceptions of licensed practical nurses (LPNs) in a post-LPN–BN bridging program related to the label “real nurse.”

CONCLUSIONS. The labels that LPNs are given significantly impact them. As LPNs progress through the post-LPN–BN program, they take on new and more empowering labels.

PRACTICE IMPLICATIONS. Seeing and celebrating both LPNs and registered nurses as “real nurses” may assist in healing the rift that has been present between registered nurses and LPNs for almost 50 years. Nursing may be better served by replacing the label “real nurse” with a label that all nurses can aspire to—that of an exemplary nurse.

Keywords

Concept analysis, education, professional issue

Introduction

And whilst he slept he thought he saw the fairy smiling and beautiful, who after kissing him, said to him. Well done Pinocchio. To reward you for your good heart I will forgive you for all that is past. Boys who minister tenderly to their parents and assist them in their misery and infirmities, are deserving of praise and affection . . . (Colladi, 1883, pp. 245-246)

While Colladi (1883) was describing Pinocchio, a wooden boy who through his good actions became a “real” boy, Colladi’s descriptions might equally describe nurses. Nurses are believed to have “good heart [s], minister tenderly to their [patients] and assist them in their misery and infirmities” (pp. 245-246). In return, it is posited that nurses should be “deserving of praise and affection” from others (p. 246). This is not always the case in a world where professionalization is highly commercialized, situated in a complicated bureaucratic healthcare system (Bolton, 2005), and propelled by a consumer marketplace (Lovan & Catlett, 2011).

Just as Pinocchio longed to be a “real” boy, nurses still long for legitimization (McNamara, 2009; Wolf, 2006). The term *real nurse* still tends to surface repeatedly in the literature and media (Bassett, 2002; Howett & Evans, 2011; Ousey, 2007). Further, the ongoing discussion of what exactly is a “real nurse” frequently centers on describing the attributes of a “real nurse” and issuing the call to arise to this epitome (Anonymous, 2009; Sears, 2006; Spahr, 2008).

Horton, Tschudin, and Forget (2007) cite over 39 descriptors that a nurse should value and incorporate into practice. Faced with an almost impossible image to live up to, in some specialties, nurses themselves struggle at times to “claim for themselves the identity of ‘real’ nurses” (Ousey, 2007; Snooks et al., 2008, p. 637). This legitimization is even more problematic for the licensed practical nurse (LPN) who faces additional barriers and often is not viewed as a “real nurse” (Salisbury, 2010). LPN marginalization, in terms of critical race theory, could be attributed to “institutionalized racism” (Yosso, 2005, p. 72). The lack of legitimization and added “marginalization [which occurs from] within” (Ramirez-Sanchez, 2008, p. 89), and across societal and healthcare structures, makes this an ongoing and salient issue for nurses today. The purpose of this paper is to explore the impact of the label “real nurse” on post-LPN to baccalaureate nursing (BN) students.

Literature Review

The word *real* can be understood as a state of being where one “becomes” (Janzen, Perry, & Edwards, 2011). Janzen further describes the concept of “real” as being an “active process” that is “co-defined by all individuals who interact . . . within a given” environment, and which through sustained “effort by all participants . . . evolves and grows . . . [inter] dimensionally” (p. 2). This suggests that in a profession such as nursing, the members of that profession define what is “real,” and this definition is subject to change. Additionally, the social construction of “real” is mediated by culture, history, and the larger social structures of the society (Vygotsky, 1978).

This is partially reflected in the evolving scope of practice of the various facets and fields of nursing over the past 120 years since nursing was first proposed to be a “professional occupation” in North America (Boutillier, 1994). Boutillier suggests that from the underpinnings of the 1890s, an idealist picture of what constituted a “real nurse” emerged as “an exclusionary and hierarchal model of nursing professionalization” (p. 20). This hierarchy, which still continues well into this new millennium (Platzer, 2004), has done little to provide clarity in defining the “real nurse,” leaving even the profession asking “Will the real nurse please stand up?” (Elms & Moorehead, 1977; Fletcher, 2007; Porterfield, 1986).

Specialization has only served to compound the debate of who exactly is a “real nurse” (Happell, 2006). In addition to the presence of nurse attendants and LPNs, other levels and fields of expertise in nursing have been introduced into the healthcare arena. These include (but are not limited to) telenurses (Snooks et al., 2008), advanced nurse practitioners (Paniagua, 2010), correctional healthcare nurses (Hardesty, Champion, & Champion, 2007), addiction nurses (Clancy, Oyefeso,

& Ggodse, 2007), mental health nurses (Happell, 2006), nurse educators (MacPhee, Wejr, Davis, Semeniuk & Scarborough, 2009), and nurse managers (Bolton, 2005).

For almost 50 years, there has been a call for registered nurse (RN) to become and epitomize what was coined by Smith (1953) as a “real nurse.” At a time when the role and scope of nursing assistants (the precursors of today’s LPNs) were being determined, it was deemed that the “problem as a profession [was] to learn how [nursing assistants] best fit into a successful nursing team” (Smith, 1953, p. 180). Smith notes that, while very much needed, these nursing assistants were not considered “real nurses” but rather helpmeets for professional RNs who were struggling to deal with an ever-increasing workload and responsibilities.

While the role and title of RN have been synonymous with being a “real nurse” for decades (Porterfield, 1986; Smith, 1953), the title and role of an LPN are still anecdotally disparaged as an acronym for “least paid nurse” (Anonymous, 2007a, para. 1), “little pretend nurse,” or “licensed partial nurse” (Porterfield, 1986, p. 65). This sentiment continues to be accepted by those within and without the nursing profession, including patients, the general public, the media, nurses themselves, and other healthcare practitioners (Anonymous, 2007b; Howett & Evans, 2011; Ousey, 2007; Porterfield, 1986; Saliday, 2004) who decry the LPN as not being a “real nurse” (Salisbury, 2010).

While studies on the socialization of RN to BN students continue to emerge, there are few studies and academic writings that explore the socialization of LPNs in post-LPN-BN bridging programs (Melrose & Gordon, 2008). Melrose and Gordon (2011) note that LPNs “face unique barriers as they transition towards a new and more complex nursing role” (p. 31). Ham (2002) describes the LPN-RN transition as “difficult” (p. 3). Duncan and DePew (2011) cite that although the preexisting identity of an LPN is strong, a new identity is formed in a resocialization process, which for many LPNs is problematic.

Shane (1983) describes a resocialization process that is fraught with role conflict. Idealism as an LPN is confronted with realism of a changing role (Duncan & DePew, 2011; Harrington & Terry, 2009). Feelings of “frustration, fear of failure, and inadequacy” can result (Sweet & Fusner, 2008, p. 204). Could it be that role conflict and the struggle with new identity formation are partially rooted in the LPN not being considered a “real nurse?”

As there is relatively little known about the socialization of LPNs in post-LPN-BN bridging programs, unanswered questions arise. How do post-LPN-BN students view themselves given the labels that are placed upon them by others? Do post-LPN-BN students come to terms with these labels, and if so how? Is there a shift in perception when LPNs enter and progress through post-LPN-BN nursing programs? The purpose of this paper is to explore the perceptions of LPNs in a post-LPN-BN bridging program related to the term real nurse.

Methods

This project is part of an overarching program of research exploring the transitions that LPNs experience when they upgrade their education to become RNs. Framed from a constructivist theoretical framework, the purpose of the study was to describe post-LPN-RN student nurses’ experiences with professional socialization as they learned a more complex nursing role.

Setting and Participants

Participants were 27 LPNs enrolled in a BN nursing program who were currently attending a practicum on an acute hospital unit.

Data Collection and Analysis

Data sources included four face-to-face digitally recorded, transcribed focus group discussions. The focus groups were conducted in different cities over a period of two university terms. QRS International's NVivo 9 was used to organize the data collection and analysis. Transcripts from the focus group discussions were analyzed for themes. Investigator triangulation and member checking ensured trustworthiness and authenticity of the findings. Full ethical approval was granted by the university's research ethics board. In our analysis of the data, our findings led us to a variety of different issues that LPN to RN students face, and we report on these issues elsewhere. In this article, we discuss our findings related to a theme that stood out for us as particularly impactful. Our LPN participants expressed how, for them, the term RN did not just stand for registered nurse, but also "RN stands for real nurse."

Findings

The Label of LPN: "You're Just an LPN"

Post-LPN-BN students, given the labels that were placed upon them by others, experienced considerable bias about being LPNs. They felt looked down upon by many of their nursing RN counterparts as if they, as LPNs, were "less than" the RNs. They felt that this was a process where they were "stomped on." One student framed this, saying, "It's almost like there's no recognition for what we've done in our careers and that is extremely frustrating because it's like none of that mattered ..."

One student related, "Even [as] an LPN, [there are] RN's that are going, you're just an LPN." Despite having many of the same skill sets as the RNs, students felt "offended" and "insulted" that their expertise as LPNs was not always recognized. Students became "defensive of the LPN role." One student, who had been an LPN for 4 years prior to entering the post-LPN-BN program, described the frustrations . . .

You kind of get tired after a while of being like, oh yeah. I'm in school doing my RN. You're not an RN? No. I don't know, you don't feel like . . . you feel like you're doing all that stuff already and so why shouldn't I be getting ... I mean it's not about pay, and I don't want it to seem like it is, but at the same time, it kind of is! In the end, if we're doing the same thing and getting paid different, and I mean it's not necessarily just the skills, because I know that that's the number one argument for RNs, right? Is this idea that RNs see you know, this bigger scope and you're kind of you know, population, and critical thinking which we kind of ... it can be a little offensive sometimes because it's like so my entire last 4 years, I have never looked at a patient in context of their life, you know? Or a wound in context of health or whatever and it's just you do that, and maybe we've had to learn it more on the job because all we really got was skill base in our program . . .

It was not the RNs alone who expressed that LPNs were "less than" but their patients as well. This was attributed to both the historical view of LPNs as nurses' aides and a skewed view of what a nurse was. Many patients did not know what an LPN was . . . "And you get that question, what's an LPN? It's frustrating because we are nurses already but people don't see that. And they don't know the difference." Another student echoed this sentiment with the patients that the student cared for.

I think people don't actually know what the role is of an LPN. Like you say, people say, oh well, what does an LPN do that's different from an RN. I think that's why when you say, oh, I'm an LPN, and they kind of look at you differently because they might have this thought in your mind, or in their mind that you're kind of like a nursing attendant or something, because that's kind of what we've been historically but now our scope is just like changing so fast that yeah, I think people just don't know . . .

At times, this bias was so pointed that patients requested that the LPN get an RN when assessments were being done. One student related, “Even when I do my assessments I have like the residents say, well, maybe you should get an RN ...”

LPNs were not viewed as “real nurses” because “real nurses” were attributed by patients to being solely an RN. This was illustrated by one student who said, “I think it’s more that you hear [you’re] just an LPN . . . you’re not a real nurse. Because people think RN stands for Real Nurse.” Another student reflected upon her experiences, saying, “But I mean, I’ve actually had people, I had people say to me when I was going through the PN program, oh, well, are you in the program to be a real nurse or one of those other nurses?”

There were several additional labels for LPNs that arose from patient and staff encounters. These included “limited,” unqualified, “less common sense,” “less . . . ability,” less “capable,” “less professional,” and “unable to critically think.” These labels were both “frustrating” and “offensive,” and undermined LPNs’ self-confidence.

Coming to Terms With Labels: “I Don’t Even Say LPN, I Say Nurse”

These post-LPN-BN students come to terms with these labels in several ways. Some felt that they had to “prove themselves” to those around them because, as one student said, “[s]ometimes there’s a fallacy that an RN gives you more . . . common sense or abilities than an LPN might have.”

You know, trying to prove myself to all of these RNs and LPNs that have worked here for so long and that’s how you know, you gain their respect as an LPN by proving yourself, you know. It’s a tough world, but it’s kind of like one of those things.

Being questioned for their ability to critically think was a common experience for almost all the students. What resulted was an internal struggle. “And so I’m still finding there’s a bit of an inner battle with that because I do believe that as LPNs we are critical thinkers. We are you know, we’re amazing nurses . . .” This often led to feeling “defensive,” and as one student expressed, “I’m sick of being undervalued.”

I have been critically thinking for 7 years. Like I do total care for my patients and monitor all their blood work and all their diagnostics and everything, it’s not like I go in and do a bed bath and say, you know. I’m done for the day! No. Like get somebody up and walk them, and you know, we do everything.

Other students came to terms with the labels that they had been given by publicly relinquishing the title of LPN. Instead of telling patients that they were LPNs, they referred to themselves as only “nurses.”

I don’t even say LPN. I say nurse. When they ask what I do. I’m a nurse. It’s just because how am I supposed to explain the distinction when I don’t feel like there is much of a distinction in my role . . .

Another student framed it this way: “I don’t say to people. I’m going to be your practical nurse today. I’m your nurse today. My name is (name) and I’m going to be your nurse today. I’m here until this time.”

Students felt that without making their LPN identities known, no one “could tell the difference” between themselves and an RN. It was only when they were asked to do something outside their scope that this difference was identified by others. One student related:

I also felt limited because I feel like LPNs sometimes get that stigmatism. You would be doing work and then somebody would ask you to do something that’s out of your scope and you say, sorry, I am an LPN. And they would go, oh, I didn’t know that you’re an LPN.

This was substantiated by another student who said:

It's almost sometimes attributed as a negative—oh, you're an LPN! Or oh, I didn't know. Well, if you didn't know, then you know, why is it. . . . It must not matter. Why is it a negative? Because you couldn't tell before that point.

Even as students moved through their post- LPN-BN practicum, they often continued to refer to themselves only as student nurses. This was a source of conflict for them as they still “felt proud of [themselves] ... for the knowledge [they] already had.” In their minds, they felt they were “already a nurse.” Being a student was a step backward for them, as in their practicum they were not allowed to do many of the skills that they did with regularity as LPNs. The students felt pressed to leave their identities and knowledge as an LPN behind, and “think like an RN.” One student reflected:

I'm still very proud of the work I do as an LPN and I've found it frustrating with some of the teachers and some of the assignments, like okay, you know, because there was one in I think our second cluster of classes about . . . the whole paper was on the transition and I was just like, what do you want me to say? Well, even our independent study class, she kept hammering me, well, all that stuff you do as an LPN too, this is a baccalaureate program, you need to think like an RN. And I already feel like I do think like an RN and I found it very frustrating and almost devaluing the work that I've already put into the profession.

Shifts in Perception: “It’s All About Empowerment”

There was a shift in perception when LPNs entered and progressed through the post-LPN-BN nursing program. There were many impetuses that contributed to this shift. Part of this was attributed to recognizing the limitations of being an LPN and the lack of mobility. One student explained it this way: “You reach a certain point where that piece of paper only gets you so far as an LPN.” Another related, “There are not so much options to further your career if you're an LPN whereas if you're an RN, there's so many opportunities out there that you can go to, to specialize.”

While some students still saw being an RN as “just a piece of paper,” which would legitimize them and their knowledge, others began to identify the many ways that being an RN would change their lives. One student described this shift as “nurse life changing.” Many students began to recognize that a “transition” was occurring within them where they began to see themselves as RNs instead of LPNs. This was articulated clearly in the words “I am an RN.”

Students began to recognize that being an RN changed their outlook. While students felt that at the beginning of their program RNs and LPNs were only differentiated by their scope of practice, this perception changed. One student reflected: “In this practicum we've kind of realized like an RN and an LPN have totally different jobs and the amount of like thinking and researching and whatnot is totally different. And I didn't know that till now.” While LPNs were reluctant to relinquish their title as LPNs, they were quick to identify what being an RN would mean for them. Students expressed a newfound “sense of validity.”

For myself I think, it gives me a sense of I have the right to be here, you know what I mean? I've earned the right and then people aren't going to question what I bring because I am an RN.

Another student expressed: “So you can say, I'm an RN and therefore I deserve, you know, your respect.” No longer did they have to approach RNs as a conduit to physicians and decision making, but they were able to appropriate this independently. This was freeing for them. One student related, “I think that was the biggest transition for me was actually going from helpless to feeling capable.”

The students were able to construct new labels for themselves, such as “powerful,” authoritative, “role model,” “respected,” collaborator, “generalist,” “capable,” deserving, “strong,” “influential,” “autonomous,” “independent,” and “confident.” Perhaps the most impactful label that they constructed for themselves was “empowered.”

It's all about empowerment... As a Licensed Practical Nurse, we were never taught about things like that. We were never taught that we were powerful people. We were never taught . . . that we were strong, strong individuals. In this upgrading program, we feel empowered now as we're growing into this role.

Discussion

The results of this study lend support to the proposition that role conflict and the struggle with new identity formation are partially rooted in the LPN not being considered a “real nurse.”

Role Conflict

“Role taking [is perceived to be] an ongoing social process [which is] situated within a social system” (Bolton, 2005, p.10). The role of LPN can be simultaneously embraced and distanced, which according to Goffman (2004a) has consequences. Goffman sees these consequences as the “penetration of ego- boundaries,” which can leave individuals “fearful [and] threatened” as they attempt to stabilize their worlds (p. 137). This supports the LPN experience of significant emotion as they move through finding their place and fitting into their new roles as RNs.

LPNs can view themselves as simultaneously engaging in what Goffman (2004b) describes as two incongruent roles. One role represents an affirmation in the belief that they are still “real nurses” and another role where they are not recognized as such. This creates a sense of role conflict (Goffman, 1959).

The sense of frustration and conflict is posited to be beneficial, if not necessary, for new identity formation (Corwin, 1961). As the post-LPN-BN students find their way of being in the world (Heidegger, 1962), the role conflict that they experience does not appear to subside. While this suggests that a resolution of conflict does not occur, further study may assist in determining if the conflict eventually resolves as their identities become more solidified in their roles as RNs.

Identity Formation

Role conception, role certainty, and role frustration “all represent tangible means through which a person establishes and validates an identity” (Corwin, 1961, p. 86). Doane (2002) emphasizes that “nurses’ identities [emerge] through layers of negotiation with self, with others, and within the context of social organization” (p. 630). As post-LPN-BN students moved through their program, the negotiation was not a linear process. Rather, the process was iterative in nature as the students came to a more solidified identity and were able to construct positive labels for themselves. These new, empowering labels superseded the stigmatizing labels that had been given to them as LPNs.

Corwin (1961) describes identity formation as a process that includes both the “real” and the “ideal.” The process of establishing and validating identity is the “ideal,” while “ambiguities, conflicting and frustrating circumstances” are the “real,” or replicate the current or ongoing situation (p. 86). “Proving to others what [the LPN] already knows” (p. 86)—that they come to the program already as “real” nurses— reflects these processes. This is consistent with Cragg’s (1991) observations where the identity as a nurse is already in place through prior socialization. Bolton’s (2005) conclusions are also supported that there exists an “enduring image ... as a nurse” despite the movement toward an alternate professional role (p. 19).

The “real” represented the identity that the LPN already had, while the “ideal” was a construct to which the LPN would become. This “becoming” seems to be centered in an ongoing process where LPNs “earn [both] the title” and identity of RN, for both themselves and others (Happell, 2006, p 156). This, in turn, brings “strength, creativity and diversity” (p. 156), and could represent an ongoing developmental process in which post-LPN-BN student negotiates being in the world or the world of the nursing profession (Heidegger, 1962).

The Attribution of Labels

Conceptions of the labels “ideal nurse” and the “real nurse” appear to be socially or other-constructed, as well as self-constructed. While it is believed that students personally construct their identity as a nurse (Corwin, 1961; Stockhausen, 2005), it is posited that the labels that have been socially constructed also contribute to identity formation in LPNs. These labels can be internally adopted by LPNs, and may influence resultant behaviors, decisions, beliefs, and self-concept (Ketola, 2009). The negotiation of identity could be described as an internal struggle where conceptions and labels of the “real nurse” were pitted constantly against those of the “ideal nurse.”

Williams (1978) suggests that conceptions of “the ‘ideal nurse’ [are] incongruous with those of [the] ‘real’ nurse [which are highly tied to] self-concept,” and thus their emerging identity (p. 44). In essence, the LPN comes to a crossroad where each student must choose between the “real” and the “ideal.” Publicly relinquishing his/her title as LPN may reflect this process.

Metaphorically, an LPN—like a baby bird who struggles to emerge from its shell—may find the label of not being a “real nurse” restrictive and requiring action. The resultant struggle and action toward becoming an RN could be understood as prerequisite in developing a new “RN” identity. Just as the bird’s struggle is necessary for its survival in the larger world, perhaps the struggle that the LPN engages in prepares the LPN for the rigors of the professional world in which the LPN, now as an RN, will enter.

It is a common perception that RNs “eat their young,” which can be devastating for new RNs. The post-LPN-BN students who emerge from their educational programs do so with feelings of newfound strength, confidence, and courage. This could be attributed to the considerable bias they have experienced as LPNs. The ability to construct new labels for themselves may be protective as well as empowering.

Just as a mother bird must push their young out of the nest in order to fly, the new labels can act as a springboard for launching post-RN-BNs in their new professional careers. What may result are RNs who fully believe that they can make a difference as they begin to not only fly but also soar.

Limitations

Although the purpose of qualitative research is not generalizability, a small sample presents as a limitation of this study. Krueger and Casey (2009) outline several criticisms of focus groups. These include potential intellectualization, the communication within the group lacking emotion, the possibility of not accessing true data in terms of participants making up answers, trivial results, and the presence of dominant individuals who may influence results. These limitations were countered in part by the use of multiple focus groups, the expertise of the research assistants regarding interview techniques to promote reflection, the sharing of emotion and inviting the voices of all group members, and the restriction of group size which is felt to help decrease shallow and inconsequential comments (Krueger & Casey, 2009). Additional research is needed to more fully understand the resocialization processes of the post-LPN-BN bridging program.

Implications

In response to the plea for the “real nurse to stand up,” one questions if the “real nurse” even exists or simply reflects a composite, socially constructed mirage that has become mediated and portrayed by history, culture, and sociality. There appear to be no clear answers to this question. Perhaps it is time to redefine the label of “real nurse” and instead reflect a label of the “exemplary nurse” (Perry, 2009). This may potentially be the ideal to which both LPNs and RNs can aspire without the disparaging acronyms and labels that have existed for decades.

Just as the entire human race consists of human beings despite varied skin colors, languages, cultures, and skills, it is posited that LPNs and RNs are all collectively “real nurses.” While the scopes of nursing practice serve to differentiate LPNs and RNs, the sharing of commonalities is a prospect in bringing them together. The commonalities that the label of “real nurse” provides—that of caring for, with, and about those with whom they are entrusted—can potentially identify members of both professions as “real nurses.” This can bring RNs and LPNs together rather than cause and perpetuate the divisions that have and still do exist. As Ketola (2009) noted, “the most injurious component of nursing is not the work overload, not the acuity of patients, not the cantankerous behaviour of some physicians—it is the damaged relationships we have with each other” (p. 253). Healing the fissure that has existed for almost 50 years between LPNs and RNs can only serve to strengthen their common profession—that of nursing.

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EDUCATION (PSYCHIATRIC MENTAL HEALTH LEARNERS)

Creating a psychiatric mental health portfolio: An assignment that works



[PDF – 98 KB]

Citation

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Abstract

Creating lively, engaging and reflection-oriented assignments for learners is an important area of focus for educators. The Center for Nursing and Health Studies at Athabasca University in Canada offers a program for Licensed Practical Nurses to earn a Bachelor of Nursing degree from their home communities both virtually through online course delivery and in-person through attending clinical placements. This article provides a description of one novel assignment, the construction of a portfolio, which is completed during a course in psychiatric mental health. Students work on the assignment both online and as a member of a clinical learning group. The four portfolio artifacts include, first, learners examine the incidence and prevalence of mental health issues in their own community. Second, they explore nursing and psychological theorists. Third, they analyze a referral instrument relevant to their current or future practice noting author, reliability and validity. Fourth, they construct two inpatient case studies in collaboration with the mental health team. Insights into the experiences students found engaging and difficult as they

completed the assignment are discussed and practical suggestions for designing portfolio learning activities are offered.

KEYWORDS

Psychiatric; Nursing; Portfolio; Online

Introduction

This article describes a portfolio assignment that is one assessment tool in a psychiatric mental health course. The course is required for online students in the Post LPN to BN (Bachelor of Nursing) program at the Center for Nursing and Health Studies, Athabasca University, Athabasca, Alberta, Canada. Post LPN to BN students are adult learners who have approximately two years of vocational education and who have practiced as Licensed Practical Nurses for at least 1 year. In addition to the portfolio assignment, students are required to complete both a scholarly paper and an examination.

In Canada, provincial nursing associations have recently initiated a process of requiring graduates to demonstrate an annual competency profile. While this process has become more established in other jurisdictions such as the United Kingdom, Australia, the United States and other Canadian provinces, it is still a new task for some Registered nurses in Alberta. Portfolios, which have traditionally been used to showcase artists' creations, practitioners' professional development as well as students' progress, are one approach nurses can use to demonstrate ongoing competency. For Post LPN to BN students, their psychiatric mental health portfolio assignment is a section of an ongoing portfolio that they continue to add to throughout their program. On graduation, the variety of artifacts they have constructed provides evidence of meeting different sets of course objectives and the beginning a professional practice competency profile.

A hybrid program, the Post LPN to BN is completed both online using a WebCT course management system as well as at institutions such as hospitals for clinical practicums. Students come from all across Canada, and in their psychiatric course, they spend 60 h in a self-selected mentored placement in their home community and a further 80 h at a provincial mental institution as a cohort. However, the primary medium for ongoing communication, instruction and assessment within the program is asynchronous text-based threaded discussions within a WebCT environment. Table 1 situates the specific portfolio artifacts discussed in this article in relation to the course objectives and one key overarching practice competency identified by the provincial nursing association.

Table 1 Linking artifacts to course objectives and competencies

Provincial association competency: Provides service that is professional, evidence-based, ethical and in collaboration with the client, significant others and fellow health care professionals (CARNA, 2000)	
Course objectives	Course assignment
Critically examine the unmet mental health needs, across the lifespan, of clients, families and groups within the community	Incidence and prevalence report
Recognize acute symptoms of mental illness that require urgent intervention	- Case studies - Exam
Explore mental health conditions related to mood, thought and behavior	- Case studies - Exam
Construct assessment, screening and referral documentation relevant to a variety of disciplines and health care contexts.	Analysis of a referral instrument
Understand selected therapeutic approaches currently implemented by nurses and other members of mental health care teams	Lunch with the theorists
Reflect upon the stigma and barriers that exist within the field of mental health	Scholarly paper
Analyze the implications of addiction for individuals, families and the community	Scholarly paper
Actively incorporate mental health promotion into practice in the workplace as well as with vulnerable aggregates	Scholarly paper
Pose research questions that remain unanswered both in your personal learning and in the profession of psychiatric mental health nursing	Scholarly paper

Literature review

A portfolio has been defined as ‘a collection of evidence’ which is selected for a particular purpose and for the attention of a particular audience (Brown, 1995). While the evidence, purpose, and audiences for portfolios may differ, a process of reflective thinking is central to the meaningful construction of portfolios (Barrett, 2005; Pietroni, 2000; Zubizarreta, 2004).

And yet, understanding the process of reflective thinking is not straightforward. Dewey (1933) established that reflective thinking requires ‘active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends’ (p. 118). Schön (1983) described reflective thinking as processes that have been triggered by confusion, that question how a present experience relates to past understanding in order to generate new knowledge (reflecting-in-action) and that explore how the outcome of previous experience could be improved (thinking-on-action). Theoretical approaches that underpin reflection further suggest that the process involves ‘deliberate learning’ (Boud et al., 1985) and ‘critically challenging assumptions and imagining alternatives’ (Brookfield, 1991). Johns (2000) described reflection as a window through which the practitioner can view experiences, working towards the

resolution of contradictions between what may be desirable and what is realistic in actual practice. Moon (2004, 2005) asserted that, in academic settings, since the process and outcome of reflection is most likely represented in written form and will be used to assess learning outcomes, student definitions of the construct include 'what our professor want to hear'. Freshwater et al. (2005) call for more integration of reflective activities in nurse education and practice.

The benefits of portfolio construction among nurses are well documented. In professional nursing practice, Jasper (1995a) identified that portfolios provide potential for recording nurses' embedded practical knowledge. They can list professional goals to be achieved, related time frames and individual progress towards meeting those goals (Oermann, 2002). They provide an invaluable reference source of nurses' achievements (Shakespeare, 2002) and an accurate record of the skills and accomplishments nurses must present when they are seeking new employment opportunities or promotion (Hutt et al., 2004). From a global perspective, regulatory bodies worldwide are increasingly considering requirements for portfolio development (Meister et al., 2002).

In nursing education, Williams (2001) posited that linking portfolio assignments to clinical practice expectations enhances program credibility. Portfolios are evolving as authentic (Wenzel et al., 1998) and holistic (McMullan et al., 2003) tools for assessing practice competencies in ways that tests or grades may not. In her seminal work with graduate students, Jasper (1995b) presented a portfolio workbook assignment that invited student self-direction and reflection to meet identified course outcomes. She asserted that the approach could be incorporated into all forms of education and training events with both a practical and theoretical element.

Since then, in different clinical areas and with different undergraduate learners, a variety of approaches to creating portfolio assignments have been described. For example, Sorrell et al. (1997) collaborated with faculty from the English department to use writing portfolios as tools for learning academic writing as well as assessing critical thinking. Thompson and Farrow (1999) used portfolios to provide ongoing formative assessment and feedback throughout a psychiatric mental health practicum without assigning a formal grade. Tracy et al. (2000) used portfolios to systematically document select student achievements throughout all of their clinical placements. Lettus et al. (2001) used portfolios with adult students returning to university to help them demonstrate competence in unfamiliar acute hospital settings. Williams (2001) used portfolios to facilitate reflection with senior students in an acute adult oncology placement. Corcoran and Nicholson (2004) used portfolios with Specialist Practitioner Qualification students in the critical care area. And Schaffer et al. (2005) used portfolios with learners in a public health course to achieve population-based public health nursing competencies.

Problems with portfolio use include a limited evidence base regarding their effectiveness (Bowers and Jinks, 2004), issues of rigor in measurement (McMullan et al., 2003) and an increase in evaluation time compared to traditional methods (Cole et al., 1995; Lettus et al., 2001). Artifacts may be considered less credible because they are subjective and personal (Ball et al., 2000). A focus on learning how to complete the portfolio can distract from clinical learning, particularly in the early stages of students' careers (Scholes et al., 2004). Further, an inherent philosophical conflict exists between institutional needs for valid and reliable data for accreditation and learner needs for support, collaboration and formative assessment (Barrett, 2005). A final barrier is that students may be unclear on the benefit of using a learning portfolio, and fulfilling the criteria for the portfolios can remain a low priority (Corcoran and Nicholson, 2004).

The psychiatric mental health portfolio assignment

Learners develop their comprehensively referenced portfolios as an ongoing activity throughout their psychiatric rotation. At the beginning of the course, instructions are provided online within a WebCt course platform and note that completed portfolios are expected to illustrate self-reflection on educational and professional experiences, to demonstrate ability to apply theory and to make clinical decisions in practice.

Throughout the course, both in online and clinical discussions, students are invited to share the work they are doing on each of the artifacts with classmates, members of the staff teams and instructors. With this approach, the final product learners

submit for marking includes input from a variety of sources and will be familiar to instructors. And, the completed artifacts are also all posted in online discussion forums for classmates to read. The portfolios consist of four different assignments that examine incidence and prevalence of a mental health issue, explore nursing and psychological theorists, analyze referral instruments and construct case studies.

The first artifact: examining incidence and prevalence

The first artifact examines the incidence and prevalence of mental health issues in the learner's own community. Since students in the Post LPN to BN program live all across Canada, issues differ between regions. Students are required to initiate e-mail or telephone contact with the national mental health association office in their area and inquire about the specific programs offered. They pose questions that will enable them to identify three or four key mental health needs in their own community. The work is evaluated in a two-page summary of the findings that includes a minimum of two references.

Examples of issues that emerged for students in core urban areas included homelessness among individuals diagnosed with a psychiatric illness such as schizophrenia. Issues in suburban city areas included the stigma of seeking help for psychiatric illnesses such as depression, stimulant medication for children diagnosed with attention deficit disorder and eating disorders. Students in rural areas targeted similar issues and included a limited access to treatment in their discussions. One student, who lived near a First Nations reserve for Canada's aboriginal peoples, commented on the increased incidence and prevalence of suicide within this community. Another student, from a small northern mining town, noted the pervasiveness of alcoholism in his area. And, issues of drug and alcohol addiction were certainly apparent in all areas of the country.

References used for the incidence and prevalence artifact included local reports and strategic plans from hospital or regional treatment centers, national government publications and World Health Organization documents. For many students, accessing a web or print publication from a local health care agency and comparing the information with national and international data was a new experience. The collaborative nature of the portfolio assignment invited learners to seek help from instructors and the mental health professionals in their community to access and interpret appropriate references.

The initial contact students made to complete this aspect of their portfolio was also valuable in seeking practicum placements at a later time. The student who contacted a First Nations reserve nurse for more information on the high incidence and prevalence of suicide among native Canadians was later able to complete her individual practicum with this nurse. Similarly, the student who contacted a Fetal Alcohol Syndrome agency for more information about the pervasiveness of alcoholism in his northern mining town also obtained an individual practicum with this agency.

Posting the incidence and prevalence reports in the online discussion forum for classmates provided the class with a variety of information on mental health issues across the country. Reading classmates' work stimulated useful reflection on both the content of the reports as well as the process of seeking out information about mental health issues from local, national, and international resources.

The second artifact: exploring theorists

The second artifact explores nursing and psychological theorists. As learners can find the scope of theories underpinning psychiatric nursing approaches overwhelming, this artifact seeks to demystify the information by personalizing the theorists themselves. Students are invited to imagine that they have an opportunity to join Hildegard Peplau and two psychological theorists for lunch.

In their portfolios, students write up a one or two page account of the kind of conversation that might occur amongst the group. While no references are required, the work is expected to demonstrate an understanding of the ideas and thinking

purported by the theorists. Students are encouraged to incorporate humor, to present the disagreements that would be expected between members of the lunch group and to join in the discussion and interject their own thoughts.

This assignment is due after the online groups have met one another and completed their group practicum at a psychiatric hospital. Therefore, in addition to instructors, classmates, and practitioners from community agencies, input from practitioners on acute psychiatric units can also be incorporated. Students have reported that this artifact is the one they have had the most fun with.

Reading about the theorists with the intention of literally inviting them to join the mental health team over lunch in a hospital cafeteria calls for innovative interpretations of textbook material and has produced stimulating discussions. Students individualized this artifact in a variety of different ways. Melrose (in press) elaborated on how students created lively lunch conversations centering on patients they met in the clinical area as well as on their own families and workplaces.

The third artifact: analyzing a referral instrument

The third artifact analyzes a referral instrument relevant to the learners' current or future practice and notes author, reliability and validity. Students are required to select one assessment tool that would be useful in their own workplace. The tool may be applicable for clients with an identified psychiatric problem or for functioning individuals seeking balance and mental well being. Students must identify the original creators of the instrument and at least one research study testing reliability and validity. They are to include both an electronic blank copy of the instrument for future reference and an example of the completed tool in a Word document. They are reminded to include the source of the tool and any copyright restrictions on any copy used. Instructions include a comment that students may need to communicate with the original author or institution to obtain permission to use the instrument. And they are required to follow the American Psychological Association guidelines.

Examples of instruments that students have presented in this artifact include the Global Assessment of Functioning Scale, the Folstein Mini Mental State Examination, the Hamilton Rating Scale for depression, the Edinburgh Post Natal Depression Scale and the CAGE alcohol abuse screen. With this learning experience, students commented that they gained a deeper understanding of how they might use reliable and valid referral instruments to advocate for patients beyond the psychiatric specialty.

For instance, on a post natal home visit, in addition to noticing that a new mother seemed sad, the student who researched the Edinburgh Post Natal Depression Scale reflected on how she could use this tool to obtain psychiatric intervention for her patient if necessary. As a reflective tool, this artifact calls learners to examine ways they can incorporate evidence based psychiatric documentation in to their existing nursing practice.

The fourth artifact: constructing case studies

The fourth artifact constructs inpatient case studies that summarized learners' inpatient clinical experiences at the psychiatric hospitals. Students present case studies of two patients they met or worked with and include medical diagnosis (all DSM IV axis), relevant mental status examination findings, all prescribed medications (classification and expected side effects), any presenting side effects and multidisciplinary treatment approaches. Instructions placed an emphasis on nursing care approaches and entry to practice competencies. Case studies were expected to conclude with a reflective analysis of the personal learning achieved. Students were invited to work on drafts of their case studies throughout their practicum and to critique writing within the clinical groups before submitting work for marking. Data from patient's charts as well as practical tips gleaned from interviews with staff and unit care plans were expected to be included. Students were told that the case studies would serve as a remembrance and summary of their inpatient practicum and of all the people they met during their

stay at the institution. They were encouraged to have fun with this section of their portfolio and create a product they felt proud of.

Lessons learned

Overall, feedback from participants about the process of co-creating and sharing their portfolio artifacts was positive. Initially, the requirement to read local, national, and international publications on the incidence and prevalence of psychiatric mental health disorders seemed daunting. Although these adult learners were employed in health care facilities, few were familiar with the formal publications such as strategic plans and community reports that their agencies published. Posting this artifact in the online WebCT classroom offered opportunities to compare and contrast issues among different geographical communities. Associating a member of the class with a report from a particular region helped bring the issue to life. And, in several instances, students began asking questions in their workplaces when mental health issues were targeted in strategic plans but not followed up by actions. While this first artifact in the portfolio was clearly challenging for learners, by sending incomplete assignments back with revisions and suggestions before marking, instructors modeled both the high expectations inherent within the course and opportunities for collaboration.

Where students experienced difficulty with this artifact was in interpreting statistical analysis of disease conditions. Also, in the smaller rural areas, agency documentation was less comprehensive than in the larger urban centers, leaving some students feeling disadvantaged.

The experience of looking for theorists to talk with, sitting around the lunch table 'with' them and discussing possibilities for bringing their work to life was enjoyable. The invitation to balance the previous artifact with this more lighthearted activity was welcome. And, the conversations this activity generated among students and practitioners were lively.

While students found this artifact engaging, instructors expressed some difficulties. As they began the project, students were not sure what the final product was expected to look like. Offering direction and constructing a fair marking rubric was not straightforward. Wherever possible, students were honored for their creativity and instructors sought to strengthen knowledge deficits through ongoing communication. And, when students' public lack of understanding about a theoretical concept became apparent, it was not easy to build in private remedial strategies.

Analyzing referral instruments used in the psychiatric area was intriguing for most students. Previously, their experience with written tools for collecting patient information generally involved working with instruments their managers selected. Seeking out the original authors and reliability and validity studies of tools such as the mini mental status examination raised important questions. Students commented that the assignment helped them view forms used in their workplaces in different ways. And, several commented that they intended to incorporate the instrument they chose to their current practice.

Difficulties for students with this task involved seeking out concise instruments that would be available for nurses to use. Also, when several students in a cohort group all chose to work on the same tool, the postings become less varied.

Constructing case studies of their patients engaged students readily. Most had previous experience with this process but appreciated the additional learning of identifying and prioritizing mental health needs. And, the opportunity to analyze personal learning at the end of the course was well-received. Students did find the complexities of the psychiatric patient presentations difficult to understand, but the collaborative reflective nature of the portfolio construction encouraged questioning and communication with staff teams.

Conclusion

The psychiatric mental portfolio artifacts illustrated in this article were adaptable assignments for adult learners in both online and clinical practice educational events. Creating engaging collaborative activities that showcase knowledge, invite authentic assessment and meet rigorous professional competencies is both a challenge and an opportunity for nursing education practice.

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Clinical teaching in mental health nursing



[PDF – 1.1 MB]

Citation

Melrose, S. & Shapiro, B. (1996). Clinical teaching in mental health nursing. In What's new in research ... a cross-country sampling of recent initiatives and works in progress. *The Canadian Nurse* (92)10, 20.

The purpose of this research in progress is to investigate how student nurses develop personally meaningful constructs during their psychiatric mental health clinical rotation. A secondary purpose is to examine the role that personal construct theory can play in the process.

Three questions guide the research: How do student nurses construe staff activities? What changes, if any, do student nurses perceive in their personal ways of knowing about mental health nursing? And, does the construction of a repertory grid help student nurses to articulate what they learn?

A constructivist conceptual perspective undergirds the project. This view sees the individual not as a passive recipient of knowledge, but as an active constructor of meaning. Personal construct theory extends readily from a constructivist world view and lends itself to exploration and inquiry in complex, interactive situations. The methodology, repertory grids, is logically derived from the theory.

The study will begin in mid-January 1997. Six second-year students will be recruited from the Calgary Conjoint Nursing Program. Students will be interviewed at the beginning and end of their mental health clinical placements on psychiatric wards of general hospitals. Data will be collected by May 1997.

The study should provide insight into current learning needs of participating student nurses. Investigation in this area may also inform practice in terms of developing collaborative nursing educational experiences from a personal construct theory approach. The research may suggest important changes in our understanding of clinical teaching in psychiatric mental health

rotations. Findings Could also contribute a Canadian perspective to the developing body of international literature linking personal construct theory and nursing education.

The project will provide a description of learning in a local nursing program. It emphasizes 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 is the objective of this investigation to weave a common thread between the two to gain insight into student nurses' ways of knowing in mental health nursing. The study argues for the importance of including student nurses' voices in the scholarly dialogue surrounding their learning.

Learning psychiatric mental health nursing: One student's experience



[PDF – 5.6 MB]

Citation

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Abstract

Few Registered Nursing students intend to work in the mental health area. This descriptive research casts the story of a second year baccalaureate student, who is interested in this specialty and using a literature review of psychiatric clinical teaching. A constructivist conceptual framework and qualitative methodology using a case study approach guide the investigation. Insights into experiences which one student found engaging and difficult as she developed skills in psychiatric nursing are revealed. Two themes in the student's story are identified and discussed to describe significant features of the psychiatric clinical learning experience.

Key Terms: Learning Psychiatric Nursing

Introduction

With the rapid and complex changes occurring in both health care and nursing education, student Registered Nurses interested in a career in mental health face unprecedented challenges in psychiatric clinical practice environments. Few psychiatric agencies today have escaped cutbacks, downsizing and restructuring of provision of services. In nursing education, revolutionary curricular changes have occurred in response to delivering programs of study through colleges and universities rather than hospital based schools. Compounding the hurdle of learning from a new curriculum in clinical areas undergoing turbulent organizational restructuring, students now see fewer Registered Nurses choosing to practice in the psychiatric speciality. Research related to clinical teaching in psychiatric mental health is limited and further study is essential in order to develop approaches which explain and promote the field. In this paper, we examine the process of learning psychiatric mental health nursing through the eyes of one student who hopes to work in the area.

Literature Review

A serious lack of interest in pursuing psychiatric nursing as a career option exists among Registered Nurses graduating from baccalaureate programs (Amswald, 1987; Perese, 1996; Rushworth & Happell, 1998). Amswald (1987) reported that fewer and fewer nurses were choosing psychiatric nursing for both employment and graduate study

Following an analysis of the research literature, she suggested that the integration of psychiatric nursing into general nursing curricula and a negative undergraduate experience in the psychiatric clinical area were the two factors most responsible for the disinterest (Amswald, 1987). Perese (1996) asserted that “the decline in the number of students selecting psychiatric nursing as a preferred practice area from a three decade level of 5% to the present 3% (Francell, 1990. p.163) is ominous” (p.281). Furthermore, Rushworth and Happell (1998) concluded that “Psychiatric nursing is not a popular career choice among undergraduate nursing students” (p.324).

Research offers educators and practitioners little guidance in resolving the current problem of disinterest in the field. Early psychiatric nursing research studies in clinical teaching centred on measuring students' attitudes towards psychiatric patients. For example. Holmes, Klein, Stout and Rosenkranz (1975) and Bairan and Farnsworth (1989) measured how psychiatric courses, particularly those providing an in-patient hospital practicum, were effective in favourably changing nursing students' attitudes towards mental illness. Using the Opinions About Mental Illness (OMI) scale, these investigations affirmed that traditional six or eight week nursing courses, which focused exclusively on psychiatric content, made a significant difference in the way student nurses felt about their psychiatric patients. The findings were similar to five previous healthcare investigations rising the OMI (Creech, 1977; Gelfand & Ullmann, 1961; Lewis & Cleveland, 1966; Morris, 1964; Smith, 1969) in that psychiatric courses reduced attitudes which stigmatized the mentally ill.

Later, 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 when students spent six weeks immersed in courses dedicated exclusively to psychiatric nursing, they generally entered their practicum with trepidation, but emerged with a sense of recognition that the experience had provided an opportunity to develop both personally and professionally. Schoffstall (1981) found that students were initially concerned about their own ability to cope and contribute. They expressed fear about physical danger, concern about being similar to psychiatric clients, worries about psychiatric clients being stereotyped as 'different,' and apprehension that the experience might be emotionally painful. Krikorian and Pavlanka (1984) reported that students' “overwhelmingly identified clinical experience and self-awareness as the primary change-producing factors in their education, 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 as second.

Similarly, reflecting on student comments following their traditional psychiatric rotation, Marley (1980) noted that students

often approach their psychiatric rotation with feelings of “high anxiety, ... fear [of] being hurt emotionally and physically ... and wonder what they will do if a patient should reject them” (p.16). Illustrating the emotional intensity students experience during psychiatric practicums, Marley (1980) suggested that “about two students out of ten, of each rotation, seek counselling for their own inner turmoil” (p.20). She emphasized the importance of instructor, peer, and staff interactions to facilitate meaningful learning throughout this unique rotation

Contemporary’ mental health courses in baccalaureate Registered Nursing programs can differ dramatically from traditional hospital diploma programs. Traditionally, diploma students spent six or eight weeks immersed in classes and clinical practice focusing almost exclusively on psychiatric nursing content. By contrast, today, in baccalaureate programs, content related to advanced medical – surgical nursing, community healthcare and optional university courses are often delivered concurrently with a psychiatric clinical practicum. Students no longer live in hospital nurses’ residences. They may be employed adult learners returning to academia or single parents supporting families. Practicum placements are not expected to be confined to hospital units. DeLaGarza and Martinez-Rogers (1996) described how a run-down Texas mission house provided a valuable psychiatric learning experience for students. Slimmer, Wendt and Martinkus (1990) wrote about assigning students to a community Veterans Medical Centre and a private hospital. Perese (1996) placed students in a Continuing Treatment Centre and a Psychosocial Club.

Although current literature addressing teaching and learning in the psychiatric mental health clinical area does provide useful instructional strategies, exploring the experience from a student’s perspective has generally been overlooked. For example, Arnold and NicSwiadomy (1997) described a pre-clinical exercise to reduce student anxiety; Mingelle and Benson (1995) explained critical incident analysis as a way of helping students debrief; McAllister (1995) suggested the metaphor of students visualizing themselves as tour guides; Landeen, Byrne and Brown (1995) noted the value of reflective journal writing and Armstrong and Pieranunzi (2000) created weekly interpretive exercises to supplement student learning. However, in addition to constructing these kinds of innovative practicum placements and instructional strategies, it is important to try and understand the experience of foaming psychiatric nursing from a student’s perspective.

Clearly, students today face different and overwhelming demands that compete with their nursing education. In addition to the classic concerns Scholffstall (1981) identified that students who typically must also travel farther to clinical placements, orient to new surroundings more frequently, and continue to maintain their personal and family responsibilities. We may no longer presume that clinical practice sites are in a position to easily integrate students into staff groups. In response to restructured workplaces, practitioners also find their own time is stretched in different ways and opportunities to guide and mentor novices are not straightforward. Given the current disinterest in mental health specialization, it is essential to gain insight into clinical experiences which engage students, to understand what students find difficult and to aggressively promote the image and desirability of the field. This project has been an attempt to learn about the experiences and perceptions of student nurses during the psychiatric portion of their nursing education program.

Methodology

In an effort to understand the nature of today’s undergraduate psychiatric practicum from a student’s point of view, we followed “Heather” (a pseudonym she chose herself), through her clinical rotation at a provincial mental institution site. We used a constructivist conceptual research perspective, where observers are included in the domain of the observed and the focus is on process and pattern, and qualitative methodology to create a collaborative case study report of her experience. Data sources included before and after repertory grids (Kelly 1955/1991), a questionnaire (Perese, 1996) and audiotape recorded transcribed the interviews. Content was theme analyzed (Berg, 1995), Vee Heuristic diagrammed (Novak and Gowin, 1984) and concept mapped (Novak and Gowin, 1984). The case study was written collaboratively with the student. Ongoing interaction and member checking six months after the practicum ended by confirming the trustworthiness and authenticity of the work. The report of Heather’s experience is part of a larger three year project which included five other students, a pilot study and the incorporation of findings into a clinical curriculum (Melrose, 1998; Melrose & Shapiro, 1999). The “story” which follows is a snapshot portrayal of one student. Heather, and what it was like for her to learn about psychiatric nursing.

Heather's Story

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

Heather was the only member of the study group who expressed an interest in pursuing the field of psychiatric mental health nursing. She chose to complete her clinical experience at a provincial mental institution, The site was about a three-hour drive out of town. Throughout the six-week clinical placement, students and their clinical instructor drove out individually to the facility on Thursday mornings. They met as a group for a preconference, 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 was single and her family lived out of province. She boarded in Calgary and worked twenty to forty hours a week as a waitress during her program.

At the end of the course. Heather continued to be interested in the field of psychiatric mental health nursing. She indicated that she felt 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 “favourite so far” and she described it as “excellent interesting and stimulating.” For Heather, the process of engaging and sustaining her interest in the field revolved around two main themes. The first theme was clarifying her personal and professional growth and the second theme was discovering the need for reflective time.

Theme One: Making Distinctions: Clarifying her Own Personal and Professional Growth

When Heather first arrived on her assigned unit, she stated that 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. Nevertheless, 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, where several of Heather’s classmates completed their clinical experiences, professional staffs often dress in ways that make them indistinguishable from their patients. However, in this particular provincial institution setting, 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. Unlike her peers in city hospital placements, who described feeling unsure about how to become involved in a psychiatric milieu. Heather immediately sensed that she was a part of the staff team. She 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.” Yonge 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 and 1991. After listening to the nurses, the 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). Yonge 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 expressed a sense of this feeling of belonging and subsequently found the concept of a therapeutic milieu “easier” to understand. The day Heather was interviewed on her clinical unit mid-way through the course, she talked about how her own learning was progressing. In particular, she commented on two issues she was in the process of working through. The first centred on establishing therapeutic

boundaries. The second involved clarifying the tasks of the nursing role. She found it difficult to distinguish activities specific to nursing from activities implemented by other professional group, such as social workers and occupational therapists. Describing concerns with the first issue, Heather questioned how she could establish therapeutic boundaries with an “infatuated” female patient “who likes me and fellows 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.” As she struggled to move beyond simply supporting her patients and to help them therapeutically, Heather found herself feeling “upset, exhausted, funny, and disjointed” when she left the clinical laboratory.

As Heather reflected on the second issue of separating activities specific to nursing 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 “spent a lot of time advocating for patients when they were 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 chilli 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 the mid-term interview, in addition to discussing the difficulty she experienced in the process of learning about therapeutic boundaries and the nature of the psychiatric nurse’s role, 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.” 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.”

Theme Two: Discovering the Need for Reflective time

As noted above, the first theme which emerged in this investigation of Heather’s learning experience was a thoughtful process of making distinctions as she clarified her own personal and professional growth. The second theme involved discovering the need for reflective time, in concert with her existing interest in the field and the feeling of inclusion which she experienced during her practicum.

Heather indicated that her identity as a novice psychiatric nurse became 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 university course requirements very exhausting. She described waking up one morning “not knowing right away whether I was at clinical, at the restaurant or at home!”

Time to reflect and interpret the new ideas and knowledge she was seeking to assimilate was essential to the richness of the clinical experience for Heather and she remarked on its absence in her program, due to all of the demands on her time. Brookfield (1990) criticized 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 (1990) 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 students and all those involved with their education 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 much time to rest. 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 her to create a space within the 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 the opportunity to talk about her experience stimulated 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, Heather commented on what stood out for her:

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.

These comments reflect the 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 framing the emotionally charged learning experiences she faced in the 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 summary, Heather demonstrated striking changes in her understanding of psychiatric nursing during her practicum at a provincial mental institution. She was motivated by and interested in the field before the course even began. She grew personally and professionally and valued the affirmation she received as she learned to establish therapeutic boundaries with her patients. She also learned to define the psychiatric nursing role in a personally relevant way. It was vitally important for her to have time to reflect and discuss her emotional responses and the profoundly different nature of the experience.

Discussion

Together, the two themes of clarifying her own personal and professional growth and discovering the need for reflective time illustrate one student's experience learning psychiatric nursing. 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 pursuing work 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). However, the researchers did not comment on whether or not the students in their findings indicated that novice psychiatric

nurses had clear constructions of 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 emphasized the "difference" of the practicum and how she quickly felt a strong sense of identity within the psychiatric area.

Heather's positive experience leads us to question how other Registered Nursing students can be provided with attractive and valuable learning opportunities in mental health nursing. Theme one in Heather's story illustrates the importance of preparing and organizing resources for students to turn to as they sort out and clarify the special kinds of personal and professional growth which can occur in this unique area. To ensure that support is available to students, university nursing curricula must acknowledge the contrasting nature of the field, introduce adequate psychiatric content and orient students throughout their programs by facilitating increased student contact with mental health practitioners. Also, practitioners must understand the changing nature of students' educational experiences and make certain that activities which welcome and involve them are made available. Theme two in Heather's story emphasizes the essential need to create more time to talk with students and to encourage their reflections. What does the world of psychiatric mental health nursing look like to a novice? A plethora of exciting possibilities emerge when we create opportunities to listen to students, to view the workplace through their eyes and to invite them into conversations about their perceptions and experiences.

Conclusion

Heather's story reflects a human face behind the paradigm shifts occurring in healthcare and nursing education. Today, few Registered Nurses are interested in specializing in mental health, sweeping changes have impacted clinical practice settings and university programs now replace hospital schools of nursing. In this radically changed environment, it has become more important than ever to empathize with novices entering the profession and to understand what they find engaging and difficult about this unique clinical area. For Heather, learning psychiatric nursing centred on themes of clarifying her own personal and professional growth and discovering the need for reflective time. Students, with their fresh insights and perceptions, provide us with a mirror image of how psychiatric clinical practice environments can appear to newcomers. To ensure that this image is a positive one, it is imperative that university curricula include adequate mental health content. Furthermore, it is equally imperative for practitioners to involve and mentor students in new and creative ways.

Failing to address the current crisis of disinterest in the speciality, short-changes students as well as the educators and practitioners who are expected to facilitate their progress. By listening to the voices of learners, we may be inspired to reverse this disturbing trend. This is both a challenge and an opportunity for the field.

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An exploration of students' personal constructs: Implications for clinical teaching in psychiatric mental health nursing



[PDF – 14.1 MB]

Citation

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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.

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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 to 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 preemptive ('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.

Students' perceptions of their psychiatric mental health clinical nursing experience: A personal construct theory exploration



[PDF – 170 KB]

Citation

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Abstract

Personal construct theory and repertory grid technique provides a suitable framework for exploring Registered Nursing students' perceptions of their psychiatric practicum. This descriptive research was designed to understand students' own ways of constructing knowledge during their mental health clinical experience. A constructivist conceptual perspective and George Kelly's personal construct psychology were the theoretical bases of the research. A qualitative case study methodology allowed creation of and reflection on personal construct changes as provided in participants' review of repertory grid ideas about psychiatric nursing. The participants were six Canadian second year nursing students in a Baccalaureate programme that integrated psychiatric and medical surgical nursing curricula. The following three overarching themes were identified and are used to explain and describe significant features of the psychiatric clinical experience: 1) students' anxiety related more to feeling unable to help than to interactions with

mentally ill patients; 2) students' feelings of a lack of inclusion in staff nurse groups; 3) student emphasis on the importance of nonevaluated student-instructor discussion time.

Keywords: personal construct theory, psychiatric, repertory grid technique, students' perceptions, practicum

INTRODUCTION

In this article we describe a naturalistic case study research project that investigated how university student nurses developed personally meaningful constructs during a psychiatric mental health clinical rotation which integrated medical surgical nursing content. The inquiry is grounded in a constructivist approach, where observers are included in the domain of the observed, and the focus is on process and pattern (Novak & Gowin 1984; Candy 1989; Shapiro 1991, 1994; Novak 1993).

Personal construct theory, and the methodology that extends from it, including repertory grid technique (Kelly 1955/1991), provided a framework to listen credulously and to include the voices of student nurses themselves in the project. The psychology of personal constructs honours people as knowing individuals, self-inventors and interpreters of their world (Bannister & Fransella 1971, Shaw 1980, Pope & Shaw 1981, Bead 1985, Fransella 1995).

Most applications of personal construct theory are in the area of psychotherapy. However, the approach also holds considerable promise in the fields of higher education and nursing research. In higher education, 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. Fromm (1993) used personal constructs to evaluate what university psychology students learned in seminars on mental illness.

In nursing, existing research guided by personal construct theory and repertory grid technique offers important insights to nurses and nurse educators. 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 critical care nurses, gerontology nurses and general nurses, repertory grids demonstrated differences in the way nurses perceive effective practice and demonstrated the importance of context as an important defining characteristic of nursing (Wilson & Retsas 1997). With psychiatric nurses, general nurses, and mental health social workers, Kelly's (1955/1991) 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, the techniques inspired by Kelly have 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 have served as educational tools as well as providing research methodology. In a study by Diamond & Thompson (1985) the approach was useful for learners to compare their own conceptualizations with fellow students' ideas and the course objectives. Use of personal construct analysis was effective in stimulating personal awareness of pejorative attitudes towards people who attempt suicide (Costigan et al. 1987) and ways of using available resource people in the clinical laboratory (Davis 1985). Awareness of constructs 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 defences (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 hospital diploma student nurses enrolled 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. The framework has not, however, been used to investigate university student nurses' perceptions of their mental health clinical experience in programmes of study where psychiatric nursing content is delivered concurrently with advanced medical surgical nursing concepts.

THE RESEARCH APPROACH

We designed this naturalistic exploratory study to understand students' own ways of knowing during their 6-week mental health practicum on acute hospital units. The theoretical bases of the research included a constructivist conceptual perspective emerging from George Kelly's personal construct psychology. Our qualitative methodology used the case study approach to describe the experiences of six Canadian second-year Baccalaureate nursing students from their own perspectives. Data sources included before and after repertory grids (Shapiro 1987,1991,1994), a questionnaire (Perese 1996) and audio tape-recorded interviews. Content was theme analysed (Berg 1995), Vee heuristic diagrammed (Novak & Gowin 1984; Smith 1992) and concept mapped (Colling 1984, Novak & Gowin 1984). (See Figure 1 for a diagrammatic representation of the research process.)

The case studies were written collaboratively with students, and ongoing interaction and member checking by correspondence 6 months after the practicum ended confirmed the trustworthiness and authenticity of the work. The study spanned 3 years, included a pilot project and incorporated the resulting student 'stories' into a clinical curriculum. Reflecting on personal construct changes illustrated in the before and after repertory grids, the cornerstone of the investigation, served as both a research and pedagogical tool, and we explain this dual purpose in the following section.

BEFORE AND AFTER REPERTORY GRIDS

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 grid techniques (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)' (Fransella & Bannister 1977).

Repertory grid techniques are objective in that scientific systems of analysis do exist. However, they are not mechanically scored questionnaires that 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 & Shaw (1981) asserted that grids provide potentially 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"' (pp 9).

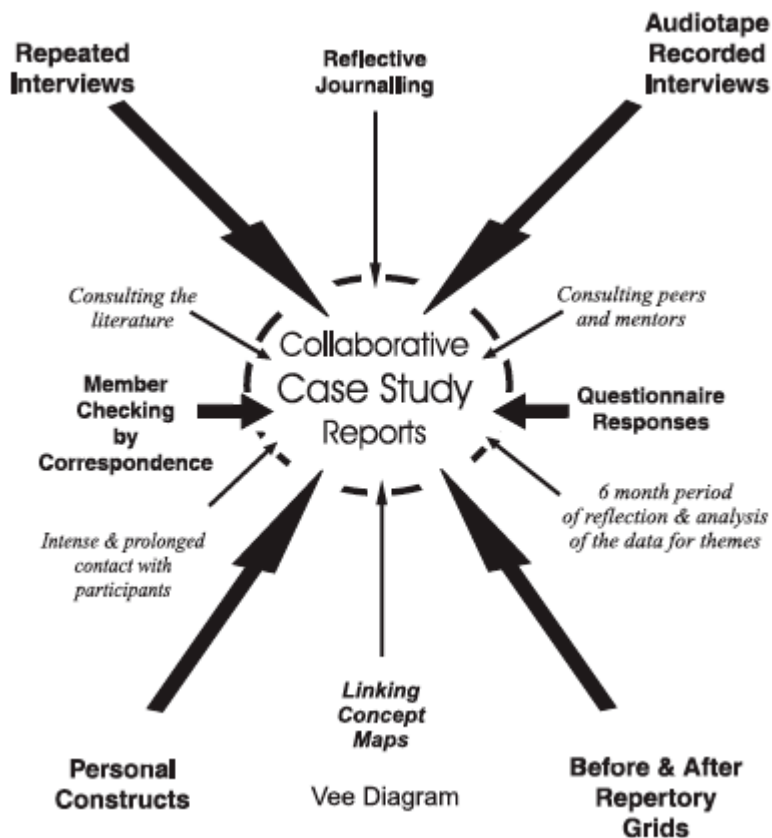


Figure 1 Features in the process of constructing the case study reports.

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 that 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, pers. comm. 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 explanations that follow detail 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 in the subject's experience (Pollock 1986). The constructs are personal bipolar descriptive dimensions that can be applied to each element. For example, 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) stressed 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 were required to attend 2 days each week for a 6-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 underscored 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 and students in the pilot study. The elements are presented in Table 1.

Personal constructs. Fransella (1997) described a personal construct as the 'unit' (p.l) of Kelly's (1955/ 1991) theory and explained that it is 'a porthole through which we peer to make sense of events swirling around us' (p.l). She emphasized that a construct is not a concept or a rule and that it has the following main features: 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 behaviour, inseparable from feelings and can be used effectively within counselling. She summarized the meaning of personal constructs as follows:

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, p. 6)

Table 1 Chart of elements or nurses' activities

1. Wearing street clothes on the unit
2. Administering a PRN as necessary 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 noncompliant 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 nonverbal behaviour

Presenting a patient to the healthcare team during unit rounds 10 Facilitating a group therapy session

In the present study, we used triadic elicitation. Here, 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 that 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). For example, discussing elements 2, 8 and 6, one student described 2 and 8 as 'therapeutic', and differentiated 6 as 'nontherapeutic'. Another student, discussing elements 1, 10 and 4, described 1 and 10 as 'professional activities', and differentiated 4 as 'personal or social activities'.

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 and then ranked or rated. Rawlinson (1991) noted 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 the present 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 techniques now exist. Rawlinson (1991) identified 38 different computer programs used to analyse construct ratings. It is beyond the scope of this article to enter into a discussion of how correlations within the matrix can be analysed statistically. In this case study research, the pre- and postcourse repertory grids were treated as educational tools to stimulate discussion between the researcher and participants and to develop individual case study reports. As in Shapiro's (1991) work with student teachers, the personal constructs and resulting grids in this study were also 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 that constituted the analysis. The following three overarching themes emerged from the final case study reports and represent key findings. The first theme was that students' anxiety related more to feeling unable to help than to interacting with mentally ill patients. The second theme was that students felt a lack of inclusion in staff nurse groups. The third theme was that nonevaluated student-instructor discussion time was vitally important.

THEME ONE: STUDENT ANXIETY RELATED MORE TO BEING 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 (Holmes et al. 1975, Marley 1980, Schoffstall 1981, Krikorian & Paulanka 1984, Yonge & Hurtig 1987, Bairan & Farnsworth 1989, Slimmer et al. 1990, Perese 1996, Arnold & Nieswiadomy 1997, Melrose 1998). 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, narrative from the students' experiences emphasized that this was not the case. Through conversations about their personal constructs, we discovered that these students left the experience still feeling anxious about their ability to help mentally ill patients. For example, the student who created the constructs of 'therapeutic' and 'nontherapeutic' rated the elements almost identically on both her before and after repertory grids. This finding illustrates, in part, how she left the course without feeling that she had gained therapeutic skills in the area. Similarly, in several instances, as students used their own words to discuss similarities in the ways they viewed elements at the beginning of the course and again at the end of the course, we were struck by how frequently they commented on an inability to understand how to 'help' their patients.

Hospital psychiatric nursing activities often look different from those that students have observed and participated in on other units. First-year 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 preclinical 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 limited preclinical 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' ability to allocate time to mentor students. As a consequence of this combination of circumstances, students in this study found themselves without many of the conventional and reassuring learning resources historically associated with a psychiatric clinical practicum. 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. In response to these kinds of student concerns, it is essential to address learner anxiety in fresh ways, such as introducing psychiatric nursing skills in the first year of university programmes of study.

Through the process of inviting students into conversations about their learning with repertory grids, and by 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 TWO: STUDENTS FELT A LACK OF INCLUSION IN STAFF NURSE GROUPS

This research was conducted on hospital units where professional staff 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 8-h shifts each week for 6 weeks, by the end of the course, none of the students on 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 medical surgical 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. As students used element 1, 'wearing street clothes on the unit', to create their personal constructs at the beginning of the course, they voiced a host of questions related to 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 counselling and medicine. Through the process of discussing repertory grids again at the end of the course, we learned that, although students initially wanted to be included in the staff groups, they did not know how to establish contact, and they were disturbed by some nurses' lack of professional presentation. Without background information explaining behaviour modification treatment programmes; they found some of the nursing activities related to rewarding only positive behaviours distasteful.

Discussing movement on the construct charts, we found that students did become more comfortable wearing street clothes as the course progressed. However, on a deeper level, we also discovered that time after time, their comments centred on how they continued to feel alienated from staff members. As students co-created case studies from their own interview data and repertory grids, they expressed concern about fulfilling the graded assignments designated by their university course requirements and how they frequently felt uncertain about their place within the unit groups. Eventually, students explained that they no longer even tried to involve themselves in staff groups. Instead, they spoke about how they went their separate ways to create individual situations where they could use their clinical time well. For example, using words from personal construct charts, the first student described how she distanced herself from the nursing unit and 'studied' towards her eventual goal of attending medical school. The second turned to a subgroup of peers, naming the time he spent with them his 'life support.' The third found a friend and learning partner with whom she could share her experiences. The fourth, intending to practice in the medical surgical area, focused her energy on this more concrete component of the course. The fifth established an important relationship with her instructor. The sixth could not imagine herself becoming a member of a group of hospital psychiatric nurses, even though she expressed interest in pursuing work in psychiatric nursing.

By considering the practicum experience from the student's perspective, the present research approach leads us to appreciate the difficulties students experience as they grapple with psychiatric nursing concepts. 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 that students can feel a lack of inclusion in staff groups in the psychiatric mental health area.

THEME THREE: NONEVALUATED STUDENT- INSTRUCTOR DISCUSSION TIME WAS VITALLY IMPORTANT

When given an opportunity to share their perceptions about personal ways of knowing and expressing understanding through personal construct changes and narrative reflection, 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 nonevaluated discussion time with their instructors the greatest number of times during 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 assignments, they did not find them helpful. One student explained: 'it's hard to read them when we don't know anything to begin with'.

Students were 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.' However, they emphasized that instructor time was their primary resource and commented that they needed more of it. The student who viewed nursing activities as either 'professional' or 'personal/social' experienced dramatic reversals in her thinking. During nonevaluated conversations with her teacher, she appreciated exploring her ideas about how activities she previously associated with social situations, such as drinking a cup of coffee with a patient, could also be construed as an important aspect of a professional interview. One student explained that his clinical instructor also 'talked' with him through her comments in his reflective journal and that he valued this exchange as well. Another student 'sorted out' how she could establish personal boundaries with her patients during discussion time with her instructor and expressed how she felt 'safe' during talks with her teacher.

Although 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 nonevaluated discussion time that students spoke of when they were asked to describe experiences that 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. The experience of one student, who found herself remembering her own sexual abuse victimization during the rotation, reflects 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, another student also described how a peer disclosed a personal struggle with a mental health problem to her. 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. Although nonevaluated 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.

DISCUSSION

The aforementioned three themes, developed from discussing changes on construct charts, illustrate how student nurses today face new and complex challenges in their personal process of acquiring psychiatric clinical nursing knowledge in programs which integrate both psychiatric and medical surgical content. In this project, Shapiro's (1987, 1991, 1994) adaptation of 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 as students created and reflected on their personal constructs and then developing overarching themes revealed different and important new ways of looking at anxiety, group inclusion needs and nonevaluated time with instructors. Previously, student anxiety in the clinical area was considered to be related to fear of bizarre or aggressive patient behaviour and this anxiety was expected to dissipate, once students came to know their patients and became involved with the therapeutic milieu of the unit. However, the present investigation 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.

CONCLUSION

In this article, we have presented a personal construct theory research approach which provided a suitable framework for exploring student perceptions. In contrast to other methods of data collection, that may simply emphasize results, we found that our research approach itself was valuable in generating in-depth information and offering a pedagogical tool to learners. Through the process of constructing before and after repertory grids, we were able to create case study reports collaboratively with each student and then develop common themes. The experience of working together and using students' own words to articulate their learning and change enabled us to listen in new and meaningful ways to students. We extended existing understanding of what it is like for students during their psychiatric clinical practicum by identifying three overarching themes. In our work, we found that students can be more anxious about helping their patients than about the behaviours which mentally ill patients might manifest, that students felt a lack of inclusion in staff groups and that nonevaluated student- instructor discussion time is vitally important. We 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 we learn about their thinking.

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A clinical teaching guide for psychiatric mental health nursing: A qualitative outcome analysis project



[PDF - 90 KB]

Citation

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Abstract

Limited curriculum enhancement resources are available to psychiatric nurse educators. This article provides a clinical teaching guide for novice instructors teaching an introductory psychiatric nursing course. The investigation is grounded in a constructivist theoretical framework and extends a previous case study project that explored how students learn during a mental health practicum (Melrose 1998, Melrose & Shapiro 1999). The guide was tested and modified by applying a qualitative outcome analysis methodology. Insight into interpreting student behaviour and providing appropriate and stage-specific teaching tools is revealed. Theoretical components, assessment questions for teachers, student behavioural signs and teaching strategies are identified and discussed to describe significant features in creating personally meaningful learning experiences.

Keywords: psychiatric teaching guide, qualitative outcome analysis

Introduction

With the rapid and complex changes occurring in both health care and nursing education, student Registered Nurses and their clinical instructors face unprecedented challenges in psychiatric practice environments. Few mental health agencies today have escaped cutbacks, downsizing and re-structured provision of services. In nursing education, revolutionary curricular changes have occurred in response to delivering programmes of study through colleges and universities rather than hospital-based schools. Research related to clinical teaching in mental health is limited and further study is essential in order to develop contemporary teaching approaches that invite students to construct personally meaningful knowledge of the area.

This article presents an innovative one-page clinical teaching guide. Both instructors and students found that the guide was helpful in promoting personally meaningful learning outcomes. It was modifiable when applied in different psychiatric clinical settings and thought-provoking during an introductory mental health rotation. The work, grounded in a constructivist, student-centered epistemology, employed qualitative outcome analysis methodology and incorporated findings from a previous or base project as well as published work from educational researchers.

The purpose of the study was to work collaboratively with teachers and their students to create, test and refine a useful guide for nurses beginning to teach psychiatric nursing. The research extended four theoretical components derived from a base project that applied personal construct psychology in a case study design to examine how student nurses learn in the psychiatric clinical area. The aim of the guide, modified in the present study by the participating teachers and students themselves, was to identify practical assessment questions, to describe behavioural signs that demonstrated meaningful learning outcomes and to suggest relevant teaching strategies.

Two key areas of research are pertinent to this study – clinical teaching in psychiatric mental health nursing and qualitative outcome analysis (QOA). A constructivist theoretical framework undergirds the project. A constructivist approach to research is a view that sees the participant not as a passive subject, but as an active co-creator of knowledge and emphasizes that observers are included in the domain of the observed, and that the focus is on process and pattern (Novak & Gowin 1984, Candy 1989, Novak 1993, Peters 2000). QOA methodology extends readily from a constructivist worldview and lends itself to exploration and enquiry in complex interactive situations. This article describes the research approach, presents the guide as Table 1 and emphasizes practical instructional assessments and strategies in a discussion of the findings.

Although Gaberson & Oermann (1999) provided a strong introduction to clinical teaching, a serious lack of current, practical, research-based guidance for instruction specific to the psychiatric area exists in published scholarly works addressing nursing education. Limited available research provided classic but dated or anecdotal suggestions (Gelfand & Ullmann 1961, Morris 1964, Lewis & Cleveland 1966, Holmes et al. 1975, Creech 1977, Marley 1980, Schoffstall 1981, Krikorian & Pavlanka 1984, Yonge & Hurtig 1987, Bairan & Farnsworth 1989), emphasized disinterest in psychiatric nursing (Arnsward 1987, Perese 1996), highlighted contrasts with general nursing (Moir & Abraham 1996, Wells & McElwee 2000) and reflected an immediate need to explore creative teaching strategies that invite students to understand the area more deeply (Rushworth & Happell 1998, Mohr & Naylor 1999, Taymore 1999, Armstrong & Pieranunzi 2000).

While it is clear that engaging student interest in the field of psychiatric nursing poses a longstanding challenge, instructors today also face the additional hurdle of a restructured workplace. In response to a paradigm shift in both nursing education and health care delivery, Canadian clinical teachers may be employed only on a short-term contract basis and by more than one employer. They can be required to orient to new curricula and clinical surroundings frequently and may not be involved in course planning decisions. Researchers exploring the nature of the teaching role acknowledged that limited support and direction is available to clinical nursing instructors (Crotty 1993, Owen 1993, Ferguson 1996, Forrest et al. 1996). Thus, using qualitative outcome analysis to create, test and refine a practical and concise teaching guide for novice instructors in the psychiatric clinical area is timely. This project makes three significant contributions. First, it responds to the current need for lively curricular innovations to promote interest in the specialty. Second, it transfers ideas about engagement and involvement generated from students themselves directly into theoretical components, assessment questions, behavioural signs and instructional strategies that promote personally meaningful learning outcomes. Third, it organizes relevant

educational research to provide explicit direction to new instructors in a way that would not otherwise be available to them. The next section explains the research approach.

Table 1

A clinical teaching guide for psychiatric mental health nursing

Theoretical components	Assessment questions	(Student) behavioural signs	(Teaching) strategies
ONE Understanding psychiatric mental health nursing is a personal process	Does the learner believe that mental health concepts are relevant?	Express links between course concepts and personal interests Discuss the process of making connections between concepts and intended area of practice	Co-construct a personal learning-plan with each student Expect students to identify personal learning in a weekly reflective journal Supply sample RN exam questions Provide examples of excellent student work
TWO Feeling unsure about how to help patients provokes anxiety	Can the learner articulate relevant patient outcomes such as those stipulated in the course curriculum?	Identify common psychiatric disorders Implement appropriate assessments Demonstrate knowledge of medications and other therapeutic interventions Report/chart concerns promptly Individualize nursing care in response to patient presentations and agency milieu	Invite unit staff and consumers from local agencies as speakers Provide concept maps, games, puzzles and word matches, etc. to supplement lecture/text Display information on agency bulletin boards Create files of newspaper and magazine articles on mental illness
THREE Group involvement and cohesion is highly valued	Is the learner an engaged member of the clinical group?	Contribute ideas for climate-setting Attend to peer needs and group process	Generate group 'rules' Initiate optional student phone support lists Establish peer learning partners Facilitate opportunities for students to role-play their own patients
FOUR Non-evaluated discussion time with instructors is essential	Does the learner view instructors/perceptors as both mentors and evaluators?	Initiate conversation about meaningful learning achievements or problems	Phone each student before the course starts Post sign-up sheets for talk-time appointments Emphasize balanced self-evaluation Frame evaluative comments positively Close the course with <i>unanswered questions</i>

The research approach

This research applied a particular method of developing guides that applied qualitative research findings from a previous, or base project to practice (Morse et al. 1998, 2000, Morse 1999). The theoretical basis of the work stemmed from a constructivist conceptual perspective. Cresswell (1998) described a constructivist perspective as one that incorporates an emerging design, a context-dependent enquiry and inductive data analysis. Rooted in a client/student-centred worldview and context, QOA methodology is a practical applied outcome-oriented approach that seeks to translate theory generated from research directly into the practice arena. Morse et al. (1998) assert that developing a guide permits interpretation of (student) behaviour and provides appropriate (in this case psychiatric) specialty knowledge and (in this case introductory) stage-specific teaching strategies. Morse et al. (2000) further explain that QOA is used to: 'confirm the efficacy of interventions when the experience changes over time, to extend the repertoire of intervention strategies and to further the clinician's understanding of possible outcomes' (p25). It is beyond the scope of this paper to elaborate on either the base

project or the entire process of developing a guide. Essentially, descriptive qualitative theory derived from a base project, in this case Melrose (1998) and Melrose & Shapiro (1999), is deconstructed to form the theoretical components. Assessment questions and behavioural signs are then elicited from the theory. Intervention strategies are extrapolated both from theory and from clinical teaching knowledge. Finally, the guide is implemented and tested using techniques of QOA to modify the guide and expand the repertoire of strategies.

In this project, the technique of QOA was collaborative writing and 1-hour long audio-tape recorded and transcribed interviews. The participants were six contract instructors (with limited teaching experience) and six of their students. The instructors implemented suggestions that they thought would be useful from an original guide drafted by the researcher. Both instructors and students tested and provided feedback on the ideas and the guide was re-constructed. The course was a required second-year psychiatric clinical practicum in a Canadian Baccalaureate programme. The practicum involved two 7-hour shifts each week for 7 weeks on an acute psychiatric placement. Participants in this study were not taught, evaluated or supervised by the researcher and represented inpatient units and outpatient programmes associated with three different urban hospitals and one rural provincial mental institution. Ethical approval was obtained from two Research Ethics Boards. In addition to the 12 designated interviews with key informants, extensive support and explanation was provided to all participants in person and by telephone before, during and after the course. All the resources required to implement the instructional strategies were provided by the researcher. The one-page guide was refined collaboratively during extensive discussions with the 12 participants. As participants' suggestions were incorporated and the changes made, the modified guide was re-written and circulated among the teachers and students. This ongoing verbal and written interaction and member-checking verified and confirmed the trustworthiness and authenticity of the work. The QOA aspect of the study spanned 6 months. Given that the theoretical findings from the 3-year base project emphasized a studentcentred context and perspective and were generated entirely from a group of student nurses, it was logical to test and refine the guide created in the present study by including a population of students once again. Morse et al. (1998) suggested that researchers obtain data from clients/ students in the setting to evaluate the guide, its components and the efficacy of the selected interventions. Evaluating and modifying the guide and interventions with participants by using QOA, and then disseminating the results, bridges the gap between theory and practice, extends the theory and expands the repertoire of research-based strategies (Morse et al. 2000).

Evaluating whether ideas from the base project made sense and had clinical relevance as theoretical components included questioning whether the work demonstrated Morse et al.'s (1998) criteria of theoretical appropriateness, adequacy and structure. Participants in both studies expressed that the four theoretical components were a 'fit' and relevant (appropriateness) and that they 'worked' and could be modified (adequacy). Participants in the present study commented that the structure of the final draft of the guide was systematic. Several commented on the simplicity of the linkages. A recurring theme that also emerged time

and again during analysis of participants' audio-tape recorded interviews was that the project had been thought provoking. It is important to emphasize that, even though points presented in the guide may be known implicitly to experienced faculty, the information is not readily available to novice clinical teachers and a QOA framework has not yet been used to extend case study research, or in nurse education. Essentially, testing the efficacy of this guide served as both a research and a pedagogical tool – and the following discussion of the teaching guide explains this dual purpose.

The teaching guide

The guide tested in this research offers a fresh look at the pedagogy of clinical teaching and learning. The format used to organize and present the information followed a four-step template for constructing assessment guides illustrated in Morse et al. (1998). The first step was identifying theoretical components. The second step was preparing assessment questions. The third step was identifying (student) behavioural signs. The fourth step was selecting (teaching) strategies. The theoretical components reflect students' real-world experiences and drive the guide. The assessment questions were constructed to sensitize and invite further discussion rather than simply to request a forced choice of 'yes' or 'no'. The behavioural signs were

created to be specific and useful indicators of student learning and they illustrate answers to the assessment questions. The teaching strategies were clear, concise actions that combine theoretical deduction and expert nursing education knowledge. This section uses the four theoretical components to frame a discussion of participants' contributions as they tested and refined the guide.

Theoretical component one: understanding psychiatric mental health nursing is a personal process

Findings from the base project (Melrose 1998) concluded that student nurses learn about and come to understand psychiatric nursing in a very personal way. Given that the specialty can be perceived as unique, it is not unexpected that learners initially view the area as separate from their intended practice areas in mainstream nursing. Thus, articulating the individual processes that students employ to actively create their own personal connections to psychiatric mental health concepts is essential.

Assessment question

Actively involving students in a personal way 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 (McKeachie 1986, Ramsden 1992, Davis 1993, Johnson 1995). 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. However, assessing learner involvement in a specialized field is complex. In this study, participants agreed that the assessment question: 'Does the learner believe that mental health concepts are relevant?' effectively opened a dialogue about personal learning between clinical teachers and students.

Behavioural signs

Links between course concepts and personal interests. Participants in the present study confirmed that the following two behavioural signs would indicate that a process of active personal learning had been initiated. First, students would 'Express links between course concepts and personal interests'. Without exception, during the research interviews, each student participant described a family member, friend or acquaintance that struggled with a mental health issue. Students valued opportunities where they could express how they were creating links between these familiar experiences and the new and unfamiliar course concepts. Instructor participants described how students learned from one another when these links were articulated during conferences.

The process of making connections between concepts and intended area of practice.

Second, students would 'Discuss (their) process of making connections between concepts and intended area of practice'. When this behavioural sign was presented as an expected outcome, instructors commented favourably on the depth of student responses. One student, who intended to practice in the area of emergency nursing, created a set of index cards summarizing characteristics of psychiatric illnesses she might encounter in an emergency room. Another student, who intended to practice in obstetrics, gathered information about postpartum depression. Students found this behavioural sign

particularly helpful in that it provided them with a personal way of constructing meaning within the field of psychiatric nursing.

Instructional strategies

Co-construct a personal learning plan.

A prominent feature of both the base project and the present study was the importance that student nurses placed on acknowledging personal learning. The first instructional strategy, 'Co-construct a personal learning plan with each student', was well-received by student participants. Although some instructors perceived that this strategy would be time-consuming and chose not to implement it, those who did so found it invaluable. A personal learning plan can readily be structured around the teaching guide presented as Table 1. Throughout the rotation, students simply wrote out how they used the first assessment question to identify mental health concepts that were personally relevant, how they expressed links between course concepts and personal interests, and finally, how they made connections between these concepts and their intended area of practice. The students and instructors who chose to coconstruct a personal learning plan to supplement required curricular objectives found that the strategy provided a useful measurement of personal learning. One student commented: 'It helped make evaluation in this subjective rotation fair.'

Learning journals.

Learning journals can enhance the clinical practicum experience (Landeem et al. 1992, Patton et al. 1997). The second instructional strategy, 'Expect students to identify personal learning in a weekly reflective journal', provided an opportunity to incorporate the personal learning plan described above into a learning journal. Several student participants in this study supplemented their required journal assignment with a personal learning plan. According to one student: 'Without trying this I might not have done much extra work in this course. A lot of students just call psych the "ping-pong and cards rotation", but I liked using the time to find out the things I need to know when mental health comes up in paediatrics – that's where I'm going to work'. An instructor commented: 'It's easier to see how students are actually integrating clinical knowledge with these personal learning plans'.

Exam questions.

The third instructional strategy, 'Supply sample RN exam questions', was considered important by students and easy to implement by instructors. 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 programme of study. Highlighting test questions from examination preparation books such as the Canadian RN Exam Prep Guide (Canadian Nurses Association 2000) provided students with examples of questions related to psychiatric nursing.

Examples of student work.

Similarly, the fifth strategy, 'Provide examples of excellent student work', was valued by students and easy to implement by

instructors. Obtaining student permission to copy exemplary assignments students constructed and sharing them with fellow students and even staff members was useful. Elbow (1986) encouraged instructors in higher education to design assignments that would be read by peers. Student participants in this study felt that they learned from the content of their peers' assignments as well as the process other students engaged in as they completed the task. Agency staff, particularly those new to the area, also sincerely appreciated reading students' work and gained a deeper understanding of the students' clinical objectives. One student remarked: 'I do a better job with an assignment if I think that somebody besides my instructor will read it'.

Theoretical component two: feeling unsure about how to help patients provokes anxiety

Student narrative from the base project (Melrose 1998) indicated that student nurses felt anxious about their ability to help psychiatric patients. This finding was not unexpected and was consistent with existing studies. Arnold & Nieswiadomy (1997) provided a useful preclinical exercise to begin to address this issue. However, none of the contract instructors who participated in the present study felt that they had sufficient training or experience with teaching methods to deal adequately with students' essential need to know about what to 'do' for their patients. While the assessment question and behavioural signs in this section were considered useful guideposts to students, they offered only nominal direction to instructors. However, participants all agreed that the instructional strategies did help to reduce anxiety, to entice students to explore available knowledge and, ultimately, to construct their own ideas about how best to help their patients.

Assessment question

It is important to reiterate that the guide presented in this paper was designed as a supplement to enhance the existing curriculum. Clearly, the most important assessment questions clinical instructors pose is whether students can articulate relevant patient outcomes in relation to the objectives and evaluation criteria stipulated in course guidelines. Thus, participants agreed that the assessment question, 'Can the learner articulate the relevant patient outcomes stipulated in the course curriculum?', offered useful direction.

Behavioural signs

Participants found that the following five behavioural signs were adequate indications that a student was able to help patients in the psychiatric mental health area:

- Identify common psychiatric disorders
- Implement appropriate assessments
- Demonstrate knowledge of medications and other therapeutic interventions
- Report/chart concerns promptly
- Individualize nursing care in response to patient presentations and agency milieu.

Instructional strategies

Guest speakers.

The instructional strategies presented in this section were considered helpful. Participants all believed that the first strategy, 'Invite unit staff and consumers (of mental health services) from local agencies as speakers', stimulated discussions about important nursing care. Students, particularly those with a predominantly auditory style of learning, valued a brief 'Welcome Talk' from their agency placement manager and opportunities when practitioners joined the student group to describe specific psychiatric nursing interventions. Community mental health agencies often have a 'Speakers Bureau' where individuals recovering from mental illness carry out volunteer speaking engagements with interested groups. At the end of the course, the students in this study expressed that these speakers had made a strong and positive impression on their learning. A similar strategy, which also emphasizes the experience of mental illness from a patient-centred perspective, is to make available memoir books about authors' own experiences with mental illness. Sayre (2001) described a method of using personal accounts of mental illness as a teaching tool and recommended 32 relevant books.

Activities to supplement course requirements.

By count, it was the second strategy, 'Provide concept maps, games, puzzles and word matches, etc. to supplement lectures/texts', which participants found the most helpful and thought-provoking. Once instructors introduced playful ways of organizing course information, students followed suit and risked constructing their own methods of categorizing psychiatric mental health nursing concepts. The games and activities are not included in this paper but can be obtained by contacting the researcher.

Concept maps are graphic organizers (Novak & Gowin 1984, Baugh & Mellot 1998, Daley *et al.* 1999). Ideas can be arranged visually to show the connections between and among concepts as they are studied. Inspiration (2000) software offers useful templates for creating maps.

Puzzles, inspired by Poston (1998), were constructed from an inexpensive computer program from Expert (1997) software entitled 'Crosswords and Word Games'. Basic psychiatric vocabulary was introduced into the program and puzzles were easily generated.

Word matches, i.e. linking a word to a definition, were computer-generated in this study, but could also be done using two simple columns. The process of working through the games, puzzles and word matches stimulated lively discussions. One participating instructor described another game where she brought in finger paints and invited students to express their feelings about the rotation through this medium. Another instructor brought in recycled glossy magazines, glue sticks and scissors for students to construct a collage. These strategies appealed to students with a kinesthetic learning style.

Bulletin boards.

The third strategy was: 'Display information on agency bulletin boards'. Elementary school classrooms generally have enticing and colourful displays of information on bulletin boards. In higher education settings or health care practicum sites, bulletin boards are also sources of information, but they are seldom arranged or decorated systematically. Instructors in this study found that requesting space on agency bulletin boards was an efficient method of communicating course material. This strategy appealed to visual learners and created another link between university curricula and the practicum site.

Articles.

The fourth strategy, 'Create files of newspaper and magazine articles on mental illness', was also supplied by the researcher. Although none of the novice instructors in this study had yet developed a collection of non-professional articles, they expressed interest in maintaining their own ongoing and accessible files of newspaper and magazine articles related to mental illness at their practicum sites. The collection could include contributions from both practitioners and students. Students commented that this genre was easier and more stimulating to read than journal articles. During pre- and postconferences, instructors facilitated discussion around the differences and similarities between popular and professional literature. Focus issues included how sensationalist writing can intensify the stigma associated with mental illness. Students found it intriguing to talk about what it might be like to write different kinds of articles, and instructors encouraged students to view themselves as authors instead of simply readers.

Teaching assignments.

The fifth strategy was, 'Assign students to teach psychiatric conditions to patients, peers or auxiliary staff'. Student nurses are often expected to teach patients about their illness and prescribed medications. A variation on this established practice is to direct students to teach a younger or more junior student, an auxiliary staff member, 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.

Theoretical component three: group involvement and cohesion is highly valued

Student nurses consistently expressed a strong need for involvement with their clinical group throughout both projects. Instructors also expressed a commitment to creating cohesion within their student groups. The guide served as a reminder of the importance of fostering group involvement and stimulating awareness of group process and team building.

Assessment question

Participants found that posing the question, 'Is the learner an engaged member of the group?', did begin a process of sharing group maintenance tasks among students. The question prompted discussions related to group dynamics and norms, the roles that members and leaders assume in groups, and stages of group growth.

Behavioural signs

Student participants, in particular, reported that the following two behavioural signs provided them with a clear indication that they were expected to take responsibility for climate-setting and group process within their psychiatric mental health clinical group:

- Contribute ideas for climate setting

- Attend to peer needs and group process.

Instructional strategies

Ground rules.

The first instructional strategy, 'Generate group "rules"', was well known to all the instructors who participated in the present study. It was surprising to note, however, that none of these instructors had considered using the strategy with their student group. Again, the one-page guide served as a prompt to discuss the merit of creating a safe group learning environment for students during this rotation. Students appreciated generating ground rules and one student remarked: 'It's good to see how nurses are supposed to lead groups. We're taught about "facilitating", but I like actually seeing it done.' Examples of ground rules generated in this study included an expectation of confidentiality, respectful communication and the right and responsibility to participate in different ways. Snyder & Weyer (2000) encouraged affording 'more time . . . to attend to group roles and process' (p319) during clinical experiences.

Optional phone support lists.

The second instructional strategy, 'Initiate optional student phone support lists', was welcomed by students and was simple to initiate for instructors. Given the essential need to respect privacy, participants discussed the point that any disclosure of phone numbers or contact information must remain optional.

Peer learning partners.

Encouraged by the success of Goldenberg & Iwasiw's (1992) experience with reciprocal or peer/collaborative learning during a medical surgical rotation, the idea of learning partners was incorporated into the present teaching guide as the third strategy. Although some instructors were not interested in this strategy, those who did create student learning partnerships clearly found the practice useful. Students who worked in partnerships were unanimous in their agreement that the experience was a highlight of their learning. At the beginning of the rotation, instructors assigned each student to a partnership. In the case of an uneven number of students in a clinical group, a dyad was modified to a triad. Within the partnership, students completed the puzzles together, double-checked one another's medication knowledge and were encouraged to actively listen to each other throughout the clinical experience. According to one student: 'It really helped to talk about my own feelings with my learning partner. I might not have felt as comfortable to do that if it wasn't set up like this.'

Role-play.

The fourth strategy, 'Facilitate opportunities for students to role play their own patients', was considered nominally useful. Instructors agreed that the strategy seemed more appropriate toward the end of the rotation. Student reaction was mixed in that some students enjoyed role-play, while others did not. However, even students who felt reluctant to participate, chose to include the strategy in the final presentation of the guide.

Theoretical component four: non-evaluated discussion time with instructors is essential

Time and again throughout the base project (Melrose 1998), students emphasized the benefit of non-evaluated discussion time with their instructors. Similarly, students in the present QOA study made frequent reference to individual conversations with their clinical teachers.

Assessment question

Performance evaluation considerations can dominate a clinical experience for students and novice instructors. However, clinical teachers are also expected to mentor their students. The assessment question, 'Does the learner view instructors/preceptors as both mentors and evaluators?', was useful in emphasizing that tasks of mentoring, as well as evaluating, are inherent within the clinical teaching role.

Behavioural signs

Participants agreed that the behavioural sign, 'Initiate conversation about meaningful learning achievements or problems', invited students to share their own constructions of knowledge.

Instructional strategies

The strategies participants agreed should be presented in this section could easily be overlooked. However, gestures such as: 'Phone each student before the course starts', and, 'Post sign up sheets for talk-time appointments', created a positive impression with students. Also, learner strengths were supported through strategies such as 'Emphasize balanced self-evaluation', and 'Frame evaluative comments positively'.

Given the complex nature of psychiatric nursing, it is not unexpected that an introductory clinical course in the field leaves students with many unanswered questions. In addition to honouring students for the competency knowledge they demonstrated in relation to their course objectives, and the individual knowledge they constructed in relation to their personal learning plans, it was helpful to recognize that unknown knowledge also exists. The final strategy, 'Close the course with unanswered questions', addressed this issue. Linking back to the process students in this research used to connect their psychiatric clinical experience to an intended area of practice, the strategy of inviting unanswered questions was considered appealing. For example, a student who hoped to work in pediatrics commented: 'My unanswered question is about the difference between some children's inappropriate behaviour and an actual psychiatric illness.' Another student left the rotation thinking more deeply about the issue of recidivism. One instructor viewed the strategy as 'a relief – I can't possibly set up opportunities for everything.'

Conclusion

The teaching guide presented in this article was created and tested by students and instructors in the psychiatric mental health clinical area. The qualitative outcome analysis research approach used in this project was unique in that the methodology applied theoretical findings from a previous naturalistic study directly into clinical teaching practice. The

process of testing the efficacy of the guide served as a pedagogical tool for novice instructors and made implicit knowledge about clinical teaching methods more explicit. The guide extends existing nursing education knowledge by creating useful and thought-provoking assessment questions, behavioural signs and instructional strategies from learner-centred theoretical components. The work emphasizes a continuing need to explore clinical teaching strategies that engage students, sustain their involvement and invite them to construct personally meaningful knowledge. Readers are invited to continue testing the merit of the guide and to extend their repertoire of strategies.

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A message from Simone



[PDF – 100 KB]

Citation

Melrose, S. & Shapiro, B. (2000). The Canadian Nurse. 96, 2, p.45.

Abstract

Many health care professionals are concerned that, at a time of increased patient acuity, few registered nurses are opting for mental health nursing as a career choice. Since student nurses’ undergraduate experiences — and their perceptions of these experiences — may well contribute to the problem, it is essential that we make every effort to welcome students to mental health wards. We use the voice of [Simone], a second year student, to illustrate how one nurse can make a very special difference to a student’s experience and perception of mental health nursing, during her psychiatric mental health practicum. In my second year, after a single class orientation on mental health nursing, I arrived on the first day of my acute hospital psychiatric ward placement feeling completely unprepared and overwhelmed. In contrast to traditional psychiatric rotations that focus exclusively on mental health, many nursing education programs today offer an integrated curriculum. In addition to attending a clinical placement site two days a week, I was also enrolled in required medical-surgical nursing classes and optional university credit subjects. The academic demands on my time away from the unit were stringent and there seemed to be few resources that addressed mental health nursing. As their mental health rotation progresses, students see a sophisticated interdisciplinary team co-operating intensely for the welfare of the patient. They come to understand that street clothes can help break down barriers and that assessing affect is also a critical “vital sign.” They see how skilled

therapeutic use of self and suicide assessments are very serious matters that could mean the difference between a patient's tentative first steps toward insightful mental health or a debilitating, even fatal, outcome. By the end of their clinical placement, students' language often includes a lexicon of new terms drawn from the fields of medicine and counselling, as well as nursing. Their days become so full that they struggle to find time to chart. Invariably, they leave their psychiatric mental health practicum with a deep respect for their patients and powerful new insights into the persistent stigma and marginalization associated with mental illness.

Many health care professionals are concerned that, at a time of increased patient acuity, few registered nurses are opting for mental health nursing as a career choice. Since student nurses' undergraduate experiences — and their perceptions of these experiences — may well contribute to the problem, it is essential that we make every effort to welcome students to mental health wards. We use the voice of Simone, a second year student, to illustrate how one nurse can make a very special difference to a student's experience and perception of mental health nursing, during her psychiatric mental health practicum.

Simone's story

Like many students, I entered a registered nursing program to care for patients experiencing physical illness. My first-year courses did not emphasize content such as suicide, living in an altered state of reality or sexual abuse. I had no background and no experience with psychiatric mental health nursing.

In my second year, after a single class orientation on mental health nursing, I arrived on the first day of my acute hospital psychiatric ward placement feeling completely unprepared and overwhelmed. In contrast to traditional psychiatric rotations that focus exclusively on mental health, many nursing education programs today offer an integrated curriculum. In addition to attending a clinical placement site two days a week, I was also enrolled in required medical-surgical nursing classes and optional university credit subjects. The academic demands on my time away from the unit were stringent and there seemed to be few resources that addressed mental health nursing.

Early on in my practicum, I approached two nurses who were standing in the medication room to ask a question. I was totally unprepared for what happened. One nurse asked me to leave and closed the medication room door, leaving me standing outside. As I looked in through the glass window, I wondered whether I would ever be part of this staff nurse group.

Yearning to become a full participant in the activities of my practicum, I attended team conferences, and observed therapy groups and behaviour modification programs. Still feeling that I needed time to process and talk about this bewildering new information, but not knowing how to approach staff, I spent a lot of time with fellow students. One friend, in particular, proved an invaluable learning partner. We spent a great deal of time talking and going over our required assignments. During this time, I was not just chatting or passing hours with my classmate. We were actively involved in discussions as colleagues. On other units, I helped make beds or joined nursing staff implementing physical care. But initiating contact was difficult, and it felt safe and comfortable to stay closely connected to my student cohort.

A turning point occurred when Irene, a staff nurse, engaged me in conversation over coffee. Irene told me how she had lived in a hospital nurses' residence during her own nursing education program and explained how students often "staffed" the wards in traditional clinical placements. She commented: "I like students, I learn with them," and asked me about my university program.

Irene's friendly overture made a striking difference in the quality of my mental health experience. I never thought that nurses learn from students. I thought that they were there to show us. But after speaking with Irene, I realized that students not only have a contribution to make, but they are the mental health caregivers of the future. I was able to see Irene not only as a

nurse but also as a wife and a person outside of the unit, a friend. By sharing information with me she was able to make me feel part of the mental health milieu.

As my rotation progressed and my understanding of psychiatric mental health nursing deepened, I observed various gestures other nurses made to my peers and I, that made a difference to the quality of our learning experience. These included: approaching us to see if our meds were done; offering suggestions; asking if our needs were being met; asking us to come back in a couple of minutes, if they were busy; including us in nurse/physician discussions; being willing to listen; and inviting us to join them when they interacted with patients.

Six months after my practicum, I still hadn't forgotten my initial apprehension, isolation and difficulty engaging with the staff group. But I remembered how Irene made a difference by carving out time away from her own busy schedule to reach out to a student.

Students' concerns

Studies show that the first few days of a clinical placement are anxiety provoking for students. In the psychiatric area, without uniforms to wear and hourly vital signs to record, students voice many fears. Will I be able to help my patient? What if I say something wrong and somehow make the patient worse? Might an aggressive patient hurt me? How can I bring myself to ask patients if they have ever thought of harming themselves, or if they see or hear things that others do not? What if I do poorly or fail this rotation and am unable to continue in nursing? How do I even find the words that these nurses are using in my nursing textbooks? And what am I supposed to do all day long anyway?

As their mental health rotation progresses, students see a sophisticated interdisciplinary team co-operating intensely for the welfare of the patient. They come to understand that street clothes can help break down barriers and that assessing affect is also a critical "vital sign." They see how skilled therapeutic use of self and suicide assessments are very serious matters that could mean the difference between a patient's tentative first steps toward insightful mental health or a debilitating, even fatal, outcome. By the end of their clinical placement, students' language often includes a lexicon of new terms drawn from the fields of medicine and counselling, as well as nursing. Their days become so full that they struggle to find time to chart. Invariably, they leave their psychiatric mental health practicum with a deep respect for their patients and powerful new insights into the persistent stigma and marginalization associated with mental illness.

Conclusion

Second-year students can feel a profound lack of inclusion in staff nurse groups. The heart of assisting them to learn about psychiatric mental health nursing involves helping them to feel welcome and included in a staff nurse group. Connecting with mentors in the mental health field is difficult. Opportunities to engage with students are easy to miss. In an environment that is strong in relationships, connecting over a cup of coffee may seem an overly simplistic solution to the problem. Yet, when practitioners in the field reflect on their own attraction to the area, often memories of a meaningful personal communication with a special mentor come to mind.

As new groups of student nurses arrive on clinical sites, it is more important than ever to continue to reach out and question them about their undergraduate experience and interests. Words of welcome, orientation and explanation will be remembered long after textbooks are closed and clinical days have ended and, in turn, may inspire other nurses to be equally generous in their own personal encounters with students.

Challenge and opportunity in an inner-city practicum



[PDF – 410 KB]

Citation

Solohub, N. & Melrose, S. (2008). Challenge and opportunity in an inner-city practicum. *The Canadian Nurse*, 104(8), 6-8.

Traditionally, most nursing students complete their mental health practicums on in-patient psychiatric units. However, licensed practical nurses pursuing a post-licensure university education can be expected to already have experience in institutional settings. What they are not as likely to have had are opportunities to join multidisciplinary teams providing community mental health care, particularly to inner-city clients. In this article we describe a unique practicum one student was involved in as part of a psychiatric/mental health nursing course for online students in the Post-LPN BN program at the Centre for Nursing and Health studies at Athabasca University.

Although few community agencies have been able to accommodate our requests to place nursing students, Boyle Street Community services agreed to accept and preceptor Nicholas Solohub, a post-LPN student, for an eight-week, full-time practicum. In his journal entries, Nicholas offered his initial impressions of the agency, his growing understanding of stigma and the development of genuine regard for the inner-city clients and agency staff. Some of those entries are shared here.

Boyle Street, established in 1971, is a multi-service agency serving over 8,000 people each year. Its programs, designed to meet the individual and community needs of people in the inner city, include an adult outreach service, housing support, youth and adult drop-ins, and group homes for children and youth.

The agency also collaborates with Streetworks to deliver harm reduction services to injection drug users.

In one of his first journal entries after he started working at the agency, Nicholas wrote:

I entered this practicum both as a student and a practising LPN with four years of experience on an acute orthopaedic surgical unit. I had cared for the mentally ill, the homeless and clients with addiction problems. But the interactions

were entirely within an institutional environment providing acute postoperative care; there was no time to understand a client's lifestyle or background.

An unfortunate result of this approach was that I would see these individuals discharging themselves against medical advice, being only partially compliant or leaving the unit unannounced. These actions were usually met with further stigmatization and discrimination by health-care professionals, from all disciplines, who made few attempts to understand the individuals' issues and explore new aspects of providing care.

During discussions with instructors and agency preceptors, Nicholas explored the sense of powerlessness that he was beginning to observe among the inner-city client population. He had moved away from the familiarity of nursing in a hospital and was now interacting with clients on their own terms. He spoke about "switching roles" and began to view the experience of hospital care through the eyes of those who are homeless. His observations led him to reflect on the power and control that nurses and other health-care professionals have over this population.

Once, Nicholas accompanied a man who was very reluctant to seek care to an emergency department. During their hours together, while they waited for a psychiatric admission, the client shared his feelings — hurt, resentment, anger — and Nicholas felt the man's lack of trust in the system. The client left the hospital before he could receive help. In an effort to understand this experience, we began to explore the literature pertaining to stigma.

Nicholas's experience of walking with an inner-city client into a hospital was quite different from how he had been coming to work every day on a hospital unit. The stigmatization that homeless, mentally ill and addicted clients can face in health-care settings was now apparent to him. Given that nurses need to know more about homeless clients in order to meet their unique health-care needs, Nicholas wanted to know why educational opportunities like this one weren't available to more nursing students. Students need such opportunities to help them gain insight; otherwise the potential for inner-city clients to continue to be stigmatized is great.

Nicholas's respect for clients grew as he took part in daily intakes, rode in the Streetworks van and spent a night at a downtown shelter:

As a student nurse, I was out of my institutional (hospital) element, in unfamiliar surroundings, and the homeless/mentally ill/addicted individuals were in an environment that was home to them. Perceptions of having power and control over these individuals dissipated as I began to engage them.

I feel that switching environments was one of the greatest contributors to my personal and professional development — and a key factor in helping me become more aware. I was afforded the chance to get to know, understand and respect just how unique these individuals are and how difficult their everyday life is.

I appreciate the dynamic approach of the nursing role and how nursing care can be delivered at the community level. With the help and guidance of the nursing manager and staff nurses, through interacting directly with the community and by applying a non-judgmental and non-stigmatizing approach, my view has slowly evolved (and continues to evolve); these individuals are unique, dynamic, resilient and highly resourceful. I value their rights and dignity.

Nicholas's time in this setting was clearly a transformative educational experience, and he was proud of his contributions to the agency. For example, he determined that a need existed among clients to have a better understanding of caring for their casts. As an experienced orthopaedic nurse, he developed a practical and easy-to-understand teaching handout geared to the specific needs of homeless clients.

Nicholas saw the profound difference that an accepting attitude from health-care professionals can make. The following entry shows how this attitude led to a completely different outcome than the earlier incident in the emergency department:

A community elder was taken to a nearby emergency department because of a seriously infected knee. This individual was severely intoxicated, had been wearing the same clothes for several days, was unkempt and had soiled himself repeatedly. As we interacted with the triage nurse, she remained professional, courteous and composed. This approach served to promote the elder's compliancy to wait the multiple hours it took to be seen and treated by a

physician. as we left him in his wheelchair awaiting assessment, he assured us he would stay until a physician could see him. As a result, he was admitted and given wound debridement and IV antibiotics to treat his infection over the next two weeks. a simple acknowledgment of this individual's dignity was a huge factor in getting treatment and being far more well than when he was brought in to hospital.

What Nicholas gained from his practicum was deep and meaningful. No doubt the clients he met benefited as well. Given that nurses can be expected to meet homeless, mentally ill and addicted clients in many aspects of their practice, it is critical that we provide opportunities for students to communicate with clients from inner-city agencies. Educators should promote ongoing collaboration between universities and inner-city agencies to ensure these opportunities are available.

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Clinical instruction in mental health nursing: students' perceptions of best practices

Clinical instruction in mental health nursing: students' perceptions of best practices

[PDF - 352 KB]

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Citation

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Abstract

Objectives: Negative clinical educational experiences for student nurses are predictors of negative attitudes and perceptions towards mental health. In clinical education, instructors take on this important role often with little to no formal training. This study explored nursing students' perceptions of instructional best practices in mental health clinical education.

Methods: A qualitative descriptive design was used, and 10 Canadian baccalaureate nursing (BN) students were interviewed. These students had completed a six-week practicum on an acute inpatient psychiatric unit in either their second, third or fourth year of study.

Results: Through thematic analysis, three themes were identified: (1) Students valued feeling prepared at the beginning of the clinical placement. (2) Students felt empowered when instructors encouraged self-direction. (3) Students appreciated positive role modeling by their instructors.

Conclusions: Suggestions for clinical teaching strategies are made to mitigate student stress, increase confidence, and address the influence of mental health stigma on learning.

Keywords: best practices in clinical education; constructivism; mental health nursing instructor; qualitative description.

Introduction

Clinical education in mental health nursing practicums is designed to offer students the opportunity to integrate learned knowledge and skills in an area that is unique amongst other areas of health care. Mental health nursing is seen to be a unique specialty as the skills needed rely heavily on being able to communicate and develop therapeutic relationships with patients (Choi et al., 2016). Baccalaureate nursing (BN) students can feel limited confidence in their communication skills, and they may have prejudicial or stigmatized views of mental illness which can create barriers for effective clinical education (Goh et al., 2021; Janse van Rensburg, 2019; Knaak, Mantler, & Szeto, 2017; Stuhlmiller & Tolchard, 2019). This can be influenced by students experiencing concerns related to the management of agitated patients, fears of saying something wrong, or low mental health literacy (Abraham, Cramer, & Palleschi, 2018). Mental health literacy is defined as the level of knowledge and understanding of mental illness and treatment; decreasing stigma related to mental health problems; and, enhancing help-seeking efficacy (Kutcher, Wei, & Coniglio, 2016). For nurses who instruct students in psychiatric clinical settings, providing students with supportive measures to help reduce stress, increase practice confidence, and address mental illness stigma are essential features for education (Snyder, 2020; Vuckovic, Carlson, & Sunnqvist, 2021).

A current barrier to effective clinical education is the lack of formal training for nurses who instruct BN students in these kinds of psychiatric clinical settings. As outlined by Booth, Emerson, Hackney, and Souter (2016), education and nursing are two different disciplines, and clinical expertise does not naturally result in teaching expertise. Findings arising from existing literature only provide minimal insight toward how nurse instructors who practice in this specialized area can address the concerns that students may bring to their mental health learning experiences. Subsequently, the aim of this study was to address this gap by exploring students' perceptions of best practices for nurses who instruct in mental health clinical settings.

Literature review

For the purpose of the study, a broad search was conducted using three databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL®); MEDLINE/PubMed®; and Academic Search Complete through EBSCO. Broad search terms including *Nursing Clinical Instructors OR Nursing Clinical Facilitator, Nursing Students Perceptions OR Attitudes, and Mental Health Clinical Placement OR Mental Health Clinical Education* were used. These terms were entered separately and in varying combinations to generate the broadest search. Multiple search modes such as, but not limited to, Boolean/Phrase, and applying related words were used. Studies were limited to full text, English language, scholarly (peer reviewed) journals, and published dates of 2014–2021. This search generated 970 title matches. To further narrow the number of articles found, other search terms including *effective education, undergraduate mental health nursing students, and clinical education* were applied, resulting in 90 remaining title matches.

A critical review of the abstracts was completed, and articles were deemed relevant if they discussed concepts regarding nursing students or nursing clinical instructor's perceptions of effective clinical education. Twenty articles were found to meet this inclusion criteria. The results included 12 qualitative studies, four quantitative studies, three studies using mixed methodology and one qualitative integrative review. The research articles included international representation from the

following countries: Canada, Australia, Singapore, South Africa, United Kingdom and the United States. Of the 20 articles only three pertain to mental health clinical education, including one publication from 2010 (Grav, Juul, & Heilzen, 2010; Janse van Rensburg, 2019; Slemon, Jenkins, Bungay, & Brown, 2020; Stuhlmiller & Tolchard, 2019). While the Grav et al., (2010) publication was older than the 2014 inclusion criteria, the article was included due to its strong relevance to the study.

Competency, teaching style, and personality were themes found to accurately identify characteristics of best practices for nurses instructing student nurses. Students favored instructors with expertise in the area of what they taught and preferred nurses who had advanced education on education theory (Collier, 2018; Janse van Rensburg, 2019). Teaching styles vary among instructors, and students found pedagogy effective that was rooted in being adaptive to students and instructors being able to deliver effective feedback (Niederriter, Eyth, & Thoman, 2017; Sweet & Broadbent, 2017). Personality traits seemed to have played the largest role in influencing students' perceptions of whether instructors were perceived as effective educators. The literature reviewed for this study demonstrates that clinical instructors can impact the way students view their mental health clinical experiences (Ismail, Aboushady, & Esw, 2015; Meyer, Nel, & Downing, 2016; Slemon et al., 2020). Nurses who instruct act as role models, and they mentor students while ensuring that the nurses of tomorrow are prepared and capable of delivering the high level of care patients deserve.

This literature review also exposed how mental health clinical placements are a unique setting compared to other areas of nursing. The instructor is seen to have different challenges such as addressing high rates of anxiety among students while challenging prejudicial or stigmatic views towards mental health nursing. Though limited in the research, it seems that effective instructors provide students with a positive learning experience through being advocates for patients, championing therapeutic relationships and modeling empathy (Collier, 2018; Ismail et al., 2015; Meyer et al., 2016; Niederriter et al., 2017; Padagas, 2020; Reising, James, & Morse, 2018; Sadeghi, Oshvandi, & Moradi, 2019; Stuhlmiller & Tolchard, 2019). However, the current state of the literature is limited. A gap remains in the literature which fails to provide an in-depth understanding of the specific teaching strategies that clinical instructors can use to address the specific challenges instructors in Canada experience while facilitating mental health clinical education.

Conceptual framework

A constructivist framework, which holds participants' experiences and perspectives in high regard, was used to guide this study. This framework offers researchers an opportunity to understand the unique ways individuals construct knowledge and meaning from their experiences (Creswell, 2013). Further, the constructivist paradigm is based on a relativist ontology which asserts that there are multiple realities (Adom, Yeboah, & Ankrah, 2016). Reality is not singular, and rather is uniquely understood by the individual who is experiencing it. By sharing their knowledge, the nursing students who participated in this research project provided meaning and guidance on clinical education, both for themselves and others. From a subjective epistemological view, knowledge can be extended when researchers co-create new understanding and reconstruct existing perceptions with studies rich in authenticity and trustworthiness (Adom et al., 2016). In keeping with the axiological beliefs that are fundamental in constructivist thinking, the participants' values were acknowledged, honored, and respected throughout the research activities (Creswell, 2013). This intention produced an informed description, and interpretation of the experience at the point that it existed in the real world for these nursing students.

Methods

Study design and sample

A qualitative descriptive design was implemented, where researchers seek to understand and describe the perspectives of people experiencing the phenomenon under investigation (Bradshaw, Atkinson, & Doody, 2017; Lincoln & Guba, 1985; Sandelowski, 2000, 2010). In qualitative descriptive research, the focus is on recognizing the subjective nature of problems, understanding individual human experiences, contributing to change and quality improvement in the practice setting; and not on increasing theoretical or conceptual understanding (Doyle, McCabe, Keogh, Brady, & McCann, 2020).

The purposeful sampling for this study included current students enrolled in a four-year BN program at one university located in Calgary, Alberta, Canada. To be included in the study, these students must have completed a six-week practicum on an acute inpatient psychiatric unit in either their second, third or fourth year of study. Ten students were recruited with eight female students, and two male students. Eight students were in their third year of education, and two were in their fourth year of education at the time of this study.

Data collection and analysis

Data was collected via transcripts from 10 semi-structured, Zoom videoconference interviews that were approximately 1-h each in length. An interview guide ensured consistency and members of the research team (who instruct in Canadian undergraduate mental health nursing courses) developed the guide around open-ended questions that allowed participants to describe their experiences and perspectives in their own words. Questions were sequenced from broad to narrow and time was allocated for follow up questions based on participants' comments. An example interview question was: *"Tell me about teaching strategies your instructor used that were especially effective."* Ethical approval was granted by the university to conduct the study; participants signed consent forms, and all data was de-identified. Finally, members of the research team did not possess evaluator capacities over any of the study participants.

Thematic analysis was implemented through a three-phase inductive, open coding approach (Alhojailan, 2012). The transcripts were read and re-read at different times over a four-month period. Text relevant to the purpose of the research was highlighted, field notes were incorporated and discussions among the research team were held. Using NVivo 12 (QSR International PTY LTD, 2018), three levels of themes were organized and titled respectively: basic themes (rudimentary micro understandings of the data); organizing themes (two or more basic themes that possess similarities and fit under a broader definition); and global themes (a summary and consolidation of themes previously identified) (Akinyode & Khan, 2018). The resulting themes provide what Alase (2017) refers to as a thick description of *what* participants experienced and the context or *how* they were affected.

Data saturation was reached by the eighth interview, when weekly discussions among the researchers identified that participants' comments had become repetitive and no new information was forthcoming. However, two additional interviews were conducted to ensure data saturation. Faulkner and Trotter (2017) explained that data saturation occurs when researchers believe that further data collection would yield similar results.

Trustworthiness was established using Lincoln and Guba's (1985) criteria of credibility, transferability, dependability, and confirmability. Credibility, or truthfulness of the study was established through member checking, or respondent validation. Participants were provided with their transcripts as well as a summary of the themes. All participants confirmed the accuracy of the transcripts. Although two participants did not reply, eight of the 10 participants confirmed that the themes were accurate and resonated with them. Transferability, or applicability of the study to other contexts was established by providing

rich, thick description. Dependability, or demonstrating that findings can be repeated was established with an audit trail. Confirmability, or degree of neutrality was established through reflexive journaling and weekly research meetings.

Findings

The following three themes represent key findings. First, students valued feeling prepared at the beginning of the clinical placement. Second, students felt empowered when instructors encouraged self-direction. Third, students appreciated positive role modeling by their instructors. See Table 1 for best practices in psychiatric mental health nursing derived from these themes.

Table 1: Best instructional practices in psychiatric mental health nursing clinical education.

Theme	Teaching strategy	Explanation/rational
Preparation of students	– Pre-clinical placement (contact students 7–14 days before clinical) – <i>Provide a brief explanation about the unit, and the roles nurses play in delivering care to patients.</i> – <i>Breakdown of typical day for each shift.</i> – <i>Schedule of the entire clinical placement (assignments, topics of pre/post conferences).</i> – Safety (typically takes place in first week of clinical “orientation”) – <i>Acknowledge typical concerns and invite students to openly discuss what they are worried about.</i> – <i>Offer any available crisis intervention training.</i>	
Self-directed learning	– Maintain appropriate levels of space for students – <i>Avoid ‘hovering’ over students while they are talking to patients (increases feelings of stress and awkwardness)</i> – <i>Implement alternative evaluation to direct supervision. i.e., Review charting and seek feedback from staff and patients.</i> – Regularly check in with students throughout the day to ensure that you are available for any questions and concerns. – Promote collaborative discussions on patient assignments – <i>Let students identify what kind of patient they would like and help facilitate that to the best you can.</i> – Have students identify learning goals for their clinical placement – <i>Learning goals should be specific and follow the objectives outlined in the course syllabus.</i> – <i>The clinical instructor needs to be engaged with this process and provide feedback, when necessary, either informally or formally to ensure goals are met or not met.</i>	
Role modelling	– Demonstrate professional behaviour with respect to organization, positive demeanor, and engaging. – Model communication skills. – <i>Through role playing, demonstrate how to engage with a patient with an emphasis of being less formal (i.e., discuss weather, play cards).</i> – <i>Demonstrate either through role playing or on the unit on how to complete mental status exams (MSE’s) or suicide risk assessments.</i> – <i>Demonstrate through role playing on how to deal with verbal conflict from a patient.</i> – Model a calm disposition while on the unit. – <i>Students take their emotional cues from their clinical instructor therefore, if instructors are calm, the students will be calm.</i>	

Theme one: students’ valued feeling prepared at the beginning of the clinical

placement

Participants identified a spectrum of emotions as they began their mental health clinical rotation. Emotions of fear, stress, anxiety, and excitement were amongst the most cited. There was a consensus amongst the participants that these emotions were fueled by a general lack of knowledge about mental health nursing. This participant highlights their limited knowledge:

I knew that it would really rely on my communication skills and just knowing that like in [medical] nursing where you have to be super technical, check IV placement, do your safety checks. Like they don't have safety checks here. It's more that your safety checks are all through your non-verbal and your verbal communication. (Participant 2)

When asked about their perception of mental health nursing prior to their rotation, participants described having very little understanding of what mental health nursing entailed other than what they had been exposed to through the media, their peers, or personal/familial experiences. The most common concerns expressed focused on personal safety and feeling unprepared or ill-equipped to handle crises such as an aggressive patient. This was seen to be a unique issue exclusive to mental health nursing as all the participants denied having these types of concerns prior to entering previous clinical areas. This is how one participant described their anticipatory anxiety leading up to their rotation:

I think I was pretty nervous going into it. Just because I didn't have like a lot of experience with mental health. (Participant 3)

Participants emphasized how their clinical instructor played an important role in mitigating their anxiety, both before and during their practicum. In particular, best instructional practices that helped students feel prepared at the beginning of clinical were pre-placement contact and addressing safety concerns. These are discussed in the following section.

Pre-placement contact

In this study, pre-placement contact refers to clinical instructors contacting students via email prior to the start of a clinical rotation. The contact typically occurred between seven and 14 days prior to students first day on a unit. Participants noted the content of the email greetings varied. Participants 2, 4, 5, and 7 mentioned how receiving resources to prepare for clinical, such as brief explanations of the unit, commonly used medications, and unit schedules, were helpful.

Participants also described that in addition to a simple greeting, and providing resources, clinical instructors took this opportunity to ask information of the students that they deemed important for the instructor to know. Participants 4, 6, and 9 commented on how the opportunity to privately describe their personality, interests, and importantly, their individual learning styles was valuable to them. They described how the best instructional questioning practices related to uncovering ways they learned in the clinical setting and any challenges they were facing in their personal life that might hinder learning. Participants equated this gesture with feeling supported and assured that the instructor valued their perspectives as well as their mental wellness.

Feeling unprepared was frequently identified as a factor that increased the level of stress and anxiety. For example, one participant described how beneficial it was for them to receive a schedule that outlined what a typical day looked like on the unit as well a schedule of the overall clinical rotation. This participant discussed struggling to conceptualize what a nurse's role was on the mental health unit, which further increased their stress. They explained:

They were like super specific with the details which helped us because some clinical instructors don't say anything like until the last minute, but they were quite like prepared I guess ahead of time. So that really helped the students get organized before meeting as a group. (Participant 9)

Addressing safety concerns

During the first week of any clinical rotation, instructors often take the first day(s) to orientate students and discuss unit and patient information. In psychiatric mental health settings however, this everyday practice must be extended to address safety concerns.

Participants in this study consistently identified that they worried about their personal safety. They viewed the patient population as unpredictable and dangerous. Four participants (3, 6, 7, and 10) admitted that their perception of mentally ill patients as dangerous was influenced by media portrayals of people suffering from acute mental illness as violent. They found that during this orientation phase, their anxieties of personal safety were best mitigated by instructional practices such as facilitating group discussions around safety protocols, inviting students to discuss their potential fears, and having them participate in any available crisis intervention training. Participants preferred a direct approach that was clear and impactful for students to understand. This was evident by this participant's comment:

The thing I valued the most, was to have concrete things to keep in mind, like having an exit. I think certain things need clarity and certain things you can be muddy about. Safety is not a good thing to be muddy with. (Participant 7)

Theme two: students felt empowered when instructors encouraged self-direction

Self-direction was defined by the participants as an approach where the instructor remains somewhat 'hands off' and allowed students to have an increased amount of space and autonomy in their own learning. Six of the participants (1, 2, 5, 7, 8, and 9) described how they found a self-directed approach increased their sense of empowerment.

Having autonomy in their learning was observed to help build confidence in their own abilities and offer a glimpse into what it is like to be a nurse:

I didn't expect to enjoy it as much as I did and then I really did enjoy it. I loved the independence that students got. It felt like I was a real nurse ... that kind of was unexpected. (Participant 4)

Another student commented on how this approach was transformative in affirming their decision to choose nursing as a career:

It also helped me see like what I want to do because I found myself like more self-advocating then I was like subconsciously I was starting to determine like, “Oh wow! Like I actually really love this because I’m putting more effort into it and I actually care about this!” And I didn’t realize that until I started to become more self-advocating for myself versus second and first year. (Participant 2)

Participants explained that despite this seemingly distancing ‘hands-off’ approach, they knew the instructor was available on the unit as they regularly checked in with them throughout the day and were observing “from afar.” In lieu of hovering around students while they were talking with their patients, participants described alternative instructional practices that could be used to evaluate progress. For example, reviewing students’ charting, and seeking feedback from staff and patients. Students conveyed their desire for independence, but they also expected their instructor to be present to assure them that they were not left on their own.

Collaborative goal setting

Participants commented on how they felt especially empowered when instructors engaged them in collaborative goal setting. Students felt that their autonomy was enhanced when their instructors collaborated with them to create individual learning goals that targeted what students themselves wanted to learn about psychiatric disorders, and the areas where they wanted to improve their communication skills. One example of best instructional practice identified was to invite students to select their own patients when possible:

Like I’d say [to the instructor], I couldn’t handle a depression patient, then I would steer towards like more a schizophrenia patient or whichever. I got to set those boundaries and I got to say like, “Yes, I’m still learning. Yes, I’m just taking it at my own pace. I’m not expected to be a nurse right now. I’m just expected to be a student.” Every time we chose a patient, they asked like, “You guys always have the right to let me know when you’re uncomfortable and when you want to switch patients.” They always made that very clear. Like when our boundaries were pushed and when we felt uncomfortable. (Participant 2)

Theme three: students appreciated positive role modeling by their instructors

All 10 participants in this study identified how significant it was for their professional development and education that the clinical instructor be a positive role model throughout the clinical rotation. They noted that characteristics of a positive role model were professionalism, organization, having a positive disposition, and demonstrating an engaging demeanor.

The importance of positive role modelling in clinical education is well known (Jack, Hamshire, & Chambers, 2017; Melrose, Park, & Perry, 2021). However, the nuance of how it is executed is unique in psychiatric clinical areas. Participants were concerned that they could not communicate effectively with patients. Specific issues included discomfort posing assessment questions related to suicide, trauma, and psychosis. For example:

Like I was just kind of worried of like how I might interact with people ... with patients on the mental health unit because I was worried that I wouldn't be able to like to connect with them in the way that I would on regular acute units. (Participant 10)

Another participant described being worried that they would say something wrong and potentially harm the patient.

I think that part [communication] scared me a little bit where it was like I could easily trigger a patient or especially when I'm being just introduced to the patient, I don't know anything about their background. Like obviously I get a brief history, but you don't fully know their triggers and that kind of scared me a little bit, like offsetting a patient just because of my lack of knowledge. (Participant 2)

In response to their concerns, participants described best instructional practices that instructors implemented to mitigate these concerns and strengthen their confidence. They mentioned how effective role-playing with instructors and fellow students was. Role playing gave students a chance to observe their instructor demonstrating expected behaviors and to "test" their own skills in simulated scenarios. Additionally, participants described how valuable it was to observe their instructors interacting with patients. This participant highlighted their appreciation of positive role modeling:

Some of us got to observe how they [instructor] communicated with them [patients] so it kind of helped me with like what I should do ... like prompt me with what I should do when I'm talking to my patients ... I just remember they would be you know, on the same level ... like same eye level as the patient, making sure that you're being ... your body posture is like open and interactive with the patient so you're not looking away but you're looking towards them. You're not crossing your arms. (Participant 10)

This participant also discussed how the clinical instructor would model informal approaches to mental status assessments.

They encouraged me to step out of my comfort zone, but also still be safe with that. Step out of my comfort zone and go communicate and talk to these patients where they're sitting in the common area and just kind of like sit down with them ... like talk to them as like they're your friends I guess and like rather than going there and asking specific questions about like, "How are you feeling today?" (Participant 10)

By modelling effective communication and normalizing a less formal approach in conversing with patients, participants reported feeling less pressured to "say the right thing." In turn, this reduced students' anxiety, increased their feelings of empathy, and gave them needed tools to engage in stronger therapeutic student- patient relationships.

Discussion

Stigma towards mental illness exerts a negative influence on learning (Canadian Association of Schools of Nursing & Canadian Federation of Mental Health Nurses, 2015; İnan, Günüşen, Duman, & Ertem, 2019). Given the inaccurate portrayals of mentally ill individuals in the media, it is not unexpected that many people, including health professionals and students, hold stigmatized views. Research examining the pervasive nature of mental illness-related stigma in healthcare concluded that a lack of understanding of mental illness was a strong predictor for fostering stigmatic views among health care workers and students (Knaak et al., 2017). Many nursing students are unaware of their stigmatized views prior to entering their clinical placement (Choi et al., 2016). Transformations in thinking can only occur when students are supported towards questioning their ideas and embracing a willingness to take on new perspectives (Tsimane & Downing, 2020; Knaak, Karpa, Robinson, & Bradley, 2016). This can be done by addressing mental health literacy, which increased with nurses who cared for patients who had mental illness (İnan et al., 2019; Knaak et al., 2017).

Findings from the present study align with this thinking. Prior to their rotation on an acute psychiatric inpatient unit, students described stigmatized views, fears for their personal safety and limited confidence in their ability to communicate effectively with patients. By preparing students before and during their rotation; using a self-directed approach; and modeling competent nursing care, instructors increased their students' awareness and mental health literacy. Following their rotation, students all agreed that their experiences were positive, their thinking had transformed, and that the stigma they initially felt was misguided. Clearly, best instructional practice in mental health nursing is grounded in addressing stigma.

The etiology of stigma and the process of changing the way people think about mental illness is complex, and it is beyond the scope of this article to fully address the concept. High levels of stress impact mental wellness and make it difficult to embrace new perspectives. Nursing students entering mental health clinical placements are vulnerable to stress and may struggle to cope academically and personally when presented with stressors (Galvin, Suominen, Morgan, O'Connell, & Smith, 2015; Oner Altıok & Ustun, 2013; Registered Nurses Association of Ontario, 2017). High levels of stress create challenges for students as it impacts their confidence, ability to learn, and decision making (Oner Altıok & Ustun, 2013). Emotional distress can worsen and significantly hinder students' educational experiences (Choi et al., 2016).

Best instructional practice must take students' mental wellness into consideration. Students in this study welcomed instructors' efforts to get to know them, and to understand barriers that could impede their learning, including issues affecting their own mental wellness. Comments such as: "What if I say the wrong thing will I be safe?" illustrate potential emotional distress. Experiencing stress in psychiatric clinical settings is not limited to students, mental health nurses are reported to have some of the highest stress among any group of nurses as well (Galvin et al., 2015). Promoting mental wellness and striving to mitigate stress associated with working and learning in this specialized area is not straightforward.

Promoting mental wellness includes balancing instructional support with students' personal control over their learning. In their seminal research examining occupational stress, Johnson and Hall (1988) identified that when individuals have only limited control over job requirements but are in jobs that demand a great deal of them (such as nursing students trying to prepare for and succeed in clinical rotations), they experience significant mental strain. In mitigating this strain, Johnson and Hall (1988) found that the high demand being experienced by students is effectively buffered when both feelings of support and control are also high (Galvin et al., 2015). These results were similar to the present study, as the best practices students described addressed both instructional support and personal control of learning.

Instructional support

When students feel supported by their clinical instructors, they are more likely to have positive and successful learning experiences (Collier, 2018). The present study extends this understanding by articulating specific strategies that instructors can implement to provide needed support in mental health clinical placements. Mental health placements are unique, and

instructors must recognize student concerns related to stigma, stress, limited mental health literacy, and their personal safety in order to support their students.

Supportive teaching strategies, such as instructors contacting students prior to their clinical placement, is a simple but very important first step. The information solicited by this type of contact provides clinical instructors with important insights about their students. It opens the door to better understand who they are as nursing students, what their goals are, how they plan to achieve them, and the kinds of challenges they face in other areas of their lives. In keeping with the constructivist thinking that guided this research, clinical instructors can use this insight to tailor their approach and construct an environment which better meets the individual needs of students. As described by participants in this study, when clinical instructors aim to understand the student experience, such as their mental wellness concerns, the students felt more supported and ultimately had positive educational experiences.

Personal control of learning

A striking finding from this study was how empowered students felt when instructors supported self-direction and provided opportunities for them to feel a sense of personal control over their learning. When instructors remained present and accessible, but still very 'hands-off,' they communicated their confidence in students' abilities. When they invited students to choose their own patients, they conveyed their respect for students' capacity to think critically.

Instructional practices that facilitate personal control of learning are well documented in the nursing education literature (Torbjørnsen, Hessevaagbakke, Grov, & Bjørnnes, 2021). However, limited direction exists for mental health clinical instructors, particularly on acute inpatient units. Findings from this study, which present specific strategies, such as remaining 'hands-off' (when in other clinical areas this strategy may not be advisable) make an important contribution to the field. This study found that in mental health clinical placements, students preferred having more control and independence in their education as it increased their level of performance. In clinical practice on medical units, this approach may be difficult to implement as students require closer supervision in performing skills or interventions such as hanging intravenous medications, as the potential to harm someone is greater. In mental health clinical education, the interventions are mostly communicating with patients and thus are less risky and do not require this level of supervision. Students in this study unequivocally identified this difference between clinical areas and were surprised at how much they enjoyed the independence they received, which positively impacted their view of the overall experience.

Further, students felt a sense of personal control over their learning when instructors worked collaboratively with them to set goals. This strategy created a more harmonious and less hierarchical experience. Participants found that the clinical instructor was less intimidating in this role and they did not feel as though they were being constantly evaluated, which students internalized as being trusted and competent in delivering care.

Limitations

In this small-scale descriptive study, limitations include a modest sample size and data collection from one English speaking institution. Further, implementing a single interview approach with each participant did not allow for repeated or follow-up conversations. Videoconference interviews may have restricted the interviewer's observations of participants' non-verbal communication cues. As instructors in mental health nursing courses, the research team may have inadvertently introduced biased interview guide questions and interpreted data in relation to their own subjective experiences. Possible future research on a larger scale should include multi-site and multi-jurisdictional sampling and research team members. Methodologies that integrate a series of interviews with participants, focus group sessions and survey instruments could build on the foundation established by the present study. Supplemental teaching strategies, such as simulation activities should be investigated further in relation to students' perceptions of best practice in mental health nursing practicums.

Conclusions

The findings of this study indicated that nursing students valued feeling prepared at the beginning of the clinical placement; they felt empowered when instructors encouraged self-direction; and they appreciated positive role modeling by their instructors. The present study extends knowledge and understanding of clinical education in mental health by describing specific and effective strategies clinical instructors can implement into their practice. Additionally, this study demonstrated how mental health stigma and students' mental wellness were unique challenges that played significant roles in how they learned during their clinical placement. Implementing these practices can positively impact students' learning, their mental health literacy, and potentially, the care they provide to patients with mental illness throughout their careers.

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EDUCATION (GRADUATE STUDIES LEARNERS)

Online Graduate Study Health Care Learners' Perceptions of Instructional Immediacy



[PDF – 94 KB]

Citation

Melrose, S., & Bergeron, K. (2006). Online Graduate Study Health Care Learners' Perceptions of Instructional Immediacy. *The International Review of Research in Open and Distributed Learning*, 7(1). <https://doi.org/10.19173/irrodl.v7i1.255>

Abstract

Instructional immediacy is an established communication strategy that teachers can implement to create engaging learning environments. Yet, little is known about experiences distance education learners in graduate study programs have had with immediacy. This article presents findings from a qualitative research project designed to explore healthcare students' ideas about and activities related to instructional immediacy behaviors within a masters program offered exclusively through a WebCT online environment. A constructivist theoretical perspective and an action research approach framed the study. Data sources included two focus groups and 10 individual audio-tape recorded transcribed interviews. Content was analyzed by both the primary researcher and an assistant for themes and confirmed through ongoing member checking with participants. The following three overarching themes were identified and are used to explain and describe significant features of instructional immediacy behaviors that healthcare learners who graduated from either a Master of Nursing or Master of Health Studies distance education

program found valuable: 1) Model engaging and personal ways of connecting; 2) Maintain collegial relationships; and 3) Honor individual learning accomplishments.

Keywords: immediacy; online graduate study; healthcare learners

Introduction

This article describes findings from a qualitative research project that investigated the experiences, reflections, and feelings of online healthcare students during times in their graduate study program where they experienced or would have valued experiencing instructional immediacy. While the main purpose of the project was to explore learners' ideas about instructional immediacy, a secondary purpose was to consider instructional strategies that respond to learner needs. The research was guided by the question: *What specific instructional immediacy strategies do online graduate healthcare learners perceive as helpful in creating a warm environment rich in social presence and sense of community?*

Participants in the study were graduates of either the Master of Nursing (MN) or Master of Health Studies (MHST) programs offered through the Centre for Nursing and Health Studies at Athabasca University – Canada's Open University. While students enrolled in the MN program hold undergraduate degrees in nursing, those in the MHST program come from nursing, physiotherapy, occupational health, dietetics, medicine and other healthcare disciplines. Both male and female students are enrolled in these graduate study programs and are required to have practiced in their field for at least two years. Graduates of the 2005 class were predominantly women and lived all across Canada as well as in a variety of other countries.

Course work in the MN and MHST programs is completed exclusively online using a WebCT course management system, therefore convocation ceremonies at the university campus were the first opportunity for students in these programs to meet their classmates and instructors. Data for the present research was gathered during these ceremonies.

The primary medium for communication, instruction and assessment within the MN and MHST programs is asynchronous text-based threaded discussions within a WebCT environment. In most courses, cohorts of approximately 20 students led by one instructor progress through a study guide identifying a series of readings, discussion questions, and learning activities during a 14 week time frame.

Literature Review

A literature review revealed that educators have consistently recognized the link between teachers who demonstrate warm friendly behaviors and the creation of welcoming interactive learning environments. One valuable instructional communication strategy that facilitates a sense of community and fosters a learning climate rich in social presence is immediacy. Considerable research has been undertaken to investigate instructional immediacy behaviors and their effect on students in a variety of different learning events. There is a "gap," however, in our understanding of how online graduate healthcare learners perceive instructional immediacy within their learning experiences.

The Construct of Immediacy

Immediacy is defined as an affective expression of emotional attachment or closeness to another person and was originally developed by social psychologist Albert Mehrabian in the 1960s (Mehrabian, 1967; 1971; Wiener and Mehrabian, 1968). The construct of immediacy is founded on the premise that individuals are drawn toward persons and things they like, evaluate highly and prefer. Expressions of immediacy include both verbal and non verbal behavioral cues. A “we” or “our” statement communicates immediacy while a “you” or “your” statement does not. Subtle variations in language indicate different degrees of separation or non-identity of speakers from the object of their communication.

Immediacy in Higher Education

Educational research examining the process of adapting the construct of immediacy from communication theory to applications in higher education classroom environments has proliferated over the past few decades. Building on Mehrabian's work, Andersen (1979) introduced the concept of instructor nonverbal immediacy in the college classroom. Andersen explained that immediacy is a nonverbal manifestation of high affect and is demonstrated through maintaining eye contact, leaning closer, touching, smiling, maintaining a relaxed body posture, and attending to voice inflection. Furthering our understanding of the verbal component of the construct, Gorham (1988) identified that using personal examples, engaging in humor, asking questions, initiating conversations with students, addressing students by name, praising student work, and encouraging student expression of opinions are also all examples of instructional immediacy. Links between teacher immediacy, student motivation and affective learning have been examined (Christophel, 1990; Christophel and Gorham, 1995).

In online classroom environments, despite limited or absent non verbal visual cues, knowledge of instructional immediacy continues to develop. In a meta-analysis of 35 studies examining the relationship between teacher immediacy and cognitive learning, Hess and Smythe (2001) asserted that while most research offers only moderate correlations between immediacy and cognitive learning, the experience of liking and feeling close to the instructor led to positive effects in the classroom. Baker (2004) later further affirmed the correlation between immediacy and affective learning. Russo and Benson (2005) determined that perceptions of the instructor's presence were significantly correlated with both affective learning and with student learning satisfaction, an outcome in an online class that is consistent with findings on teacher immediacy literature in traditional classes. These findings all underscore the role of the teacher in establishing an engaging learning environment.

Arbaugh (2001) concluded that instructor immediacy behaviors were significantly associated with student learning and satisfaction in Web-based Masters of Business Administration (MBA) courses. He suggested that teachers who readily used verbally immediate behaviors in face-to-face classrooms could translate the strategies to an online format. In group discussions, he emphasized the importance of instructor's use of personal examples, humor, openness, and encouragement of student ideas. In individual discussion, he emphasized the importance of prompt responses and addressing students by name. Hutchins (2003) posited that instructor success with immediacy behaviors could advance the current theoretical framework for enhancing instructional effectiveness in distance education. Woods and Baker (2004) suggested that instructors can positively affect the quality of communication in the online environment when they move from mere interaction to authentic immediacy and interpersonal closeness.

Immediacy, Social Presence, and a Sense of Community

Instructional immediacy impacts social presence, which in turn, can strengthen the sense of community within learning experiences. Social psychologists Short, Williams and Christie (1976) defined social presence as the degree of salience within interpersonal relationships in mediated communication. Salience implies feelings of presence, engagement, affection, inclusion, and involvement. In essence, social presence is the degree to which a person is perceived as a “real person” in

mediated communication. Short and colleagues measured social presence with a series of bipolar scales, sociable-unsociable, personal-impersonal, sensitive-insensitive, and warm-cold. A higher level of presence in a medium confers the attributes of being more sociable, more personal, more sensitive, and warmer.

Scholars in online education have investigated social presence extensively and it is beyond the scope of this article to elaborate on this comprehensive body of work. However, given the established associations among instructional immediacy, social presence and sense of community, a brief snapshot of seminal studies are identified. Within these associations, it is critical to distinguish that, from a constructivist framework, while teachers are responsible for the instructional immediacy behaviors that can set the stage for affective communication, both teachers and learners are responsible for behaviors that contribute to social presence and a sense of community.

According to Gunawardena (1995), immediacy increases social presence and thus enhances the degree to which a person is perceived as 'real'. Rourke, Anderson, Garrison, and Archer (2001) defined social presence as the ability of learners to project themselves socially and affectively into a community of inquiry. Social presence has been found to be related to students' perceived learning and satisfaction (Gunawardena and Zittte, 1997; Richardson and Swan, 2003), persistence with their courses (Rovai, 2002), more complex discussion postings (Polhemus, Shih and Swan, 2001) and a significant factor in improving instructional effectiveness (Tu, 2002).

The complexities of establishing a sense of community among online learners has also been studied extensively. Social presence, with its underpinnings of immediacy, is considered a key element in establishing strong communities of inquiring and connected learners. Anderson (2004), referring to Garrison Anderson, and Archer's (2000) community of inquiry model, explained that social presence relates to the establishment of a supportive environment "such that students feel the necessary degree of comfort and safety to express their ideas in a collaborative context. The absence of social presence leads to an inability to express disagreements, share viewpoints, explore differences, and accept support and confirmation from peers and teacher" (p.274).

Current research has begun to explore the role of networked based learning tools designed to support interaction and social presence. Anderson (2005) discussed how these tools, known as educational social software (ESS), may be able to resolve students' conflicts between the freedom to pace their own learning and yet still work cooperatively with other students. Newer educational ESS tools are cost effective and offer students opportunities to connect with one another beyond the traditional methods of email and conferencing. In designing these tools, Anderson (2005) noted the importance of including mechanisms for students to make their presence online known, to notify them that new content or communication has been entered in to a learning space, to have systems that filter out illegitimate information, to refer them to activities where others are engaged, to model profiles that reflect individual learners, to facilitate introducing learners to one another, to promote helping others and to document and share constructed objects. At Athabasca University, Anderson (2005) has initiated research examining one social software tool set, the ELGG open source software.

Finally, Woods and Ebersole (2003) asserted that strong connections exist between a positive social dynamic and learning, but that creating that dynamic doesn't 'just happen,' rather, it must be intentionally created through a variety of communication cues. Likewise Aragon (2003) urged educators not to take social presence for granted and ensure that strategies promoting relationship development are built in to online course design and instruction.

Health Care Learners Valuing of Closeness

Although the constructs of instructional immediacy and social presence may not be identified specifically in research examining healthcare learners' experiences with online courses, a scan of current studies does suggest that a feeling of closeness and community is desired and valued. In their seminal work benchmarking best practices in Web-based nursing courses, Billings, Connors and Skiba (2001) identified an expectation that connectedness, where students and faculty form an online learning community that overcomes isolation, is present. Further, in her overview of best practices in online clinical

content courses, Herie (2004) emphasized the crucial importance of establishing a climate of psychological safety where learners feel supported by their instructor and peers. Diekelmann and Mendias (2005) discussed the importance of teachers being a supportive presence in online courses by knowing and connecting with students through writing.

In continuing education, an exploration of Canadian nurses' experiences with Web-based learning through surveys and focus group interviews noted nurses' appreciation of interactions with one another and their teachers in the forum and found these connections "sustained them" (Atack and Rankin, 2002, p. 20).

In undergraduate education, a comparative analysis of different instructional communications methods online found significant group differences in satisfaction when carefully planned communication strategies were implemented (Frith and Kee, 2003). Also, in their work with second degree students comparing web-based and traditional course delivery methods, Kearns, Shoaf and Summey (2004) identified that students in the traditional course were more satisfied. A key contributor to students' dissatisfaction with their online course was the untimeliness of instructor feedback. These students "... expressed a strong sense of uncertainty about progressing with remaining coursework due to feedback delays" (Kearns, Shoaf and Summey, 2004, p.283).

In graduate education, a pre-test/ post-test survey of perceptions and preferences highlighted specific needs for adequate socialization and instructional support (Wills and Stommel, 2002). Similarly, in doctoral education, case study reports illustrated how helpful teachers' welcoming practices such as sending personal email were in reducing anxiety (Diekelmann and Gunn, 2004).

The Research Approach

This project was framed from a constructivist theoretical perspective (Appleton and King, 2002; Peters, 2000) and a naturalistic action research design (Altrichter, Posch and Somekh, 1998; Corey, 1949; Kemmis and McTaggart, 1990; Stringer and Genat, 2004). Data sources included two focus groups and ten audio tape-recorded transcribed interviews with graduates who attended Convocation ceremonies at Athabasca University campus. Content from these data sources were analyzed by both the primary researcher and an assistant. The transcripts were thoroughly read and re-read and a systematic process of content analysis was developed (Loiselle et al., 2004) to create the categorization and coding scheme that led to the themes. Pseudonyms were used when participants' comments are reported verbatim. Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity. Full ethical approval was granted by the university.

Naturalistic Action Research

Action research is a reflective, spiral process where teachers use research techniques to examine their own educational practice carefully, systematically and with the intention of applying their findings directly to their own and other educators' every day practice. Kemmis and McTaggart (1988) offered the seminal explanation that action research is deliberate, solution-oriented investigation that is group or personally owned and conducted. It is characterized by spiraling cycles of problem identification, systematic data collection, reflection, analysis, data-driven action taken, and, finally, problem redefinition. The linking of the terms "action" and "research" highlights the essential features of this method: trying out ideas in practice as a means of increasing knowledge about or improving curriculum, teaching, and learning (Kemmis and McTaggart, 1988). Kemmis and McTaggart (1990) also suggested that the participatory nature of action research, where researchers collaborate with participants in order to understand and improve educational events, can reduce the distance between researchers and participants and the "... problems they intend to solve, or the lived experience they intend to interpret" (p. 28).

Naturalistic research reflects a qualitative approach. As Ferrance (2000) explained: “The idea of using research in a ‘natural’ setting to change the way that the researcher interacts with that setting can be traced back to Kurt Lewin, a social psychologist and educator whose work on action research was developed throughout the 1940s in the United States. “Lewin is credited with coining the term ‘action research’ to describe work that did not separate the investigation from the action needed to solve the problem ” (as cited in McFarland and Stansell, 1993, p. 14) . . . ” (p. 7)

In the 1940s and 1950s, at Teachers College at Columbia University, Steven Corey (1949) was one of the first to advocate action research approaches in the field of education. In Corey’s view, action research was different from the existing quantitative paradigm focusing on findings that could be generalized to “. . . uniformities, explanatory principles or scientific laws” (p. 63). Rather, Corey stated “The action researcher is interested in the improvement of the educational practices in which he [sic] is engaging. He undertakes research in order to find out how to do his job better – action research means research that affects actions” (p. 63). In his view, action research was valued more for the change it can initiate in everyday practice than for a quantitative goal of generalizing the findings to a broader audience.

In their text *Teachers Investigate Their Work: An Introduction to the Methods of Action Research*, Altrichter, Posch and Somekh (1998) identified that interviewing students is an effective method of data collection and that developing categories and coding data is an effective method of data analysis within an action research approach. In healthcare, Stringer and Genat (2004) call for health professionals to engage in action research to “. . . seek practical solutions to problems in particular contexts . . . to engage participants in inquiry and enable the most effective use of knowledge available” (p. iv).

The following three themes emerged from analyzing the interview and focus group data collected from and confirmed with students who successfully completed their graduate studies online. The themes represent students’ perceptions of key areas of instructional behaviors that demonstrate immediacy online. The first theme was to model engaging and personal ways of connecting. The second theme was to maintain collegial relationships. The third theme was to honor individual learning accomplishments.

Theme One: Model Engaging and Personal Ways of Connecting

Without exception, participants in this project all commented on how instructor communication that was appropriately personal in nature demonstrated immediacy and engaged them. When teachers introduced themselves at the beginning of a course by mentioning their family life as well as their work life, participants discussed how this modeled a meaningful way of relating within the course.

It is not unexpected that learners who have actively practiced in a healthcare discipline and who may demonstrate strong immediacy themselves would value having the skill modeled in an online setting. In traditional healthcare learning events, facilitators who begin classes by reaching out to participants individually, who share aspects of their own experiences and who use words that project gentle encouragement are well received.

Despite an absence of non verbal immediacy cues, similarities exist when adapting this established process of engagement to online classrooms. At the beginning of the course, an instructional strategy such as sending a private email welcoming each participant can communicate interest in learners as individuals. As Marg explained: “I had this wonderfully warm email introduction . . . before the course even started . . . [from an instructor who] just made me feel that she knew who I was and that she was looking forward to having me as part of her course. She gave a little synopsis of the course in a friendly and informal way, which made me have a sense that I would really enjoy the course. It was so welcoming – you just felt as if you really belonged.”

Similarly, Lana described her response to a private email she received: [The instructor said] “Welcome Lana, nice to have you from Toronto, you bring a lot to us because of your focus and where you work.” Small thing . . . but [the instructor] recognized and read [my introduction]. Just a general ‘welcome to the class’ isn’t nearly as personal.”

From the students’ perspective, a key indication of immediacy was communicated in an instructor’s first introductory posting.

In Carol's words: "As a teacher, I would suggest that you talk about yourself, a little about the human aspects of you as a person . . . it just makes it more personable than artificial." Linda added: "The teachers that took time to introduce themselves and talk about their interests . . . 'I have a dog,' 'I live here' and established humanness really made a difference. And Claire continued: "The instructors I felt comfortable with set the stage [in their introductions] about who they were. That was very important to me to have a sense of who they were, their family, where they graduated from, what their work experience was, what their day was like, that sort of thing."

Further, including pictures in an introductory message was particularly important. Ella commented: "My first instructor posted a picture of herself, which I appreciated. This was actually a real person at the end of the line, somebody we could really connect with." Bonnie noted how the inclusion of pictures could be further personalized: "One of the instructors did a profile of everybody. [She collected] pictures and information about everyone in the class and gave us a document."

Addressing students by name communicated genuine interest. Rainu, whose first language was not English, stated: "For people like me, not from Canada, I was glad when instructors attempted to learn my name and use it." English speaking students concurred that seeing their names written out personalized communication as well.

Enhancing more formal course content messages with inspirational or humorous sayings also modeled immediacy and strengthened social presence. Karen observed: "One example of how an instructor showed caring . . . she gave a lot of herself in the course . . . was an idea about how you might reach out to others with an 'appreciagram'. She made a little email card with a picture patting someone on the back that says 'I appreciate.' Her name was on the bottom and then she wrote feedback to me on it. I developed one for my work and started using it. I asked my staff to put these cards at each of their sites and they can do the same thing." Similarly, participants in the focus groups discussed how postings that included poems, metaphors and tasteful humor helped create a safe welcoming environment where they felt willing to take risks.

Theme Two: Maintain Collegial Relationships

A striking feature of the present project was the value learners placed on language that reflected immediacy. Examples of instructors' words that stood out for participants included invitations to join, to journey with, to learn together, to enjoy, to care and to appreciate. Responses that were valued included: this is a thoughtful, helpful or useful comment; it ties in with . . . , how you feel about . . . and thank you for sharing. And, rather than noting what students "should" have done, guiding questions such as have you thought of . . . , might you consider . . . or how could you explore . . . were appreciated.

Prompt responses clearly contributed to students' perceptions that their instructors were present, accessible and immediate. Emily explained: "Getting emails answered promptly from the professors, that was wonderful. . . . Having confirmation that papers I submitted were received right away. Knowing where the instructors were, if they were out of town at a conference and couldn't get back to you right away, that promoted collegiality, I could respect their time." Kristin added: "I felt like I wasn't just a student at a computer. My instructors were always there. They allowed you to ask questions, no matter how silly they sounded. The more you could question the more connected you felt. With the best professors, you felt heard and that it mattered to them that you were there and that what you were contributing was useful."

By contrast, delayed responses and limited postings communicated disinterest. John clarified: "There were some instructors who were quite invisible. You didn't see them. Some of them said that right at the beginning that this was their style and that they would stand back unless they were asked questions. That behavior, right away, I felt they were not interested or they could not be bothered."

Encouraging social conversations in 'coffee room' forums rather than in course content areas stimulated social presence. Time and again, the adult learners in the present research expressed difficulty balancing the volume of reading required in graduate courses with their home and work demands. While the support from classmates for life events such as family births or deaths, achievements and challenges were all welcome conversations, being able to distinguish between academic and social messages was useful.

Maintaining teacher-student communication through private email further strengthened collegiality. Instructors who ‘checked in’ with students individually projected immediacy. Lynn’s reflections described one instructional strategy that stood out for her. “The one thing I remember about the course wasn’t the content of the material; it was the instructor saying ‘tell me what you do to keep yourself healthy – what is your wellness plan?’ So, an interest in me outside of my academia and wanting to actually make me a better person really stuck in my head.” Other participants spoke about feeling connected with instructors who asked them: “So, how are you? Are you doing OK? Is the course too overwhelming? I’m feeling that you are struggling here?”

Theme Three: Honor Individual Learning Accomplishments

Private emails that acknowledged strengths and offered constructive feedback on student work inspired social presence. While public acknowledgement of accomplishments was discussed in the research interviews, several participants commented that: “If you don’t get mentioned – you think what’s wrong with my work?” Students’ clear appreciation of detailed feedback is reflected in comments such as: “A lot of us can take the negative feedback, but if it is not constructive – how is it going to help us?” . . . “The teachers who gave you feedback instead of just a mark. . . ” The ones who would do ‘track changes’ on your assignments . . . ” “When they directed you and said you did this well and this is where you can improve. . . ” “When someone takes the time to really explain how you can do something better, to me – that’s caring!”

Responding to individual learning concerns and offering different perspectives also communicated immediacy. In response to Betty’s “. . . thinking I should be making 90% or above at least in all my courses,” her advisor helped her “focus, get back on track and remember that this is education and learning – not just achieving high marks.”

Similarly, responding by offering resources specific to individual student projects fostered immediacy. Mai-Ling valued: “When an instructor would say – ‘I’ve read an article about that in such and such a spot, you might acknowledge it’ or ‘have you heard of this book’ – sharing resources like that lent a good feeling.”

Adapting course requirements when life crisis’s emerged for students was also perceived as instructional immediacy. During discussions of instances when they were granted extensions to attend to family or work situations, participants frequently mentioned how instructors “understood” their personal needs during these difficult times.

Discussion

The aforementioned three themes, developed from discussions with students who successfully completed their graduate degrees exclusively through a WebCT online course management system, begin to illustrate the kinds of instructional immediacy behaviors that this group of learners’ value. Listening attentively as students discussed their experiences and memories revealed useful ways of looking at how to create possibilities for learning environments rich in immediacy and social presence.

Specific instructional strategies that were important to students included modeling engaging and personal ways of connecting, maintaining collegial relationships and honoring individual learning accomplishments. These findings are consistent with Arbaugh’s (2001) work with MBA students. They provide support to Woods and Baker’s (2004) call to create more opportunities for authentic immediacy within online instruction. And, the idea of intentionally using verbal cues to project warmth, sensitivity and sociability is not significantly different from the ideas about immediacy first identified by Albert Mehrabian in the 1960s.

However, some of the strategies that stood out for this group of professional graduate level learners are unique. Posting self-introductions that include pictures and personal information about home and work, particularly at the beginning of the

learning event, can be expected to communicate immediacy. Creating a document with biographical information about all members of the class can be helpful in developing a sense of community within the class group. Initiating private emails to learners can express personal interest. Responding promptly can indicate that an instructor is consistently present and available. Including affective learning elements such as poems, metaphors and tasteful humor in forum postings can strengthen social presence. Ensuring that social conversations, while enjoyable, do not dominate or distract can project respect for learners' limited time. As well, writing individuals' names, choosing words with gentle connotations and responding empathically to students' expressions of their individual needs can be well received. Therefore, instructors who risk implementing these kinds of online teaching approaches may be perceived as likeable and friendly.

The present investigation suggests expanding our ideas about facilitating learning with online graduate learners to include acknowledging the importance of establishing personal and collegial connections among students and teachers. In turn, this acknowledgment can guide us toward a deeper understanding of how best to model and respond with immediacy and to encourage meaningful social presence within online learning environments. Knowing how much online graduate learners value immediate instructors leads us to look for ways to demonstrate warm and inviting behaviors in our virtual classrooms. Affirmations of the value of instructors' willingness to share their personal experiences, to remain involved in discussions and to honor each student in unique ways inspires us to pay careful attention to these activities.

Conclusion

This article presented findings from a naturalistic action research study that explored online graduate students' perceptions of specific instructional immediacy strategies that helped create a warm environment rich in social presence and a sense of community within a WebCT course management system. In contrast to other studies that explored the construct of immediacy, this project extends existing understanding of instructional immediacy by describing professional healthcare workers' reflections on their own experiences during their masters program by identifying three overarching themes. This research found that learners especially valued instructors who modeled engaging and personal ways of connecting, who maintained collegial relationships and who honored individual learning accomplishments. The article calls for the creation of more opportunities to understand how students themselves perceive immediacy and social presence and for continued attention to constructing teaching strategies that respond to and collaborate with students in innovative and genuinely friendly ways.

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Research Ethics Review Processes: Potential Teaching Tools for Health Professions Students



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Citation

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Abstract

This article highlights how research ethics review processes have the potential to be used as teaching tools. Health professions students at the graduate level often conduct research involving human participants as part of their program requirements. Applying for approval from a reviewing committee may be one of their first experiences implementing a research project. Beyond their ethics application, novice researchers require additional support as they encounter the challenges of incorporating research ethics principles into practice. We argue that such support can, and should, be provided through Research Ethics Board activities such as participating in classroom teaching, providing support to research supervisors and remaining available to applicants throughout their research projects.

Keywords

Research ethics boards; Ethics review processes; Health professions graduate students

Introduction

Health professions students often conduct research involving human participants as part of their graduate program requirements. One of their first experiences implementing a research project is to submit an application for ethical review to an academic committee. The committees are most commonly referred to as Research Ethics Boards (REB's), but they may also be known as Institutional Review Boards (IRB's) or Research Ethics Committees (REC's).

As established by the 1964 *World Medical Association Declaration of Helsinki*, the primary role of an REB is to assess whether research protocols provide participants with sufficient knowledge to make an informed and voluntary consent; to safeguard participants' privacy and confidentiality; and to assess risks and benefits [1]. Once an application has been reviewed, REBs have the authority to approve projects, request revisions, reject proposed projects and terminate ongoing projects [2]. REB membership is usually multidisciplinary and decisions are generally communicated to applicants through formal memorandums.

Most REB's are governed by jurisdictional regulations. For example, in the United States, the *Federal Policy for the Protection of Human Subjects*, known as the 'Common Rule,' drawn from the Code of Federal Regulations Title 45: Public Welfare, part 46 (45 CFR 46) provides oversight to REB's [3]. Governance in the United Kingdom is provided by the *Health Research Authority* [4]; in Australia, by the *National Statement on Ethical Conduct in Human Research* [5]; and in Canada by a second iteration of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* [6].

In the health professions, researchers may require ethical approval from clinical sites as well as from community and academic REB's before they can begin projects. These institutions can all have different reviewing guidelines. Understanding the required processes can seem complex to novice researchers. Even experienced researchers have identified that "getting through ethics" can feel like "jumping through hoops" [7]. A recent study in the United States revealed that one-third of researchers investigating innovative clinical therapies felt that the "cumbersome" ethical review processes they experienced actually limited their innovations [8].

For graduate students, the complex processes involved in the ethical review of their projects is significant for their learning and has lasting impressions on those who strive for careers as researchers [9,10]. The authors, as chairpersons of Canadian university and community REBs, believe that many of the reviewing processes REBs implement have the potential to be used as teaching tools. Beyond their duty to protect research study participants and to follow jurisdictional governance requirements, REBs are in a unique position to provide student researchers with needed education.

The purpose of this article is to identify commonly implemented research ethics review processes and highlight how these processes have the potential to be used as teaching tools. Drawing from our experiences leading and participating on academic and community REB's, we suggest innovative ideas that other reviewing committees may find useful. We invite REB members to participate in classroom teaching, to support research supervisors and to remain available to applicants throughout their projects. We call for members of REBs to go beyond reviewing and granting ethical approval, and consider possibilities for expanding the role of REBs to include intentionally offering relevant support to student researchers.

Participate in Classroom Teaching

One underutilized teaching tool that REBs can readily implement is to participate in classroom teaching at institutions they are affiliated with to address research ethics content that students require. REB's routinely engage in discussions that link ethical principles to applications submitted by researchers. During deliberations on whether applications should be approved, revised or rejected, committee members provide rationale for their decisions. In essence, the discussions bring theory to life. As a teaching tool,

exemplars from these REB deliberations provide real-world examples of translating ethical theory into practice that could be shared in the classroom setting.

Work on reviewing committees is time-consuming and the practitioners and academics involved may be reluctant to take on additional teaching responsibilities. However, knowing where curriculum planners have positioned ethics content can help REB members find time-limited opportunities to participate in and to enhance classroom teaching. Most health professions programs strive to integrate content related to research ethics into their curriculum. In many programs, designated courses specifically addressing ethical issues are offered [11,12]. Information is often presented through didactic lectures, written assignments, group discussions, guest lectures, movies and videos, case study analysis, and peer presentations [13,16]. Simulations, role-play and vignettes have also been used to help students contextualize different sides of research ethics, particularly aspects that are usually invisible to research participants [15,16].

Opportunities to contribute to these existing instructional activities may be available. For example, REB members can participate as guest lecturers or guest speakers in face-to-face and online classrooms, making recordings of the sessions available to those unable to attend. Insights from REB meeting deliberations can be included in any case studies and role-plays currently in use as well as those in development. Similarly, course designers may value integrating REB members' experiences into self-directed learning modules for students to complete independently. When REB members seize opportunities to become involved in classrooms, to actively collaborate with educators, and to share the knowledge they have gained from their deliberations, they contribute to student success. In particular, this success is likely to be observed in stronger proposal submissions from students and perhaps from those who supervise and educate them as well.

In some instances, existing research ethics content in health professions programs can be limited. For example, students may not fully understand the theories and principles that guide ethical research practice [17,18]. Specific content topics that students view as important include research misconduct, authorship and publications, peer review, protection of human subjects, and accuracy of data management [19]. Students also identified a need for more instruction on the ethical dissemination of research findings, particularly fraud, plagiarism and undeserved authorship [20].

Many of these topics are likely to emerge during REB discussions. When REB members share different points of view that emerged during deliberations they have engaged in, they provide students and their educators with new perspectives that may not otherwise be available to them. REB members can identify what a strong research proposal should look like and they can comment on common pitfalls and elements that can easily be missed. In turn, these new ideas and practical suggestions help students gain a deeper understanding of how theoretical knowledge can guide their projects and enable them to build ethical integrity into their research.

Support Research Supervisors

Providing support to the academic and field supervisors who mentor students throughout their research projects is another potential teaching tool REB members can implement. It is common practice for REBs to include feedback with decisions rendered, particularly in situations where a proposal has been rejected or is in need of revision. In our experience, only one or two submissions per year out of 100 are approved on first submission. Likewise, approximately one or two are deferred each year for major modifications or a re-write of the proposal. The majority of submissions, >90%, receive feedback and provisos for modifications and applicants are required to re-submit with revisions before they are approved.

If students can access aspects of this feedback from their supervisors prior to submitting their proposals, the experience would be construed as more collaborative. Students could first submit their application to the supervisor who might then collaborate with the REB in some fashion if s/he is unsure about aspects of the student's application. Certainly collaborative conversations after the decision has been rendered should occur. In a study exploring graduate students' perceptions of research ethics, participants identified that they wanted the option to submit their proposal for an ethical pre-review with opportunity to make any suggested revisions, before the application was assigned for formal REB review [21].

While it is not feasible to expect REB members to respond directly to all student inquiries about projects they are working on, it may be possible for one or more designated members of the REB to communicate with research supervisors. This adaptation of an existing REB practice shifts the focus more towards an educational approach rather than solely an evaluative function. When supervisors and students view the ethical review application process as a positive, mutual process of exchanging knowledge, students are able to strengthen their research designs [22]. Further, when stronger applications are submitted, REBs will spend less time and resources reviewing incomplete work and students will experience less frustration with the process.

In addition to providing opportunities for supervisors to discuss questions directly with a REB member, indirect strategies for making information available can also be useful. REBs can develop and update websites housing a plethora of information documents and templates. For example, frequently asked questions; guidance notes on ethical issues that researchers commonly encounter; highlights of jurisdictional requirements applicants may not be familiar with; exemplars of stellar ethics applications; and consent form templates are all very useful to novice researchers.

Further, requirements for data management including access, linkage, storage, security, retention and destruction should be specified. Recorded

sessions on relevant research ethics topics can be posted for access by researchers at any time. Educational sessions benefit both students and educators [23] and the online resources developed by one REB may be of interest to researchers external to the institution as well. For example, in Canada, the Athabasca University website is informative

<http://research.athabasca.ca/ethics/>. Also, community REB's affiliated with healthcare based organizations in Canada also have website resources available for their researchers, such as <https://www.interiorhealth.ca/AboutUs/ResearchandEthics/Pages/default.aspx>.

Opportunities for supervisors to increase their own knowledge by seeking advice from REB members and accessing information provided online can enhance their ability to mentor students. The relationship that graduate students have with their supervisors affects their learning and perceptions of ethical research practice. Students' self-confidence is developed through research experiences and positive mentoring [24]. Supervisors can reduce the complexity and frustration of the ethics review process for students by sharing their own experiences and by competently pre-reviewing the ethics application with them in detail [25,26]. Knowledge translation and socialization into the research community is bolstered when supervisors are able to provide credible instruction and practical guidance to students [27].

The importance of establishing 'safe spaces' in situations where ethical issues are discussed and research plans are reviewed should not be underestimated [28]. Students in health professions programs are often invested in earning high marks, providing 'correct' or 'right' answers and succeeding. And yet, ethical issues in research are seldom simply black or white, right or wrong. Research, particularly in health related disciplines, is complex with a myriad of factors to consider and students need to know how to rationalize options and understand which decision is best and why. When supervisors feel a sense of trust and openness with their REBs, they are better equipped to create the 'safe spaces' their students need to become ethically responsible researchers.

Remain Available to Applicants throughout Their Projects

A further ethics review process that can be used as a teaching tool is for REBs to remain available to applicants throughout their research projects. Students may view the experience of submitting a proposal to a review committee as one that ends once permission for the research to proceed has been granted. Regulations in some jurisdictions may require researchers to submit mid-point and final reports updating the committee. However, ongoing communication between REBs and researchers is not usually expected.

Continued REB involvement with all research projects reviewed is clearly an unrealistic goal. Yet, for some researchers, especially students who have little or no experience completing a research study from conceptualization through to

dissemination, perplexing ethical questions may come up long after their proposal has been approved. Supervisors, mentors and colleagues can be of some help, but their knowledge of ethical principles may not be as robust as members of REBs. In these cases, when students and their supervisors need additional and likely unexpected support, it can be reassuring to know that they can reach out to their REB for guidance.

In order for students and their supervisors to feel comfortable disclosing concerns and discussing issues, some of which could involve negative incidents, a view of REB processes as supportive rather than punitive is important. Perceptions of REBs as punitive can intensify when members, however inadvertently, communicate ‘mission creep.’ ‘Mission creep’ occurs when REBs require applicants to re-submit their applications and include additional details related to harms that are imagined, minor or highly unlikely [29-31]. On the other hand, when REBs consistently communicate a genuine interest in strengthening the ethical integrity of students’ proposals, they are perceived as more approachable.

Approachability and a willingness to remain available to applicants throughout their projects can be projected both explicitly and implicitly. Using websites to provide specific contact information for REB members designated to respond to inquiries indicates an intention to help. On a subtler level, applicants may be sensitive to indicators such as response times and the depth of responses. In his seminal book *The Ethics Police? The Struggle to Make Human Research Safe*, Robert Klitzman urges REBs to pay careful attention to “the quality, contents and tone of memos and communication” [32]. When students and their supervisors believe that the initial review of their proposal was a positive experience, they will be more inclined to seek additional help from their REB once the project is underway.

Finally, REBs can communicate an openness to remain available, if and when they might be needed, by projecting transparency. Suggestions for doing so include making meeting minutes publicly available [32]; ensuring that at least one public representative is present at meetings [33]; and including students as members of REBs [34]. Some researchers have recommended that REB deliberations, which are usually conducted in-camera, should be opened to allow applicants to ask questions and seek clarification during the sessions [7]. More informally, REBs can contribute to continuing education activities that faculty, practitioners and researchers attend.

Conclusion

Historically, REB’s in many institutions have been perceived (whether or not the perception is warranted) as an adversary whose role is to challenge rather than support research. Efforts to demonstrate a desire to be collaborative, approachable and collegial with researchers may be a good strategy for REBs to utilize in trying to change this perception.

REBs need to go beyond reviewing and granting ethical approval of student research projects and provide more support and education on research ethics principles for novice researchers. Respecting that REBs are often under resourced and with jurisdiction limited to the institution they represent, they still have an opportunity to impact students’ knowledge related to research ethics for those who submit ethics applications to their committee. They can also supplement education provided by academic and health care institutions, and champion a culture where the core concepts of ethical research are imbedded throughout the research life cycle and not just part of an initial application for approval to proceed.

REB’s are charged with a great responsibility but also tremendous opportunities. Expanding their roles to participate in classroom activities, support research supervisors and remain available to applicants throughout their projects will create environments that foster increased confidence in the ethical conduct of research and ultimately, greater protection of human participants.

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Skills for succeeding in online graduate studies



[PDF – 29 KB]

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Abstract

For online graduate learners, knowledge of practical skills that promote successful help seeking that go beyond simply suggesting that students ask their instructor for further direction, are invaluable. Skills for succeeding in online graduate health studies shaped from a student's perspective and data collected from an already published study are identified. The skills essential for succeeding in online graduate studies are enlisting help from family, friends and co-workers, recruiting others to proof read assignments, and creating discussion groups outside of the online setting.

Introduction

Balancing the demands of full time employment, raising a family, and completing graduate studies online creates extraordinary challenges for health care professionals (Bocchi, Eastman, & Swift, 2004). Few adult learners feel confident in

reaching out for help within “normal” learning environments. Previous attempts to seek help may have resulted in peer and instructor perceptions of incompetence, negative instructor feedback, and feelings of self-doubt. Compounding the often-isolating experiences of learning online, students are commonly confused in the help seeking process. Institutional guidance for online graduate students may be limited to directions requiring them to seek help only from their instructors. Research related to how online graduate students can best seek help and the skills they need to use that help to succeed is limited, making further study essential. In this paper, three critical skills for succeeding in online graduate study programs are presented. These three skills are: (1) enlist help from family, friends, and co-workers, (2) submit assignments for proofreading, and (3) create discussion groups.

These skills were originally identified from data collected in a project reported elsewhere (Melrose, Shapiro, LaVallie, 2005 in press). The project was framed from a constructivist theoretical perspective (Peters, 2000) and a naturalistic action research design (Corey, 1949; Kemmis, 1990; Altrichter, Posch & Somekh, 1993; Stringer & Genat, 2004). Data sources included fifteen responses from one question on a program satisfaction questionnaire, two focus groups of five participants and ten audio tape- recorded transcribed interviews with graduates who attended Convocation ceremonies at the Athabasca University campus in Athabasca, Alberta, Canada in June 2003 and June 2004. The researchers analyzed content from these data sources first independently and then collaboratively. The transcripts were thoroughly read and re-read and a systematic process of content analysis was developed (Loiselle et al, 2004) to create the categorization and coding scheme that led to the themes.

The research approach was conceptualized from tools examining help-seeking within learning that were tested in an earlier project (Shapiro et al, 2003). Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity. Full ethical approval was granted from the Athabasca University Ethics Committee.

The following question was included on the graduate satisfaction questionnaire and provided the structure for discussion in both the focus groups and the individual audiotape recorded transcribed interviews:

Seeking help with learning can be difficult for online students at the graduate level. Please describe an incident when, even though you read the study guide, that you did not understand all the instructions and did not know what to do. As the course progressed, and other students began to work-what did you do? What kind of help did you need and who did you seek it from? What happened? Do you think other people in the class would do the same thing? Are there “unwritten rules” for getting help as an online graduate student? If you would be willing to describe your experience in more detail, please e-mail Sherri Melrose (sherrim@athabascau.ca).

In the original project, the following four themes emerged from analyzing the data and represent key findings. The first theme was that self-help included reflection and rereading directions available within the course. The second theme was that a primary source of help was other students in the class. The third theme was that involving family, friends and co-workers provided important educational support. The fourth theme was that instructors’ first message, involvement in weekly discussions and anecdotal comments were highly valued. This article expands on the third theme and elaborates on specific skills that students can implement to succeed in online graduate studies.

Findings revealed how enlisting help from others is essential. Given that online learning occurs in relative isolation, it is necessary to remain self-directed. WebCt is an asynchronistic, online learning environment that creates a virtual classroom affording graduate students the opportunity to work at their own pace. It offers forums for posting discussion regarding course content, a coffee room to create a supportive environment, and chat rooms for virtual synchronistic discourse. In spite of all the positives of WebCt that assist with successful online graduate studies, students find a number of challenges in comprehending content. As one participant identified, due to the flexibility of time in working on course content, working after everyone else has gone to bed is common. Few online resources are available at midnight or on the weekends. Another participant articulated the limitations in immediate discussion, due to the absence of a face-to-face classroom setting. Although the chat rooms are accessible, there is a lack of convenience in setting up the situation. Many participants echoed the feeling that using asynchronistic learning environments often creates a barrier to immediate assistance. Consequently, participants reported that they enlist help from family, friends, and co-workers, recruit others to proof read assignments, and create discussion groups outside of the online setting.

Review of the Literature

A literature review revealed that the process of seeking help within an educational environment is a valuable and strategic resource for learners (Karabenic, 1999; Conrad, 2002; and Stokes, 2000). The ability to reach out to others to ask for help when it is necessary is an adaptive learning skill that promotes success. In the field of education, research into the experience of seeking help has been undertaken in primary and secondary schools (Bee-Gates, Howard-Pitney, LaFromboise, & Rowe, 2002; Nelson-Le Gall, 1981; and Newman, 2000), in undergraduate university settings (Karabenick and Knapp, 1991; Karabenick & Sharma, 1994; and Bailey, 1997), in an undergraduate school of nursing (Price, 2003), in an online undergraduate program (Taplin, Yum, Jegede, Fan, & Chan, 2001), and in an online graduate program (Melrose, Shapiro, & LaVallie, 2005, in press). Other articles aimed at graduate level learners explore seeking help for mental health related issues (Ekong, 2004.), how to build community within the online environment (Hasler-Waters & Napier, 2002; Wang, Sierra, & Folger, 2003, Swan, 2002; Woods & Ebersole, 2003; and Royal, 2002), or strategies for accessing library resources. While an understanding of how online graduate learners seek help is beginning to emerge, little is known about the specific strategies these learners require to lessen their isolation, and increase their comprehension of the material.

Fear of negative responses from instructors deters learners from seeking help (Karabenick, 1998; Taplin et al, 2001; and Price, 2002). Karabenick (1998) emphasized how “Help seeking has traditionally been associated with learning dependency, even dishonesty, and at best a mere coping strategy” (p.1). Bornstein (1992) supports this notion in identifying that fear of appearing ignorant prevents individuals from seeking help. Price (2002, p. 2) asserted that learning is a “difficult journey because we have been socialized to measure ourselves in terms of what we know, can do and can prove to others.” Price identified how perceptions of the value of help seeking can start with how individuals represent themselves to others. Among learners, a belief can exist that the instructor is the expert and that help seeking is a concession of ignorance. Students fear that if they concede to not knowing one thing, the instructor may question their competence.

Taplin et al (2001) notes how high-achieving undergraduate students do seek out help more often than low achievers, and urged for a move away from the debate around why students seek help. Instead, Taplin et al encouraged a deeper exploration of where learners do seek help and how their own strategies might strengthen. Affirming the need to communicate help seeking skills that lead to success in learning, Taplin et al (p. 8) identified “the need to explore strategies that will make it less troublesome for students to seek help when they need it.” For online graduate learners, knowledge of practical skills that promote successful help seeking that goes beyond simply suggesting that students ask their instructor for further direction, are invaluable. Drawing from the data collected during the Melrose, Shapiro and LaVallie (2005, in press) project and the author’s own experience completing a Master of Health Studies (MHST) online graduate degree, the skills for succeeding in online graduate studies are discussed.

Enlist Help from Family, Friends and Co-workers

The importance of enlisting the help of friends, family, and co-workers is essential to succeeding in online study. Friends, family, and co-workers are accessible, provide an outside perspective, and are supportive. These factors nourish success for students. Participants identified that reaching out to family, friends, and co-workers is very helpful. Students take a proactive approach to learning by anticipating the need to reach out beyond the borders of online learning and secure available systems early on. Involving family, friends, and co-workers affords students opportunities to fine tune opinions and understanding before presenting it to the somewhat-daunting atmosphere of graduate education. This outside support is not a replacement for the efforts educational institutes make in creating an online community, but does enhance this process by increasing accessible resources. Participants identified that they made friends with fellow classmates and kept in contact for support and direction as the program progressed, even when they were in separate courses.

Friends, family, and co-workers are valuable resources in comprehending content, providing direction and guidance. As one

participant identified, “Sometimes I would just take the email message to friends or librarians and ask them how they would interpret what I did not understand.” Other participants identified that because of the distance-learning situation they sought help from a number of co-workers who had completed graduate degrees from other universities, for clarity and direction before submitting assignments. Participants used co-workers to “bounce ideas off of.” One participant described how (he/she) would do their readings ahead of time and then take the concept to work to get a better understanding and different views:

I think if you're working in a health environment at the time you're taking the courses, or if you're not working, it doesn't matter—and I wasn't working in a specifically health care situation—it would have been very valuable—a bonus I guess—it didn't take away from my experience, but to get a group of people who you check in with in person every three months. Whether it's over coffee or whatever, people who are health care professionals, who probably some of them your friends, maybe some of them just co-workers that you've had in the past that you know maybe it would change every course according to what content you're taking—to bounce ideas—not like an accountability group, but that kind of—almost a support group.

In addition to immediate comprehension of material, family can assist in creating an environment conducive to studying. Family members watch children, offer financial resources, and much like friends, provide the subtle needs of debriefing, guidance, and interpretation. They are also important in debriefing with you when you receive uncomfortable feedback, or course content that is challenging. It is comforting to be able to pick up the phone and contact a trusted person to discuss your experiences. Enlisting friends, family, and co-workers is an essential skill in succeeding in online study.

Recruit Others to Proof Read Assignments

Recruiting someone else to proofread your paper could mean the difference between a clear, succinct document and a paper full of disjointed ramblings. We have not met the spouse of a graduate student not enlisted to proofread an assignment (a vow, not specified during the wedding ceremony). One participant identified that proofreading is not meant to substitute reading your own work over, “it would be more asking them what direction I should proceed if I was, in their opinion, following what I should be in terms of the outline, and the instructions that were given.” Having someone else proof read your paper, enhances clarity and direction. Participants identified that having others proof read their material supported their feelings of credibility. Recruits who have taken graduate studies are even more valuable. Enlisting someone who has knowledge and experience regarding graduate level writing is crucial to academic success. Students encourage recruits to provide honest feedback and suggestions for improvement, keeping in mind that the more feedback provided, the deeper the level of comprehension. In addition, if the online educational institution allows, hiring a technical editor is of benefit.

Students may hire someone to type their assignments if their computer skills are lacking. Accessing efficient word processing programs is also crucial for student success. Typing forum postings in a word processing document before posting online, assists with spelling and grammar concerns, not always identified. Success in online graduate studies relies heavily on recruiting others for proofreading assignments.

Create Discussion Groups

Creating discussion groups outside of the online environment support a deeper comprehension of course concepts. One participant identified “bringing content to discuss at work helped me shed light on difficult concepts.” Creating discussion groups among co-workers to acquire diverging opinions and depth of comprehension is essential when enlisting educational supports. One participant stated,

I did need that kind of personal face to face talking it through context, and so one of the things I found really helpful personally was to find people within my work area that would follow me through each course. Because much as you can express yourself online it's still of—you know you don't actually get the time to actually work it through and discuss it through and try to get some understanding of it. I really did use my co-workers at work a lot, almost as my tutorial group and again it wasn't something that I did at the beginning.

Discussion groups can be formal or informal, structured or unstructured, scheduled or unscheduled. Discussion groups happen synchronistically (in real time), a situation not always possible through online learning. Discussion groups promote diversity of discussion, challenges of ideas, and spontaneous critical thinking to deepen understanding. Didactic discourse is also valuable with co-workers. Co-workers are not the only resource. Relying on family and friends in discussion is another critical factor. Diversity of opinion is the key to surviving content comprehension. In addition to discussing course content, when creating an outline for assignments, students may bring concepts to discussion groups to explore topics to address in the assignment. The verbal discussion of course topics and potential content in group conversations supports critical thinking and enhances successful online learning

Conclusion

Few adult learners feel confident in reaching out for help within learning environments. Online graduates may be limited to directions for learning support because of the isolated learning environment and the desire to remain self-directed. The importance of enlisting the help of friends, family, and co-workers, recruiting others for proofreading, and creating discussion groups outside of the online environment is critical to succeeding in online study. Ultimately, implementing the three skills of enlisting the help of friends, family, and co-workers; recruiting others for proofreading; and creating discussion groups outside of the online environment, supports student success in online graduate studies.

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Mentoring online graduate students: Partners in scholarship



[PDF – 82 KB]

Citation

Melrose, S. (2006). Mentoring online graduate students: Partners in scholarship. *Education for Primary Care*, 17(1), 57-62.

Abstract

Mentoring graduate students toward scholarly research and writing activities has become an important area of focus for faculty at the Centre for Nursing and Health Studies at Athabasca University in Alberta, Canada. With an emphasis on teaching excellence, instructors seek out and create experiences to involve graduate students in their own programme of research and publication. However, despite a plethora of literature available on the concept of mentoring, few definitive guidelines exist to illustrate what the process might look like within Masters programmes offered exclusively through a WebCT online environment. This paper describes an approach to mentoring two graduate students in the Master of Health Studies programme that was perceived as positive and mutually beneficial for the protégés as well as the mentor. Insights are revealed into the experiences that these students found both engaging and difficult as they developed skills in analysing qualitative research and submitting manuscripts for publication. The students' stories are discussed to describe significant features of the experience of 'partnering in

scholarship' with their teacher. Suggestions and practical strategies for mentoring online graduate students are offered.

SUMMARY

Mentoring graduate students toward scholarly research and writing activities has become an important area of focus for faculty at the Centre for Nursing and Health Studies at Athabasca University in Alberta, Canada. With an emphasis on teaching excellence, instructors seek out and create experiences to involve graduate students in their own programme of research and publication. However, despite a plethora of literature available on the concept of mentoring, few definitive guidelines exist to illustrate what the process might look like within Masters programmes offered exclusively through a WebCT online environment. This paper describes an approach to mentoring two graduate students in the Master of Health Studies programme that was perceived as positive and mutually beneficial for the protégés as well as the mentor. Insights are revealed into the experiences that these students found both engaging and difficult as they developed skills in analysing qualitative research and submitting manuscripts for publication. The students' stories are discussed to describe significant features of the experience of 'partnering in scholarship' with their teacher. Suggestions and practical strategies for mentoring online graduate students are offered.

WHAT IS ALREADY KNOWN IN THIS AREA

Considerable research from a variety of disciplines is available on the value of mentoring – both in long-term relationships as well as for only short periods of time. Traditionally, faculty/student collaboration on publications has been limited.

WHAT THIS WORK ADDS

An illustration of what the process can look like in a graduate programme offered exclusively through a WebCT online environment. Case studies highlight experiences that engaged students and those that were difficult.

SUGGESTIONS FOR FUTURE RESEARCH

How can primary care educators intentionally create mentoring opportunities that extend their own scholarly activities to include student protégés?

INTRODUCTION

'In the Greek mythology tale The Odyssey, when King Odysseus left home for the Trojan Wars, he asked his trusted friend Mentor to care for his wife and infant son Telemachus. During the 20 years Odysseus was away, Mentor not only educated Telemachus, but was also responsible for shaping his character, counseling him to make wise decisions and advising him to remain clear and steadfast. Since then, wise and trusted advisers have been called "mentors"'.¹

This article describes the experience of mentoring, or seeking to offer 'wise and trusted' guidance to two online graduate

students in the Master of Health Studies (MHST) programme at the Centre for Nursing and Health Studies, Athabasca University, Athabasca, Alberta, Canada as they developed skills in analysing qualitative research and submitting manuscripts for publication.

The MHST programme is completed exclusively online using a WebCT course management system. The primary medium for communication, instruction and assessment within the programme is asynchronous text-based threaded discussions within a WebCT environment. In keeping with an intentional commitment to support mentoring connections, instructors are invited to involve learners in their own scholarly activities. Examples of one-on-one opportunities to mentor students include extending an aspect of a course and employing students as research assistants. This paper illustrates how extending an aspect of a course (in this case an assignment) into co-authoring a manuscript and employing a student as a paid research assistant both created meaningful mentoring opportunities.

LITERATURE REVIEW

A literature review revealed that considerable research has been undertaken to investigate the value and benefits of mentoring for both mentors and their proteges within healthcare learning events. There is a 'gap', however, in our understanding of how graduate study faculty can provide mentorship to learners in an exclusively online learning environment. In particular, specific direction for involving students in scholarly activities, such as faculty research projects and publication efforts, is lacking.

Traditionally, and well before online learning opportunities became available, publications extending from faculty-student research collaboration have also been limited. Taylor studied 285 nurses in academia who stated that, while they felt that they had been mentored, they had not collaborated in research (56%), co-authored a paper (71.2%) or presented a paper with a mentor (74.7%).² Similarly, Whitley and Oddi explored the influence of selected factors on the publishing efforts of student authors who published in the *Western Journal of Nursing Research* during a five-year period, and identified that, although faculty were involved as research advisors for a majority of students and spent several hours per week in supervising students' research activities, the existence of collaborative mentorship culminating in student faculty co-authorship was not apparent.³ Further, after an exploration of factors that influenced student authors who published in *Nursing Research* during a five-year period, Whitley and colleagues called for graduate study educators to examine mentoring in more depth, and to encourage collaboration in authorship with students.⁴

Anecdotal reports of the benefits of the mentoring relationship, especially for women, are well documented. Byrne and Keefe noted that, even when resources were limited and optimal long-term relationships with expert research mentors were not available, women valued inclusion in projects over short periods and multiple sources of mentors across their careers.⁵ Faculty researchers who mentor well can increase their own productivity in addition to strengthening their school's reputation and resources.⁶ Braithwaite described the excitement of the mentoring relationship while conducting collaborative international research.⁷ Owens and Patton used examples of an email mentoring experience to illustrate a win-win situation for both participants.⁸

Barriers to mentoring are also acknowledged. These can include limited time to offer additional instruction and a lack of confidence.⁹ And, when the mentor is also the teacher, there may be conflicts between mentoring and other teaching roles, such as evaluation and discipline.¹⁰ Role confusion may develop as teachers take on a mentoring role. Teachers are often advised to keep a professional distance when interacting with students and this can conflict with the belief that a mentor should be a friend and confidant.¹¹ Further, in relation to the imbalance of power, teachers may be concerned that their own self-serving need to 'publish or perish' may influence the relationship and constitute exploitation of students.³

Additionally, suggestions for implementing processes that contribute to successful mentoring have been identified. At the beginning of a project, Morrison-Beedy and colleagues noted that the key factors for effective implementation of research mentoring are to set clear goals for the project, define expectations for the proteges, establish and maintain good

communication and share values related to research.¹² During the selection of proteges, Paul and colleagues asserted that enthusiasm, willingness to participate and having the time available to commit to the project are more important than grade point averages.⁶

In setting up collaborative writing plans, Davidhizar and Dowd stressed the importance of determining the sequence in which authors will be listed on any manuscripts.¹³ Correspondingly, Klein and Moser-Veillon affirmed the need to articulate that substantive contributions are expected to claim a byline.¹⁴

As the relationship progresses, Brey and Ogletree advised striking a balance between personal and professional issues and investing in time and patience.¹⁵ Also, Thorpe and Kalischuk indicated that performing collaborative formative and summative evaluations are helpful.¹⁶ Furthermore, given the goal of independent functioning for the protégé, and the intense and frequent contact within the relationship, Owens and Patton pointed out the importance of attending to closure.⁸

However, while a body of research related to the processes involved in mentoring healthcare learners towards scholarly research and writing activities continues to evolve, illustrations of what the experience might look like in an online environment are limited. Next, to offer examples of practical teaching strategies that respond to experiences which students found engaging as well as difficult, I describe my own experience of partnering in scholarship with two online students, Terry and Cate.

THE MENTORING APPROACH

The mentoring approach used with Terry and Cate was guided by a constructivist student-centred conceptual epistemology and framed from the Daloz mentorship model.^{17,18} Daloz presented a mentorship model for the teaching of adults which was drawn from mythic figures such as Mentor in *The Odyssey* and which used the metaphor of learners undergoing a developmental journey. Effective mentors, he suggested, can encourage and partner with proteges at different times in their learning journeys by offering support, challenge and vision. In the area of support, Daloz emphasised a commitment to nurture the relationship and to create a climate of trust in which the protegee feels safe to risk taking on new perspectives and make mistakes. In the area of challenge, Daloz proposed the idea of introducing tension by raising disorienting questions or setting tasks. In addition, in the area of vision, Daloz recommended providing a sense of direction and movement towards where the journey leads.¹⁸

THE PROTÉGÉS

Terry's story

Terry is a Registered Dietitian who I worked with on two online courses. She consistently participated in online discussions, sought help when she needed it and didn't hesitate to express her opinions. In fact, with one of her class papers, in addition to presenting a well-organised and comprehensively referenced assignment, Terry described an incident that caused me to laugh out loud. I agreed with Terry's description of the incident and found her suggestions for change intriguing. However, in my feedback, I did encourage her to frame her academic comments with less flamboyance.

Terry was employed on a contract basis with three different employers, travelled widely, and, like most online students at the Centre, completed one graduate course each fall, winter and spring term. Although her time was clearly stretched, Terry hoped to obtain a full-time teaching position and viewed writing for publication as an important personal learning objective. As a supplemental work project, I offer a standing invitation to all members of my classes to collaborate with me and develop

one of their course assignments into a manuscript that might be disseminated at a conference or in an academic journal. Knowing that this process can extend their course from the required 14 weeks to well over a year, students may not choose to participate. However, this invitation was particularly engaging for Terry and she expressed a keen interest.

We began the project when Terry initiated contact about six weeks after the course finished, and we ended the project nearly two years later. Via email, we discussed the author guidelines for a variety of academic journals and agreed to submit a manuscript to a journal whose readership included both nurses and dietitians.

One important point of emphasis that I raised with Terry in my invitation and again at various points throughout the project was the possibility that our manuscript could be rejected. I also stressed how authors often feel a variety of emotional responses when co-authors and editors revise their work. Highlighting this aspect of the publication process was important as our first submission was rejected by the editor of the journal. Terry found that this initial rejection was one of the most difficult aspects of the project. However, this editor brought our work to an alternate journal where we were invited to reduce the word count and revise the manuscript.

Cate's Story

Cate is a Registered Psychiatric Nurse who, like Terry, was also in two of my classes. Given my own background in psychiatric mental health nursing, I found that communication with Cate was straightforward. She was an active, strong and confident participant in class discussions. She would readily ask for help when she needed it and consistently followed through on any feedback. Cate's academic writing strengthened with each assignment and her attention to detail was impressive. She instructs at a college and, like Terry, one of her personal learning goals was to develop research and publication skills.

In her closing message to me in our second course together, Cate offered to work with me on any research projects I was involved with. Although I did not need assistance at that time, I kept her offer in mind and several months later developed a proposal that required a paid research assistant. When funding for my proposal was approved, I contacted Cate and she accepted the position. Given the potential for exploitation of younger and vulnerable students by older faculty members simply seeking an unpaid research assistant, it was important to mentor Cate within the role of an employed research assistant. Cate's tasks included both independent and collaborative analysis of survey data, focus groups and tape-recorded interviews with graduates of the MHST programme.

As we began the project, we established ground rules. With our common background in both teaching and mental health, it was not difficult to discuss our commitment to attend to and articulate emotions and concerns as they emerged. Knowing that working intensely with qualitative data gathered from graduates of Cate's own programme could be emotionally charged for her, this strategy was particularly engaging.

Just as she had done in her classes, Cate completed tasks such as coding and categorising large volumes of data promptly and thoroughly. She sought clarification and direction when she needed it and offered helpful suggestions. When offering direction to Cate, it was useful to identify that 'fitting' data into themes was a creative process that was not expected to be straightforward. Within a three-month period, we finished our qualitative analysis of the data and I presented the findings at a conference. We also co-authored a manuscript and submitted it to a refereed journal.

CONCLUSION

Adapting the Daloz model to mentoring or partnering with these graduate students towards scholarly research and writing was a positive and rewarding experience. In the area of support and establishing a trusting relationship, it was helpful to know the proteges well, to observe for cues where students themselves initiated project ideas and to establish ground rules for

working together. In the area of challenge, it was useful to articulate the possibility that our manuscripts might be rejected, that the process of qualitative data analysis is seldom straightforward, and that the projects would be time consuming. In the area of vision, it was valuable to identify our goal of submitting manuscripts for publication, to discuss our motivation as educators to achieve this common goal and, on a practical level, to designate the sequence our names would be listed on manuscripts right at the beginning of the project.

In conclusion, Terry and Cate's stories begin to illustrate practical collaborative strategies for mentoring online graduate learners. Creating possibilities to involve students and partner with them in research and scholarly writing activities is both a challenge and an opportunity for faculty.

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Graduate students' experiences with research ethics in conducting health research



[PDF – 253 KB]

Citation

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Abstract

Graduate students typically first experience research ethics when they submit their masters or doctoral research

projects for ethics approval. Research ethics boards in Canada review and grant ethical approval for student research projects and often have to provide additional support to these novice researchers. Previous studies have explored curriculum content, teaching approaches, and the learning environment related to research ethics for graduate students. However, research does not exist that examines students' actual experience with the research ethics process. Qualitative description was used to explore the research ethics review experience of eleven masters and doctoral students in health discipline programs. Data analysis revealed four themes: curriculum, supervisor support, the ethics application process, and students' overall experience. The results of this research suggest ideas for enhancing curriculum, deepening students' relationships with supervisors, and developing the role of research ethics boards to support education for novice researchers. This study contributes to comprehension of the research ethics experience for graduate students' and what they value as new researchers.

Keywords

Graduate students, experience, research ethics principles, research ethics board, qualitative description

Introduction

Graduate students in health programs at the masters and doctoral levels in Canada often conduct research with human subjects as part of their studies. For many students this is their first experience as a researcher and, hence, they have much to learn about research methodologies, conducting a literature review, designing and implementing a research project, and disseminating results. Consideration of ethics is a key focus in conducting research involving humans and students must learn research ethics principles and apply them throughout their projects.

In Canada, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS2) outlines three core principles for research ethics: respect for persons, concern for welfare, and justice (Canadian Institutes of Health Research et al., 2014). These values are reflected in research through: free and informed consent, respect for privacy and confidentiality, data access and information security, minimizing harm and maximizing benefit, inclusiveness and justice, and respect for vulnerable populations.

The ethics review process is often the student's first experience with research ethics and serves as an important component of their education as a researcher (DePauw, 2009; Michael Smith Foundation Health Research, 2007). Novice researchers often need support as they strive to incorporate ethical principles into their research with human participants.

Research Ethics Boards (REBs)¹ in Canada are comprised of researchers, community members, and others with specific expertise (e.g. in ethics, in relevant research disciplines) and are established by institutions to review the ethical acceptability of research involving humans conducted within their jurisdiction. These boards provide review and approval for student research projects and, therefore, need to understand what students learn through curriculum and what support they receive from academic supervisors, in order to identify what assistance the REB might offer.

The focus of this research project was to investigate graduate students' experience with research ethics; specifically, this research sought to bring greater understanding to

1. The term Research Ethics Board is used in Canada but in other jurisdictions the term Institutional Review Board or Research Ethics Committee may be used for a committee with the same purpose.

- What graduate students in health disciplines learned about research ethics principles;
- What perceptions of research ethics did the graduate students have; and
- What was the experience of graduate students with applying research ethics principles when they conducted health research projects?

Literature Review

A broad search for literature on the topic of graduate students and research ethics was conducted to establish what and how they are taught the principles of research ethics in health programs, and how they translate their learning into research practice. Five interconnected themes related to curriculum content, teaching approaches, learning environments, research relationships, and REB processes were found to impact students' experiences with research ethics. There was, however, a paucity of research describing students' actual experiences with the research ethics process.

Graduate curricula in health disciplines vary in content on ethics, principles of research ethics, and responsible conduct of research. Designated courses in basic ethical theory, virtue ethics and moral reasoning are necessary for students to learn how to identify and address ethical issues and discrepancies (Aita and Richer, 2005; Demir Küreci et al., 2008; Schmaling and Blume, 2009; Weyrich and Harvill, 2013). However, most institutions with health science programs do not invest enough in research ethics education for their graduate or post-doctoral students, despite the availability of abundant peer reviewed content developed by experts in the field (McDonald et.al, 2011).

Curricula should also include instruction on the ethical dissemination of research findings for those graduate students who wish to publish a thesis or dissertation. Research by Arda (2012) found that doctoral candidate students in health sciences were deeply concerned with ethical concerns regarding fraud, plagiarism and undeserved authorship. The scientific integrity of publications depends on these novice researchers being trained in critical reading and writing skills.

A variety of teaching approaches have been utilized to promote deeper understanding of research ethics principles. Research ethics in academic programs have been taught through a variety of methods including: didactic lectures, written assignments, group discussions, guest lectures, movies and videos, development and analysis of case studies, peer presentations, and role-play (Chapman et al., 2013; Eisen and Parker, 2004; Löfström, 2012; Rissanen and Löfström, 2014). Semester long courses, workshops and specialized training programs (Loue, 2014), laboratory orientations, combined in-class and online programs (Cho and Shin, 2014) and experiential learning (Teixeira-Poit et al., 2011) have all been demonstrated to be effective.

The Panel on Research Ethics (PRE) in Canada provides an online tutorial on research ethics that is freely available to anyone, though predominantly used by people conducting research with humans (Panel on Research Ethics, 2014). Academic institutions in Canada may mandate completion of this tutorial before students under their affiliation are approved to conduct research with human participants. Similarly, the National Institutes of Health (NIH) in the U.S. have training requirements for the responsible conduct of research (RCR) however, there are no set standards for the skills required to practice ethical research. Research by Plemmons and Kalichman (2013) found that RCR instructors held diverse opinions regarding what ought to be taught in RCR courses.

Bowater and Wilkinson (2012) proposed that it is important to have a learning environment that provides a safe space for active engagement with ethics issues. Students' perceptions of the organizational climate impact the ethical decisions they make with regards to research (Langlais and Bent, 2013). Faculty commitment to integrate research ethics topics into academic activities is essential, however, some academic leaders assume the principles are well known and do not need to be taught (Adams, 2002; Freeberg and Moore, 2012). Contrary to this belief, students may in fact need more instruction and guidance and often feel quite lost in tackling their first ethics application. University programs need to create and foster a culture of ethical research that reinforces scientific integrity as ensuring regulatory compliance alone is not good enough to preserve public trust (Minifie et al., 2011).

The positive relationship between graduate students' and their academic supervisors is essential to support a student's

self-confidence with research ethics. Supervisors influence students' knowledge and perceptions of responsible conduct of research by socializing them into a research community that values research integrity (Fisher, et al., 2009a). Transmission of knowledge is best when the mentor provides direct instructions, practical guidance and integrates the research ethics process into supervision by sharing their own experiences (Fisher et al., 2009b; Richards, 2010). Commitment to academic and research integrity should be notable in teaching, advising and mentoring activities (DePauw, 2009).

The last related theme from the literature focused on the role that REBs have with students. When REBs share knowledge and negotiate the ethics review process the experience is more positive for novice researchers (Boyd et al., 2013). Students who develop relationships with REBs have better understanding of processes governing research ethics and use that knowledge to mitigate risks in health research (Shore, 2009; Snowden, 2014). When students attend REB meetings for the review of their research project they show ownership for their research, can answer ethical concerns, and benefit from the educational experience (Heasman et al., 2009). Some REBs also include a student member of the board whose experiences can then be used to mentor other students with research ethics processes (Walton et al., 2008).

Knowledge of research ethics and ethical theory may not be consistently integrated in curriculum requirements for masters and doctoral students in health disciplines who plan to conduct research with human participants. Existing literature indicates that students want more education and practice with ethical dilemmas related to research. Relationships with supervisors, academic learning environments, and contact with REBs all affect what and how graduate students learn about research ethics principles. There is no research, however, that specifically examines student perspectives on the research ethics process and how they integrate ethical principles into their research projects.

Method

The primary purpose of this study was to explore masters and doctoral students' knowledge and perceptions of research ethics principles and describe their experience with applying them in research practice. Fundamental qualitative description provides a comprehensive summary of the participants' events in their natural setting. This methodology allows for the presentation of data in everyday language from the participants, capturing their beliefs, behaviors, and perceptions to richly convey their personal experiences (Neergaard, et al. 2009; Sandelowski, 2000).

A social constructivist perspective aims to understand the world that participants' live and work in, and how their experiences contribute to their ways of understanding their world. Framing a study from a constructivist paradigm with relativist ontology fosters openness to multiple realities and understandings (Denzin and Lincoln, 2011:13). In the research community student researchers, faculty supervisors and REB members each represent different experiences and understandings of research ethics and the ethics review process; hence, knowledge creation can be reciprocally shaped through dialogic interchange.

This investigation was founded on existing knowledge of research ethics principles (Canadian Institutes of Health Research et al., 2014), and the use of naturalistic inquiry to explore graduate students' experience with no prior commitment to spin one theoretical view. With this approach, data are interpreted with low inference through inductive reasoning to convey facts accurately and in proper sequence in order to understand the 'who, what and where' of the phenomena (Neergaard et al., 2009; Sandelowski, 2000).

Graduate students in health disciplines having completed their masters or doctoral programs in the past five years were the purposeful sample for this project as they had recent research ethics experience to draw on and were able to provide rich data specific to the research question. A sample size ranging between 8 and 12 participants can provide complete and adequate data for a homogenous sample in qualitative research (Sandelowski, 1995). The sampling strategy should be adequate to achieve a sufficient level of depth, and appropriately represent the individuals addressed in the research question (Guetterman, 2015); thus a target sample size of 10 participants was determined to be appropriate and relevant for this descriptive inquiry.

The use of social media has been established as an effective way to recruit specific populations that may be difficult to recruit

for research (Kapp et al., 2013; O'Connor, et al., 2014; Ryan, 2013). Social media was used as the recruitment strategy for this study due to the following challenges. Masters and doctoral students who had graduated from their programs were unlikely to keep in touch with the academic institutions, so posting recruitment materials in those venues was unlikely to reach them. As most universities are public institutions in Canada they are not allowed to provide an individual's contact information for the purpose of contacting a person to participate in research (Freedom of Information and Protection of Privacy Act, 2015). Direct recruitment through professor contacts was considered but may have put the scholars in a position of power over or conflict of interest with their students if they maintained an ongoing work relationship after graduation.

Therefore, Facebook and Twitter social media were used to access a large number of potential participants and a mixed sample of graduates from different health programs and universities across Canada. A Facebook site and Twitter account were created exclusively for recruiting the targeted number of participants for this research project; no data were collected directly from either social media site. Twitter and Facebook messages including a brief description of the project and contact information were communicated to health and academic research communities across Canada over a six-week period. Once the target number was reached and participants had been confirmed, the Facebook and Twitter accounts were closed. Students who expressed interest in participating were provided a letter of information and consent form, with an interview date and time arranged at their convenience.

Eleven graduate students enrolled in five different universities volunteered to participate. The students represented a variety of health disciplines and were at various stages of degree completion. Participants had used quantitative, qualitative and mixed methods in their research designs related to a wide range of health research topics (See Table 1).

Table 1. Participant Demographics

University Location	Health Discipline	Level of Education	Year Graduated	Research Methodology
Canada	Community Health Science	Doctoral	2015	Mixed Method
Canada	Social Dimensions of Health	Masters	2016	Mixed Method
Canada	Social Dimensions of Health	Doctoral	Candidate	Qualitative
United States	Nursing	Doctoral	2013	Qualitative Phenomenology
Africa	Public Health	Masters	2015	Qualitative Participatory Action Research
Canada	Rehabilitation Sciences	Doctoral	Candidate	Quantitative
Canada	Rehabilitation Sciences	Masters	Candidate	Qualitative Interpretive Phenomenology
Canada	Nursing	Doctoral	Candidate	Qualitative Narrative
Canada	Rehabilitation Sciences	Doctoral	Candidate	Grounded Theory
Canada	Rehabilitation Sciences	Doctoral	2016	Quantitative
Canada	Nursing	Masters	2016	Qualitative Description

Data were collected using one-hour interviews conducted via phone or in-person and audio-recorded with the participant's consent. Semi-structured interviews, using open-ended questions, were used to guide the conversation while also allowing participants flexibility to share their story in their own sequence of events. Participants were invited to review their interview transcript and verify the accuracy of data representation and sequencing.

Thematic analysis is an independent, reliable approach to identify, analyze and report the patterns and themes across multiple interviews (Vaismoradi et al., 2013). Each transcript was read through twice, the first time to review content against the audio recording and to gather general knowledge; the second time to focus on key messages.

Codes and themes were defined and applied to the focus words after the second reading. The analysis was data driven for authenticity and consistency, and to eliminate researcher bias. Any repeated data, surprises or data similar to the literature were coded and categorized and the categories were reviewed for relationships.

Ethical considerations for this project were respected through the three core principles of the *Tri-Council Policy Statement* (Canadian Institutes of Health Research et al., 2014): respect for persons, concern for welfare and justice. All participants were honored for their participation and the knowledge and values that they shared. Consent was fully informed and participants had the opportunity to withdraw at any time without consequence or to choose to not answer any of the interview questions. The dual roles of the researcher as a research ethics leader and REB Chair were discussed with participants prior to the interview so they were fully informed of the purpose and intentions for this project. Risks and benefits, and the protection of confidentiality and privacy were explained to each participant and no identifiable participant information is included in the dissemination of the findings. Prior to commencing research activities, ethical approval was obtained from the Athabasca University Research Ethics Board.

Results

The data analysis resulted in four themes that were categorized to align with the original research questions: curriculum content, support from supervisors, the ethics application process, and the graduate students' perceptions and overall experience.

Curriculum content

Participants described that curriculum content in both masters and doctoral level programs is delivered through research methodology courses but a minimum amount of time is devoted to it. Some doctoral students were required to complete a separate ethics course, and some students voluntarily took extra ethics workshops. Research ethics tutorials like the TCPS2 CORE tutorial (Panel on Research Ethics, 2014) are not mandatory for all students in programs where research is conducted with human subjects and only half of the participants in this study had completed the CORE tutorial. Three of the participants had completed the US Office of Human Research Protections tutorials (US Department of Health and Human Services, Office of Human Research Protections, n.d.) as they had attended university in the United States or conducted international research. The graduate students noted that training modules provided by government agencies responsible for the protection of research involving humans should be utilized consistently in academic programs.

Participants indicated that current academic curriculum content related to research ethics is lacking depth and specific instruction on research ethics principles and how to integrate them into research practice. All of the students requested more detailed instruction regarding the ethics application process and information on how to create participant recruitment materials such as letters of invitation and consent forms.

Four of the eleven students believed that graduate programs should include a mandatory research ethics course, and one participant suggested that requirement would then heighten awareness of research ethics across the university, not just at the health science department level. Another participant shared that ethics material delivered in health program courses was not translated for research practice, even though the basic ethics principles could be applied. She proposed that ethics content from various academic courses should be connected through knowledge translation activities.

Support from academic supervisors

In Canada, masters and doctoral students are assigned a supervisory committee of two or more faculty members to provide advice and assessment throughout their program. Initially, students usually work closely with one committee member who is recognized as their academic supervisor as they conduct their research. Other committee members become involved as the

program progresses and in the end students defend their research to all members of their committee along with an external examiner.

All of the participants identified the need for a positive working relationship with their academic supervisor and that it was instrumental for their success, but only half of the participants described feeling that they had received sufficient support. The students who did feel supported identified how supervisors mentored them and described what good support looked like. Characteristics of academic supervisors recognized as being supportive included: experience with supervising graduate students; a teaching style that allowed for self-directed learning; encouragement for critical thinking and integration of ethics principles; mentorship; significant research and field experience; and being approachable and easy to work with.

Participants who did not feel supported described their supervisors as providing broad suggestions with little hands-on support, or being disengaged from the mentorship process. These students expressed frustration and experienced time delays due to navigating the research ethics application process on their own. Student participants who did not feel supported by their academic supervisors often turned to other members of their supervisory committee for assistance and used these meetings to discuss ethical concerns or to search out expertise in a particular area. Unfortunately, the feedback from committee members sometimes differed from their supervisors, thus causing more confusion for the student.

Ethics application process

The ethics application process is a key step in the research ethics experience for graduate students. Some had to apply to more than one research ethics board (REB) and found health institution boards were more demanding with provisos. Students felt REBs put too much emphasis on minor details of application documents, versus the actual ethical considerations for their projects. Electronic submission systems and obtaining operative approvals from research sites posed additional challenges. Every graduate student received provisos from the REB they had applied to and the provisos were often focused on: dual role and qualifications of the researcher; justification of sample size and inclusion criteria; recruitment and consent processes; and data management. If a student had previous experience with the ethics application process it was easier for them to complete the initial application and respond to requests for modifications.

Some of the students reported receiving support from REBs through website information, examples of completed applications, templates for participant materials, and ethics workshops. Other participants had not experienced access to these types of REB resources and suggested that all REBs should have similar education materials available. Novice researchers want clear information on details of the ethics review process and completion of application forms. Participants stated that conflicting or overlapping questions should be removed from the application, and three students suggested that REBs should revise their forms to be more applicable to qualitative methodologies. Other suggestions for REB support included: a 'frequently asked questions' document; video tutorials or webinars to demonstrate completion of an application; examples of participant materials and consent forms; guidelines for confidentiality; and requirements for data storage, retention, and destruction. Further, student researchers would like the option to submit an ethics application for pre-review and to make revisions before their submission progresses to a full board or delegated REB review.

Some of the graduate students reported that the REBs had a designated contact person for student projects and an expedited process for review of student projects, making the process more efficient. For others who did not experience this type of support, communication could be enhanced through greater accessibility to ethics office staff. Other avenues for improving communication between researchers and the REB include simultaneous electronic notifications to the student (co-investigator) and the supervisor (principal investigator) and use of chat lines. Participants also indicated that if academic and health authority REBs took advantage of opportunities to collaborate in harmonized review processes and shared understandings of the complexities of research conducted in health systems, the ethics review process would be more positive.

Graduate students' perceptions and overall experience

The depth of the graduate students' perceptions was reflected in their overall experience. Many of the students remarked on the importance of research ethics to protect participants, especially vulnerable populations, safeguarding the balance of benefits and risks for each individual involved in their projects. Participants shared that the research ethics process strengthened their research design through adding credibility and quality to their work; for the participants, these added benefits helped justify the time and work involved with the ethics review process. Half of the participants noted that the research ethics process was more than just an application and that they needed to integrate ethics throughout their research project. Two of the students expressed increased confidence in their role as a researcher as a result of the ethics review process.

The eleven participants identified four research ethics principles as the most important to integrate into health research with human participants. First, the dual role of the researcher as both a student and a clinician was significant and they were careful to mitigate any power over participants during recruitment. Student researchers focused on developing trusting relationships with both research participants and work colleagues in a transparent and culturally safe manner. Secondly, the student researchers respected confidentiality and privacy with the location of interviews and focus groups, secure storage of research data, and the protection of identity for both participants and work colleagues in dissemination of research results. The third important principle was consideration for vulnerable population groups as participants in research. Each of the graduate students targeted a population often seen as vulnerable for participation in research including: student mothers, adolescent mothers, university students, frail elderly, caregivers of spouses with dementia, parents of children receiving health services, breast cancer patients, patients with pain, and marginalized people. The students described their concerns for the welfare of these individuals and the need to balance risks and benefits. Informed and ongoing consent of participants was the fourth research ethics principle noted as most important, and the consent process had to be appropriate (i.e., verbal versus written, consent forms read to participants with poor reading comprehension).

The depth of perceptions and overall experience with research ethics described by the graduate students was remarkable and revealed in their descriptions of their research. One participant reflected on her role as the researcher, "I feel like it's protective of my caregivers and I feel so strongly about them that I want them to have that. So I'm sort of pleased to provide that to them" (Participant 11). Another participant shared her thoughts on the impact for research integrity, "It really does test a researcher to balance between the rigor of a study and the quality of a study and the respect for the population that's providing you with the data" (Participant 1). A third perspective shared was thoughtful about the participants' experience: "I think it holds researchers accountable to being transparent and ethical and respectful and considerate to people that they're asking for information from so that it avoids treating participants as just participants. Like they're people living their life and giving their time and it's the people that are going to help you make the difference and you need to treat them well" (Participant 7).

Trustworthiness

Credibility for this study was established through regular peer debriefing with the supervisory committee throughout the project timeline. Transcripts of interviews were compared to audio-recordings for referential adequacy and reviewed by participants to verify accuracy. Representation of an accurate description of participants' experience in proper sequence is essential in qualitative description (Neergaard et al., 2009; Sandelowski, 2000); herein, a summary of the research findings was sent to each participant for member checking and validation of results. Member checking, also recognized as member reflection, allows for a direct affirmation of the research findings and interpretations (Lincoln and Guba, 1985; Tracy, 2010). Involving participants in interpretation of data can enhance the trustworthiness of results (Birt et al., 2016).

The role and bias of the researcher was acknowledged through bracketing and reflection and documented in a methodological journal during the course of this study. As a REB Chair, the researcher often provided ethical review for

student research projects, and issued provisos related to: recruitment and consent, privacy and confidentiality, data security, dual role, and potential conflict of interest. These reviews stimulated this exploration of students' knowledge and perceptions of research ethics principles, but in order to gain a fresh perspective and understanding, the researcher had to set aside previous assumptions through bracketing. The researcher also chose to recruit through social media, rather than the two institutions where she is a member of the REBs, in order to avoid any potential for conflict of interest, coercion or power over participants who may have submitted student research projects to these boards.

Limitations

Limitations for this research project include limited engagement with participants (just one interview) and a single source of data (versus triangulated data). It might also have been valuable to use negative case analysis as a way to help confirm the study's findings.

The results are limited in transferability to other graduate student populations outside of health programs; however, the rich description may enable readers to assess the applicability of the findings of this research to another population of student researchers. The focus of this research was on providing a comprehensive, descriptive summary; a more in-depth, detailed interpretation was not planned for this study.

Discussion

This inquiry provided a rich, descriptive account of graduate students' experience with research ethics. The strengths and weaknesses of curriculum content related to ethical principles and suggestions for enhancement were outlined. Future studies could help identify curriculum requirements to meet student needs (e.g., through using the Delphi method), and evaluate the effectiveness of separate ethics courses. Faculty could be engaged in research to gain a better understanding of how they can integrate more ethical content into graduate programs, including research training conducted in laboratory settings.

The relationship between a graduate student and his/her academic supervisor impacts all aspects of the student's ethical training, and is instrumental in contributing to their self-confidence as a novice researcher. Characteristics of a supportive academic supervisor were identified in the present research however; additional exploration with faculty regarding their perspectives could further clarify how the role of the supervisor can be strengthened.

Connections with REBs have significant influence on students' ethical research practice; therefore, REBs need to invest in opportunities for improving support and educational resources provided to these novice researchers. REBs might also collaborate with faculty to host joint presentations that focus on enhancing the skills of both supervisors and students for integrating research ethics in practice. Research ethics staff should be accessible to student, as effective communication between the research ethics office and researchers is essential for a positive experience.

Conclusion

Qualitative description, within a constructivist framework, was used to gain a better understanding of: what graduate students in health disciplines learn about research ethics principles in curriculum; what support they receive from academic supervisors; what perceptions they have of research ethics; and how they apply ethics in research practice. Eleven graduate

students from nursing, rehabilitation sciences, community science, public health and social dimensions of health participated by sharing their experience through interviews.

This inquiry has provided student researchers a voice to describe how they assimilate research ethics principles into health research practice. The students shared their heightened awareness of research ethics and confidence in their roles as novice researchers. Academic faculty and the research ethics community can assimilate this knowledge and respond by addressing the identified gaps in education and support. Each member of the research community has a significant role to play in endorsing this next generation of health researchers with ethical research practice.

Declaration of Conflicting Interests

The Authors declare that there are no conflicts of interest.

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Online Interest Groups: Virtual Gathering Spaces to Promote Graduate Student Interaction



[PDF – 247 KB]

Citation

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Abstract

This article discusses a 15 month educational innovation project, the objective of which was to investigate the perceptions of health profession students about their participation in a program-wide virtual community gathering space (Clinical Interest Groups) during their online graduate studies. Participants were students in two graduate programs who joined online forum discussions of the Clinical Interest Groups. The project was developed as action research and employed an exploratory, descriptive methodology to generate data from three sources: participant responses to a 15-item Likert type questionnaire, five open-ended questions included on the questionnaire, and online postings contributed by participants to the forum discussions. Findings of use to online educators are that the Clinical Interest Groups provided a gathering place in which graduate students could discuss common interests and support one another, and that participation in the groups was limited due to competing demands on students' time from other commitments.

Keywords

Clinical Interest Groups, Education, Healthcare, Online Graduate Studies, Program-Wide Virtual Gathering Space, Social Integration

INTRODUCTION

Literature suggests that supportive student-student interactions foster social and academic integration (Kanuka & Jugdev, 2006; Rourke et al., 1999; Thomas, 2000) and that such integration leads to increased satisfaction (Mayne & Wu, 2011; Richardson & Swan, 2003) and course completion (Lovitts, 2000, 2001; Rourke et al., 1999). Literature also reveals that student-student ties and support evolve over time (Oren, Mioduser, & Nachmias, 2002; Stodel, Thompson, & MacDonald, 2006; Yuan, Gay, & Hembrooke, 2006). However, the research investigating social integration in online learning that was reviewed for this study focused on students in discrete courses as the unit of study. Research was not found that examined the experience of social integration from a perspective that takes into account the development of student-student interactions over time. Our action research project is unique in that it was completed from a 'program' perspective and spanned several discrete courses taken over a period of time. Other online educators may be interested in replicating this innovation with graduate students who are health care practitioners.

In this article we describe findings from a research project that investigated the experiences, reflections and feelings of students who participated in a program-wide virtual community gathering space during their online graduate studies. Online interest groups (Clinical Interest Groups) were created within Moodle, an online learning platform, to provide opportunities for health professions students to engage in asynchronous discussions about shared clinical interests, distinct from the online activities of any particular course. While the main purpose of the project was to explore learners' perceptions of participating in a non-graded program-wide activity, a secondary purpose was to consider ways in which we could improve our online learning environments and students' online learning experiences based on their feedback.

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

The project was guided by the Community of Inquiry (COI) framework described by Rourke, Anderson, Garrison, and Archer (1999). The COI framework highlights three major dimensions of the online learning environment that overlap to form the educational experience of the student: social presence (interpersonal connection), cognitive presence (construction of meaning through communication) and teaching presence (facilitation of active learning). Of these dimensions, social presence is the most relevant to this project.

Social presence is defined as the ability of learners to project themselves socially and emotionally in a community of inquiry (Rourke et al., 1999). Social presence includes feeling comfortable, safe and willing to accept both support and differing points of view (Anderson, 2005). Rourke et al. suggest that social presence increases academic, social and institutional integration, resulting in increased persistence and course completion. There are a number of studies that have supported this suggestion, concluding that social presence is created in online learning environments and contributes positively to learning, satisfaction and persistence in online learning (Aragon, 2003; Mayne & Wu, 2011; Melrose & Bergeron, 2006; Richardson & Swan, 2003; Russo & Benson, 2005; Swan & Shih, 2005; Tu, 2002). On the other hand, feelings of isolation can be exacerbated when students do not feel a sense of social presence or when they do not feel that they are part of a community (Jung, 2001).

Social presence is based in social integration. In graduate studies, Lovitts (2000) explained that social integration "develops

through informal, casual interactions between and among graduate students and faculty outside the classroom” (para. 6). Social integration has been found to increase program completion and reduce program attrition (Thomas, 2000; Tinto, 1975). Online graduate students appreciate course designs that include optional nonacademic social discussion forums to promote social integration (Pate, 2008). As Rovia (2002) comments, although learning needs will attract adult learners to a program, they are not sufficient to retain them; social integration has a significant positive effect on retention of adult learners. Online educators are responsible to provide educational intervention activities that enhance social integration by creating a ‘social dimension’ within educational programs (Kanuka & Jugdev, 2006; Mayne & Wu, 2011), inviting collaboration (Shen & Wu, 2011), building a sense of community and reducing feelings of isolation (Brandes, 2006; McGivney, 2004). Social integration activities must include more than course-related activities. From their synthesis of studies that explored social issues in online course activities, Oren et al. (2002) concluded that support of social activities in online learning environments must extend beyond course activities. They suggested creating a range of virtual spaces in order to respond to different social needs, and enabling participants to contact each other for multiple purposes rather than solely for learning purposes. Viewing social integration as integral to success, Saunders and Lynch (2008) used web sites with interactive membership pages and blogs to help education students become more integrated into the graduate student community of their program. However, it is important to note that student-student ties and support evolve over time: they become strong by ‘the end of the course’ (Atack, 2003; Oren, Mioduser, & Nachmias, 2002; Stodel, Thompson, & MacDonald, 2006). Similarly, Yuan, Gay, and Hembrooke (2006) found that connectedness in task-related social networks grew significantly over time.

Based on this review of literature, we speculated that it could be a useful educational strategy to provide a virtual space for graduate students to engage in interactive activities with fellow students who share common interests. Such a space would create an electronic network of practice. In industry, the term ‘network of practice’ refers to informal emergent social networks or groups where individuals with common interests interact and exchange information (Seely-Brown & Duguid, 2000). In educational settings, the term ‘network of practice’ evolved from Wenger’s work with ‘communities of practice.’ Wenger asserted that professionals are believed to learn best during informal workplace gatherings where stories are shared, novices learn from experts and gaps in practice knowledge are identified (Berry, 2011; Lave & Wenger, 1991; Wenger, 1998; Wenger, McDermott, & Snyder, 2002; Wenger, 2006, 2009). In virtual learning communities, electronic networks of practice involve self-organizing networks of geographically distributed individuals who share a mutual interest in engaging with others in discussions related to a common practice but who do not know one another, do not meet face to face and interact via online, computer-mediated communication (Daniel, Schwier, & McCalla, 2003; Wasko & Faraj, 2005). We reasoned that the creation of such a network amongst the students could reduce feelings of isolation, facilitate increased social integration and create a sense of belongingness to the university. In addition, the space could assist students to establish links between course activities and their employment and other personally relevant activities.

CLINICAL INTEREST GROUP RESEARCH PROJECT

Participants in the Clinical Interest Groups were enrolled in a Master of Nursing (MN) or Master of Health Studies (MHS) program at a Canadian university. While students in the MN program hold undergraduate degrees in nursing, those in the MHS program come from a variety of health disciplines including nursing, physiotherapy, occupational health, dietetics, and medicine. Course work in the program is completed exclusively online using the Moodle learning management system. The primary medium for communication and interaction is asynchronous text-based threaded discussions completed in 14-week online courses. However, there is no opportunity outside of the courses for students to gather together and interact with other learners in their programs. The programs focus on development of leadership skills and, despite the fact that most students are employed in clinical settings and have extensive clinical expertise, there is no option for students to engage in discussions with their peers about clinical areas of interest.

We created a Moodle environment that facilitated interactions amongst students with similar professional practice interests. The environment consisted of password-protected discussion fora for three interest groups in the clinical areas of mental health, gerontology, and spirituality and healing. These foci for the Clinical Interest Groups were selected on the basis of an

informal review of clinical interests expressed on program application forms and faculty expertise. The Clinical Interest Groups were opened for participation via an invitation to students posted on our faculty website, and participants were invited to join one or all of the groups.

In order to gain access to the Clinical Interest Groups, participants e-mailed a request to join the groups to a faculty member of the research team who did not have teaching responsibilities in the program. The participants received an email response from the faculty member that provided access information (URL and password for the Moodle site) and offered general suggestions for respectful participation. Faculty members of the research team posted a welcome to each of the three Clinical Interest Groups, and a graduate student monitored the groups on a daily basis and facilitated discussions by responding to comments and posing questions to extend conversations. Thirty-one students and faculty were provided access to the Clinical Interest Groups during a 15 month timeframe. Requests for participation from students at other universities were not able to be accommodated. A request from an undergraduate student at our university was accepted. At the same time as access to the Clinical Interest Groups was provided, participants were invited to participate in a research project investigating their experiences of participating in the Clinical Interest Groups. Full ethical approval of the research was granted by the university's Research Ethics Board. Participants were informed that they would be asked to complete a questionnaire about their experiences in the interest groups, and that the frequency and content of their discussions in the groups would be analyzed. Only 8 of the 31 participants in the interest groups responded with their consent to participate in the research project. Those 8 participants were emailed the questionnaire approximately six months after initially accessing the interest groups. Only 5 participants returned completed questionnaires.

The Clinical Interest Group innovation was developed as an action research project. Action research is a reflective, iterative process in which educators use research techniques to examine their practice carefully, systematically and with the intention of applying their findings directly to their own and other educators' every day work (Altrichter, Feldman, Posch, & Somekh, 2007; Corey, 1949; Kemmis & McTaggart, 1990; Koshy, Koshy, & Waterman, 2011). Kemmis and McTaggart (1988) offered the seminal explanation that action research is a deliberate, solution-oriented investigation that is group or personally owned and conducted. It is characterized by spiraling cycles of problem identification, systematic data collection, reflection, analysis, data-driven action taken, and, finally, problem redefinition. The linking of the terms "action" and "research" highlights the essential features of this method: trying out ideas in practice as a means of increasing knowledge about or improving practice (Kemmis & McTaggart, 1988).

Action research is valued more for the change it can initiate in everyday practice than for a quantitative goal of working with large sample sizes and generalizing the findings to a broader audience (Koshy, Koshy, & Waterman, 2011). "The action researcher is interested in the improvement of the ... practices in which he [sic] is engaging. He undertakes research in order to find out how to do his job better – action research means research that affects actions" (Corey, 1949, p. 63). In our Clinical Interest Group project, we sought to improve our teaching practice through the action of providing and then collecting data about a program-wide virtual community gathering space with a small group of our online graduate students. We continue to work with our participants to reflect, analyze and redefine our educational innovation.

An exploratory, descriptive design was employed to collect data about the Clinical Interest Groups innovation. We did not locate existing research that examined students' perceptions of participating in program-wide virtual communities and this design supported our desire to find out about students' perceptions (exploratory) and describe what we found (descriptive). "Descriptive study is the method of choice when straight descriptions of phenomenon are desired" (Sandelowski, 2000, p. 339). The expected outcome of such research is a straight and "largely unadorned" (p. 337) descriptive summary of the data. Qualitative data are summarized in the language of participants without transformation into abstract conceptualizations or theory. Quantitative data are summarized as descriptive statistics such as frequencies and measures of central tendency.

The team used across-method triangulation to obtain multiple perspectives of the students' experiences of the Clinical Interest Groups (Thurmond, 2001). Across method triangulation refers to the use of quantitative and qualitative data collection methods and analysis to support data completeness (achieving as complete an understanding as possible) and confirmation (determining the extent to which findings derived from different methods converge or are confirmed) (Casey & Murphy, 2009). Data were collected via a questionnaire that included both quantitative measures (a 6-point Likert scale) and a qualitative component (written responses to open-ended questions) (Appendix). In addition, data were collected through

analysis of the postings that participants contributed to the Clinical Interest Group forum discussions. The Likert scale included 15 6-point items designed to measure the extent to which participation in the interest group discussions supported clinical expertise (items 1, 2, and 3), problem-solving and critical thinking (items 4 and 5), and social presence and integration (items 6 to 9 and items 11 to 14). Two items (10 and 15) measured overall usefulness of the interest group discussion. These ordinal-level data were analyzed by calculating the median to determine if the quantitative measures confirmed the qualitative comments of the participants.

The open-ended items on the questionnaire (see Appendix for specific questions) were designed to solicit qualitative data about the students' experiences of participating in the interest groups, such as reasons for joining and memorable experiences. In addition, forum discussion postings of those participants who consented to the study were analyzed to discern themes within the discussions (Loiselle, Profetto-McGrath, Polit, & Beck, 2007). The qualitative data from the open-ended questions and the forum postings were analyzed using a process of "thematizing" (Mitchell & Jones, 2004) in which themes in the data emerged through an iterative process of reading and re-reading the data. Three criteria guided the generation of themes: recurrence, repetition and forcefulness (Owen, 1984). Recurrence of ideas within the data occurs when ideas are determined to have the same meaning but different wording (for example, "connections with other learners" and "connecting to people"). Repetition refers to the existence of the same ideas using the same wording (for example, "sharing ideas" and "ideas were shared freely"). The final criterion, forcefulness, is found when the importance of a response was reinforced by the emphatic tone of the response or the use of quotation marks, underlining, italics or bolding to provide emphasis (for example, "if we keep others joining, it will grow and prosper!").

To overcome potential bias of a single-investigator approach and enhance the credibility of the findings and interpretations, the study made use of investigator triangulation in which more than one researcher collected and analyzed data (Halcomb & Andrew, 2005; Thurmond, 2001). The study employed a team approach with multiple investigators and intra-team collaboration and communication to decrease the potential of bias in gathering and analyzing data. The team consisted of four educators experienced in the delivery of online courses to graduate students in health disciplines, a research assistant who was a senior graduate student at the university and an instructional media analyst who designed the Moodle learning environment for the Clinical Interest Groups. Each member of the team was involved in development of the design of the study and the questionnaire as well as analysis of the data that were generated in the study.

FINDINGS

Given the very small number of study participants (5), our findings can be considered tentative at best. We recognize that the number of participants is low. However, we believed that even with this sample size there were important lessons to be learned. Two themes emerged through thematic analysis of the open-ended questions and forum postings: the Clinical Interest Groups did provide a gathering place where common interests could be discussed and support for one another shared, and participation in the Clinical Interest Groups was limited due to competing demands on students' time from other commitments. The theme of "a gathering place" seemed to be confirmed by the medians of the items on the Likert scale (Table 1). However, statistical analysis of such a small sample cannot be considered reliable and should be viewed with caution.

Theme 1. Clinical Interest Groups as a Gathering Place

The Clinical Interest Groups provided students an opportunity to discuss common interests with one another. Analysis of the open-ended questions and the online discussions revealed the following topics:

1. Hoping that the Groups will be a place for sharing knowledge, a place for rich, ongoing conversations, an opportunity to connect with a community of online learners, and an opportunity to explore new ideas with like-minded individuals;

2. Discussing their practice settings and roles and issues at work, and specific clinical information from their settings;
3. Sharing resources, including journal articles, web sites and professional conferences, with discussion of how these could be useful in their work settings;
4. Revealing their passion for their clinical work;
5. Appreciating the discussions as a “break” from course work;
6. Providing academic coaching (writing objectives, formatting papers, organizational strategies).

Table 1. Median scores of questionnaire items

Participation in the Online Clinical Interest Groups:	Median
1. Provided opportunities for information exchange about my clinical area of interest	5.5
2. Strengthened my clinical knowledge base	5
3. Offered solutions to clinical questions	4.5
4. Presented problem-solving opportunities	4.5
5. Reinforced my abilities to think critically	4
6. Provided opportunities to network with like-minded others	4
7. Created a sense of belongingness with my program community	5
8. Established a sense of support with fellow students	4
9. Allowed me an opportunity to contribute my ideas	5.5
10. Was a worthwhile use of my time	5
11. Fostered possibilities for emotional closeness	3.5
12. Facilitated cooperation for mutual benefits	3.5
13. Left me feeling that my participation was valued	5
14. Stimulated a sense of camaraderie	5
15. Overall, could be described as a positive experience	5

Analysis of the quantitative measures seems to support this theme, as Table 1 demonstrates. In Table 1, negatively worded items have been rescaled to present scores as positively worded items. As noted earlier, the results of statistical analysis can be considered only suggestive because of the small size of our sample.

Participants indicated that they agreed that the interest groups supported clinical expertise (items 1, 2 and 3), problem-solving and critical thinking (items 4 and 5), and social presence and integration (items 6 to 9 and item 13). The medians of two of the items designed to measure social presence and integration (11 and 12) could be interpreted as neutral responses. Participants also agreed that the clinical interest groups were a worthwhile and positive experience (items 10 and 15).

Theme 2. Limited Participation due to Competing Demands

A second theme that emerged from thematic analysis of the qualitative data was that competing demands kept participants away from the forum discussions. Participants found it difficult to remain actively involved in the Clinical Interest Groups over time, citing time pressures from course work, full time employment and personal or family commitments. Even though questionnaire responses suggested that participation in the Clinical Interest Groups was positive and useful and participants

stated they would encourage others to join the groups in order to build relationships with colleagues, they also noted that they would caution potential participants to ensure that they had the time to commit to the group.

DISCUSSION

Anderson (2004) notes that each discipline has its own ways of understanding and communicating about knowledge, that is, its own “world view,” and students need opportunities to experience this. It is also the case that specialties within health disciplines have their own language, clinical approaches, and areas for scientific study. By creating online interest groups that extended beyond both course time frames and the leadership focus of the program, our Clinical Interest Groups offered students an opportunity to experience social integration within a network of practice.

The findings presented in the previous section illustrate key features of social integration. Participants felt safe and comfortable sharing their views, commenting about the way in which “ideas were shared freely” and they “felt open to be very honest” in an environment that was “very respectful and inquisitive.” The interest groups addressed multiple purposes, helping students to learn from one another regarding both their clinical areas of interest and their roles as graduate students. The students felt connected to people from across the country and, in the words of one participant, this helped to provide “the interfacing that makes learning most enjoyable.”

The student-student ties and support that are integral to social integration evolve over time. Although there are suggestions that these ties and support were developing, participants commented on the slowness of formation of a sense of group identity. At times there were long delays before a particular student’s post would be commented on by others and that was discouraging. None-the-less, students were positive about the potential of the interest groups, encouraging faculty to keep the groups going so that others would join and the groups would “grow and prosper.”

The difficulties we experienced in sustaining participation in the Clinical Interest Groups are comparable to those reported by other researchers exploring professional interest group activities. McKee, McKague, Ramsden, and Poole (2007) reported only 30% participation in a Family Medicine Club interest group offered to undergraduate medical students. While evaluation reflected that offering the group was a valuable endeavor, McKee et al. attributed the low participation, in part, to limited student and faculty time. McKee et al found that involvement became a challenge as students moved on in their training and as their practicum work increased.

In their study of a 10-year online professional development group for teachers, Riverin and Stacey (2008) also noted that participants experienced diminishing participation in their online community despite improvements in technology and other supportive efforts. They identified that lack of time to access the discussion forum and connect with others was a significant barrier to participation. They speculated that information overload due to growing Internet use may have affected participation in their online community. They questioned whether, over time, active participants became ‘lurkers’ or peripheral participants, threatening the sense of community. Finally, they recommended that, as newer electronic social networking tools become available to create communities of practice, attention be paid to managing the barriers of time and information overload.

Riverin and Stacey (2008) identified the importance of using community-building practices to support online communities. As part of our process of facilitating the groups, we deliberately implemented community building activities. For example, expectations for respectful participation were identified at the outset and options provided in case members believed those expectations were not being met. Faculty members posted welcoming messages to each group forum and ongoing faculty participation in the group discussions demonstrated our commitment to the groups and our belief that the groups could be valuable in supporting student integration, learning and development as graduate scholars. A moderator provided personal greetings to each new member, asked questions and followed up with student postings to support discussions. However, participants suggested strategies that could have improved community-building and interaction within the interest groups. Participant feedback indicated that students would value more frequent responses from a moderator and the inclusion of

planned activities such as posting journal articles or specific topics for discussion. These suggestions will be incorporated in future groups. The development of an instrument to use in evaluating virtual networks of practice (Appendix) is a valuable contribution to understanding online communities of graduate students. The instrument was developed through a collaborative effort of the research team members. To develop the Likert scale, two research team members reviewed literature and research of social presence, social integration and online communities to identify outcomes that could be expected as a result of participation in the Clinical Interest Groups. Terms or phrases that were perceived as conveying the same meaning (for example, feeling part of a community and sense of belonging to a community) were consolidated and a list of possible items to be included on the instrument was created. The list of possible items was considered by team members in light of our experiences in online education and those determined to be most relevant were selected for inclusion on the instrument. Three items specific to the clinical focus of the groups then were added to the instrument. Finally, in order to capture student experiences that were not included in the Likert scale items, open-ended questions were added to the instrument. Given that this study was an initial exploratory attempt to collect data about online networks of practice, we did not undertake testing of the reliability or validity of the instrument prior to its use. However, such testing could be included in future studies.

There are important lessons learned from this action research project about how we as educators can promote success in online learning environments. Some students welcome the opportunity to belong to a community that expands their interactions and learning beyond the time-limited boundaries of individual courses in a program. However, such communities require nurturing in order to flourish and strategies to promote interaction and learning should be carefully designed and implemented to ensure that participants feel welcome and believe that time spent in the community is worthwhile. Strategies should address issues that threaten the viability and sustainability of online communities. How much activity should be free-flowing discussion among students and how much should be planned activity initiated by a moderator or faculty member? How can 'lurkers' be identified and encouraged to remain active? How can an online community of practice become a relevant part of the students' integrated electronic networks that includes email, blogs, wikis and social media? How can the barrier of time be managed?

However, we would be remiss if we did not ask other, larger questions. Are program-wide virtual gathering spaces important to online graduate students or is our commitment to such groups an example of a mismatch between "faculty dreams and student realities"? Is this type of social networking useful or, given the increased availability of social media, are students already overloaded with networking opportunities? Do the demands of course work, employment and family life mean that such online groups become burdensome rather than supportive? These are questions that warrant further investigation.

CONCLUSION

Initiating the Clinical Interest Groups and reflecting on our educational innovation was an important first step in offering our health professions students an environment where they can gather, share common interests and develop feelings of belongingness as part of a community of learners. By creating a program-wide virtual community gathering space, online graduate students were offered opportunities to engage in practice related discussions, exchange resources and extend their social time together even after courses ended. Although competing demands on their time often kept students from participating, they appreciated having the opportunity available. Students enjoyed the connections they made with other like minded individuals and they valued the chance to reveal their passion for their clinical specialty. Our Clinical Interest Groups established a space where communities of practice could emerge. The groups were a place for the interpersonal connections so essential to enhancing social presence and social integration in online learning. The present investigation encourages faculty to acknowledge the importance of offering online graduate students opportunities to connect in program wide virtual communities. Knowing how much learners value discussion areas that are based on common interests and that do not end when courses are over leads us to look for other ways to establish and improve similar virtual communities.

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APPENDIX

Online Clinical Interest Group Questionnaire

Please indicate how much you agree or disagree with each of these statements about your participation in the online Clinical Interest Groups by underlining the appropriate number.

Table 2. Underline only one number for each statement.

Participation in the Online Clinical Interest Groups:	Completely Disagree	Mostly Disagree	Slightly Disagree	Slightly Agree	Mostly Agree	Completely Agree
1. Provided limited opportunities for information exchange about my clinical area of interest	1	2	3	4	5	6
2. Strengthened my own clinical knowledge base	1	2	3	4	5	6
3. Offered solutions to clinical questions	1	2	3	4	5	6
4. Presented minimal problem-solving opportunities	1	2	3	4	5	6
5. Reinforced my abilities to think critically	1	2	3	4	5	6
6. Provided opportunities to network with like-minded others	1	2	3	4	5	6
7. Created a sense of belongingness with my program community	1	2	3	4	5	6
8. Established a sense of support with fellow students	1	2	3	4	5	6
9. Did not allow me an opportunity to contribute my ideas	1	2	3	4	5	6
10. Was not a worthwhile use of my time	1	2	3	4	5	6
11. Fostered possibilities for emotional closeness	1	2	3	4	5	6
12. Facilitated cooperation for mutual benefits	1	2	3	4	5	6
13. Left me feeling that my participation was not valued	1	2	3	4	5	6
14. Did not stimulate a sense of camaraderie	1	2	3	4	5	6
15. Overall, could be described as a positive experience	1	2	3	4	5	6

Please answer the following questions:

1. What prompted you to join the Online Clinical Interest Group(s)?
2. What stands out most for you about your experiences participating in the Online Clinical Interest Group(s)?
3. What did you particularly like about the Online Clinical Interest Groups' initiative?

4. Do you have any suggestions for how the Online Clinical Interest Groups' initiative could be improved?
5. Would you recommend others join the Online Clinical Interest Groups?

Instructor immediacy strategies to facilitate group work in online graduate study



[PDF – 48 KB]

Citation

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Abstract

An increasing number of online graduate study programs require students to participate in collaborative work projects. And yet, educational research examining instructional strategies that facilitate learning in small groups online is limited. This article describes findings from a qualitative research project that investigated instructor immediacy at different stages of group development. The research was framed from a constructivist theoretical perspective and a descriptive research design. Participants were health care practitioners from two WebCT online graduate study programs. Data sources included four focus groups and twenty individual audio recorded transcribed interviews. The data was collected in person over a three year period, analysed for themes by two researchers, and confirmed with participants through ongoing member checking. Instructional immediacy strategies that students believed facilitated meaningful learning in small groups are presented in the three overarching stages of first, beginning/engagement; second, middle/encouragement; and third, ending/closure. Findings suggested that, in the beginning/engagement stage, learners valued knowing their instructors were available “if you need me” and that it

was “safe” to contact them. In the middle/encouragement stage, they appreciated personal help with networking and managing conflict, particularly in relation to participation and marking and they valued private feedback. And, in the ending/closing stage, they needed opportunities to debrief and reflect.

Introduction

Instructors who demonstrate immediacy are well-received by students in a variety of different learning events. Health care professionals undertaking graduate study in online environments, particularly when they are required to work in small groups, value feeling personally connected and close to their teachers. However, the processes involved in linking the construct of immediacy to facilitation strategies for small group work online are not well understood. Groups can be expected to progress through predictable developmental stages, and it is important for instructors to implement relevant and specific strategies that learners themselves value in a personal way during each of these stages. Three key areas of theoretical understanding provide background for this study – the construct of instructor immediacy, predictions of learning group development, and the individual needs of group members.

Literature review

The construct of instructor immediacy

The construct of immediacy was originally presented by social psychologist Albert Mehrabian in the 1960s, and was defined as an affective expression of emotional attachment, feelings of liking and being close to another person (Mehrabian, 1967; 1971; Weiner & Mehrabian, 1968). In traditional higher education classrooms, instructional immediacy was further defined as a non verbal manifestation of high affect and is demonstrated through maintaining eye contact, leaning closer, touching, smiling, maintaining a relaxed body posture and attending to voice inflection (Andersen, 1979). Verbal components of the construct include using personal examples, engaging in humour, asking questions, initiating conversations with students, addressing students by name, praising student work, and encouraging student expression of opinions (Gorham, 1988). Links between teacher immediacy, student motivation and affective learning have been well documented (Christophel, 1990; Christophel & Gorham, 1995).

In online classroom environments, where non verbal cues are absent, the construct is not as easy to articulate. However, associations between instructor immediacy behaviours and student learning and satisfaction are significant (Arbaugh, 2001). The experience of liking and feeling close to instructors can lead to positive effects in online classrooms (Hess & Smythe, 2001). Correlations between immediacy and affective learning exist (Baker, 2004; Russo & Benson, 2005). And, immediacy behaviors are believed to enhance instructional effectiveness (Hutchins, 2003; Woods & Baker, 2004).

Predictions of learning group development

Predictions of learning group development suggest that small groups will typically progress through expected stages. Tuckman's (1965, 1977) seminal work identified that small groups will progress through the five stages of *forming*

(characterised by anxiety and uncertainty about belonging); *storming* (characterised by competition, individuality and conflict); *norming* (characterised by attempts to resolve earlier conflicts, clear expectations of behaviors and roles); *performing* (characterised by cooperation and productive work); and *adjourning* (characterised by termination and disengagement from the group).

Later, Johnson and Johnson (1997, 2000) identified that students in small groups will progress through the seven stages of defining and structuring procedures and becoming oriented, conforming to procedures and getting acquainted, recognising mutuality and building trust, rebelling and differentiating, committing to and taking ownership of the goals and other members, functioning maturely and productively and, finally, terminating.

In online classroom environments, groups are also expected to progress through similar stages. And yet, Palloff and Pratt (1999) noted that aspects of communication affecting group interactions may be significantly different. Salmon (2004) identified that students who are separated from one another by time and distance will progress through the five stages of *access and motivation* (characterised by welcoming and encouraging); *online socialisation* (characterised by familiarising and providing bridges between cultural, social and learning environments); *information exchange* (characterised by facilitating tasks and supporting use of learning materials); *knowledge construction* (characterised by facilitating process); and *development* (characterised by supporting and responding). In addition, Salmon (2004) suggested that computer networking requires learners to understand technological aspects of online interpersonal communication and networking. Describing an 'interactivity bar,' she asserted that the intensity of interaction will be different at each stage of development. Examining pre-masters health professionals' transitional process while engaged in online learning, Giddings, Campbell and Maclaren (2006) identified four stages where learners progress through 'virtual paralysis,' 'engagement,' 'getting into it' and ultimately 'surprised enjoyment.'

Individual needs of group members

Individual needs of group members create an important dynamic within small group projects. Maslow (1982) asserted that individuals all have a hierarchy of needs where *survival needs* (physiological needs for air, water and food; and safety needs for security and protection) must be fulfilled before they can meet the *psychological needs* for esteem, belonging and self actualisation. When individuals become members of groups, Beebe and Masterton (2006) explained that they need groups to satisfy different needs. While some may have a high need for safety within a group, others may have a high need for esteem and respect from the group. And, when aspects of individuals' personal survival and psychological needs are not being met, limited participation in a group can be expected.

When individuals form and interact in groups, Schutz's (1958) classic theory of interpersonal behaviour postulated that they also all have needs for *inclusion* (feeling recognised and included and reaching out to make others feel included), *control* (feeling in control, contesting issues, vying for leadership and resolving conflicts) and *affection* (giving and receiving emotional support). Facilitating balance between individuals' needs as group members and the need for a group to progress is not straightforward. Instructor immediacy, where students like their teachers and feel emotionally close to them, can begin to offer guidance.

Existing direction to help instructors balance students' needs both as individuals and as members of small groups are limited. Resources such as Barker, Wahlers and Watson (2001), Clark (2003) and Westberg and Jason (1996) offer general help for facilitating group communication processes. Bates and Poole (2003) and Collison, Elbaum, Haavind and Tinker (2000) offer explicit help for facilitating online groups. Further, the specific processes involved in creating an effective teaching presence in online classrooms have also been examined (Anderson, 2004; Anderson, Rourke, Archer et al., 2001; Garrison, Anderson & Archer, 2000; Stacey & Rice, 2002). However, little guidance is available on specific ways instructors can continue to support students as individuals during the times they are members of small groups. As McLoughlin (2002) asserted: "Placing students in groups and assuming that this will bring about collaboration is mistaken, as negative group interaction may hinder rather than promote effective team behaviours" (p.252).

One resource, a workbook developed by Carr, Herman, Zarotney-Keldsen et al. (2005a) offers activity templates that participants in small group learning teams online can complete at different stages of their development. An instructor resource manual accompanying the student workbook (Carr, Herman, Zarotney-Keldsen et al., 2005b) offers suggestions on integrating team learning in course syllabi; creating teams; developing team contracts to establish ground rules, expectations for performance and criteria for performance feedback and evaluation of each team member; managing meetings and conflict; peer feedback; after action review and evaluation and closing. However, Carr Herman, Zarotney-Keldsen et al's (2005a; 2005b) suggestions are grounded in the belief that students are accountable for their performance and for the requirements of the course when they work in small group learning teams. Within this approach, individual learning needs of group members are once again not addressed.

The research approach

The goal of the research was to listen to the voices of students who successfully completed their graduate studies online, in order to understand the kinds of instructional strategies that were meaningful to them. The program of research addressed both the topic of student help seeking and the topic of instructor immediacy. With the topic of help seeking, the initial phase of the work explored online graduate students' help seeking behaviours (Melrose, Shapiro & LaVallie, 2005). Next, in response to students' belief that their primary source of help was other students in their class, strategies to facilitate student interaction were described (Melrose, 2006).

With the topic of instructor immediacy, when it became apparent that students' valued teaching strategies that demonstrated immediacy and found them helpful, the next phase of the work examined the concept of instructor immediacy in depth (Melrose & Bergeron, 2006). Later, within the process of investigating learners' experiences with helpful and immediate instructional behaviours and their interactions with one another, issues related to working in groups emerged. Bergeron and Melrose (2006) identified students' perceptions of issues that they faced during group work and the instructional strategies that helped. The present article elaborates on the next phase of the research, where specific facilitation strategies are described to demonstrate instructor immediacy during different stages of group development.

The purpose of this qualitative research was to explore health care students' ideas about instructor immediacy at different stages of their small group work, within a masters program offered exclusively through an asynchronous, text based, WebCT online environment. Student participants included nurses, social workers, dieticians, occupational therapists and physicians. They were predominantly female and lived in countries all around the world. This project was framed from a constructivist theoretical perspective (Appleton & King, 2002; Kelly, 1955; Piaget, 1954; Vygotsky, 1978) in that knowledge is believed to be constructed through an individual's interactions with social processes and contexts. The research design was descriptive and the findings a case study representation of two health care graduate programs offered in English at Athabasca University, an open Canadian Distance Education University. The work was guided by the questions: what issues do online graduate learners face during the beginning, middle and end stages of their small group work; and what instructional behaviours are helpful in addressing these issues.

The methods included collecting data from four focus groups and twenty individual audio recorded transcribed interviews. Each focus group consisted of seven or eight participants. The data was collected over a three year period, from 2003 through to 2005, to include personal contact with the 31 participants when they attended Convocation ceremonies at the Athabasca University campus in Athabasca, Alberta, Canada.

Content from these data sources were analysed first independently and then collaboratively by the researchers. The transcripts were read numerous times and on different occasions to glean a thorough understanding of the phenomena and allow the researchers to become immersed in the data. A systematic process of content analysis was developed (Denzin & Lincoln, 1994; Lincoln & Guba, 1985; Loiselle, Profetto-McGrath, Polit et al., 2007). Specifically, as the transcripts were read, color coded fonts and highlighting were used to extrapolate descriptive phrases. Throughout the process of organising these descriptive phrases in relation to similarities and patterns, Microsoft Word files were created to index the categories of

information which repeated in a patterned fashion and constituted themes. In order to reflect on the data and re-examine the files for consistency, weekly email and telephone appointments were established between the researchers, who were separated by time and distance.

Trustworthiness and credibility was established through ongoing interaction and member checking with participants to ensure authenticity. Information was clarified with participants after the interviews through email communication. To ensure anonymity, pseudonyms were used when participants' comments are reported verbatim. Full ethical approval was granted from the Athabasca University Ethics Committee for each phase of the work and all participants gave informed consent.

As an organising schema, the themes are presented by integrating the Tuckman (1965), Johnson and Johnson (1997, 2000) and Salmon (2004) predictive models of learning group development into three stages: beginning, middle and end. First, learners can be expected to progress through a beginning stage where engagement with content and process issues occurs; second, through a middle stage where encouragement towards task completion occurs; and third, through an ending stage where closure occurs. At each stage, participants in this project valued different instructor immediacy behaviours.

Findings

The beginning/ engagement stage

Availability

When participants in the present research discussed their initial recollections about beginning to work in small groups, they consistently expressed a need to know that their instructor would remain attentive to their needs as individuals. Instructors who communicated: "I'm here if you need me" were perceived as available to them, immediate and present.

Students identified that their instructors' first introductory postings communicated whether or not they were genuinely available. As Carrie stated: "I found that first introduction really gave you a sense of how closed or open the instructor was". Paul commented:

Instructors I felt comfortable with set the stage about who they were right off the bat in their introductions. That was very important to me. But, there were other instructors who were quite invisible. You didn't see them. They said that right in the beginning. That that was their style, to stand back unless they were asked questions. That behaviour right away I felt like, well they are not that interested in us and I was less likely to approach them.

Visual cues such as including instructor names on each small group roster and posting online office hours for chat room discussions were further demonstrations of instructor availability. And, directing students to contain their communication within the WebCT class environment instead of engaging in phone or face to face conversations suggested that instructors would be observing group communication.

Safety

From the students' perspective, where designating final mark assignments were controlled by instructors, feeling that it was "safe" to reach out for individual help when they needed it was critical. As Donna explained:

It's the teachers who are marking, and that's how we're going to get through this course. So, their perceptions and

what they want is very important. I didn't mind working in groups, but there has to be a mechanism where you feel safe to be able to comment about the groups.

Discussing how she did not feel that it was acceptable to contact one instructor when an issue emerged during group work, Megan stated: "I thought about going to the professor and then decided not to. I thought it would be obvious enough." Derek added:

Instructors see the postings. You know big brother is watching, but not intervening at all, so you're not really sure if it's safe [to make contact].

The middle/ encouragement stage

Networking

Students appreciated instructional help to join appropriate groups and to network. While some students who had completed a number of classes within the program expressed comfort in self selecting group membership, Kelly felt "letting us sit out there and go 'anybody want to work with me?'" was frustrating. Discussing the difficulties of requiring individuals from different geographical areas to create their own online groups, Vidushi explained that

...if you don't know anybody, and haven't seen the names before, you really don't know how to approach [classmates], that was tough.

Carol advised: "Maybe the instructor could pull people together in the groups. Newer students don't have the background, help us share some little personal thing and then we can build on it to get to know each other." Instructor initiated networking opportunities such as inviting students to post introductions and pictures were viewed as helpful. Sean described how important it was for

...instructors to spend some time at the beginning [of the project] encouraging us to introduce ourselves to one another and provide some biographical information. That really helped make others in the group more than just a name. It really encouraged you to start looking at people as people and to share what we were doing both in careers and personal life. That built networking.

Conflict

Conflict within small group work can be expected and, when managed well, can strengthen learning. However, conflict can also cause undue anxiety and frustration. It is within the experience of conflict where instructor immediacy may offer significant insight. Articulating a clear understanding of instructor and student expectations, particularly in relation to participation and marking is critical. As professional health care providers, many of the online graduate students participating in the present study were experienced group facilitators themselves. Familiar with the importance of establishing rules or guidelines and roles and responsibilities within groups, they were nonetheless appreciative of instructor direction.

Participation

Discussing participation, Jin expressed:

I think part of the challenge with groups, and it needs to be clear up front, you develop your group norms, your group expectations, but [what about] the instructors? There's always that sense that they can see maybe people aren't participating, that the group is asking 'where's your work', 'what do you think about that.' And the instructors are not sort of jumping in.

Cara added "You HOPE they're looking!" Knowing what they could expect in terms of involvement from their instructors helped students to in turn establish expectations with one another in their groups.

Early instructor guidance directing groups to determine consequences for limited participation was useful. Students described situations where groups agreed to "fire" non-participants and other situations where missed meetings and commitments were tolerated. In these experiences, whether they remained included in a group or experienced the rejection of being excluded, students valued feeling close to their teachers. Clearly, expressing immediacy within the process of supporting individuals towards withdrawing from courses can be expected to strengthen the experience.

By count, students emphasised problems with group participation the greatest number of times during the research discussions. Descriptions included "others not doing their share," "carrying others," "doing work for them" and "others getting marks without doing the work." When asked about instructor immediacy strategies that were perceived as helpful responses to participation issues, Lisa described an experience in one course where her instructor "designated a group leader." She continued:

We didn't always do that, the professor asked us that time. [There were some problems with participation.] It allowed the professor to deal privately with one person if something was happening. She said, 'there's seems to be a bit of an issue, do you need my help or are you going to deal with it [in your group] first?' That's what happened in the group that we had a huge problem with.

Marking

With regard to marking, reflection on incidents where instructor expectations were not clear stood out for students. Wiping tears from her eyes, Mary disclosed:

I never fought for something and there's one course that I fought the teacher because I was upset [about] the way she did the marking. How she explained it was so convoluted to start with, and then the way she assigned it! In essence, she said that we all marked ourselves within our own group at 60%. I knew we hadn't because we discussed it, we said we assign, we would each do our own mark, but we all felt that we put in equally, so we would mark above a certain number. Well I called, I was so upset, and I have never in all these years fought a teacher for anything, I fought this one. And it was very disheartening to say the least.

In further discussions with Mary, it was clear that although the incident had occurred well over a year previously, she continued to feel troubled by the memory and still did not understand her instructor's marking expectations in that assignment.

Private feedback

In addition to providing students with clear directions about the level of instructor involvement that they could expect and how their assignments would be marked, students welcomed private emails from their instructors once their small group project work was underway. During the focus group discussions, participants frequently mentioned how private emails "opened the door" to share their individual needs. Whether it was difficulties at home, at work or even "with technology," private emails from their instructors invited students to explore issues such as their participation.

Individual mid term evaluations, as well as requiring groups to submit formative evaluations of their progress was seen as helpful. Privately asking students about how they felt they were progressing and providing some feedback on their contribution to their small group was valuable, “Some indication that you’re on the right path.” In Beth’s words: “Ask how [a student] is doing. How are you doing – and continue to explore that. It’s an easy question.”

Students commented on how private instructor feedback about participation could be very “powerful,” particularly when participation was limited but there was still time remaining in the course. Discussing student-to-student feedback in response to limited participation, Jill stated:

You don’t know what else is happening with that person’s life. You don’t want to drive them out [of the course] and add extra stressors to them when they already can’t cope. But I have actually been in almost – you know, not every course, but a lot of courses, where a good 50% of the group isn’t functional.

Urmy also acknowledged challenges in offering negative feedback to fellow group members.

It’s hard to say ‘you’re not really pulling your weight here, can we help you out in another way?’ You wonder, are we too assertive? It’s a very personal question. That’s a tough behaviour to learn online.

On the other hand, when students were demonstrating strong participation, private instructor affirmations were very encouraging. When Karen shared that she worried she wasn’t contributing, her instructor sent an email stating “I don’t know why you’re saying this because what you bring is very valuable.” Instructor responses such as “yeah, that’s exactly the way I’d like to see it” were heartening.

Although participants in the present study did not agree on whether marks for small group work should be the same for all members, the issue was mentioned frequently during the research discussions. Bruce questioned:

What do you do when your group members just aren’t functioning? And it happened a fair bit. I was in some good groups and I was in some really crummy groups. But everyone gets the same mark, and if you were to say anything you feel like you’re going to be – you don’t know – am I going to be docked?

However, once again, instructor responses that demonstrated immediacy were perceived as positive elements within the experience of group, especially during times of conflict. Anna summarised:

The instructor(s) would gently bring things back to probably what the learning objectives of the course and that kind of thing were. They set some of those limitations ... Tell you to focus or re-do, [that] was so helpful.

The ending/closure stage

Debriefing

Inviting students to formally debrief their experiences by encouraging them to share with others what they learned was viewed as helpful during this stage. Commenting on how students’ posted their final products for colleagues to review and critique, Mae-Ling stated: “Sharing resources like that was big and helpful and certainly lent to the feel that this was a good thing”. “Celebrations” and “virtual wine and cheese parties when it was over” were “fun.”

Reflection

In addition to discussing content that groups had worked on, opportunities to debrief group process were needed. In the present research, as participants reflected on their experiences, few comments about closure in individual courses were expressed. Angie enjoyed how

...one professor particularly wrote a summary of all our feelings and then skilfully put them together and she added some of her perspectives – which I really thought was just amazing. It made it just much more personable for us as a group.

Failure to achieve closure with a small group experience can leave learners feeling unsettled long after the learning event has ended. As Mary's earlier comments reflect, even a year after her class, a lack of understanding about how her group had been marked left her tearful and feeling she had to "fight" with her teacher.

It is interesting to note that, throughout the research discussions, participants consistently commented on how much they valued the process of talking about their learning experiences. There was general agreement that the present project served as an important opportunity for students to reflect and debrief at the end of their program.

Discussion

The findings presented above illustrate stage specific instructor immediacy strategies that health care learners believed were helpful during their small group work. Listening attentively as students who successfully completed graduate studies online shared their memories offered important insights.

In the beginning stage of small group work, where engagement with both tasks and one another was required, students' valued messages from their instructors that communicated a genuine willingness to remain available and present. This finding is consistent with Giddings, Campbell and Maclaren's (2006) work emphasising the importance of early personal communication between online health care learners and their teachers. On an affective level, when assessing the safety of an online learning environment, students felt that it was instructors' first introductory messages that determined whether they were immediate or not. And, students identified that they consistently remained aware of instructors' ultimate control of marking.

In the middle stage of small group work, where encouragement to work through and complete projects was required, students' appreciated personal help with networking and managing conflict, specifically in the areas of participation and marking. Facilitation strategies, such as compiling picture and biographical summaries of group members were helpful in presenting students personally and professionally to one another. Instructors' private feedback through emails, mid-term evaluations and participation assessments demonstrated immediacy and an ongoing awareness of their students' individual learning needs. Explicit rubrics for marking both group processes and products reduced uncertainty.

Instructors who were perceived as immediate were those who had contingency plans in place for constructive conflict management. Examples that stood out for participants in the present research included asking project groups whether they wished to resolve the conflict themselves or with instructor help and designating one member of the group as a spokesperson. Adaptations of Carr, Herman, Zarotney et al's (2005a) activity templates for team contracts, meeting management, peer feedback and after action reflection also offer useful suggestions. Areas of online group conflict identified by students in the present research are similar to the non-participation issues described by Anderson and Simpson (2004), the time consuming nature of the group commitment described by Gabriel (2004) and the anxious and defensive group dynamics described by Creese (2003).

In the ending stage of small group work, where closing with the learning experience was required, students needed

opportunities to debrief and reflect. When these opportunities were absent or incomplete, negative memories persisted. And, the negative memories were linked more to feeling limited immediacy with instructors than with anger towards fellow students or with earning low marks. On the other hand, ending project group work with planned time for reflective activities, instructors' written summaries of group work and measurement of individual as well as group progress stimulated positive memories of meaningful learning. As Eggleston and Smith (2002) and Yonge, Lee and Luhanga (2006) emphasised, programs that portray themselves as learner oriented need to be mindful of parting-ways activities to close and not just end their courses.

Conclusion

This article presented findings from a descriptive research study that explored online graduate students' perceptions of instructor immediacy strategies which were helpful at different stages of small group work. In contrast to other studies, the present investigation extends our understanding of online group facilitation approaches to include the possibility that students' need for instructor immediacy may be greatest during the times they are required to work in small groups.

Traditionally, educators have expected students who are members of project groups to assume responsibility for their dynamics when they work together on a learning task. However, viewing the experience of participating in online groups through the eyes of students, we see that instructor immediacy is a critical element in acting on that responsibility. Liking and feeling close to their teachers helped these graduate learners feel safe, encouraged them to risk participating in group projects and allowed them to achieve closure. The research process itself offered a valuable personal opportunity for online learners to discuss their experiences. The work emphasises an important need to continue researching the kinds of instructor immediacy strategies that can be helpful in facilitating online group work.

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Online Graduate Study Health Care Learners' Perceptions of Group Work and Helpful Instructional Behaviors



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Abstract

Participating in small group activities has emerged as a trend in online learning events. However, little is known about how graduate students experience online group work and what instructional behaviors are perceived as helpful during the group process. This article discusses a qualitative research project that revealed how online health care professionals in two graduate studies programs valued knowing their facilitator was consistently present and available. The project was framed from a constructivist theoretical perspective and a descriptive research design. Participants were health care practitioners who graduated from a Master of Nursing or Master of Health Studies program offered exclusively through a WebCt online environment. Data sources included two focus groups and ten individual audio-tape recorded transcribed interviews. The data was analyzed for themes by two researchers and confirmed with participants through ongoing member checking. The following strategies for creating a safe and

engaging online learning climate for members of small project groups are presented. 1) Create groups intentionally. 2) Intervene with non-contributing members. 3) Measure Individual contributions.

INTRODUCTION

Small group-based learning approaches can stimulate active and engaged participation among higher education learners. In online graduate study classrooms, professional adult students returning to formal learning events can be expected to benefit from opportunities to collaborate with their colleagues on required course projects. However, participation in small group work can be a bittersweet experience. Learners may not find all group work satisfying. Educational research examining learners' experiences with group work and the kinds of instructional strategies that learners themselves perceive as beneficial during their small group work is limited. This article describes findings from a naturalistic study that investigated instructional behaviors that online health care students did believe were helpful and that facilitated cohesive group processes.

Participants in the study were graduates of either the Master of Nursing (MN) or Master of Health Studies (MHST) programs offered through Athabasca University, Athabasca Alberta, Canada. While students enrolled in the MN program hold undergraduate degrees in nursing, those in the MHST program come from nursing, physiotherapy, occupational health, dietetics, medicine and other health care disciplines. Both male and female students are enrolled in these graduate study programs and are required to have practiced in their field for at least two years. Graduates of the 2005 class were predominantly women and lived all across Canada as well as in a variety of other countries. Course work in the MN and MHST programs is completed exclusively online using a WebCT course management system. Therefore, convocation ceremonies at the university campus were the first opportunity for students in these programs to meet their classmates and instructors. Data for the present research was gathered during the time students were together for convocation ceremonies.

The primary medium for communication, instruction and assessment in the MN and MHST programs is asynchronous text-based threaded discussions within a WebCT environment. In most courses, cohorts of approximately twenty students led by one instructor progress through a study guide identifying a series of readings, discussion questions and learning activities during a fourteen week time frame. These learning activities can include project groups of four or five students participating in an online group work assignment.

Literature Review

Scholars in the field of higher education have consistently supported the belief that creating collaborative group work projects for students increases their engagement satisfaction, scope, depth and retention of knowledge (Davis, 1993; Hativa & Goodyear, 2002; McKeachie & Hofer, 2002; Ramsden, 2003). In virtual classrooms, frameworks emphasizing learner engagement through meaningful peer group interaction are widely accepted (Anderson, & Elloumi, 2004; Bates & Poole, 2003; Chickering & Gamson, 1991; Collison, Elbaum, Haavind & Tinker, 2000; Kearsley & Shneiderman, 1998).

And yet, reports from a variety of disciplines suggest that, with the absence of verbal and non-verbal communication cues in asynchronous online graduate classrooms, facilitating successful learner-to-learner interaction is seldom straightforward. Exploring interactivity among professionals returning to online graduate study in a Human Resources Development program, Ehrlich (2002) identified that students' felt anxiety about grades and consistently needed immediate feedback and guidance. Exploring how teams worked together in an online Master of Business Administration program Gabriel and MacDonald (2002) noted that students' supplemented the asynchronous communication opportunities provided for them in the course with

personal or telephone meetings. Exploring collaboration in an online Master of Education program, Agostinho, Lefoe & Hedberg (1997) posited that students had little incentive to collaborate with peers when the learning activities were not linked to their individual assessment. And, exploring cross-disciplinary team building with graduate students in Engineering and the Social Sciences, Murray and Lonne (2006) called for early identification and intervention of problematic group dynamics.

In their comprehensive review of research identifying pitfalls for social interaction in computer-supported collaborative learning, Kreijns, Kirschner, & Jochems (2003) urged educators not to assume that participants will socially interact simply because the environment makes it possible and not to neglect the social and psychological dimensions of the desired interactions. Clearly, in order to afford students the many benefits of online group work, graduate study educators need practical facilitation strategies to promote successful small group experiences. This article voices the suggestions and reflections that graduates of two health care masters programs can contribute to this ongoing discourse.

The Research Approach

This project was framed from a constructivist theoretical perspective (Kelly, 1955; Piaget, 1954; Vygotsky, 1978) in that knowledge is believed to be constructed through an individual's interactions with social processes and contexts. The research design was descriptive and the findings a case study representation of two health care graduate programs at an open Canadian Distance Education University. The work was guided by the questions: what issues do online graduate learners face when working in groups; and what instructional behaviors are helpful. In addressing these issues.

Data sources were collected in person and included two focus groups and ten audio tape-recorded transcribed interviews. Content from these data sources were analyzed first independently and then collaboratively by the researchers. The transcripts were thoroughly read and re-read and a systematic process of content analysis was developed (Denzin & Lincoln, 1994; Lincoln & Guba, 1985) to create a categorization and coding scheme leading to themes. Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity. To ensure anonymity, pseudonyms were used when participants' comments are reported verbatim. Full ethical approval was granted from the Athabasca University Ethics Committee and all participants gave informed consent.

The program of research was first initiated with an exploration of online graduate students' help-seeking behaviors (Melrose, Shapiro & LaVallie, 2005). Second, when it became apparent that students valued teaching strategies that demonstrated immediacy and found them helpful, the concept of Immediacy was examined in depth (McIroso & Bergeron, in press). Third, in response to students' belief that their primary source of help was other students in their class, strategies to facilitate student interaction were described (Melrose, in press). Fourth, within the process of investigating learners' experiences with helpful and immediate instructional behaviors and their interactions with one another, issues related to working in groups emerged. The present discussion elaborates on specific instructional behaviors that participants appreciated when they were required to work in small groups.

The following three strategies emerged as themes when analyzing the interview and focus group data collected from and confirmed with students who successfully completed their graduate studies online. The strategies represent students' perceptions of key areas where instructional help was needed to facilitate successful group project work. The first strategy was to create groups intentionally. The second strategy was to intervene with non-contributing members. The third strategy was to measure individual contributions.

Findings

Strategy One: Create Groups Intentionally

When the health care professionals in this project reflected on instructional behaviors that were helpful to them during their group project assignments, discussions frequently centered on how they came to be in the group. The anxiety of being required to self-select into their groups was apparent in comments such as: “It’s tough to ask, does anybody want to work with me? You don’t know anyone and have just seen names on a list.” And: “I don’t want to work with someone who just wants to pass.” By count, commitment to doing well and achieving a high grade was mentioned the greatest number of times during the research discussions. As Rannu explained: If we were successful, it was because there was a commitment: if commitment was missing it made it difficult.” At the outset, for students who were new to both online learning and graduate study, small group project work was perceived as overwhelming at times.

Intentionally engaging online adult learners, who may feel anxious, concerned about their grades and unfamiliar with the venue, in small group work activities is not easy. Participants in this research repeatedly emphasized that knowing their instructors were present and available was reassuring. In the process of creating groups, instructors who genuinely projected a message of ‘I am here if you need me’ were considered very helpful. Ashwin commented: “As much as instructors told us to establish norms, establish roles, establish expectations, it should also include, if you get into trouble, you can always come back to me.” Students expressed that they did not necessarily want instructors to provide answers; rather, they found it empowering to arrive at their own conclusions. Ann described a memorable professor who stated: “If you need help, I’m here, e-mail me.....just come to me, I’m willing to help you through it. I won’t do it for you, but I am willing to help you through it.”

Thoughtful composition of who would be in their small groups was important to students. They appreciated instructors who inquired about their experience with online learning, with graduate study, with professional leadership skills, with life experiences; and then applied that information to assign or direct them toward membership in a particular group. The process of seeking to know their students and to usher them toward a safe small group further communicated that instructors were present and available.

Students also valued a clear articulation of the relevance of required group work. Knowing they were expected to link the objectives and outcomes of their projects to their practice enhanced personal meaningfulness. Specific rubrics for marking group processes as well as for marking project content were expected. And finally, some participants did express a desire not to work in a group and to have alternate assignment opportunities available.

Strategy Two: Intervene with Non-contributing Members

Throughout the data collection, participants all identified experiences where they had been members of poorly functioning groups caused by non-contributing members. Non-contributing members were defined as students who did not contribute to the group process or task, as well as students who only wanted to pass without earning an A grade. In instances where instructors intervened and dealt with non-contributing members, participants emphasized that this strengthened the group process. But, when instructors did not acknowledge and address the issue, the groups were often unable to progress on their own.

Nirmila talked about the differences between addressing the issue in face-to-face groups versus online groups and in undergraduate versus graduate groups. She shared how, in an undergraduate face-to-face group, asking a non-contributing member: “Is there something going on, because you are not pulling your weight here? Can we help you in another way?” would be acceptable. However, in a graduate online group, she felt that “... it can be perceived as too assertive.”

Zara described the uncertainty she experienced when working with a non-contributing member and commented that she “did not know what to do.” Ang felt he “did not have the tools” to resolve the issue. Participants also discussed instances where group members shared their concerns over the phone with one another, “...working around the non-contributing member.” Another participant described feelings of “relief” when a non-contributing member withdrew from the course, thereby lifting the burden of requiring the group to address the problem. Given that their courses were designed for worldwide online-only delivery, students separated from one another by vast geographic distances are clearly disadvantaged without instructor intervention.

Strategy Three: Measure Individual Contributions

Methods of educational measurement that assess group projects can be controversial. Often, instructors assign the same mark to all members, regardless of individual contributions or the group’s level of functioning. For participants in the present research, this was problematic. Several expressed that this assessment method caused them to question whether they would identify problems within the group. Hui Ying explained: “Everyone gets the same mark, and if you were to say anything, you feel like you’re going to be ...docked?” And Sue continued: “There has to be a mechanism where you feel safe to comment about the group and [still know that contributions are] fairly marked.”

The research discussions raised questions and musings around whether instructors were actually observing student performance in group work. When instructional intervention was not apparent and both contributing and non-contributing members received equal marks, participants felt frustrated, abandoned by their instructor and they lacked closure with the experience.

Discussion

The aforementioned three Instructional strategies developed from discussions with professionals who successfully completed their graduate degrees exclusively through a WebCT online course management system, begin to illustrate the kind of facilitation approaches that these groups of learners find helpful. Given these findings, implications for educators include ensuring that student project groups are created thoughtfully and intentionally. Clearly, genuinely communicating that one is present and available and reaching out to understand who students are individually can begin this important process of engagement. Acknowledging non-contributing members and intervening immediately can prevent dysfunction and allow members to focus on positive processes and tasks. And, seeking ways to assess individual contributions that extend beyond simply assigning the same mark to all group members will deepen our understanding of student-centered educational measurement.

Creating small project groups online can be a creative undertaking. Some seminar activities traditionally implemented in face-to-face graduate classrooms can be transferred to online discussion boards. For example, as soon as the course has opened, inviting students to share their own ideas about forming successful groups actively involves them and establishes a climate of shared decision making early in the class. Similarly, asking students to list specific instructional strategies that they have found both helpful and not helpful in previous group experiences displays examples the present group may choose to adapt. Providing opportunities for students to share their interests and expertise before requiring them to join a group reduces anxiety. When possible, offering alternatives to group work, such as completing projects alone or in dyads defuses uncertainty.

As the small groups begin to form, including instructors’ names in each small group roster communicates their presence. Posting online office hours conveys availability. Welcoming messages within the small group meeting areas encouraging members to contact instructors affirms an open line of communication. Designating a formative progress report evaluating small group process mid-way through the project defines a place where issues can be addressed.

Before the small groups begin to work on tasks, calling for discussions about group guidelines establishes a student-generated structure for rules and norms. Encouraging brief social interactions stimulates affective connections and feelings of emotional safety. Articulating expectations of what students must do and what instructors will do determines consequences. Presenting short precis of conflict resolution models again illustrates examples the present group may adapt. Clarifying behavior that is unacceptable in the group, such as unexplained missed meetings or task completions, sets the stage for peaceful informed resolution. For example, some groups may elect to dismiss a member in response to an unexplained absence; while others may not. However, while individual group guidelines may look vary different, the principle of establishing the rules in advance is essential. Similarly, in relation to the important issue of grading, collaboratively establishing whether students will earn an individual or group grade, and what input they will have in terms of grading themselves or their peers, clarifies educational measurement. And, once the group work is underway, requiring early submissions of small pieces of the project, such as an outline for an academic paper, reveals potential problems.

The issue of non-contributing members is well represented in distance education literature addressing group work. Bates & Poole (2003) stated that online learners “object to group assignments on the grounds other students may not pull their weight” (p.237). Anderson & Simpson (2004) asserted that “despite the value of small groups, students saw non-participation in groups as a major issue with the implications for workload, the value of learning activities, and motivation to continue engagement with the group” (p. 11). And, Coliison, Elbaum, Haavirrd & Tinker (2000) declared that “ignoring the emotions participants express can be deadening. Acknowledging and honoring them can break open new levels of communication, to the benefit and enrichment of the entire group” (p.98). In their online graduate study nursing classes, Diekmann & Mendias (2005) strive to make the issue more visible by demonstrating they know about non-contributing members and will connect with them by e-mail to comment on how their behavior affects others.

Therefore, knowing that this issue can be expected to exist in graduate study group work; implementing action strategies such as involving students in decisions about who will be in their small groups, what the rules will be and how they can participate in their grading process, must become a priority for educators.

Conclusion

This article presented findings from a descriptive research study that explored online graduate students' perceptions of issues they faced when working in small groups as well as instructional behaviors that can help to address these issues. In contrast to other studies that Identified similar concerns with online group work, this project extends existing understanding by including health care professionals' reflections on effective facilitation strategies. This research found that these professional learners believed small group project work was more meaningful when instructors created their groups intentionally, intervened when members did not contribute and measured individual contributions. As the trend to incorporate small group projects in graduate study curricula continues to generate enthusiasm among educators, including the voices of students who have personal experience with this form of instruction becomes critical. This article calls for the creation and inclusion of more process oriented activities that listen to the issues students' face in online graduate study classrooms and the kinds of instructional responses they value.

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Help-Seeking Experiences of Health Care Learners in a WebCT Online Graduate Study Program

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Help-Seeking Experiences of Health Care Learners in a WebCT Online Graduate Study Program

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Abstract

Abstract: This article presents findings from a qualitative research project that explored health care students' activities related to seeking help within a masters program offered exclusively through a WebCT online environment. A constructivist theoretical perspective and an action research approach framed the study. Data sources included one question on a program satisfaction questionnaire, focus groups and ten individual audio tape-recorded transcribed interviews. Content was analyzed for themes and confirmed through ongoing member checking with participants. The following four overarching themes were identified and are used to explain and describe significant features of help-seeking experiences of online health care learners: (1) Self-help included reflection and re-reading directions available within the course; (2) A primary source of help was other students in the class; (3) Involving family, friends and co-workers provided important educational support; and (4) Instructors' first message, involvement in weekly discussions and anecdotal comments were highly valued.

[PDF – 206 KB]

Citation

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Abstract

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Résumé: L'article présente les conclusions d'un projet de recherche quantitative qui abordait les activités entourant la demande d'aide des étudiants dans le domaine des soins de la santé dans le cadre d'un programme de maîtrise offert exclusivement dans un environnement en ligne de WebCT. L'étude est appuyée d'un point de vue théorique constructiviste et d'une méthode de recherche-action. Les sources de données comprennent une question sur le questionnaire de satisfaction relative au programme, des groupes de discussion ainsi que dix entrevues individuelles enregistrées sur ruban puis retranscrites. Le contenu a été analysé en fonction des sujets puis confirmé en effectuant une vérification continue auprès des participants. On a identifié les quatre sujets déterminants que voici et on les utilise pour expliquer et décrire les caractéristiques importantes de la recherche d'aide des apprenants en ligne dans le domaine des soins de la santé: (1) les conseils comprennent la réflexion ainsi que les directives de relecture du cours; (2) les autres étudiants de la classe peuvent être d'une aide précieuse; (3) la participation de la famille, des amis et des collègues peut s'avérer un soutien éducatif important; (4) le discours de l'instructeur, la participation aux discussions hebdomadaires ainsi que les témoignages sont grandement appréciés.

Introduction

This article describes findings from a qualitative research project that investigated the experiences, reflections and feelings of online health care students during times in their graduate study program where they sought or attempted to seek help. While the main purpose of the project was to explore learners' ideas about seeking help, a secondary purpose was to begin to consider instructional strategies that respond to learner needs. The research was guided by three questions. First, do online health care graduate study learners believe they need help? Second, what specific strategies do these learners implement to seek help? Third, what kinds of problems occur throughout the help-seeking process? Preliminary findings from the project were reported at the Tenth Annual NAWeb Web-based Teaching and Learning Conference (Melrose, 2004).

Participants in the study were graduates of either the Master of Nursing (MN) or Master of Health Studies (MHST) programs offered through the Centre for Nursing and Health Studies, Athabasca University, Athabasca, Alberta, Canada (<http://www.athabascau.ca/cnhs/index.php>). While students enrolled in the MN program hold undergraduate degrees in nursing, those in the MHST program come from nursing, physiotherapy, occupational health, dietetics, medicine and other health care disciplines. Both male and female students are enrolled in graduate study programs at the Centre and are required to have practiced in their field for at least two years. Graduates of the 2003 and 2004 classes were predominantly women and lived all across Canada as well as in a variety of other countries.

Course work in the MN and MHST programs is completed exclusively online using a WebCT course management system. Therefore, Convocation ceremonies at the Athabasca University campus are the first opportunity for students in these programs to meet their classmates and instructors. Graduates and faculty congregate in the nearby city of Edmonton, Alberta, Canada for several days before the formal ceremonies and most of the data for the present research was gathered during this time in June 2003 and June 2004.

The primary medium for communication, instruction and assessment within the MN and MHST programs is asynchronous text-based threaded discussions within a WebCT environment. In most courses, cohorts of approximately 20 students led by one instructor progress through a study guide identifying a series of readings, discussion questions and learning activities during a 14 week time frame. Each course has been designed to include weekly forums where students discuss the study guide and a "coffee room" forum for informal connections. Students are graded on their participation in the weekly discussion forums. In-course e-mail, private small group work forums and synchronous chat room discussion options are also available.

Literature Review

A literature review revealed that over the past decade educational researchers have come to recognize how the process of seeking help within an educational event can be a valuable and strategic resource for learners (Karabenick, 1998). Rather than simply reflecting student dependency or an immediate need to execute a task, the ability to reach out to others to ask for help when it is necessary is an adaptive learning strategy. Considerable research has been undertaken to investigate help-seeking behaviour among students in both elementary/middle/high schools as well as undergraduate university settings. There is a “gap,” however, in our understanding of how graduate learners seek help within their learning experience.

Traditionally, the process of seeking help from others was considered somewhat of a dependent behaviour. Bornstein's (1992) review of literature from the field of psychology noted that individuals diagnosed with a dependent personality disorder tend to seek help from others more to fulfill a need for support and nurture than for specific responses to an expressed concern. However, within the field of educational psychology, research distinguishing the process of seeking help within educational events from problematic dependent behaviour began to emerge during the 1980s.

DePaulo, Nadler and Fisher (1983) published an important edited series of research studies that examined how learners seek help and this collection laid a foundation for further study. Nelson-Le Gall's (1981) seminal work examining children's learning was significant in identifying that the ability to seek help is an important developmental skill. Focusing on motives rather than actions, she distinguished between *executive* and *instrumental* motivation. *Executive* help-seeking involved asking others for help simply to complete or execute a task. By contrast, *instrumental* help-seeking involved only enough assistance from others to master the ability to complete a task independently. Although this research was implemented with children, the distinction between executive and instrumental is important in understanding motivation among adult learners, such as graduate students, as well.

Other conceptual approaches from the field of educational research also emphasized how the ability to seek help is a valuable learning strategy. For example, Ames (1983) presented the idea of seeking help within learning as a strategic achievement behaviour. And, Karabenick's (1998) edited series summarized how the work of Newman (1991, 1994), Schunk and Zimmerman (1994), and Zimmerman and Martinez-Pons (1986) led to the comprehensive explanation that “adaptive help-seeking is a strategy of self regulated learners who efficiently seek necessary assistance in response to perceived lack of comprehension” (p. 2).

While the studies noted above have focused on younger children, the view that undergraduate learners who seek instrumental assistance when necessary are more actively engaged and self-regulating has also become accepted (Karabenick & Sharma, 1994). Karabenick and Knapp (1991) identified that college students who use a variety of cognitive, metacognitive and self-regulating strategies will also seek help more frequently. In the field of library sciences, Bailey (1997) examined the extent of help undergraduate students needed when researching papers and from whom they sought assistance. Findings suggested that learners who sought assistance from peers did not always receive accurate help (Bailey, 1997). In the field of undergraduate (pre- registration) nurse education programs, only one study mentioned help-seeking. In relation to hardiness, social support and academic performance, Hegge, Melcher and Williams (1999) asserted that nursing students who sought help tended to perform better academically.

In the field of distance education, Price (2002) disseminated findings from a five-year doctoral research project that examined help-seeking among distance learners in an undergraduate (post-registration) nurse education program. His findings emphasized the emotional challenges involved with seeking help, in particular because the role of university tutor or teacher is very different from school teacher or college nurse education teacher, making the transition to university education difficult for nurses. Price (2002) identified that the role of an academic tutor aids learning by promoting individual thought rather than offering definitively correct answers and that this can pose problems for students who want to get the best help from their tutor, yet are anxious that what they say or do might seem inadequate or stupid.

Also in the field of distance education, Taplin, Yum, Jegede, Fan and Chan (2001) compared the help-seeking strategies of undergraduate students identified as high achievers with those identified as low achievers in an attempt to uncover insights

about successful help-seeking strategies that could be used by distance education students. Here, findings revealed a tendency for more of the high achieving students, particularly the women, to seek help for personal difficulties related to their courses such as test anxiety, self-motivation and finding time to study. Sources of help included family and friends, fellow students and tutors. Taplin et al. also observed that the group in which the fewest students sought help was the high-achieving men.

Deterrents to seeking help have also been examined and Karabenick (1998) noted that they included indebtedness to the provider, individualistic and cultural norms, embarrassment, self-esteem threat and characteristics of the source of assistance, such as the degree of formality. Taplin et al. (2001) also discussed the source of assistance and identified that, within a distance education environment, the main reason for not seeking help was that access to a tutor or suitable knowledgeable person was difficult.

The Research Approach

This project was framed from a constructivist theoretical perspective (Peters, 2000) and a naturalistic action research design (Altrichter, Posch, & Somekh, 1993; Corey, 1949; Kemmis & McTaggart, 1990; Stringer & Genet, 2004). Data sources included one question on a program satisfaction questionnaire, focus groups and ten audio tape-recorded transcribed interviews with graduates who attended Convocation ceremonies at the Athabasca University campus in Athabasca, Alberta, Canada in June 2003 and June 2004. Content from these data sources were analyzed first independently and then collaboratively by the researchers. The transcripts were thoroughly read and re-read and a systematic process of content analysis was developed (Loiselle, Profetto-McGrath, Polit, & Beck, 2004) to create the categorization and coding scheme that led to the themes. To ensure inter-coder reliability, once the broad conceptual categories of the four themes were decided, the researchers independently colour coded each section of data and filed it according to theme. During the process of exchanging files, modifications were made and agreement reached. The research approach was conceptualized from tools examining help-seeking within learning that were tested in an earlier project (Shapiro, Kappelman, Melrose, & Tse, 2003). Pseudonyms were used when participants' comments are reported verbatim. Investigator triangulation promoted thematic validity. Trustworthiness was established through ongoing interaction and member checking with participants to ensure authenticity. Full ethical approval was granted from the Athabasca University Ethics Committee. Funding for the project was provided by the Mission Critical Research Fund at Athabasca University.

The following question was included on the graduate satisfaction questionnaire and provided the structure for discussion in both the focus groups and the individual audio tape-recorded transcribed interviews:

Seeking help with learning can be difficult for online students at the graduate level.

Please describe an incident when, even though you read the study guide, that you did not understand all the instructions and did not know what to do. As the course progressed, and other students began to work—what did you do? What kind of help did you need and who did you seek it from? What happened? Do you think other people in the class would do the same thing? Are there “unwritten rules” for getting help as an online graduate student? If you would be willing to describe your experience in more detail, please e-mail Sherri Melrose (sherrim@athabascau.ca).

The following four themes emerged from analyzing the data and represent key findings. The first theme was that self-help included reflection and re-reading directions available within the course. The second theme was that a primary source of help was other students in the class. The third theme was that involving family, friends and co-workers provided important educational support. The fourth theme was that instructors' first message, involvement in weekly discussions and anecdotal comments were highly valued.

Theme One: Self-help Included Reflection and Re-reading Directions Available Within the Course

Without exception, participants in this project all commented on how they spent considerable time reading and re-reading course materials before reaching out beyond themselves for help. When a publication or direction for an assignment did not make sense, participants discussed how leaving the course, reflecting on the matter and then returning to it at a later time seemed effective.

It is not unexpected that professional adult learners who have experienced previous academic success and who have actively practiced in a health care discipline might implement a self-help learning process of reading, reflecting and re-reading. In fact, seeking help independently and from written resources provided within the course was sufficient for many students. One questionnaire response stated simply: “I never experience this problem.” Within the focus groups, participants frequently commented on how their professional responsibilities equipped them to “figure things out on our own.”

From the student perspective, a key problem with this process of independent help seeking emerged in terms of allocating the time needed for reading material several times and on different occasions. In addition to their graduate courses, most students continued to manage their full time employment and family responsibilities. Establishing dedicated study times of “four or five hours each week for the study guide and several days for each of the assignments” was considered a norm. For some students, taking time away from employment was possible. As Sandy explained:

As I got closer to finishing my degree, I reduced my full time employment which made a significant difference. Then—I could take a full day that would be my paper writing day, reading day, research day. I would still have two nights a week to do the discussion groups. But, taking that one full day a week to do all the other work really made a difference.

However, for students, it was the amount of time needed for reflection and the difficulty in planning for this kind of time that was particularly frustrating. For example, as one participant stated:

I didn't like to have to go back and re-read too many things. In some cases—a research study for example—it is expected. But—re-reading directions and information that just isn't clear is a waste of my time—which I don't have enough of anyway!

Implications for instructing online graduate courses become apparent as we consider how learners can be expected to first apply self-help strategies such as re-reading and reflecting that they may already have in place. For example, responding to student questions with suggestions to read or re-read course material is not likely to be construed as helpful. As Marilyn emphasized:

To receive a message (from an instructor) that says just go back and read it—it's in your guidelines—go back and read it—because I already would have done that! If I was still questioning what I read then I need somebody to turn the light on because obviously I haven't got it. There is an assumption—because I myself would never ask unless I've studied it and made my own interpretation. And, if I'm still not clear, that's when I would go to the instructor. So, I always do my homework first and try to figure it out. If I'm not clear, it is because I really do have a need for some explanation.

On the other hand, instructor responses that acknowledged both the expected amount of time spent on course requirements as well as the unexpected time spent reflecting were considered helpful. Students appreciated recognition that the additional time they spent reflecting and thinking about their learning was worthwhile. Similarly, any invitations to discuss time management, self-help strategies and reflective musings within the course were welcomed. And, students clearly expressed the importance they placed on clear, concise directions and messages that required only one reading.

Theme Two: A Primary Source of Help was Other Students in the Class

When participants in this study were unable to help themselves and did find it necessary to reach out to others, it was their classmates they turned to first. By count, students emphasized the importance of connecting with peers in the class the greatest number of times during the research discussions.

Private e-mail was used most frequently to initiate discussions. In many instances, students would pick up on a colleague's posting in a public discussion forum and add a personally relevant point by private e-mail. Initially, the connections could be sparked by commonalities such as working in the same area of health care, living near to one another or experiencing similar life stage issues. From these initial social conversations, more in-depth communication emerged and "life-long friendships" developed. Participants in this study all described how they established at least one or two of these friendships in most of their classes. And, as the relationships between and among learners did develop into friendships, students felt comfortable in asking one another for help when they needed it.

Content of the private e-mail discussions ranged from simple tips for navigating the technical environment of the WebCT course management system to more complicated concepts such as strategies for academic writing. "Gossip" related to individual instructor expectations, specific challenges within particular courses and support for "outspoken or negative feedback" from instructors and peers.

Public forum discussions and the coffee rooms were also used to forge help-seeking and help-giving connections among students. As Gerri explained, *"For me, it was most helpful in the big group because if I was having a problem, out of 20 or so other folks, somebody else probably wondered too."* When asked if the anonymity of working online rather than face-to-face lessened the risks often associated with asking for help, participants in one focus group discussed how health care professionals *"seldom have the luxury of not asking when we don't know something."*

Earning marks for weekly participation in academic forum discussions was consistently identified as a critical factor for choosing to create meaningful postings. Without the opportunity to earn marks for their participation—students in the present study repeatedly stated that they would not take the time to contribute.

It is important to note how the student-to-student exchanges continued even after the courses ended. Participants commented on how they intended to remain in touch and to continue sharing academic information. As Carol explained: *"Both the gossip-talk and the academic talk was really important for me to learn to think critically again. It was my friends in the classes that really got me through."*

Where problems occurred within the help-seeking experiences among students was when contributions to graded group projects were perceived as unequal. Here, while the process of actively and explicitly seeking help was clearly acceptable, a process of passively or implicitly seeking help was more controversial. In some of the research discussions, the definition of help-seeking was extended to include seeking help implicitly through passive behaviours such as not attending planned group chat sessions, late or very limited submissions to group papers and other examples of "not doing their share."

Participants in the present research study were fairly equally divided between positive and negative experiences with assignments requiring group work. For the most part, students did not view helping others as a burden. However, resentment towards "carrying" others when earning a group grade and "doing all the work when some students don't do much—but still get the mark" was apparent. Comments such as "there is a fine line between offering help and doing work for others" illustrated how an element of reciprocity may be an implicit expectation or unwritten rule among graduate learners online, particularly where marks and grades are at stake. In Kelly's words:

Maybe there could be recognition by instructors that peer support does occur, and that we encourage it, we support it, but—there are limits to the extent that students can actually render that support. Time is an issue; we are all busy, working, kids, trying to get our own assignments done. We want to help people—yes for sure. But, you can't do the work for them. Sometimes it is important to understand that there may have to be some extra help beyond just other students if there tends to be a lot of need for support.

Given these findings, implications for instructing online graduate students include ensuring that opportunities for students to connect with one another in a class are readily available. Design elements within the course such as private e-mail and coffee room forums are useful. Clearly, awarding marks for participation in academic forum discussions establishes this activity as a priority. Further, the importance of encouraging each student to post a thoughtful well-crafted introduction should not be underestimated. Inviting students to include pictures and brief descriptions of their workplaces and homes establishes communication that can extend social conversations into academic dialogue. And, it is critical for instructors to recognize that learners generally willing to offer help do resent situations where non-contributing members of group projects receive marks.

Theme Three: Involving Family, Friends and Co-workers Provided Important Educational Support

Throughout the research discussions, participants often commented on the important support they received from family, friends and co-workers during their program. While specific course related help-seeking questions were most likely posed to classmates and instructors, seeking help for “bouncing ideas around,” and sharing exciting new learning “discoveries” were often discussed in person with the individuals closest to the students in their daily lives.

Extending learning beyond the virtual classroom and into everyday conversation added a practical dimension to graduate students’ online experience that otherwise might have been missed for them. For example, Jan described how she created a “tutorial group” at her workplace:

I really did find that, based on the online sort of program, that I did need that kind of personal face-to-face talking it through context. So, one of the things I found really helpful was to find people within my work area that would follow me through each course. Because as much as you can express yourself online—it is still—sort of—you know you don’t actually get the time to work it through and discuss it and get more understanding. I really did use my colleagues at work a lot, almost as my tutorial group.

Similarly, Kathy commented on how she sought feedback on assignments before submitting them:

Because of the distance learning situation, one of the things that I did was to seek help from a number of my colleagues. I had several colleagues who had completed a master’s degree, not from Athabasca, but from other universities, and so at times I did actually begin my work and then ask them to look it over and give me some advice. It would not be the same as submitting the whole thing for a mark; it would be more asking them what direction I should proceed and if I was—in their opinion—following what I should be in terms of the outline and the instructions given in the course.

Problems associated with the strategy of seeking help from family, friends and co-workers included having few contacts to turn to and contacts who had limited understanding and familiarity with course expectations. In some cases, students’ contacts were not supportive of their scholarly endeavours and questioned why they were “doing this.” Also, one student discussed how she was not working in a health care environment during her program and did at times feel “alienated” when she “didn’t have those constant cues around me.”

Implications for instructors related to the important help that family, friends and co-workers can provide include creating opportunities for students to transfer their learning to their day-to-day life situations whenever possible. Constructing activities that direct students to present assignments in their workplace and then discuss any responses in class can be effective. Suggesting that forming out-of-course educational support groups may also be useful for some students can be a useful teaching prompt.

Theme Four: Instructors First Message, Involvement in Weekly Discussions and Anecdotal Comments Were Highly Valued

When given the opportunity to share their ideas about and activities related to help-seeking, participants in this study repeatedly identified how dialogue with their instructors was deeply meaningful to them. In particular, memories of instructors' first or introductory message, involvement in weekly discussions and anecdotal comments stood out for students.

The “tone” of the messages and “how quickly” instructors responded were identified as indicators of “whether or not you would get any help.” This finding is consistent with Ekong (2004) and Kearns, Shoaf and Summey (2004). Although isolated incidents of “profs who didn't get back to you for several days” were mentioned, for the most part, students spoke with great admiration about how their instructors “did everything they could” to clarify, explain and offer help with course requirements.

Looking through the students' eyes, it was the first message from their instructor that often set a “tone” of engagement and encouragement. “Friendliness” was valued over “a lot of directions.” And again, the importance of an introductory message that shared conversational information about home, work and personal as well as professional interests contributed to creating a climate where learners felt “comfortable enough to ask for help” when they needed it.

Participating in and facilitating rather than “just saying something was right or wrong” during weekly discussions also contributed to a safe and comfortable climate within classes. Knowing that their instructor was present, would add comments and could be “counted on to re-direct when we needed it” was reassuring. As Lesley mentioned:

I think honestly the thing I found most helpful and enjoyed the most were the classes where the professor participated in the postings. I had a few where the professor would sort of post one at the beginning of the week and then that was it. And, I had some where the professor would join every discussion. I found that the most helpful. I felt like I got to know the person a little bit and almost like we were a group of people sitting around a big table and participating together.

And, anecdotal comments that welcomed learners to “begin to know the professor as a person—not just their work experience” were valued. In addition to creating a warm and inviting climate, seemingly anecdotal comments became very helpful when it came to modeling tasks that might be new to students. “I really liked hearing about the prof's experiences—especially when things didn't go perfectly for them. I learned a lot from those examples.” Often, students viewed the light-hearted comments instructors interjected about their lives and experiences as invitations to share aspects of their own lives.

Relationships with instructors became critically important in one key area of help-seeking—that of students not knowing or not believing that help was needed, when in fact, it was. Several participants in this study identified times where they did not know they needed help, but received an assignment back that identified problems with their work. In these instances, where professional individuals did not seek help, and yet found themselves in the position of being required to receive it, emotional connectedness clearly strengthened the exchange.

A striking feature of the devastation graduate students in this study experienced when they received low marks emerged time and again during the private interviews. Two participants came close to tears as they shared instances when they had not earned high marks. In one situation, Jill “lost” 10 marks on a 25 mark assignment. She spoke about her initial response as “a hesitation to ask for help. Everybody else seems to get it—am I that dumb or whatever?” She continued:

I think when I realized that I did not have the concepts down well was when my assignment came back and my mark wasn't what I wanted it to be—but the professor was extremely good. What I did was put together an explanation of what I thought the concepts were and asked her to review them and explain to me where I was off base. She did that and after that my marks were OK, so I was happy again [laughing as she wiped her eye].

In another instance, Chris, who had mentioned earlier in the interview that she “would have liked to have had more opportunity to have a dialogue with the professor,” did not express a sense of closure with a low mark in one of her classes.

She described resolving the situation, “...just get it done—get it over with. After the course I can practice.” Chris commented quite emphatically that the experience left her feeling “self-defeated” and, unlike Jill, she did not choose to seek further help from her instructor once she received the feedback. Chris made a point of mentioning several times that she had achieved success in other courses and “hadn’t needed much help.”

Implications for instructors related to the value graduate students place on their first message, involvement in weekly discussions and anecdotal comments can be far-reaching. Sharing ideas, personal experiences and problem solving strategies can enhance the learning climate and provide useful role modeling. An engaging learning environment and an approachable instructor can make the often difficult task of seeking help easier during times when learners know they need help as well as during those times when they did not know or believe they needed help.

Discussion

The aforementioned four themes, developed from discussions with students who successfully completed their graduate degrees exclusively through a WebCT online course management system, begin to illustrate the experience of help-seeking among this group of learners. Listening attentively as students discussed their experiences revealed useful ways of looking at whether online graduate learners believed they needed help, the strategies they implemented, the problems they encountered, the “unwritten rules” and the preferred instructor responses. Some learners did not believe they needed help and others did not know they needed help until they received assignments back from their instructors.

Specific strategies students implemented, included extensive reading and reflection and turning to fellow students, family/friends/co-workers and instructors. The motivation guiding these strategies was consistent with Nelson-Le Gall’s (1981) definition of instrumental help-seeking directed towards independent mastery of a task and not towards dependent behaviour or a wish to have the task done for them (executive help-seeking). The behaviours were consistent with Karabenick’s (1998) explanation that seeking help efficiently and when it is necessary is an adaptive and self-regulating learning tool. The characteristic that academically strong students willingly reach out for help reflected in this study is also consistent with both Hegge, Melcher and Williams (1999) findings with undergraduate nursing students in a traditional classroom setting and Taplin et al. (2001) findings with undergraduate students in a distance education setting. And, the strategies themselves were not significantly different from those identified in research examining elementary/middle/high school and undergraduate learners.

However, some of the difficulties that this group of professional graduate level learners experienced in their process of help-seeking are unique. Self-help strategies, such as reading and reflecting can be expected to be highly developed. Therefore, questions and requests are not likely to be posed casually. Time is stretched to the extent that the intense commitment required in graduate course work may necessitate decreasing or actually leaving employment. Time management skills have been carefully developed to target priorities and eliminate activities not directly identified with earning marks, such as participation in forum discussions. So, unless marks are appropriated for discussions, in spite of the positive comments participants in this study used to describe the friendships they made in classes, graduate learners may not identify the activity as a priority. While a willingness to respond to others’ needs for help clearly exists, there is an “unwritten rule” suggesting an expectation of reciprocity and equal participation within group projects when marks are involved. Family, friends and co-workers, known to be an important educational support, may be neither available nor supportive. And, perhaps most important of all, it was the personal connections with classmates and instructors that established the foundation for efficient help-seeking for these students.

The present investigation suggests expanding our ideas about facilitating learning with online graduate learners to include acknowledging the activities they may already be engaged in to seek help. In turn, this acknowledgment can guide us toward a deeper understanding of how best to respond and offer what further help may be needed. Knowing how much online graduate learners value a safe and welcoming climate within their classes leads us to look for ways to create warm and inviting virtual spaces. The importance of establishing and maintaining an engaging learning climate within online nurse

education is consistently emphasized in the literature (Billings, Conners, & Skiba, 2001; Boyle & Wambach, 2001; Diekelmann & Gunn, 2004; Frith & Kee, 2003; Mills, Fisher, & Stair, 2001; Wills, Stommel, & Simmons, 2001). Affirmations of the value of instructors' first message, involvement in weekly discussions and anecdotal comments encourage us to pay careful attention to these activities.

Clearly, implications for future research include involving a larger sample of participants from different universities. And, while the reflections that program graduates in this study shared during their Convocation ceremonies were in depth, it would also be useful to examine these experiences at different times. The researchers were left wondering about how help-seeking experiences at the beginning of a program might be different than those articulated upon graduation.

Conclusion

This article presented findings from a naturalistic action research study that explored online graduate students' ideas about and activities related to seeking help within a WebCT course management system. In contrast to other studies that explored the experiences of students in schools or undergraduate programs, this projects extends existing understanding of what it was like for professional health care workers to reach out for help when they needed it during their masters program by identifying four overarching themes. This research found that students' self-help included reflection and re-reading, that their primary source of help was other students in the class, that involving family, friends and co-workers provided important educational support and that instructors' first message, involvement in weekly discussions and anecdotal comments were highly valued. The article calls for the creation of more opportunities to understand how students seek help and continued attention to constructing teaching strategies that respond to and collaborate with students in innovative and genuinely helpful ways.

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Facilitating help-seeking through student interactions in a WebCT online graduate study program



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Citation

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Abstract

This article discusses a qualitative research project that revealed how online health-care practitioners in a graduate studies program believe their primary source of help is other students in their class. The project was framed from a constructivist theoretical perspective and an action research approach. The participants were clinicians, such as advanced nurse practitioners, who graduated from a Master of Nursing or Master of Health Studies program offered exclusively through a WebCT online environment. The data sources included a program satisfaction survey, focus groups, and 10 individual audiotape-recorded and transcribed interviews. The data were collected over a 2 year period, analyzed for themes by two researchers, and confirmed with the participants through ongoing member-checking. The following four strategies to facilitate help-seeking interactions among online graduate study learners are presented: award marks for participation, encourage thoughtful, well-crafted introductions, create a coffee lounge, small group forums and private email within the course environment, and identify non-contributing students.

Keywords

graduate studies, help-seeking, interaction, online.

INTRODUCTION

Learners who are able to reach out for help when they need it are well-positioned to translate knowledge successfully in any learning event. In online graduate study classrooms for nurses and other health-care professionals, students' classmates can offer invaluable assistance. However, educational research examining the instructional strategies that facilitate helpful interactions among these students is limited.

This article describes the findings from a qualitative research project that investigated the help-seeking experiences of online health-care students in graduate study programs. The purpose of the study was to explore learners' ideas about seeking help and to identify instructional strategies that respond to learners' needs. The research was guided by the question: "Which specific strategies do these learners implement to seek help?"

The participants in the study included graduate students from a variety of different health-care disciplines. The Center for Nursing and Health Studies at Athabasca University in Athabasca, Alberta, Canada, offers a Master of Nursing (MN) as well as a Master of Health Studies (MHST). Although students in the MN program hold undergraduate degrees in nursing, those in the MHST program come from nursing, medical technology, physiotherapy, occupational health, dietetics, social work, medicine, dentistry, and other health-care disciplines. Within the MN stream, registered nurses are able to achieve an advanced nursing practice or nurse practitioner qualification. The program's students are predominantly nurses and female, live in many different countries, are required to have practiced in their field for at least 2 years and must complete their courses in English. The non-clinical courses are offered exclusively online using a WebCT course management system.

The primary medium for communication, instruction, and assessment within the MN and MHST programs is asynchronous, text-based, threaded discussions within a WebCT environment. In most courses, cohorts of ≈ 20 students led by one instructor progress through a study guide identifying a series of readings, discussion questions, and learning activities during a 14 week timeframe. Each course has been designed to include weekly forums where students discuss the study guide and a "coffee lounge" forum for informal connections. The students are graded on their participation in the weekly discussion forums. Small group work forums, private email, and synchronous chat room discussion options are also available.

A literature review of educational research examining postsecondary students' help-seeking behaviors reflected positive associations between help-seeking and learning successes. Karabenic's (1998) seminal work established that seeking help within an educational event can be a valuable and strategic resource. Undergraduate learners who sought help when necessary were more actively engaged and self-regulated (Karabenick & Sharma, 1994), preregistration nurse learners who sought help tended to perform better academically (Hegge *et al.*, 1999), and distance education learners who sought help were identified as high achievers (Taplin *et al.*, 2001).

However, the process is seldom straightforward for learners. Seeking help from peers might not provide accurate assistance (Bailey, 1997) and seeking help from tutors might be anxiety-provoking and perceived as conveying inadequacies (Price, 2002). Feelings of indebtedness to the provider, embarrassment, and threats to self-esteem can emerge (Karabenic, 1998).

THE RESEARCH APPROACH

This project was framed from a constructivist theoretical perspective (Lincoln & Guba, 1985; Peters, 2000; Appleton & King, 2002) and a naturalistic action research design (Corey, 1949; Kemmis & McTaggart, 1988; Kemmis & McTaggart, 1990; Altrichter *et al.*, 1993; Stringer & Genat, 2004). The data sources included a program satisfaction survey, focus groups, and 10 audiotape-recorded, transcribed interviews with graduates who attended convocation ceremonies at the Athabasca University campus in Athabasca, Alberta, Canada. The data were collected over a 2 year period to accommodate personal contact with graduates when they traveled to the university campus for their convocation ceremonies.

The content from these data sources were analyzed first independently and then collaboratively by the researchers. The transcripts were thoroughly read and reread and a systematic process of content analysis was developed (Loiselle *et al.*, 2004) to create a categorization and coding scheme leading to themes. Trustworthiness was established through ongoing interaction and member-checking with participants to ensure authenticity.

The research approach was conceptualized from tools examining help-seeking within learning that were tested in an earlier project (Melrose S., unpubl. data, 2003). The overarching themes (Melrose *et al.*, 2005) identified that learners sought help first by rereading directions, second by turning to classmates, and third by involving family and friends. LaVallie and Melrose (2005) expanded on the strategies involving family and friends that online graduate learners can implement to obtain the help they need and the present article expands on the strategies involving interaction with fellow students that instructors can implement to facilitate helpful student connections in online classrooms.

To ensure anonymity, pseudonyms were used when participants' comments are reported verbatim. Full ethical approval was granted from the Athabasca University Ethics Committee and all participants gave informed consent.

ACTION RESEARCH

Action research is a reflective, spiral process where teachers use research techniques to examine their own educational practice carefully, systematically, and with the intention of applying their findings directly to their own and other educators' everyday practice. Linking the terms "action" and "research" highlights the essential features of this method, where researchers and participants work collaboratively to try out ideas in practice as a means of increasing knowledge about or improving the curriculum, teaching, and learning (Kemmis & McTaggart, 1988; 1990). The term "naturalistic" within this methodology reflects how projects are completed in a setting that is both natural and familiar to researchers and participants (Lincoln & Guba, 1985).

In the 1940s, the social psychologist and educator, Kurt Lewin, first applied the term "action research" to "describe work that did not separate the investigation from the action needed to solve the problem" (McFarland & Stansell, 1993; p. 14). In the later 1940s and 1950s, the educator, Steven Corey, argued against the existing quantitative paradigm that focused on findings that could be generalized to "... uniformities, explanatory principles or scientific laws" (Corey, 1949; p. 63). Rather, Corey (1949; p. 63) stated:

The action researcher is interested in the improvement of the educational practices in which he [sic] is engaging. He [sic] undertakes research in order to find out how to do his job better – action research means research that affects actions.

In his view, action research was valued more for the change it can initiate in everyday practice than for a quantitative goal of generalizing the findings to a broader audience.

Today, in the educational research field, action research methods, such as collecting interview and survey data from learners who have completed an educational event and then analyzing that data through developing categories and coding processes,

are well-established (Altrichter et al., 1993). Similarly, in the health-care field, practitioners are encouraged to engage in action research and the practical nature of the findings is highly regarded (Stringer & Genat 2004).

RESULTS

Strategy 1: Award marks for participation

When the continuing health-care professionals in this project identified that they were unable to help themselves and did find it necessary to reach out to others, it was their classmates they turned to first. By count, the importance of connecting with peers in the class emerged the greatest number of times during the research discussions. Opportunities for student interaction within courses were highly valued. However, despite the value associated with class discussions, unless marks were awarded for participating in them, participants also emphasized that they would be less inclined to engage with their peers. Given this finding, the importance of awarding marks for participation as a facilitation strategy for online educators becomes clear. As Jill explained:

I think you need marks for participation. People need those marks for motivation. By participating, you can really make this program significant. With kids and working full-time, it's hard. But the marks help make the discussions part of your life. You learn so much from one another, sometimes even more than what you get from research articles and books.

In traditional learning environments, students often turn to one another to discuss a point of interest or to clarify an aspect of the educational material presented. Facilitators in a variety of learning events build on this behavior and stimulate small group conversations to promote student interactions. Adapting this established process to an online environment is also effective. In Rick's words:

The learning is multilayered. You have the curriculum that provides the readings and some incredible perspectives. Then you have the professors' ideas and then you have all of the students, many of whom are experts. We were beginners in some areas and interpreting differently. To have the experts saying what they thought and the novices saying how they would look at it differently, depending on previous experience, were layers that built on top of each other.

Kim commented:

I found that interacting with the other students in my class, even online, was extremely helpful for learning how to think critically. But, without the marks for participation, we wouldn't have had that.

Strategy 2: Encourage thoughtful, well-crafted introductions

As online environments lack non-verbal and other visual communication cues, facilitating student interaction can involve strategies that encourage learners to know one another on a personal, as well as a professional level. For Mary:

Once I got started, the biggest thing that helped me initially was interacting with the other students. I found that usually there were one or two students in each class where there was a commonality. It might be stage of life, working in the same area of health care or where we lived.

Thoughtful introductions that illustrated who participants were at work, what their families looked like, and the kinds of interests they enjoyed were well-received. Including pictures of families, pets, and geographic areas were valued.

The instructors' own thoughtful, well-crafted introductions modeled the value of pictures and anecdotal "stories." In Anna's view:

The most helpful thing was when professors talked a bit about themselves. I felt like I got to know the professor as a person. It made it easier for all of us to talk about ourselves when the professor did. It was like we were a group of people sitting at a big table and participating together.

By contrast, limited attention to facilitating introductions restricted student interactions. According to Keiko:

I would have liked more opportunities to dialogue with the professors. Beyond clarifying assignments, it would be nice to find out more about their area of work or what they thought, beginning to know the professor as a person. Some of those anecdotal kinds of things really make everybody feel comfortable.

For participants in the present research, the social conversations that emerged from thoughtful, well-crafted introductions led to more in-depth communication. Rather than distracting the students, sharing anecdotal information within the online classroom helped to create a climate of safety and decreased anxiety, and encouraged a willingness to risk asking for help from peers when it was necessary.

Strategy 3: Create a coffee lounge, private email, and small group forums within the course environment

In addition to the comprehensive content knowledge that continuing health-care learners expect in educational events, opportunities to translate knowledge in personally meaningful ways are also required. In online classrooms, creating areas where learners are invited to interact, such as a coffee lounge, small group forums, and private email are helpful.

Given that most online learning environments provide a permanent record of all interactions, this strategy begins to address Bailey's (1997) finding that seeking help from peers might not provide accurate assistance. With access to the coffee lounge and small group forums themselves, instructors can identify and intervene if participants inadvertently offer inaccurate direction or responses.

Furthermore, creating these areas can indicate that helpseeking and help-offering behaviors among learners are expected. In turn, these expectations serve to lessen the barriers to seeking help, such as feeling anxious and inadequate (Price, 2002) or embarrassed and threatened (Karabenic, 1998).

For some, the inherent anonymity of online learning made areas for student interactions particularly appealing. Zabida felt that:

. . . being online means there is less risk of looking stupid in front of your classmates because they really can't see you, so it was, for me anyway, not too intimidating to ask a classmate something. I could ask in the coffee room or the small group forum. If I really didn't want anyone to know what I didn't know, I could use the private email.

Karen added:

You can always ask your colleague a stupid question and no one will laugh at you on the Web. If you really don't understand, somebody can tell you and help you learn. With the anonymity of your computer, you can ask the questions that people wouldn't ask if they were in a public classroom.

Although chat rooms are available in the WebCT courses at Athabasca University, some students expressed a difficulty in accessing them. For other students, however, the chat rooms were well-used and provided learners with another venue for

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interaction. Recognizing that learners find these areas useful and then including them in the initial design of an online course is a simple but important facilitation strategy that readily promotes student interaction.

Strategy 4: Identify non-contributing students

When given the opportunity to share their reflections on how online instructors can best facilitate helpful interactions among learners, the participants in this study repeatedly described instances where some students did not “do their share.” Although responding to colleagues’ help-seeking was consistently seen as “a compliment to be asked” rather than a burden, these health-care professionals also clearly resented “carrying” others who did not contribute.

Summarizing the importance of instructional intervention when a learner is not contributing to a group task, Mai-Ling stated:

There is a fine line between helping and doing work for someone. My approach, when someone in the group is going to get the same mark, but they haven’t done the work, is to email the instructor privately. I won’t hold back because I want the project done well. But, at the same time, you really need the instructor to get in touch and say something. You need to have some discretion and not air these things in public, but it is really important for the instructor to step in and act.

Just as in traditional classroom learning activities when students’ contributions are unequal, the early identification of the issue is essential in online classrooms as well.

DISCUSSION

The aforementioned four instructional strategies, developed from discussions with clinicians who successfully completed their graduate degrees exclusively through a WebCT online course management system, begin to illustrate the kind of facilitation approaches that these groups of learners appreciate. Given these findings, the implications for online healthcare educators include ensuring that opportunities for students to connect with one another are readily available. Clearly, awarding marks for participation establishes this activity as a priority. Also, encouraging and modeling introductions that include pictures and descriptions of workplaces and homes help create a safe climate. In addition, creating a coffee lounge, small group forums, and private email are simple design elements that provide the virtual space needed for student interaction. Finally, intervening immediately when a student is not contributing strengthens group processes.

CONCLUSION

This article presented findings from a naturalistic action research study that explored strategies to facilitate helpseeking through student interactions online. In contrast to other studies that explored learners’ help-seeking experiences, this project extends existing understanding by presenting specific strategies unique to educators working with health-care professionals.

Connecting with colleagues can enhance the process of translating knowledge from theory to clinical practice. Participation marks, well-crafted introductions, comfortable virtual spaces, and instructional intervention when learners are not contributing are examples of facilitation strategies that health-care professionals value. As educational events for nurses and other health-care professionals move to online environments, creating intentional strategies to facilitate student interactions is both a challenge and an opportunity for the field.

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MENTAL HEALTH (DEPRESSIVE DISORDERS)

Late life depression: nursing actions that can help



[PDF – 315 KB]

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Abstract

Purpose: This article explains the symptoms of late life depression (LLD) and discusses evidence-informed actions that nurses can implement to provide older adults with the help they need.

Conclusions: Recognizing and addressing depression in older adults can enhance quality of life.

Practice Implications: People with LLD may not appear sad or express feelings of depression. Instead, they demonstrate loss of interest, frailty, cognitive impairment, suicidal ideation, unexplained somatic complaints, and loneliness. Documenting symptoms, screening, and assessing suicidal ideation are essential. Positive outcomes are associated with antidepressant medications, cognitive behavioral therapy, electroconvulsive therapy, neuromodulation therapies, and exercise.

Keywords
late life depression, LLD, nursing care for older adults

I | INTRODUCTION

Late life depression (LLD) is the occurrence of a major depressive disorder in adults aged 60 years or older.¹ When symptoms that do not meet major depressive disorder criteria are also considered, subsyndromal depressive disorders and clinically significant symptoms of depression in later life are estimated to affect between 0.9% and 49.0% of adults aged 65 years or older.²⁻⁴ As many as 17% of adults over 75; 25% of adults over 85; and 49% of adults over 90 are affected by at least some symptoms of depression.^{2,5}

LLD is associated with cognitive impairment, increased morbidity and mortality from co-occurring medical illness, increased death by suicide as well as increased health care utilization and cost.^{1,3,6} Depression in older adults is often undetected or inadequately treated.⁷⁻¹³ Existing literature has focused on providing physicians with information related to diagnosing and treating LLD. However, nurses in a variety of practice areas also encounter many older adults who are struggling to cope with symptoms of depression. Psychiatric and mental health nurses are well positioned to provide these nurse peers with a deeper understanding of the complexities of the condition. When nurses recognize LLD and implement evidence-informed care, they are better able to support the older adults in their care toward an improved quality of life. This article presents an explanation of LLD and suggests nursing actions that can help.

2 | TOWARD AN EXPLANATION OF LLD

People experience depression later in their lives in different ways and for a variety of different reasons. Explanations of LLD are seldom straightforward. LLD is generally explained as depression that occurs after the age of 60 years, although onset and definition of cutoff may vary.¹⁴ Presentations of LLD can include reoccurrence of a previous depression, termed early onset depression; a mood disorder secondary to a general medical condition; a depressed mood secondary to a substance or medication use (including polypharmacy); or as a new-onset depression, later in life, termed late-onset depression (LOD).⁵ As many as half of the cases of LLD are late onset and are occurring among people who have not previously experienced clinically significant symptoms of depression.¹⁵ In this article, the term LLD will refer to LOD. Unless otherwise specified, the information presented can be considered relevant to the care of older people experiencing any form of depression.

Both the diagnosis of major depressive disorder (MDD) and the presence of subsyndromal or clinically significant depressive symptoms are associated with LLD.¹⁵ According to the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5),¹⁶ to receive a diagnosis of MDD, an individual must exhibit symptoms of depressed mood and/or loss of interest plus four or more associated symptoms, including changes in appetite, sleep disturbance, psychomotor agitation or retardation, fatigue, inappropriate guilt or feelings of worthlessness, poor concentration or indecisiveness, and recurrent thoughts of death or suicidal ideation. Symptoms must be present nearly every day for at least two weeks and cause clinically significant distress or functional impairment.¹⁶

However, in older adults, the two core symptoms of MDD, depressed mood (sadness or dysphoria) and loss of interest in activities once found pleasurable (anhedonia) can differ from those seen in younger people.¹⁷ The affective symptom of a “depressed mood” can actually be absent in some older adults who are suffering from depression. Rather, a lack of sadness or dysphoria, known as *depression without sadness*, where mood does not appear sad is common.¹⁸⁻²⁰ Similarly, rather than clear indications of sadness, symptoms like *lack of vigor, apathy, and withdrawal*, known as “depletion syndrome” are apparent.¹⁹

In contrast, the second MDD core symptom of “loss of interest” is usually pronounced in LLD.¹⁷ Clinicians, family members, and older adults themselves may inadvertently view anhedonia more as a part of normal aging than as a critical indicator of depression.⁹ It can inaccurately be perceived as an understandable reaction to limitations imposed by medical conditions; retirement; death of a partner; decreasing social contacts; and lifestyle changes, such as moving to a care facility.¹⁰

Further, the additional MDD symptoms of changes in appetite, sleep disturbance, psychomotor agitation or retardation,

fatigue, inappropriate guilt or feelings of worthlessness, poor concentration or indecisiveness, and recurrent thoughts of death or suicidal ideation can be overlooked in LDD. Loss of *appetite* and weight loss, a common and important symptom of LDD, is also associated with cognitive deficits²¹ and can predict an increased likelihood of developing dementia.²² Sleep disturbances, particularly *early morning awakenings*, are present in most cases of LDD and are predictive of a poor prognosis and future depressive episodes.^{3,23}

Psychomotor retardation more so than psychomotor agitation is common in LDD.⁵ Although some slowing is not unexpected in normal aging, psychomotor retardation, such as disturbances in speech, facial expression, fine motor behavior, and gross locomotor activity (especially a *decreased walking speed*) are more apparent in people with LDD.²⁴ Fatigue is often experienced as a *physical tiring* and lack of energy rather than as a mental fatigue.²⁵ It is important to note that symptoms of *frailty* (including loss of interest, weight loss, psychomotor slowing, and physical tiring) overlap with symptoms of LDD and are frequently associated with comorbid medical concerns.²⁵

Inappropriate guilt or feelings of worthlessness are less frequent in older adults than in young people.^{20,26} By contrast, there is often actual impairment in people's ability to concentrate and make decisions.²⁰ Further, compounding any assessment of how poor concentration and indecisiveness might be linked to depression is the question of whether medical conditions are causing disturbances in thinking and slowing information processing abilities.⁶ In LDD, the depressive symptom of "poor concentration" could be manifested more as *memory loss* or cognitive impairment with *executive dysfunction* (a clinical expression of frontostriatal abnormalities where the brain is less able to control cognitive processes, such as carrying out tasks).²⁷ The cognitive impairments in LDD mimic symptoms of dementia.²⁷

This cognitive impairment also makes people with LDD at high risk of death by suicide.²⁸ Symptoms of recurrent thoughts of death or *suicidal ideation* in LDD are especially concerning. Older adults can act on their suicidal ideation with more serious intent, less warning, and more lethality than younger populations.²⁹ Signs that indicate impending suicide include feelings of hopelessness or lack of purpose, feeling trapped, talking about death, preparing for suicide, social withdrawal, increased substance use, and reckless behavior.⁶ Factors believed to provide some protection against acting on suicidal thoughts include social connectedness, spirituality, religious beliefs, and cultural attitudes against suicide.⁶

For older adults, particularly those living with physical illnesses, increasing *somatic complaints* more so than typical symptoms of MDD are highly suggestive of LDD.^{30,31} Persistent complaints of pain, headache, fatigue, insomnia, gastrointestinal distress; unexplained delayed recoveries after surgery; and failure to thrive in institutional settings can be linked to depression.³¹ For people with cerebrovascular disease, any microdamage occurring in the small vessels compromises the ability of the frontal-subcortical circuits to regulate mood, resulting in a depression known as vascular or subcortical ischemic depression.^{32,33} Higher rates of LDD occur in people living with heart disease, diabetes, asthma, and arthritis.¹² While it is understandable that people will experience distress caused by their physical illnesses, it is important to emphasize that unexplained somatic complaints are indicative of LDD.

Finally, people experiencing *loneliness*, or feeling as though they do not belong, are susceptible to LDD.³⁴⁻³⁶ Studies indicate that between 5% and 10% of people between the ages of 60 and 80; and between 40% and 50% of people over 80 reported feeling lonely frequently.³⁷ Those at greatest risk of experiencing loneliness are women, particularly those who are older; and people who are without partners, are financially insecure and are physically unwell.³⁷ As many as 87% of older adults with depressive symptoms reported co-occurring feelings of loneliness.³⁶ Loneliness has been found to exacerbate depressive symptoms, decrease quality of life, and leave older adults feeling as though they have no control over their situation.³⁶

In his seminal commentary on depression in later life, Dan Blazer urged clinicians not to limit their assessment of LDD to diagnostic categories of depression, but rather to include depressive symptoms that do not fully meet the criteria but nonetheless cause significant distress.²⁰ As the preceding discussion explained, older adults with symptoms of depression without sadness, lack of vigor, apathy and withdrawal, loss of interest, loss of appetite, early morning awakenings, decreased walking speed, physical tiring, frailty, memory loss or cognitive impairment with executive dysfunction, suicidal ideation, somatic complaints, and loneliness could be suffering from LDD. Recognizing and addressing these symptoms can decrease depression and functional impairment and enhance quality of life for older adults.³⁸ Next, actions that nurses can implement when they encounter the many older adults who are struggling with depression are suggested.

3 | PRACTICE IMPLICATIONS: ACTIONS THAT CAN HELP

3.1 | Document symptoms of LLD

Recognizing and documenting the aforementioned symptoms of LLD is a critical first step in helping people receive treatment for depression. Knowing that depressed older adults are more likely to present with loss of interest and unexplained somatic complaints than with a sad mood or self-identified complaints of depression, clinicians must intentionally inquire about LLD and maintain ongoing documentation. Seeking out information about any changes in lifestyle, social withdrawal, and feelings of loneliness from family members should also be included. Typical open ended interview questions that assess history, mental status, and level of cognitive and functional capacities should be followed by more directed questions specific to LLD.⁶

3.2 | Screen with the Patient Health Questionnaire-9

Given the prevalence, impact and difficulties inherent in recognizing LLD, screening instruments can supplement interview findings and provide the objective data needed to indicate the risk or presence of depression in older adults.³⁹ The 9-item Patient Health Questionnaire (PHQ-9), developed by Kroenke et al.⁴⁰ provides reliable, valid detection of depression in LLD.^{6,10,38,39} The PHQ-9 is self-administered, requires about 5 minutes to complete, is easily scored and interpreted, and is available for free.⁴⁰ The short questionnaire incorporates DSM-5 depression diagnostic criteria, as well as clinically significant depressive symptoms; rates the frequency of the symptoms and factors these into the scoring severity index; screens for suicidal ideation; and assigns weight to the depressive symptoms that impact how people function.⁴⁰ The PHQ-9 can be administered in a variety of settings both as an initial screening instrument and to follow up and evaluate interventions.^{10,38}

3.3 | Assess suicide risk

As with any depressive illness, suicidal ideation means that protective factors must be assessed in people who may be experiencing LLD. Suicidal ideation can range from thinking passively about death and wishing to die, to active thoughts of self-harm, plans, and an intention to die.⁶ In older adults, means can include but are not limited to, hanging, firearms, poisoning, and hoarding medications.⁶ Posing the question: “What stops you?” opens the door for people to express protective factors that are unique to their situation. Clearly, ongoing assessment, documentation, and immediate reporting of suicidal ideation must be implemented when LLD is or could be present.

3.4 | Pharmacological treatment

Selective serotonin reuptake inhibitors (SSRIs) are the most common first-line treatment for LLD.^{1,41} The SSRI-Sertraline (Zoloft), has a favorable side-effect profile and can be taken by people with a history of cognitive impairment and stroke.⁴¹ When SSRIs are contraindicated, alternative classes of antidepressants, such as Mirtazapine (Remeron), demonstrate good efficacy in older adults.⁴¹ The side effects of Mirtazapine, which include sedation and weight gain, can have therapeutic benefit to the difficulty in sleeping and loss of appetite so commonly experienced in LLD. Tricyclic antidepressants, in particular, Nortriptyline (Allegron, Aventyl), can also be effective in older adults who do not have cardiac conditions or cognitive impairment.⁴¹

Antidepressant medications are usually trialed for approximately 6 weeks; should not be withdrawn abruptly and can be

expected to be taken for at least 2 years.⁴¹ However, it is important to note that as many as one-third of older adults will not respond to antidepressant treatment; relapse rates for those who do respond are high; and the approach is less efficacious than for younger people.^{13,42}

3.5 | Psychological treatment

Psychological treatments, particularly when implemented in combination with pharmacological treatments have demonstrated moderate efficacy for some older adults.^{31,42,43} Cognitive behavioral therapy (CBT), problem-solving therapy (PST), interpersonal therapy (IPT), and reminiscence and life review therapy (RLRT) have been successfully implemented.^{43,44} In CBT, people identify and challenge distorted thinking; in PST, people identify problems, brainstorm solutions, implement a solution, and then evaluate its effectiveness; in IPT, people explore feelings and ways to change behavior in relation to interpersonal relationships, including grief and role transitions; and in RLRT people review positive life events to enhance wellbeing.⁴³

Although therapies such as CBT, PST, and IPT are implemented by trained therapists, adaptations of RLRT and approaches to celebrating positive life events, both past and present, can readily be adapted in settings where nurses provide support to older adults. Similarly, behavioral activation (BA) therapy, which seeks to create a personal environment of positive reinforcement by increasing functional and pleasurable behavior, and by decreasing avoidant and depressed behavior, uses less complex protocols, and has successfully been implemented by mental health nurses.⁴⁵ Many older adults, especially those who are over 75 and are experiencing depression for the first time, prefer not to talk about their depression and do not view pharmacological and psychological treatments as likely to be helpful.¹¹ Therefore, exploring people's own ideas about the depression they are experiencing and the solutions they believe are valuable is foundational to any treatment approach.

3.6 | Electroconvulsive therapy

Electroconvulsive therapy (ECT) can also be effective in treating LLD.⁷ People who will benefit most from ECT are those with depression that is resistant to other treatments and for those at risk of serious harm because of psychotic depression, suicidal ideation, or severe malnutrition.⁴⁶ Although cardiovascular and cognitive side effects can occur with older adults, deleterious effects of ECT in LLD are usually limited and transient, with better cognitive outcomes with unilateral ECT.⁴⁷

In one study, when elderly people with unipolar depression were treated twice weekly with right unilateral ECT, their cognition, psychomotor agitation, and psychomotor retardation improved significantly.⁴⁸ This improvement was attributed to a significant gray matter volume increase, which was most pronounced on the side receiving neurostimulation.⁴⁸ Common side effects of ECT that nurses must monitor include headache that usually responds to analgesics, temporary confusion or memory impairment, and falls immediately after treatment sessions.⁴⁶

3.7 | Neuromodulation therapies

Alternative neuromodulation therapies also provide neurostimulation, but unlike ECT, these therapies do not require anesthetic and have reduced side effects, making them safer for older adults with comorbid medical conditions.⁴⁹ Repetitive transcranial magnetic stimulation (rTMS) and transcranial direct-current stimulation (tDCS) modulate cerebral activity using brain stimulation and are usually implemented over a 4 to 6 week period.⁵⁰ In older adults with nonpsychotic depression, rTMS is well tolerated but higher intensities and greater numbers of treatments may be needed than for younger people.⁵⁰ Beyond its positive effects on mood, tDCS may also have positive effects on cognition.⁵⁰

3.8 | Physical exercise

Physical exercise programs can improve outcomes with some symptoms of LLD. In combination with antidepressant medication, exercise programs for older adults that included brief intervals of increased workload were found to decrease symptoms of depressed mood and psychomotor retardation.⁵¹ Aerobic activities, which stimulate and sustain heart and breathing rates, improved cognition and reduced disability in depressed older adults.⁵²

When high intensity progressive resistance training was integrated into exercise programs, participants' sleep quality improved.⁵³ Knowing that sleep disturbances are frequently present in LLD,^{3,23} the value of integrating resistance training into older adults' physical activities becomes clear. Weekly group exercise programs of 3 × 50 minute sessions, which included moderate cardiovascular exercise, such as walking with waving or clapping hands to music for a duration of 30 minutes, improved quality of life and perceived social support.⁵⁴ Exergames or entertaining video games that combined game play with exercise decreased subsyndromal symptoms of depression^{55,56} and improved balance and mobility.⁵⁵

In community settings, nurses can encourage older adults to participate in seniors' fitness activities in their area. In institutional settings, they can advocate for the creation of fitness programs that personalize physical exercise for patients/residents. Although medical conditions can impose limitations on peoples' mobility, engaging in some form of daily physical exercise can make an important difference in mood.

3.9 | Lifestyle modifications

In addition to increasing physical exercise, lifestyle modifications, such as improving dietary patterns and addressing vitamin D deficiencies may also exert a positive influence on some symptoms of depression. Emerging evidence suggests that modifying dietary patterns may reduce the risk of developing depression.⁵⁷ Actions that can help include: following the Mediterranean diet; increasing consumption of fruits, vegetables, legumes, wholegrain cereals, nuts, and seeds; including a high consumption of foods rich in omega-3 polyunsaturated fatty acids; replacing unhealthy foods with wholesome nutritious foods; and limiting intake of processed foods, "fast" foods, commercial bakery goods, and sweets.⁵⁷

Although causal links between vitamin D deficiency and the development of depression have not been established, studies reveal that vitamin D deficiency accompanies late-life depression.⁵⁸ For older adults, the skin capacity to synthesize vitamin D from sunlight can be reduced as much as 25%, increasing the likelihood of vitamin D deficiency.⁵⁸ Those who have limited opportunities to be outdoors or to be exposed to sunlight are particularly at risk. The 25-hydroxy vitamin D blood test indicates that vitamin D deficiency exists when levels are less than 12.5 ng/mL.⁵⁹ Vitamin D supplements may be helpful.

4 | CONCLUSION

Adults over 60 can experience symptoms of depression somewhat differently than younger people. Older adults living with LLD may not appear sad or express feelings of depression. Instead, they may demonstrate loss of interest, frailty, cognitive impairment, suicidal ideation, unexplained somatic complaints, and loneliness. In response, nurses should document these symptoms, screen with the PAQ-9 and, importantly, assess for suicidal ideation. Antidepressant medications, CBT, electroconvulsive therapy, neuromodulation therapies, physical exercise, and lifestyle modifications can bring needed support and relief to the increasing number of people burdened with LLD.

CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

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Persistent Depressive Disorder or Dysthymia: An Overview of Assessment and Treatment Approaches



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Abstract

Persistent depressive disorder or dysthymia is a recurrent depressive disorder with no clearly demarcated episodes. Onset is insidious and can occur in adolescence or adulthood. Dysthymia frequently remains unrecognized and undiagnosed for years. Co-morbid major depression, anxiety, personality, somatoform and substance abuse disorders are common. Symptoms center on sad mood, pessimism and hopelessness. Sufferers experience significant functional impairment and are at risk of death by suicide. Those most at risk are female, unmarried, live in high income countries and have family histories of depression. Screening instruments include the Cornell Dysthymia Rating Scale (CDRS). Typical treatments are antidepressant medications and cognitive behavioral analysis system of psychotherapy (CBASP). This paper provides health professionals with an overview of assessment and treatment approaches in dysthymia.

Keywords

I. Introduction

Living with the unrelenting burden of persistent depressive disorder (PDD) or dysthymia leaves those who are afflicted feeling despondent and hopeless most of their lives. PDD or dysthymia is a recurrent, prolonged depressive disorder with no clearly demarcated episodes. Dysthymia, from the Greek “ill humor” or “bad state of mind” is understudied, often undertreated and can lead to high rates of death by suicide (Cristancho, Kocsis & Thase, 2012; Ishizaki & Mimura, 2011; Niculescu & Akiskal, 2001). Existing research has focused on diagnosing dysthymia and evaluating treatment with antidepressant medication and psychotherapy. Most of this work has been directed to physicians. However, health professionals from a variety of different settings can expect to encounter people struggling to cope with dysthymia in their practice. Raising awareness about dysthymia among all members of health care teams can make an important difference in recognizing the disorder and initiating appropriate referrals. Geared to a multidisciplinary audience, this article presents an explanation of dysthymia by explaining current assessment and treatment approaches.

2. Assessment

2.1. Diagnosis

The process of diagnosing PDD or dysthymia is not straightforward. For many individuals, a constant battle with low grade depression, sad moods and a lack of excitement has become a way of life. Once known as neurotic depression, in 1980 the diagnosis of dysthymia was introduced into the third edition of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-III (American Psychiatric Association, 1980). At that time, the depressive symptoms of dysthymia were characterized as less severe but of longer duration than those of major depressive disorder (MDD). Dysthymia was associated with disturbances in appetite, sleep, energy, concentration, self-esteem and feelings of hopelessness (American Psychiatric Association, 1980).

Later, in 2000, the diagnosis of chronic depressive disorder, where symptoms of depressed mood, loss of interest in daily activities and impaired social, occupational or educational function persisted longer than two years was introduced into the DSM-IV-TR (American Psychiatric Association, 2000). Today, the DSM-5 consolidated the diagnoses of dysthymia and chronic depressive disorder into persistent depressive disorder PDD, often still identified as dysthymia (American Psychiatric Association, 2013).

Dysthymia is diagnosed in adults when individuals have not been free of their depressive symptoms for longer than 2 months over a 2-year period and have not experienced an episode of major depression or mania. In children and adolescents, the criteria span a 1-year period. However, two key features of dysthymia are first that no clearly demarcated episodes occur and second that the duration is prolonged and can occur both below and above the stipulated 1 or 2-year cut-off points (Uher, 2014). Some people may only seek help after experiencing depressive symptoms for decades rather than just after 2 years (Hellerstein, 2014).

2.2. Co-Morbidity

Dysthymia frequently co-occurs with other psychiatric conditions. Many people with dysthymia also develop major depressive disorder MDD, a condition known as double depression (Dunner, 2005; Keller, Hirschfeld, & Hanks, 1997; Klein, Shankman, & Rose, 2006). MDD is characterized by depressed mood, loss of interest or pleasure, weight gain or loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness, difficulty concentrating and suicidal ideation most of the day, nearly every day during the same two week period (American Psychiatric Association, 2013). The disorders differ in that the most common symptoms of dysthymia are low self-esteem and pessimism; while the most common symptoms of MDD are neuro-vegetative signs such as sleep or appetite disturbances (Gwirtzman, Blehar, McCullough, Kocsis, & Prien, 1997). In both MDD and dysthymia, people experience feelings of hopelessness and are unable to find relief from their despair. When double depression is present, these feelings of hopelessness intensify (Joiner, Cook, Hersen, & Gordon, 2007). Most people with dysthymia develop at least one episode of MDD in their lifetime (Klein, Schwartz, Rose, & Leader, 2000).

Further, anxiety disorders are often present in children, adolescents (Masi, Millepiedi, Mucci, Pascale, Perugi, & Akiskal, 2003) and adults (Pini, Cassano, Simonini, Savino, Russo, & Montgomery, 1997; Sansone & Sansone, 2009; Shankman & Klein, 2002) with dysthymia. Given the frequency of co-occurring anxiety and dysthymia, Niculescu and Akiskal proposed a division of dysthymia into two distinct endophenotypes or sub types: anxious dysthymia (formerly known as atypical) and non-anxious or anergic dysthymia (formerly known as typical) (Niculescu & Akiskal, 2001). Anxious dysthymia is hypothesized as having an association with low serotonin, which regulates mood, calmness and composure when dealing with stressful events. When people with anxious dysthymia perceive stress, their symptoms of insecurity, low self-esteem and restlessness exacerbate or worsen (Niculescu & Akiskal, 2001).

Non-anxious or anergic dysthymia is hypothesized as having an association with low dopamine, which is involved in motivation, thinking, and motor activities (Niculescu & Akiskal, 2001). When people with anergic dysthymia perceive they have failed, they are likely to demonstrate more intense manifestations of sluggish reactivity, low drive, low energy and psychomotor inertia. In combination with the extended duration of their depressive illness, this subtyping of symptoms suggests that these traits may have evolved as a way for individuals to cope with the stresses and failures they believe they face (Niculescu & Akiskal, 2001).

Personality disorders, somatoform disorders, and substance abuse disorders also commonly co-occur with dysthymia (Sansone & Sansone, 2009). Personality disorders, such as depressive personality disorder, which is characterized by self-critical tendencies, introversion and a gloomy, negative outlook can appear very similar to dysthymia (Ishizaki & Mimura, 2011). Similarly somatoform disorders, which are characterized by physical symptoms that suggest a general medical condition, but are not fully explained by that condition, can overlap with dysthymia (Feder, n.d.). For example, unexplained back pain, headaches and muscle soreness can be associated with both conditions (Feder, n.d.). High levels of alcohol dependence have been associated with dysthymia (Diaz, Horton & Weiner, 2012). People who develop dysthymia before the age of 21 are predisposed to developing both comorbid personality disorders and substance use disorders (Halverson, 2015).

As a non-episodic illness, dysthymia is difficult to recognize (Avrichir & Elkis, 2002; Weissman & Klerman, 1977). Health professionals may perceive sufferers as people who demonstrate sarcastic, nihilistic, morose, demanding and plaintive behaviors rather than as people experiencing prolonged and profound sadness (Spanemberg & Juruena, 2004). Having endured their illness for extended periods of time, people with dysthymia can project pessimism, gloominess and a lack of self-confidence (Akiskal, 1983). Rather than seeking help for a mood disturbance, they may describe feeling generally unwell, lethargic and chronically fatigued (Akiskal, 1996; Brunello, Akiskal, Boyer, Gessa, Howland, Langer et al, 1995). Consequently, adequate assessment of dysthymia may not occur (Spanemberg & Juruena, 2004). In 2009, Sansone and Sansone described people with dysthymia as forlorn and overlooked a representation that continues to be applicable (Sansone & Sansone, 2009).

2.3. Severity

The chronic nature of dysthymia can cause greater impairment to functioning than acute depression (Sandhu, Ghosh, & Dellenbaugh, 2016). Dysthymia sufferers are less likely to work full-time, they receive income supplements more often and they are more likely to report interference with social activities as a result of emotional and physical problems (Hellerstein, Agosti, Bosi, & Black, 2010). For those with co-occurring personality disorders, dysthymia imposes significant additional impairment to their psychosocial functioning (Hellerstein, Skodol, Petkova, Xie, Markowitz et al., 2010). People with dysthymia have a 71.4% risk of relapsing into another period of chronic depression (Klein, Shankman, & Rose, 2006). When suicidal ideation occurs in one episode of depression, it is likely to recur in subsequent episodes (Williams, Crane, Barnhofer, van der Does, & Segal, 2006). It is important to emphasize that individuals with dysthymia have been found to be more likely to attempt suicide and to be hospitalized than those with major depression (Klein, Schwartz, Rose, & Leader, 2000). As many as 51% of individuals being treated for persistent depression continued to experience suicidal ideation after 32 months (Young, Klap, Shoaib, & Wells, 2008). Clearly, when health professionals determine that individuals in their care are experiencing depression, it is critical to assess for suicidal ideation.

2.4. Prevalence

Dysthymia, a long term “smouldering mood disturbance” with infrequent and transient periods of normal mood is common in the community, primary care and mental health settings (Sansone & Sansone, 2009). The disorder has been estimated to affect approximately 1.5 percent of the adult population, with 49.7% of these cases classified as severe (Kessler, Chiu, Dernier, & Walters, 2005). Only 67.5% of those with the disorder are receiving treatment and for 27.5% of those individuals, the treatment is only minimally adequate (Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005). As many as 7% of primary care patients and 33% of psychiatric outpatients are believed to be living with dysthymia (Sansone & Sansone, 2009).

Dysthymia follows a chronic course and can have an early and insidious onset, often in adolescence (Halverson, 2015). In adolescents, approximately 11% of 13 to 18 year olds experienced major depressive disorder/dysthymia, with 3.3 % of these considered seriously debilitating (Merikangas, He, Burstein, Swanson, Avenevoli, Cui et al., 2010).

2.5. Etiology

While the cause of the disorder may not be clear, physiologic abnormalities have been associated with dysthymia. For example, polysomnography or sleep studies have indicated irregularities such as shorter periods of dreamless sleep (nonrapid eye movement NREM sleep); taking a shorter period of time to enter rapid eye-movement REM sleep (latency); and increased frequency of rapid eye movements (density) during REM sleep (Abad & Guilleminault, 2005). Interleukin-1, a group of 11 cytokines which plays a central role in the regulation of immune and inflammatory responses can be elevated (Anisman, Ravindran, Griffiths, & Merali, 1999). Further, serotonin, a neurotransmitter, can have a lower maximum rate of uptake (Ravindran, Chudzik, Bialik et al., 1994). In females with dysthymia, platelet monoamine oxidase activity, which is needed for neurotransmissions, can be lower (Tripodanakis, Markianos, Sarantidis, Spyropoulou, Taktikou, & Bistolaki, 1998).

As has been demonstrated in MDD, increased neural activity, or functional connectivity within the default mode network (DMN) of the brain may be important in the pathophysiology of dysthymia (Posner, Hellerstein, Gat, Mechling, Klahr, Wang et al., 2013). The DMN is a collection of brain regions that are less active during goal-directed behaviors and more active when in a resting state (Posner et al.). When Posner, Hellerstein and colleagues examined the effects of antidepressant medications on dysthymia, they identified that antidepressants normalized DMN connectivity, suggesting a causal pathway (Posner et al.). Psychosocially, it is possible that severe events in childhood and stressful life events such as the loss of a partner or serious illness may predispose people to dysthymia (Wu, Wang, Wei, Zhang, Shi, Gao et al., 2013). Those with family histories of major

depression, bipolar disorder, dysthymia and personality disorders are particularly susceptible (Ishizaki & Mimura, 2011; Lizardi & Klein, 2000). Women (Charlson, Ferrari, Flaxman, & Whiteford, 2013) and unmarried people are at greater risk (Markkula, Suvisaari, Pirkola, Pena, Saarni, & Suvisaari, 2015). Dysthymia is more prevalent in high-income countries than in low and middle income countries (Gurege, 2011). Females experiencing dysthymia frequently have a history of thyroid dysfunction (Scott, Baker, & Eccleston, 1988).

3. Cornell Dysthymia Rating Scale (CDRS)

As the previous discussion has illustrated, a significant number of people are living with the debilitating effects of dysthymia and are not functioning to their full potential. By screening for the disorder, particularly in familiar primary care settings where people are accustomed to coming for treatment, health professionals can help identify those who are suffering.

The Cornell Dysthymia Rating Scale (CDRS), first developed by Mason and colleagues in 1993 continues to be an efficient screening instrument (Cohen, 1997; Hellerstein, Batchelder, Lee, & Borisovskaya, 2002; Kannappan & Bai, 2007; Lam, Michalak & Swinson, 2005; Mason, Kocsis, Leon, Thompson, Frances et al., 1993). The CDRS is a simple straightforward questionnaire that all members of health care teams can readily implement with the people in their care. The CDRS is a 20-item scale developed specifically to assess frequency and severity of symptoms of dysthymia over the previous week (Mason et al.). Items are scored on a 0 – 4 basis, with a total score range of 0 – 80, where higher scores indicate greater severity of symptoms.

The scale can be either self or clinician rated and refers to current and recent symptoms rather than normal premorbid periods, thus making it particularly suitable to assessing the chronic and recurring symptoms of dysthymia (Cohen, 1997). The strength of the CDRS's severity range scores, concurrent validity and content validity indicate it is a valuable instrument (Hellerstein et al., 2002). Additionally, because the CDRS is sensitive to change it can serve as a useful tool for monitoring response to treatment (Lam et al., 2005). The CDRS is freely available in the public domain and no training is required to use the tool.

4. Treatment Approaches

4.1. Pharmacology and Psychotherapy

Studies have consistently reported the superiority of treating dysthymia with a combined approach of both antidepressant medication and psychotherapy (Jobst, Brakemeier, Buchheim, Caspar, Cuijpers, Ebmeir et al., 2016; Keller, McCullough, Klein, Arnow, Dunner et al., 2000). It is beyond the scope of this article to provide more than a brief explanation of these approaches. Although many groups of health professionals are not directly involved with either medication prescribing and administering or conducting psychotherapy themselves, having a rudimentary understanding of available treatment can be useful when referring people for the help they need.

In their seminal examination of the treatment of chronic depression, Keller, McCullough, Klein and colleagues randomly assigned patients to one of three treatment groups: a cognitive behavioral-analysis system of psychotherapy (CBASP); administration of the antidepressant nefazodone (serzone); or a combination of the two (Keller, McCullough, Klein, Arnow, Dunner, Gelenberg et al., 2000). While less than half of the patients in the individual groups responded, nearly three-quarters of those in the combined group responded favorably to the combined treatment approach.

The psychotherapeutic approach these researchers implemented, the cognitive behavioral analysis system of psychotherapy (CBASP) was developed specifically

for people experiencing chronic depression. This approach used a structured, directive “social problem-solving algorithm to address interpersonal difficulties ... [resulting in] patients learning] how their cognitive and behavioral patterns produce and perpetuate their interpersonal problems ... [thereby] remedying] maladaptive patterns of interpersonal behavior (p. 1462). The approach was fully explained in McCullough’s 1999 text: *Treatment for chronic depression: cognitive behavioral analysis system of psychotherapy (CBASP)* (McCullough, 1999). Although the strikingly positive benefits of CBASP were not duplicated in a later study (Kocsis, Gelenberg, Rothbaum, Klien, Trivedi, & Manber, 2009), this unique type of cognitive behavior therapy, with its focus on the non-episodic nature of dysthymia, continues to be viewed as an important treatment approach (McCullough, Schramm, & Penberthy, 2015; Negt, Brakemeier, Michalak, Winter, Bleich, Kahl et al., 2016).

In their meta-analysis of research directly comparing the efficacy of psychotherapy and pharmacotherapy in treating depression, Cuijpers and colleagues demonstrated that psychotherapy was more efficacious than pharmacotherapy with tricyclic antidepressants (Cuijpers et al., 2013). On the other hand, Kriston and colleagues’ analysis of treatments specifically for persistent depressive indicated that while psychotherapy with medication outperformed medication alone in chronic major depression, it was not more effective in dysthymia (Kriston, Wolff, Westphal, Holzelt, & Harter, 2014). The benefits of antidepressant medications, which can be determined after only a few weeks, can be more rapidly effective than those experienced in therapy sessions, most of which extend over several months (Thase, Friedman, Biggs, Wisniewski, Trivedi, Luther et al., 2007). Yet, intolerance to medications can make therapy a fitting choice for many people. These kinds of conflicting reports illustrate how our understanding of dysthymia as a unique and non-episodic depression is continually evolving.

Straddling both approaches, Uher suggested initiating treatment with medication and then following up with therapy (Uher, 2014). For example, antidepressants with strong efficacy and good tolerability include selective serotonin reuptake inhibitors (SSRIs) such as sertraline/zoloft; monoamine oxidase inhibitors (MAOI) such as moclobemide/manerix or phenelzine/nardil; or tricyclic antidepressants (TCAs) such as imipramine/tofranil. Once the medications have achieved at least a partial response, then therapy can be individualized to address symptoms associated with depression (Uher, 2014).

4.2. Alternative Therapies

Alternative therapies have also been considered in the treatment of dysthymia. St John’s wort/hypericum, often viewed by the lay public as an herbal remedy, has been found somewhat effective in minor depression but less so in dysthymia (Randlov, Mehlsen, Thomsen, Hedman, von Fircks et al., 2006). Cautions associated with St. John’s wort include potential interactions with blood-thinning drugs, birth control pills, chemotherapy, HIV/AIDS medications and antidepressants (Mayo Clinic, n.d.).

Likewise, exercise has been found to be beneficial as an adjunct to treatment of depression, but the effects are not well understood in dysthymia (Mead, Morley, Campbell, Greig, McMurdo, & Lawlor, 2010). Lifestyle modifications, also known as lifestyle medicine, where people adopt healthier patterns of eating, physical activity, relaxation/sleep, substance use and social interaction are believed to improve depression (Sarris, O’Neil, Coulson, Schweitzer, & Berk, 2014). Professionals from all health disciplines can invite clients in their practice to consider making changes in these areas.

4.3. Future Directions

Positive outcomes for treating dysthymia may not be immediate and trying different combinations of medications, therapies and lifestyle modifications may be necessary. Responses to treatment, like symptoms, will vary among individuals. Duration of symptoms, support systems, coping mechanisms and current life circumstances can all impact recovery. However, research continues to offer hope for relief from the debilitating symptoms of dysthymia. Levkovitz and colleagues’ meta-analysis of the efficacy of treating dysthymia with antidepressants concluded that antidepressant therapy was significantly more effective than placebo in 17 different studies (Levkovitz, Tedeschini, & Papakostas, 2011).

Plans to implement a meta-analysis of existing clinical trials which explored the efficacy of CBASP therapy in combination with medication are underway (Furukawa, Schramm, Weitz, Salanti, Efthimiou, Michalak et al., 2016). This upcoming review is framed from a differential therapeutics perspective and will seek individual participant data from each of the trials reviewed, allowing findings to be matched to specific subgroups of patients.

5. Conclusion

In summary, this paper provided an overview of persistent depressive disorder or dysthymia, explaining assessment approaches in relation to DSM-5 criteria, symptoms, comorbidity, etiology, severity and prevalence. People with dysthymia experience sad moods and feel pessimistic and hopeless to the extent that they are not able to function. Many are at high risk for death by suicide and health professionals should routinely assess for suicidal ideation.

As a non-episodic, insidious and difficult to recognize disorder, dysthymia can first appear in adolescence and remain untreated for years. Women and those who are unmarried are most at risk. Clinician or self-reported scores on the Cornell Dysthymia Rating Scale (CDRS) can immediately communicate people's views about the severity of their illness.

Living with sadness for extended periods of time can leave people suffering from dysthymia resigned to the idea that things are unlikely to change for them. Antidepressant medications offer some relief. However, cognitive behavioral analysis system of psychotherapy (CBASP) is also emerging as an effective treatment. This paper calls for health professionals to integrate dysthymia assessments and referral processes into their practice. Doing so may begin to instill needed hope to the many individuals with dysthymia who are simply enduring rather than enjoying their lives.

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Recognizing and Responding to Depression in Dementia



[PDF – 1.9 MB]

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Abstract

One-third of people living with dementia also experience depression. Treating symptoms of depression may be a protective factor and reduce cognitive decline in dementia. People suffering from depression experience sad mood, reduced energy, poor concentration, loss of interest, diminished activity and they are at risk for death by suicide. Screening instruments include the Cornell Scale for Depression in Dementia (CSDD) and the Geriatric Depression Scale (GDS). Typical treatments include antidepressant medications, which may have limited efficacy; and Electroconvulsive Therapy (ECT), which may heighten memory loss. Psychotherapeutic approaches, including cognitive-behavioral therapy, interpersonal therapy and supportive counseling can be helpful. Lifestyle modifications addressing healthy diet, exercise and the inclusion of enjoyable activities can promote improved quality of life. Providing needed education and support to caregivers, who often experience depression, anxiety and sleep disorders themselves is critical. This paper provides health professionals with an overview of approaches for recognizing and responding to co-occurring dementia and depression.

Introduction

Co-occurring dementia and depression, particularly in older adults, presents unique challenges for health care practitioners. Symptoms of dementia, such as deterioration in memory, thinking, behavior and the ability to perform everyday activities [1] can appear similar to symptoms of depression, which include sad mood, reduced energy, poor concentration, loss of interest and diminished activity [2]. Approximately 32% of people living with dementia are also likely to experience depression [3].

In the 2017 Draft Global Action Plan on the Public Health Response to Dementia, the World Health Organization (WHO) identified that preventing and managing depression may be a protective factor and reduce the risk of cognitive decline in dementia [4]. Existing research has focused on diagnosing depression in dementia and evaluating treatment with antidepressant medications. Most of this work has been directed to physicians. However, health professionals from a variety of different settings encounter people struggling to cope with co-occurring dementia and depression in their practice. Increasing understanding of depression among all members of health care teams can make an important difference in helping to prevent decline in dementia. Geared to a multidisciplinary audience, this article explains approaches for recognizing and responding to depression in dementia.

Defining Dementia

Dementia, or neurocognitive disorder is a syndrome characterized by an acquired and observable decline in cognition in one or more cognitive domains such as learning and memory, language, executive function, complex attention, perceptual-motor, and social cognition [5]. As many as 36 million people currently live with dementia and this number is expected to double every 20 years [6]. 10% of people 65 years of age and older have dementia [7].

Many conditions are considered potential causes of dementia. These include Alzheimer's Disease (AD), Vascular Dementia (VaD) and Lewy body dementia. Alzheimer's disease is the most common form of dementia and accounts for almost 80% of cases of dementia [8]. Vascular dementia, a form of brain damage caused by impaired blood flow to the brain because of diseased blood vessels [9] is the second most common form of dementia and affects about 20% of the dementia population [10]. Although the true frequency of Lewy body dementia is unclear, this condition is increasingly becoming recognized as a common cause of dementia in older people [11]. In this article, the term dementia will refer to dementia caused by Alzheimer's disease. Unless otherwise specified, the information presented can be considered relevant to the care of people experiencing any form of dementia.

Recognizing Depression

The decline in neurocognitive function and memory impairment that people with dementia experience reduces both their own quality of life and that of their caregivers [12]. Neuropsychiatric symptoms, such as depression, also compromise quality of life and have even been related to faster progression of dementia symptoms [13]. 97% of people with dementia experience neuropsychiatric symptoms, and 29-47% of these are depression [14].

Types of Depression

Differentiating among varied types of depression, or feelings of overwhelming sadness, is foundational to the process of recognizing depression in dementia. Major (clinical) depression; persistent depressive disorder (dysthymia); adjustment

disorder with depressed mood; Seasonal Affective Disorder (SAD); and late life depression are five common types of depression. Major depression is characterized by either a depressed mood or a loss of interest or pleasure in daily activities that occurs consistently for at least a 2 week period [5]. This acute depressed mood signals a significant change from the person's normal mood; is in addition to a normal response to significant loss; and it negatively impacts social, occupational, educational and everyday functioning [5].

Persistent depressive disorder also involves depressed mood and loss of interest, but the symptoms are chronic, occur for more than 2 years and may not fully impair functioning [5]. People with persistent depressive disorder often also experience co-occurring bouts of major depression [15].

Adjustment disorder with depressed mood can occur at times when people are facing a change or new and stressful life event [5]. The life event can be positive, such as experiencing a marriage or a new baby in the family; or it can be negative such as experiencing an illness or moving to a care facility.

Seasonal affective disorder is related to variations in light exposure in different seasons and occurs most frequently in winter [5]. Symptoms include overeating, craving carbohydrates and sleeping too much or too little [16]. While these symptoms also occur in other types of depression, SAD is diagnosed when people have a consistent pattern of experiencing the same seasonal depression for several years.

Late-life depression frequently occurs when people experience age related physical illnesses such as arteriosclerosis [5]. Arteriosclerosis in the elderly may induce vascular neurocognitive disorder (vascular dementia) [5], which in many cases may explain the co-occurrence of late-life depression. Symptoms primarily impair executive functions, attention, information processing, psychomotor speed and working memory [5]. Chronic inflammation, hormonal, and immune issues can impact the integrity of frontostriatal circuits as well as the amygdala and the hippocampus, ultimately increasing the vulnerability to depression [17]. Older adults living with psychosocial stressors such as poor socioeconomic status, disability, and social isolation are particularly vulnerable to late-life depression [18]. In old age, depressive symptoms have an association with cognitive decline [19]. Associations between late-life depression and dementia, although not conclusive, are increasingly being questioned and investigated [20-23].

It is important to emphasize that suicidal ideation (thoughts of suicide) can be expected in any type of depression. The risk of suicide is significant in the elderly. For example, rates of death by suicide in men over age 70 are higher than in any other demographic

group worldwide [24]. People with dementia who are most at risk of suicide are male, receiving or have a history of receiving treatment for psychiatric symptoms and newly diagnosed with dementia [25]. Whenever health professionals determine that individuals in their care are experiencing depression, it is critical to question and report whether suicidal ideation is present.

Treatment approaches for the types of depression mentioned above differ. While time-limited support may be fitting for major depression, adjustment disorder and seasonal affective disorder, more long term approaches will likely be needed for persistent and late-life depressions. In this article, the term depression will refer to major, persistent and late-life depressions. Unless otherwise specified, the information presented can be considered relevant to the care of people experiencing any type of depression.

Screening for Depression

An important first step in the process of recognizing depression in dementia is to remain aware that overwhelming sadness, loss of interest in activities once enjoyed and changes in eating and sleeping patterns are symptoms of depression and not part of normal aging. Another important step is to invite people with dementia to talk about their feelings, even when cognitive impairment is present. A further step is to document comments from family members which describe previous life experiences with depression. This documentation should include depressions people have experienced, how they coped and treatments that helped.

Screening tools also play a key role in recognizing depression in dementia. Valid rating scales are available to practitioners from different disciplines and these can be implemented with people who live in the community, in long term care facilities or are temporarily being treated in acute settings. Two scales that have been validated for use in the older adult population are the Cornell Scale for Depression in Dementia CSDD and the Geriatric Depression Scale GDS [26-27].

The Cornell Scale for Depression in Dementia, as the name implies, was designed specifically for use in dementia, includes interview information from both clients and their caregivers and can be completed in about 20 minutes [28]. Scores illustrate the severity of depression. A score of 0-7 indicates that few depressive symptoms are present; one of 8-10 indicates moderate depressive symptoms, and >10 indicates major depressive symptoms [28].

The Geriatric Depression Scale (15 item shortened version) is a self-report measure and can be used both with older adults who have or do not have symptoms of dementia [29]. Using a 'yes' or 'no' format, the scale can be completed in about 5 minutes and the cut-off score for depression is 6 points [29]. This scale is considered most effective for people with only mild cognitive impairment as internal consistency decreases in the later stages of dementia and when used with those experiencing moderate to severe dementia [30].

Responding to Depression

Pharmacological Approaches

Antidepressant medications are one important approach in the complex treatment of depression in dementia [31] and they may be helpful [32]. As many as 88% of people with co-occurring dementia and depression are treated with antidepressant medications

[33]. Selective Serotonin Reuptake Inhibitors (SSRI's) (e.g., citalopram, escitalopram, paroxetine, sertraline) are the first-line pharmacotherapy although mirtazapine, a Selective Norepinephrine Reuptake Inhibitor (SNRI) may be useful when insomnia is present [34]. Tricyclic antidepressants are usually avoided as they can cause anticholinergic effects which may further impair cognitive function in people with dementia [34].

Research indicates that evidence of antidepressant efficacy in the treatment of depression in people with dementia is inconclusive [35-37]. Studies have revealed that people with dementia who are on antidepressants have increased odds of further cognitive impairment [38]. Independent of depression, the antidepressant medications themselves have even been identified as a potential risk factor for dementia [39]. Discontinuing antidepressant treatment in people with co-occurring depression and dementia can lead to an increase in depressive and other neuropsychiatric symptoms [40]. In general, antidepressants are recommended mainly for individuals with depression where the symptoms are especially distressing and surpass the threshold for major depression [41].

Non Pharmacological Approaches

Electroconvulsive Therapy (ECT), which involves the electrical stimulation of the brain with the intent of inducing seizures, is a viable treatment for depression, especially in urgent situations where an immediate treatment response is needed [42]. When symptoms of severe agitation are present in people living with dementia, electroconvulsive therapy has been found to reduce these symptoms [43]. However, the side effects of cognitive impairment and memory loss [42] must be taken into consideration when implementing electroconvulsive therapy with older adults who are already experiencing confusion.

Psychotherapy

Moderate evidence suggests that psychotherapeutic approaches, such as Cognitive-Behavioral Therapy (CBT), interpersonal therapy and supportive counseling are effective for people living with co-occurring depression and dementia [44]. Cognitive behavioral therapy aims to challenge the distorted and negative ways people interpret situations and to support them towards finding new and more adaptive views [45]. Interpersonal Therapy (IPT), based on the premise that depression is related to interpersonal conflicts, provides people with techniques to explore and cope with grief, interpersonal conflicts, interpersonal deficits and role transitions [45]. Supportive counseling, also referred to as a person-centered or non-directive therapy, uses principles of warmth, empathy and respect to help people explore issues that are important to them [45].

These psychological interventions have the potential to improve people's quality of life, cognition, activities of daily living and they may reduce caregiver burden [44]. Therapeutic strategies that have been used effectively in late-life depression without cognitive impairment, such as reminiscing, problem solving and instigating environmental changes [45] are not usually implemented in people with dementia.

Lifestyle Modifications

Modifying patterns of diet, exercise and enjoyable activities may exert a positive influence on some symptoms of depression.

Recommendations for modifying dietary patterns include: following the Mediterranean diet; increasing consumption of fruits, vegetables, legumes, wholegrain cereals, nuts, and seeds; including a high consumption of foods rich in omega-3 polyunsaturated fatty acids; replacing unhealthy foods with wholesome nutritious foods; and limiting intake of processed-foods, 'fast' foods, commercial bakery goods, and sweets [46].

Exercise, especially activities that stimulate moderate cardio respiratory gains, such as 45 minutes of walking, running or swimming each day, can improve memory performance and reduce hippocampal atrophy in the brain [47-48]. Encouraging both people living with co-occurring depression and dementia and their caregivers to join exercise classes, walking groups and structured water exercise activities can help them maintain healthy exercise regimes.

Enjoyable activities, such as spending individual time with family or staff caregivers and 'walking and talking' in pleasant surroundings may improve mood [49]. Animal-assisted activities, such as petting and feeding dogs in sessions facilitated by dog handlers, have also been shown to have a positive effect on symptoms of depression and quality of life in older adults with dementia, especially those in a late stage [50]. Music care, for example, playing selected music with specific background melodies and rhythms, while inviting participants to move in time with the music, can bring much needed comfort [51-52]. Massages, usually provided in chairs rather than on massage tables, can help people feel less combative and restless [53].

Caregiver Support

Education and ongoing support for caregivers is a critical element in the process of responding to depression in dementia. Caregivers can be spouses, family members, care facility staff, home support workers, volunteers and others who are interested in helping. While caregiver burden can be expected to be more severe in family members who are closest to those who are suffering, others involved in their care can experience distress as well. The burden of caregiving is amplified in situations where people are especially frail [54].

Anxiety, depression and sleeping problems are known to occur among caregivers of people living with co-occurring depression and dementia [55-57]. Caregivers can struggle with feeling incompetent, guilty, and overburdened [58]. They can also feel grief and an ambiguous sense of loss when people they care for are physically with them, but yet not usually mentally

or emotionally present in the same way as before [59]. Providing needed resources and respite for caregivers can in turn help those in their care. Group activities, where caregivers can connect with like-minded others and ensuring that their time with service providers is not rushed may begin to ease the burden.

Conclusion

Dementia, usually caused by Alzheimer's disease or vascular insufficiencies, is characterized by difficulty performing everyday activities and deterioration in memory, thinking and behavior. Depression, which is also characterized by difficulty performing everyday activities, co-occurs in at least one-third of people living with dementia. Depression causes overwhelming feelings of sadness, loss of interest in activities once enjoyed and changes in eating and sleeping patterns.

Depression can occur acutely as a major or clinical episode, as a seasonal affective disorder, or as an adjustment to a new situation. It can also occur chronically as a dysthymia or persistent depression that extends over several years. Most frequently, it presents as a late life depression possibly associated with inflammation, hormonal, and immune issues impacting the frontostriatal circuits, the amygdala and or the hippocampus. Cognitive decline is associated with late life depression, making it especially difficult to differentiate from dementia. Neither the symptoms of dementia nor those of depression are normal as people age. They are symptoms that significantly decrease the quality of life for both those who are afflicted and their caregivers.

Remaining vigilant in assessing for these symptoms and implementing screening instruments such as the Cornell Scale for Depression in Dementia (CSDD) and the Geriatric Depression Scale (GDS) are useful elements in the complex process of recognizing depression in dementia. Reports from family members or previous medical histories documenting any history of depression and treatment approaches that helped should be available to all those who provide care. When symptoms of any type of depression are observed, health professionals from all disciplines are expected to immediately assess and report any thoughts of suicide.

Responding to co-occurring depression and dementia is seldom straightforward. Typical pharmacological responses, such as selective serotonin reuptake inhibitors antidepressant medications, have limited efficacy despite their frequent use. Non pharmacological responses, such as electroconvulsive therapy, may increase the memory impairment already present in dementia. It is prudent to reserve the use of antidepressant medications for severely depressed people, and the use electroconvulsive therapy for those unable to find relief from their agitation through other means.

Psychotherapeutic approaches such as cognitive-behavioral therapy, interpersonal therapy and supportive counseling can be helpful. Lifestyle modifications addressing healthy diet patterns that replace processed items with wholesome nutritious foods; and maintaining exercise programs, particularly those that provide moderate stimulation to the cardiac and respiratory systems can also be helpful. Integrating enjoyable activities which provide opportunities for people to spend individual time with family or caregivers; to handle animals; to listen to and move with music; and to receive a massage all have the potential to improve quality of life.

Caregivers, who play an essential role in the lives of people living with depression in dementia, are likely to experience depression themselves. They also may be struggling to cope with anxieties, sleep disorders and caregiver burden. At times, they can experience feelings of incompetence, guilt, grief and an ambiguous sense of loss. Providing needed education and support is invaluable. Although caregivers are not formally identified as needing services from health care professionals, treatment of people with co-occurring dementia and depression is incomplete unless the needs of their caregivers are also addressed. All those who care for and about people living with dementia can contribute to the process of recognizing and responding to depression. This is both a challenge and an opportunity for health care professionals from all disciplines.

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Seasonal Affective Disorder: An Overview of Assessment and Treatment Approaches



[PDF – 1.3 MB]

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Abstract

Seasonal affective disorder or SAD is a recurrent major depressive disorder with a seasonal pattern usually beginning in fall and continuing into winter months. A subsyndromal type of SAD, or S-SAD, is commonly known as “winter blues.” Less often, SAD causes depression in the spring or early summer. Symptoms center on sad mood and low energy. Those most at risk are female, are younger, live far from the equator, and have family histories of depression, bipolar disorder, or SAD. Screening instruments include the Seasonal Pattern Assessment Questionnaire (SPAQ). Typical treatment includes antidepressant medications, light therapy, Vitamin D, and counselling. This paper provides an overview of SAD.

I. Introduction

As sunlight decreases during the short dark days of winter, many individuals struggle with seasonal affective disorder or SAD. As the acronym so aptly illustrates, those afflicted experience feelings of sadness and loss of energy, especially during December, January, and February, around the winter solstice, when the days are shortest. Existing research has focused on the key treatment approaches of antidepressant medication, light therapy, Vitamin D, and counselling. This paper presents an overview of SAD by explaining the disorder and commenting on treatment approaches.

2. An Explanation of Seasonal Affective Disorder (SAD)

2.1. What Is SAD? Seasonal affective disorder or SAD is not considered a unique diagnostic entity. Rather, it is a type of recurring major depression with a seasonal pattern. According to the *Diagnostic and Statistical Manual of Mental Disorders* DSM-5 [1], criteria for depression with a seasonal pattern include having depression that begins and ends during a specific season every year (with full remittance during other seasons) for at least two years and having more seasons of depression than seasons without depression over a lifetime. Seasonal pattern disorders occur most frequently in winter although they can also occur in summer. People with seasonal affective disorder have difficulty regulating the neurotransmitter serotonin, a neurotransmitter believed to be responsible for balancing mood [2]. In one study, people with SAD had 5% more SERT, a protein that assists with serotonin transport, in the winter months than in summer [2]. SERT transports serotonin from the synaptic cleft to the presynaptic neuron, so higher SERT levels lead to lower serotonin activity, thus causing depression [2]. Throughout the summer, sunlight generally keeps SERT levels naturally low [2]. But as sunlight diminishes in the fall, a corresponding decrease in serotonin activity also occurs.

People with SAD may also have difficulty with overproduction of melatonin [3]. Melatonin is a hormone produced by the pineal gland that responds to darkness by causing sleepiness [4]. As winter days become darker, melatonin production increases and, in response, those with SAD feel sleepy and lethargic [5]. Although melatonin likely plays a role in impacting the symptoms of SAD, it cannot by itself account for these phenomena [6].

The combination of decreased serotonin and increased melatonin impacts circadian rhythms. Circadian rhythms or the body's internal 24-hour "clock" are synchronized to respond to the rhythmic light-dark changes that occur daily and throughout each of the seasons. For people with SAD, the circadian signal that indicates a seasonal change in day length has been found to be timed differently, thus making it more difficult for their bodies to adjust [7–9].

Further, with less outdoor exposure to sunlight on the skin in winter, people with SAD may produce less Vitamin D [10, 11]. As Vitamin D is believed to play a role in serotonin activity, Vitamin D deficiency and insufficiency have been associated with clinically significant depressive symptoms [12, 13]. Causal links between serotonin, melatonin, circadian rhythms, Vitamin D, and SAD have not yet been confirmed. However, associations among these key factors are present and are continuing to be researched.

2.1.1. Symptoms. Symptoms of winter seasonal pattern disorders center on sad mood and low energy [14–18]. Information for the lay public identify that people with SAD can feel sad, irritable, and may cry frequently; and they are tired and lethargic, have difficulty concentrating, sleep more than normal, lack energy, decrease their activity levels, withdraw from social situations, crave carbohydrates and sugars, and tend to gain weight due to overeating [5, 19–21].

Conversely, in addition to irritability, symptoms of the less frequently occurring summer seasonal pattern disorder center on poor appetite with associated weight loss, insomnia, agitation, restlessness, anxiety, and even episodes of violent behavior [22, 23]. It is important to note that seasonal pattern disorders vary in severity. Some individuals may experience a milder form of SAD known as subsyndromal S-SAD [24–26], or most commonly as "winter blues." However, others can be severely incapacitated and unable to function. In some instances, symptoms of SAD can be as severe as those experienced by

in-patients with nonseasonal depression [27, 28]. Like all depressive disorders, thoughts of suicide may be present [29, 30]. Health professionals must always implement suicide assessments with people they believe have or might have SAD.

2.1.2. History. Although low mood and low energy levels during the short dark days of winter may have always been an expected part of life for those living far from the equator, they were first identified as a treatable clinical condition during the 1980s [31–34]. When physician Norman Rosenthal moved to the United States from his native South Africa, he noticed that he felt much less productive in the winter but returned to normal as soon as spring arrived [35]. In his work at the National Institutes of Health, NIH, in the US, Rosenthal collaborated with Al Lewy, who was researching melatonin, and with Tom Wehr who was researching how light suppressed melatonin and impacted circadian rhythms. Together, they applied and disseminated their findings about how bright light could effectively treat patients with SAD [31]. The notion of SAD as a depressive condition warranting further study resonated with many who live in northern latitudes and is now a common and well-documented disorder [36].

2.1.3. Prevalence. Seasonal affective disorder occurs four times more often in women than in men and the age of onset is estimated to be between 18 and 30 years [35]. Those living farthest from the equator in northern latitudes are most susceptible [37]. For example, in the United States, 1% of those who live in Florida and 9% who live in Alaska experience SAD [38]. In Canada 15% of the population experience winter blues and 2 to 6% experience SAD [39]. In the United Kingdom, 20% experience winter blues and 2% experience SAD [40, 41]. Pinpointing prevalence is difficult as the disorder may go unreported and consequently under-diagnosed [42]. SAD can co-occur with other depressive, bipolar, attention deficit, alcoholism, and eating disorders, making it difficult to diagnose [43]. As people with SAD may also have subtle decreases in thyroid function, their hypothyroidism can mask symptoms of SAD [44]. Given that SAD is a disorder women often experience and one that is triggered by limited exposure to sunlight, nurses and other health professionals who do shift work may be at particular risk [45].

2.2. Seasonal Pattern Assessment Questionnaire (SPAQ). Clearly a significant number of people are living with the debilitating effects of SAD and are not functioning to their full potential. By screening for SAD and S-SAD, particularly in familiar primary care settings where clients are accustomed to coming for treatment, health professionals can help identify those who are suffering [46].

The Seasonal Pattern Assessment Questionnaire (SPAQ) first developed by Rosenthal and colleagues in 1984 [47] continues to be widely used [31, 48, 49]. The SPAQ is a retrospective, self-administered tool that screens for the existence of SAD and S-SAD. It is freely available in the public domain and can be downloaded from <http://www.guilford.com/add/forms/rosenthal2.pdf>. No training is required to use the tool.

2.2.1. Scoring the SPAQ. Scoring the SPAQ is not straightforward and clinicians and researchers use the tool in different ways. Questions two and three provide particularly useful information in that they yield a specific number on the Global Seasonality Score or GSS [49–51]. This number or score can immediately communicate whether SAD or S-SAD is likely present and the degree of severity. As such, health professionals can use these two questions to add GSS to their client/patient assessments.

In question two, respondents rate their sleep length, social activity, mood, weight, appetite, and energy level on Likert scales scored from 0 to 4. In question three, respondents rate the degree that seasonal changes are a “problem” (mild, moderate, marked, severe, or disabling).

A GSS of 11 or above and a problem rating of at least moderate are indicative of SAD. A GSS of 9 or 10 and a problem rating of at least mild are indicative of S-SAD.

2.2.2. Reliability, Validity, and Specificity. The SPAQ has been demonstrated to be reliable in that it measures consistently and to be valid in that it measures what it was designed to measure [49, 51–53]. However, it has been criticized for having low specificity, meaning that results may suggest people who do not have SAD will score as though they do [48]. This low specificity may misclassify people with nonseasonal depressions. This misclassification could in turn indicate misleadingly high estimates of prevalence [42, 54].

3. Treatment Approaches

Treatment approaches typically include combinations of antidepressant medication, light therapy, Vitamin D, and counselling. The next section provides a brief outline of these.

3.1. Antidepressant Medications. SAD, like other depressions, is believed to be associated with a dysfunction in brain serotonin activity. Therefore, second generation antidepressants (SGAs), such as the Selective Serotonin Reuptake Inhibitors (SSRIs), particularly fluoxetine (Prozac), have emerged as promising antidepressant medication treatments [55–57]. In the seminal Canadian study comparing the effectiveness of fluoxetine and light therapy in SAD (Can-Sad), fluoxetine was found to be as effective and as well-tolerated as light therapy and it was more cost-effective [58].

Bupropion (Wellbutrin), another SGA SSRI, has also been widely promoted as an effective medication for treating SAD [59–61]. In the northern US and Canada, one study revealed that beginning bupropion XL 150–300 mg daily early in the season while people were still well did prevent recurrence of seasonal depressive episodes [62].

With any medication treatment, it is important to draw attention to the issue of adverse effects. A Cochrane review of second generation antidepressants (SGAs) and SAD emphasized that insufficient evidence exists to come to any overall conclusions on the use of SGAs for SAD; and the authors noted that up to 27% of participants treated with SGAs for SAD withdrew from the studies early due to adverse effects [63]. Therefore, although antidepressant medication is a viable and often convenient treatment for SAD, especially for those whose symptoms are incapacitating, other options should also be considered.

3.2. Light Therapy. Knowing the difference decreased daylight can make in triggering SAD and S-SAD, approaches seeking to replace the diminished sunshine using bright artificial light, particularly in the morning, have consistently showed promise [31, 33, 43, 58, 64–67]. Light therapy is also referred to as Bright Light Therapy (BLT) or phototherapy.

Light boxes can be purchased that emit full spectrum light similar in composition to sunlight. Symptoms of SAD and S-SAD may be relieved by sitting in front of a light box first thing in the morning, from the early fall until spring [68]. In the Scandinavian countries, light rooms, where light is indirect and evenly distributed, are available [66]. Typically light boxes filter out ultraviolet rays and require 20–60 minutes of exposure to 10,000 lux of cool-white fluorescent light daily during fall and winter [67]. This is about 20 times as great as ordinary indoor lighting [38].

Adverse effects of light therapy are usually less severe than those associated with antidepressants. They include eyestrain, increased risk of age-related macular degeneration, headaches, irritability, and difficulty sleeping [5]. Ocular changes and abnormalities are not associated with light therapy [69]. Light therapy should not be used in conjunction with photosensitizing medications such as lithium, melatonin, phenothiazine antipsychotics, and certain antibiotics [69]. In some cases, hypomania and suicidal ideation may occur, especially during the first few days of treatment [70]. Light therapy use should be monitored by a health professional [71].

3.3. Vitamin D. A systematic review and meta-analysis concluded that low levels of Vitamin D are associated with depression [10]. Vitamin D concentration is assessed by serum 25-hydroxyvitamin D (25-OH D) levels: with optimal levels at 30 ng/mL; insufficient levels at less than 30 ng/mL; deficient levels at less than 20 ng/mL; and intoxication levels at greater than 150 ng/mL [72]. Low levels of Vitamin D are usually due to insufficient dietary intake or lifestyle issues such as little outdoor exposure to sunshine [11]. During the winter months of November through February, those living about 33 degrees north or 30 degrees south of the equator are not able to synthesize Vitamin D [73].

Many people with SAD and S-SAD have insufficient or deficient levels of Vitamin D, and although no further studies have confirmed the findings, research investigating this association suggests that taking 100,000 IU daily may improve their symptoms [74, 75]. Taking Vitamin D before winter darkness sets in may help prevent symptoms of depression [12]. Adverse reactions or intoxication is rare but could occur from doses of more than 50,000 IU per day [72].

3.4. Counselling. Counselling approaches can provide help and support to people with SAD. In one study, six weeks of Cognitive Behavioral Therapy (CBT) provided in group format during two 90-minute sessions per week was as effective as 30

minutes of 10,000 lux of cool-white fluorescent light each morning [76]. An overarching goal of CBT is to break down problems that seem overwhelming and negative patterns by changing the way people think about them [5].

Other forms of counselling for SAD and S-SAD integrate elements of CBT by providing new ways of thinking about sad mood and low energy. When depressive symptoms are not severe, programs that help people improve their diet by limiting starches and sugars; increase their exercise; manage their stress; avoid social withdrawal; and spend more time outdoors are all recommended [5].

On his website, Norman Rosenthal encourages self-counselling by finding ways to reduce the stress that inevitably accompanies the incapacitating symptoms of SAD. He found that Transcendental Meditation (TM), other forms of mindfulness, yoga, walking, and exercise that is personally enjoyable were beneficial [35]. Rosenthal advocates a diet high in proteins, vegetables, unprocessed foods, and complex carbohydrates. He also suggests planning winter trips to sunny locales before winter sets in and people lack the motivation to do so [35].

As the preceding sections explained, SAD is a disorder precipitated by lack of needed exposure to sunlight. Further, most SAD treatment approaches, the exception being antidepressant medications and counselling, are based on increasing people's exposure to bright light. Health professionals can play a critical role in supporting those who live with SAD by seeking to understand the condition more deeply, to integrate assessment tools such as SPAQ into their practice, and to become aware of current evidence-based treatment approaches.

4. Conclusion

In summary, this paper provided an overview of SAD and S-SAD or the “winter blues,” explaining what the disorder is in relation to DSM-5 criteria, symptoms, history, and prevalence. People with SAD experience sad moods and low energy to the extent that they are not able to function. Those who live in northern latitudes are most at risk. The self-reported Global Functioning Scores on the Seasonal Pattern Assessment Questionnaire (SPAQ) can immediately communicate people's views about the severity of their illness. Sunlight plays a critical role in the decreased serotonin activity, increased melatonin production, disrupted circadian rhythms, and low levels of Vitamin D associated with symptoms of SAD. Antidepressant medications offer some relief. However, light therapy, Vitamin D supplements, and counselling approaches are also emerging as effective treatments. This paper calls for health professionals to integrate SAD assessments and treatments into their practice, both with themselves and with those they care about and for.

Conflict of Interests

The author declares that there is no conflict of interests regarding the publication of this paper.

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Perfectionism and Depression: Vulnerabilities Nurses Need to Understand



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Abstract

Striving for excellence is an admirable goal. Adaptive or healthy perfectionism can drive ambition and lead to extraordinary accomplishments. High-achieving people often show signs of perfectionism. However, maladaptive, unhealthy, or neurotic perfectionism, where anything less than perfect is unacceptable, can leave individuals vulnerable to depression. In both personal and professional relationships, nurses need to understand how accepting only perfection in self and others is likely to lead to emotional distress. This paper reviews perfectionism as a personality style, comments on perfectionism and high achievement, discusses vulnerabilities to depression, identifies how to recognize perfectionists, and presents balancing strategies perfectionists can implement to lessen their vulnerability to depression.

1. Introduction

Striving for excellence motivates you; striving for perfection is demoralizing. (Harriet Braiker)

Striving for excellence in any endeavor is generally considered an admirable way of thinking. Setting high expectations and conscientiously striving to achieve difficult but attainable goals usually leads to feelings of satisfaction. However, when thinking shifts towards perfectionism, defined as “setting excessively high standards of performance in conjunction with a tendency to make overly critical self-evaluations” [1, page 450], emotional distress, particularly negative affect and depression, often results [2-9]. Perfectionism differs from a healthy attitude of striving to achieve. Maladaptive or neurotic perfectionism impacts individuals from all walks of life, and yet the construct is seldom addressed in the nursing literature. This paper reviews perfectionism as a personality style, comments on perfectionism and high achievement, discusses vulnerabilities to depression, identifies how to recognize perfectionists, and presents balancing strategies perfectionists can implement to lessen their vulnerability to depression.

According to the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR, major depression is defined by depressed mood, markedly diminished interest or pleasure, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation, fatigue, feelings of worthlessness or guilt, diminished ability to think or concentrate, and recurrent thoughts of death [10]. Symptoms of depression vary, and while some can present as mild responses to distressing life events, others are severely disabling and persistently distort how individuals' view themselves and the world around them. Understanding these distorted views is not straightforward. However, research revealing positive correlations between depressive symptoms and perfectionism begins to offer important insights.

2. Perfectionism as a Personality Style

Perfectionism has been conceptualized both as a stable personality trait, where individuals habitually engage in the same patterns of behavior [11] and a thinking style, or the ways in which individuals think about those behaviours [12]. A perfectionist personality style is not viewed as a disorder, but rather as a vulnerability factor in producing depression and other psychological problems in adults, adolescents, and children [13]. The following explanation of three subtypes or components of a perfectionist personality style begins to illustrate how this worldview has personal as well as social ramifications for afflicted individuals.

Hewitt and Flett [11] viewed perfectionism as a multidimensional construct with three elements: self-oriented perfectionism, other-oriented perfectionism, and socially-prescribed perfectionism. First, self-oriented perfectionism is an intrapersonal dimension that involves requiring perfection of oneself, constantly striving to achieve unrealistically high standards, and critically evaluating one's own performance. Second, other-oriented perfectionism is an interpersonal dimension that involves unrealistic expectations and harsh evaluation of others. Third, socially-prescribed perfectionism is also an interpersonal dimension. However, socially prescribed perfectionism involves the perception that perfectionist standards are held by important persons in one's life, and that these important others expect perfection and will evaluate performance critically [6, 14]. Thus, those with a perfectionist personality style can demand perfection in themselves, in others, or they can believe others will accept only perfection.

The pathways where any one of these dimensions of perfectionism can heighten an individuals' vulnerability to depression becomes clear when we consider the magnitude of dissatisfaction they live with everyday. “Striving to be flawless” [14] leaves individuals persistently feeling as though they have failed, that nothing they do will ever be good enough and that mistakes are unacceptable.

3. Perfectionism and High Achievement

On the other hand, although individuals with perfectionist personality styles are vulnerable to experiencing feelings of hopelessness and depression, they can also be well served by these tendencies. Hamachek [12] posited a seminal distinction between two forms of perfectionism. He described an adaptive, healthy positive form labeled “normal,” where individuals engage in “relaxed and careful” (page 28) pursuit of activities and evaluate themselves against high but reasonable self-standards. In contrast, he also described a maladaptive, unhealthy, negative form labeled “neurotic,” where individuals engage in “tense and deliberate” (page 28) pursuit of unreasonable expectations. While adaptive perfectionists derived pleasure from their striving, maladaptive perfectionists “never seem to do things good enough to warrant that feeling” [12, page 27].

Focusing on adaptive perfectionism, Stoeber and Otto’s [15] paper demonstrated that perfectionist strivings were associated with positive attitudes and that healthy perfectionists demonstrated higher levels of positive characteristics than either unhealthy perfectionists or nonperfectionists. Stoeber and Otto’s findings suggested that self-oriented perfectionist strivings were positive, as long as tendencies to become overly concerned about mistakes and negative evaluations by others were not present.

Further, adaptive perfectionism has been linked to conscientiousness [16], overcoming procrastination [17] and self-efficacy [18]. Perfectionist strivings can be associated with higher satisfaction with life [19]. Those with adaptive perfectionism tend to have high self-esteem and are relatively immune to the long-term detrimental effects of perceived failures [20].

Gifted people [21] and high achieving athletes [22] often show signs of perfectionism. Adaptive perfectionists achieve academically [20, 23] and frequently have high Grade Point Averages [24, 25].

Adaptive perfectionism may even help people live longer. Positive associations between perfectionist young adults and better physical health [26], as well as less engagement in health-risk behaviours such as smoking and drinking [27], have been identified. Fry and Debat’s [28] investigation of seniors newly diagnosed with diabetes revealed that perfectionist seniors lived longer than their less exacting peers who faced the same challenges. Fry and Debat’s work invites other nurse researchers to consider how a perfectionist outlook might foster clients’ ways of thinking about managing their illnesses.

4. Vulnerability to Depression

A key link between maladaptive perfectionism and depression is how critically one evaluates oneself when expected goals are not achieved. When those with maladaptive perfectionist personality styles show patterns of concern over mistakes and consistent doubts about their actions, they can be identified as “clinically significant perfectionists” [29]. Although perfectionist personality styles can foster high achievement, clinically significant perfectionism renders individuals vulnerable to depression and becoming inflexible towards changing their way of thinking, despite the negative impact that the pursuit of perfectionism has on their quality of life [9].

A critical health concern with clinically significant perfectionists is the elevated risk of suicide. Perfectionism can play a role in suicide [3], and socially prescribed perfectionism correlates positively with perfectionist thinking [30, 31]. Women with eating disorders [32], depression during pregnancy [33], postpartum depression [34], and both eating disorders and postpartum depression [35] are all particularly vulnerable to depression when their perfectionism becomes clinically significant. Similarly, given that perfectionism is closely associated with obsessive compulsive symptoms [36], when perfectionist tendencies exacerbate, the strength of that association is substantially greater and depression worsens [37].

Perfectionism is believed to be linked to depression because perfectionists base their self-worth on being successful and on the need to be actively working toward their goals. Therefore, with self-worth contingent only on fully achieving goals,

depressive symptomatology is bound to occur when some goals are not met [38]. Likewise, self-esteem lowers when perfectionists' goals are not met [3, 39–42]. Perfectionism has been found to correlate highly with internalized shame [2].

Perfectionists engage in high levels of brooding and ruminating [43], where they go over and over their mistakes. They live with a constant expectation of negative consequences [44]. In summary, clinically significant perfectionists have little respite from sustained feelings of decreased self-worth, low self-esteem, shame, rumination about mistakes, and expecting only aversive outcomes. In turn, these unrelenting negative reflections become habitual and can insidiously contribute to depressive symptoms.

5. Recognizing Perfectionists

As the above discussion illustrated, distinguishing high achieving individuals from perfectionists who are vulnerable to depressive symptoms is not straightforward. For therapists, three key psychological instruments are available to measure perfectionism: the Frost Multidimensional Perfectionism Scale (FMPS), developed by Randy Frost and colleagues; the Hewitt Flett Multidimensional Perfectionism Scale (HFMPs), developed by Paul Hewitt and Gordon Flett; and the Almost Perfect Scale-Revised (APS-R), developed by Robert Slaney.

Frost et al.'s [1] Multidimensional Perfectionism Scale (FMPS) addresses setting high standards and critical self-evaluation. The scale contains 35 items yielding six subscales. These subscales measure the six factors considered to be characteristic of perfectionists: Concern over Mistakes (9 items reflecting negative reactions to errors), Personal Standards (7 items indicating setting high standards for evaluation), Organization (6 items reflecting the importance placed on orderliness), Parental Expectations (5 items indicating beliefs that parents set very high standards), Parental Criticism (4 items reflecting belief that parents were overly critical), Doubt about Actions (4 items indicating tendencies to doubt ability). Cronbach's alpha for all of the FMPS subscales ranged from .77 to .93 indicating acceptable levels of internal consistency in a sample of female college students [1]. The FMPS is available from Dr. Randy Frost, Smith College Mass, USA.

Hewitt and Flett's [11] Multidimensional Perfectionism Scale (HFMPs) measures different aspects or factors of perfectionism. The scale contains 45 items measuring the intrapersonal and interpersonal dimensions of perfectionism: Self-Oriented Perfectionism (unrealistic standards and perfectionistic motivation for the self), Other-Oriented Perfectionism (unrealistic standards and motivations for others), and Socially Prescribed Perfectionism (believing others expect one to be perfect). The factor structure was congruent across clinical and subclinical populations. Alpha coefficients were .88 (self-oriented perfectionists), .74 (other-oriented perfectionists), and .81 (socially prescribed perfectionists) in a sample of psychiatric patients. Used in a later study with a sample of unipolar depressed patients, the HFMPs revealed that depressed patients were distinguished by a higher level of self-oriented perfectionism and that the depressed groups had higher levels of socially prescribed perfectionism than control groups [6]. The HFMPs must be purchased from Dr.'s Paul Hewitt and Gordon Flett through Multi-Health Systems, NY, USA.

While the FMPS and the HFMPs focus on maladaptive dimensions of perfectionism, Slaney et al.'s [17] 23 item Almost Perfect Scale-Revised (APS-R) was developed to measure adaptive as well as maladaptive elements of perfectionism. The APS-R measures: High Standards (how important doing one's best is), Order (how important being organized and neat is), and Discrepancy (the extent to which one feels that one's performance is meeting one's expectations) [17]. The Discrepancy subscale also measures maladaptive perfectionism by assessing the degree of chronic separation between high standards and eventual outcomes. For example, "I am seldom able to meet my own high standards for performance" [17]. Thus, the APS-R also measures critical self-evaluation and emphasizes the personal aspects of negative perfectionism in order to provide a stronger basis for assessment and clinical intervention. Alpha coefficients were .85 (high standards), .68 (order), and .92 (discrepancy) in a sample of college students. The APS-R is available from Dr. Slaney, Penn State University, PA, USA.

For nontherapists and the lay public, Gordon Flett offered a set of questions to shed light on behaviours that begin to signal

maladaptive perfectionism. Unlike the FMPS, HFMPs, and APS-R, which were designed for therapists, Flett's set of questions are readily available to the public and require no specialized training. The questions are as follows.

* Top Ten Signs You are a Perfectionist

- (1) You can not stop thinking about a mistake you made.
- (2) You are intensely competitive and can't stand doing worse than others.
- (3) You either want to do something "just right" or not at all.
- (4) You demand perfection from other people.
- (5) You will not ask for help if asking can be perceived as a flaw or weakness.
- (6) You will persist at a task long after other people have quit.
- (7) You are a fault-finder who must correct other people when they are wrong.
- (8) You are highly aware of other people's demands and expectations.
- (9) You are very self-conscious about making mistakes in front of other people.
- (10) *You noticed the error in the title of this list [45].

These important questions, framed from a light-hearted perspective, provide nurses with a useful starting point for understanding how accepting only perfection in self and others is likely to lead to emotional distress. Nurses, like many professionals who work in exacting environments where mistakes can be deadly, are not immune to maladaptive perfectionism themselves. Given that as many as two thirds of some university student samples were categorized as perfectionistic [25], that self-critical perfectionism was positively correlated with depression in a sample of both premedical and non-premedical students [46] and that strong associations between perfectionism and psychological distress were found in a sample of medical, dental, nursing, and pharmacy students [47], perfectionist personality styles can be expected among nurses.

5.1. Recognizing Perfectionism on a Personal Level. Recognizing perfectionism on a personal level is important for nurses' own health. Perfectionist tendencies such as over assuming responsibility to ensure tasks are completed flawlessly [13] leave nurses exhausted and unfulfilled. Tendencies to make excuses about why actions will not be perfect rather than to risk acting [13] leave nurses powerless and unable to learn new tasks. Tendencies to shun situations where imperfections might be displayed [45] leave nurses isolated and unsupported. Perhaps most disturbing of all however, is that tendencies to keep problems to oneself and not admit failures to others [45] leave nurses ill prepared to disclose mistakes they do make. Rather than receiving recognition for their strivings or help when they need it, maladaptive nurse perfectionists can find themselves struggling within their relationships and becoming increasingly vulnerable to symptoms of depression.

Relationships with family, friends, and colleagues suffer when nurses either demand perfection from significant others or believe that those significant others will accept only perfection. Maladaptive perfectionists who are especially depression prone have often experienced perfectionist parenting themselves [4]. When parents communicate that their affection and approval is conditional on good performance, children can develop perfectionist personality styles that persist throughout adulthood [48]. Overly demanding and critical parents' model obsessive concern with mistakes [48]. In adulthood, nurses from perfectionist primary families may expect the same critical judgement from authority figures and from those who are important to them. They may also perpetuate the cycle of perfectionism with their own children. Identifying that one may have come from a family where self-worth is contingent only on consistent achievement is an important first step in recognizing perfectionism on a personal level.

Further, recognizing perfectionism-related depression in the workplace is another important consideration for nurses' own health. Socially prescribed perfectionism, or believing that important others will evaluate one harshly, is a vulnerability factor

in the experience of burnout, job dissatisfaction, and depression [49]. In one study simulating performance situations where participants received failure feedback, perfectionism was a vulnerability factor in elevated dysphoric affect and negative cognition [50]. Perfectionist individuals are particularly sensitive to feedback indicating that their performance is not perfect, and when they believe others view their work as substandard, they experience intense feelings of decreased self-worth. Perfectionist leaders can contribute to feelings of burnout and negativity among members of their team, particularly with those who have a perfectionist personality style themselves.

5.2. *Recognizing Perfectionism on a Professional Level.* Clients who are vulnerable to perfectionist-related depression will present in all areas of nursing practice. Coping with developmental milestones, acute or chronic health issues, and caring for others can be expected to exacerbate strivings to cope perfectly. Ineffective coping is prevalent among maladaptive perfectionists [51]. When faced with disability or chronic illness, scores from one sample group of maladaptive perfectionists were significantly high for negative adjustment and above the clinical cutoff for depression [52]. As nurses engage and motivate clients to strive for excellence in managing health, recognizing their perfectionist personality styles and the depressive symptoms that are likely to accompany them will strengthen care.

When clients' ways of coping fall short of health care providers' expectations, perfectionists are likely to experience heightened feelings of being evaluated harshly. Subsequently, these demoralizing feelings could result in avoiding health care providers, not admitting to health issues, and declining much needed help. On initial assessment, a connection between clients' avoidance behaviors and seemingly limited motivation to change may not immediately signal potentially maladaptive perfectionism. And yet, recognizing when clients' strivings for excellence in managing their health care are actually manifesting as clinically significant perfectionism is critical. Follow-up assessments for symptoms of depression are indicated. Psychiatric or psychological referrals may also be indicated. As our understanding of the association between perfectionism and depression deepens, problems with the notion of accepting only perfection in self, colleagues, and clients become apparent.

6. Balancing Strategies

Shifting habitual patterns of thinking away from focusing on past or future mistakes and towards new ways of thinking will take time. Cognitive behavioral therapy with a psychiatric or psychological health professional could take months or even years. When comorbid conditions such as major depression or suicidal ideation are also present, therapeutic approaches become more complex. It is beyond the scope of this article to elaborate on comprehensive treatment of depression. However, the process of creating balancing strategies to differentiate striving for excellence from maladaptive striving for perfectionism begins with recognizing perfectionist personality styles in self, family, colleagues, and clients. Once individuals are willing to acknowledge that potential problems with perfectionist tendencies exist, they can begin to reimagine new and more balanced ways of looking at their previous accomplishments and future goals. Strategies for decreasing maladaptive perfectionist thinking will help lessen the feelings of decreased self-worth associated with depression.

For self-oriented perfectionists, or those who require perfection in themselves, self-help books offer important direction. For example, in *Feeling Good: The New Mood Therapy Burns* [53] chapter titled: *Dare to Be Average! Ways to Overcome Perfectionism* offers useful self-assessment tools and action-oriented suggestions for identifying cognitive distortions, and then replacing them with more rational ways of thinking. In *It's Your Little Red Wagon: 6 Six Core Strengths for Navigating Your Path to the Good Life*, Esonis [54] encourages readers to accept that they can be excellent, but not perfect, at some chosen goals, and mediocre at others. She invites readers to make decisions about selecting endeavours that merit their finest efforts and to plan to celebrate accomplishments—even those that were not achieved fully. In *Be Happy Without Being Perfect: How to Worry Less and Enjoy Life More*, Domar and Kelly [55] provide suggestions, especially for women, for focusing less on perceived failures or mistakes and more on successes and meaningful relationships.

For other-oriented perfectionists, or those who require perfection in others, Marano's [48] advice, although geared primarily to parents, guides individuals to acknowledge efforts others put forward more than results they obtain. For example,

rewarding family, employees', or clients' own process of dealing with an issue rather than the product or outcome they achieve projects genuine encouragement. Rather than offering external material awards, Marano [48] suggests that parents ask their children about why things went well and what they attribute their success to. Rather than expressing disappointment in completion of a task, Marano [48] encourages parents to ask children how they feel about their performance and what they might do differently next time. The same process of inquiry can be transferred to communication with adults. Parents, employers, and health professionals may not realize their demands for perfection are actually undermining performance and generating feelings of failure in those they are seeking to help. Once again, recognizing that perfectionist tendencies exist and they impact others is a key balancing strategy.

For socially-prescribed perfectionists, or those who believe important others in their life will accept only perfection, realistic assessment is essential. In instances where parents, employers, or health professionals are in fact other-oriented perfectionists, a belief that others are demanding perfection is likely credible. Here, strategies for dealing with people who are in positions of "power-over" are useful. Identifying clear specific areas where improvement is required and creating a step-by-step plan for changing behaviour is in order. Including designated times for reporting progress and discussing any further action required by the person in authority is warranted.

However, when careful assessment reveals that others are not actually demanding perfection, strategies for minimizing self-handicapping, or spending more time finding excuses for poor performance than preparing for a good performance [13], are called for. Fearing harsh evaluation and making mistakes of any sort, socially-prescribed perfectionists avoid opportunities for the very evaluation from others that could improve their performance. Here, strategies for seeking safe appraisals from those who are perceived to be personable and supportive as well as credible offer important balance. For example, teachers and coaches as well as parents can contribute to children's feelings of success. So, ensuring that children have a variety of opportunities to learn new skills and a range of adults who offer them feedback is valuable. Likewise, self, peer, and client evaluations can supplement employees' performance appraisals. In the workplace, seeking opportunities for evaluative input that extends beyond immediate supervisors is useful. In sport, learning and practice environments, seeking extra drill, lab or simulation time can help reduce performance anxiety. In environments where clients believe health professionals demand perfection, attending support groups where others share what has worked for them and what has not is beneficial.

Coping with life's inevitable failures is not easy for those whose self-worth is contingent on success. Perfectionists' deep-rooted habits of avoiding any situation where they might fail and ruminating over even inconsequential mistakes may have been present since childhood. At the heart of establishing balance and decreasing perfectionists' vulnerability to depression is learning to handle failure. As Marano [48] states: "Success hinges less on getting everything right than on how you handle getting things wrong" (page 86).

One strategy for changing an ingrained habit is to create an interruption. For example, watching an engaging movie or play can interrupt ruminative thinking. Even when the interruption is short-lived, a fresh perspective becomes possible. Following an interruption, perfectionist thinking can shift away from mistakes and towards concrete plans for change. Listening mindfully to music, playing games, and visiting friends can create interruptions and divert thinking. Days off and vacations can also interrupt ruminative thinking, and perfectionists may need to put specific plans in place to ensure that they can let go of professional responsibilities during these times. In the same way, attending to nutritious eating, appropriate exercise, and pleasant time with loved ones are other healthy lifestyle strategies that perfectionists can implement to help create balance.

Finally, intentionally replacing negative patterns of thinking with pleasurable experiences can be as simple as making time to focus on natural wonders. Moving out of a familiar room and into another space to look at a sunset or listen to a rainfall can feel invigorating. Spending time outdoors and finding ways to connect with plants and animals can provide brief respite from the relentless burdens of perfectionism.

7. Conclusion

Individuals with perfectionist personality styles are vulnerable to symptoms of depression, especially when their maladaptive perfectionism becomes clinically significant. Ingrained habits of accepting nothing less than perfection in self and others can leave people of all ages feeling worthless and even suicidal. While healthy perfectionist tendencies foster success, the patterns of concern over mistakes, selfdoubt, and expectation of criticism inherent in unhealthy perfectionist tendencies cause distorted thinking and social isolation.

Explorations of perfectionism as a vulnerability factor in depression have been underway for several decades now and sufficient evidence exists to warrant nurses' attention and concern. Recognizing when strivings for excellence have shifted into strivings for absolute perfection is critical. Depression-prone perfectionism may be reflected in behaviour such as consistently setting unrealistic goals, ruminating, never feeling satisfied with one's own or others' performance, avoiding evaluation by important others, and declining needed help. Nurses themselves, their families, their workplace colleagues, and their clients are all susceptible to maladaptive perfectionism.

Strategies for achieving balance include recognizing perfectionist personality styles in self and others, attending psychological or psychiatric therapy if necessary, acting on suggestions from self-help books, attending support groups, seeking evaluative feedback and help from a variety of different sources, learning to deal with failure, interrupting ruminative thought patterns, and looking for ways to intentionally replace negative thoughts with positive ideas. As nurses continue to learn about the links between perfectionism and symptoms of depression, more opportunities for nurturing excellence without exacerbating perfectionist tendencies will emerge.

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Paternal postpartum depression: How can nurses begin to help?



[PDF – 95 KB]

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Abstract

Men's emotional health can be overlooked during their partner's pregnancy and throughout the first postpartum year. Postpartum depression, once expected only in new mothers, is now estimated to occur in 4–25% of new fathers as well. The incidence of paternal postpartum depression is greater in couples where maternal postpartum depression is also present. Paternal postpartum depression can be difficult to assess. New fathers may seem more angry and anxious than sad. And yet, depression is present. When left untreated, paternal postpartum depression limits men's capacity to provide emotional support to their partners and children. This article reviews the incidence and prevalence of paternal postpartum depression, comments on tools to measure the disorder, identifies paternal behaviors that may indicate depression, examines the effects of parental depression on families and discusses what nurses can do to begin to help.

Keywords: nursing; paternal postpartum depression; sad dads; parental depression

INTRODUCTION

Traditionally, postpartum depression has been construed as a disorder of women. However, as many as one in four new fathers may also experience devastating depression following the birth of their new baby (Goodman, 2004; Madsen & Juhl, 2007; Paulson, Dauber, & Leiferman, 2006; Pinheiro et al., 2006; Ramchandani, Stein, Evans, & O'Connor, 2005). Adjusting to an infant impacts new fathers as well as new mothers. This article will review the incidence and prevalence of paternal postpartum depression, comment on tools to measure the disorder, identify paternal behaviors that may indicate depression, examine the effects of parental depression on families and discuss what nurses can do to begin to help.

INCIDENCE AND PREVALENCE OF PATERNAL POSTPARTUM DEPRESSION

The incidence or number of new cases of postpartum depression in men may be nearly half as high as the percentage known to be occurring in women. Goodmans (2004) literature review spanned publications from 1980–2002 and was seminal in identifying that an increasing number of cases of paternal postpartum depression have been identified during the past few decades. During this period of time, a variety of different tools were used to determine that the incidence of paternal depression during the first year after childbirth ranged from 1.2–25.5% in community samples, and from 24–50% among men whose partners were experiencing postpartum depression. Maternal depression was identified as the strongest predictor of paternal depression during the postpartum period (Goodman, 2004).

The prevalence, or number of cases of a condition present in a population, continues to illustrate how a significant number of families remain affected. In England, Ramchandani et al. (2005) found that depressive symptoms were present in 10% of mothers and 4% of fathers 8 weeks after childbirth. Ramchandani et al. (2005) used the Edinburgh Postnatal Depression Scale to measure depression. Initially developed for assessing maternal postpartum depression (Cox, Holden, & Sagovsky, 1987), the tool is increasingly being used with new fathers (Cox, 2005; Matthey, Barnett, Kavanagh, & Howie, 2001; Matthey, Barnett, Ungerer, & Waters, 2000).

In the US, Paulson et al. (2006) used a short form of the Centre for Epidemiologic Studies Depression Scale as a measurement instrument (Radloff, 1977). Paulson et al. (2006) concluded that 14% of mothers and 10% of fathers had moderate or severe depressive symptoms 9 months after childbirth.

In Brazil, Pinheiro et al. (2006) used an instrument for alcohol misuse, the Alcohol Use Disorders Identification Test AUDIT (Saunders, Aasland, Babor, De la Fuente, & Grant, 1993), and the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Pinheiro et al. (2006) determined that 26.3% of mothers and 11.9% of fathers scored above the threshold for depression 6–12 weeks after childbirth. They posited that paternal depression is significantly more prevalent when the woman is also depressed affecting up to 40% of men within that population.

In Denmark, Madsen and Juhl (2007) used the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale (Zierau, Bille, Rutz, & Bech, 2002). The Edinburgh Postnatal Depression Scale established a paternal postpartum depression prevalence of 5.0% and the Gotland Male Depression Scale one of 3.4%. Results from an analysis combining the scales revealed that 7% of fathers were suffering from postpartum depression 6 weeks after childbirth. While Madsen and Juhl (2007) acknowledged that the Edinburgh Postnatal Depression Scale had been validated for men, they questioned whether the scale was sensitive to the unique symptoms of depression that men experience. The Gotland Male Depression Scale however, was specifically developed to improve the recognition of major depression in males (Zierau et al., 2002). By using the two different scales, Madsen and Juhl (2007) included masculine appropriate manifestation of depression in their measurement.

In Australia, Bria, Pincombe, and Fedoruk (2006) review of the incidence of paternal postpartum depression revealed that significant indicators exist to suggest that some fathers find pregnancy and the postnatal experience to be overwhelming and

stressful. For these men, the added responsibility of providing for their family, adjusting to changes in lifestyle and experiencing role confusion were factors that contributed to a less than positive transition to fatherhood.

TOOLS TO MEASURE PATERNAL POSTPARTUM DEPRESSION

As the preceding discussion illustrated, researchers have used a variety of different measurement tools to understand paternal postpartum disorder. Reliable and valid tools such as the Edinburgh Postnatal Depression Scale, a short form of the Centre for Epidemiologic Studies Depression Scale, an instrument for alcohol misuse, the Alcohol Use Disorders Identification Test AUDIT, the Beck Depression Inventory and the Gotland Male Depression Scale all begin to offer insight into how new fathers may be feeling.

Nurses in practice may find some of these tools useful as well. The 10-question Edinburgh Postnatal Depression Scale (Cox et al., 1987) takes about 5 min to use, requires no specialized knowledge, has been used efficiently with new mothers for over two decades (Dennis, 2004; Downie et al., 2003; Eberhard-Gran, Eskild, Tambs, Opjordsmoen, & Samuelsen, 2001; Gibson, McKenzie-McHarg, Shakespeare, Price, & Gray, 2009; Murray & Cox, 1990; Pope, 2000) and is freely available on the internet. However, it is important to note that question nine, *'I have been so unhappy that I have been crying'* can be expected to be less applicable to fathers than to mothers. Testing the scale for reliability and validity with men, Matthey et al. (2001) determined that a significant number of fathers did not endorse crying as a symptom of depression. These researchers recommended a lower cut-off score for fathers than for mothers.

Controversy over use of the Edinburgh Postnatal Depression Scale with women has centred on uncertainty related to cut-off scores (Cantwell & Smith, 2009). Cox et al. (1987), Cox (1994) and Cox and Holden (2003) identified that women who scored above a threshold of 12/13 were most likely to be suffering from a depressive illness of varying severity and recommended that a threshold of 9/10 might be appropriate if the scale was considered for routine use by primary care workers. Dennis (2004) suggested a cut-off score of over 9 to ensure sensitivity to depressive symptomatology. However, since the scale does not discriminate levels of depression, higher scores can also indicate distress and minor depression, or 'false positive' results. Similarly, lower scores can indicate that depression is not present when severe depression actually is present, or 'false negative' results (Guedeney, Fermanian, & Kumar, 2000). Clinical judgement must always take precedence over scores on any scale (Pope, 2000). Despite this controversy, the Edinburgh Postnatal Depression Scale continues to be used internationally as a screening tool for maternal postpartum depression (Affonso, Horowitz, & Mayberry, 2000; Beck, 2008; British Columbia Reproductive Care Program, 2003; Buist et al., 2002; Gaynes et al., 2005; Horowitz, 2006; Milgrom, Martin, & Negri, 1999 Registered Nurses' Association of Ontario, 2005; Scottish Intercollegiate Guidelines Network, 2002).

The short form of the Centre for Epidemiologic Studies Depression Scale (Radloff, 1977) also takes about 5 min to use, requires no specialized knowledge and is freely available on the internet. However, this scale was developed as a first-stage screening device to assess depression in community surveys in undiagnosed populations and is particularly useful for detecting depression in chronic disease conditions. The questions are not specific to the postpartum experience and a follow up interview is recommended (Rush et al., 2000).

An instrument for alcohol misuse, the Alcohol Use Disorders Identification Test AUDIT was designed to identify hazardous drinkers, or those who are at an early stage in their drinking and have not yet reached a level of harmful alcohol consumption (Saunders et al., 1993). The 10-question AUDIT also requires no specialized knowledge and is freely available on the internet. While the AUDIT is efficient in identifying new fathers at risk for encountering harm as a result of their drinking, and excessive alcohol consumption may be an indicator of paternal depression, the tool does not measure any other symptoms of depression.

The Beck Depression Inventory (Beck et al., 1961) has well established reliability and validity. Originally developed to assess depression in psychiatric settings, the tool has been revised several times since its introduction in 1961. Researchers using the instrument to measure maternal postpartum depression noted that usual aspects of postnatal life, such as lack of sleep,

tiredness and weight changes can inflate depression scores and that mild or subclinical depression can be overlooked (Affonso et al., 2000; Milgrom et al., 1999). Specialized training is required and the tool is under copyright with the American Psychological Association so may not be used freely.

The newer Gotland Male Depression Scale (Zierau et al., 2002) uses 10 questions geared specifically towards masculine presentations of depression. Phrases such as 'stressed out,' 'burned out' and 'seeming pathetic to others' are used. The tool requires no specialized training and is freely available on the internet. Although reliability and validity studies are limited and the questions are not specific to the postpartum experience, the Gotland Male Depression Scale may be a valuable resource for nurses.

While tools such as the scales mentioned above begin to shed light on our emerging understanding of paternal postpartum depression, the current state of knowledge about this condition is limited. Scales designed to measure maternal postpartum depression (Edinburgh Postnatal Depression Scale), depression in chronic conditions (short form of the Centre for Epidemiologic Studies Depression Scale) identify hazardous drinkers (Alcohol Use Disorders Identification Test), depression in psychiatric settings (Beck Depression Inventory) and major depression in males (Gotland Male Depression Scale) may not be appropriate screening instruments for paternal postpartum depression. Traditional scales such as these may be gender biased and neglect important symptoms present in depressed men (Diamond, 2004; Marcus, Young, Kerber, & Korstein, 2005; Salokangas, Vaahtera, Pacriev, Sohlman, & Lehtinen, 2002; Winkler, Pjrek, & Kasper, 2005). However, until measurement instruments are developed with specific psychometric properties for identifying depression in postpartum males, the scales offer nurses important direction for initiating assessment of new fathers.

PATERNAL BEHAVIORS THAT MAY INDICATE DEPRESSION

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines maternal postpartum depression as a major depressive episode with onset occurring within 4 weeks of delivery, depressed or sad mood, marked loss of interest in virtually all activities, significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think or concentrate, and recurrent thoughts of death (American Psychiatric Association, 2000). These symptoms as well as other behaviors may be present in depressed new fathers.

The onset of postpartum depression may be more insidious in men than in women. Paternal depression may be evident during pregnancy (Condon, Boyce, & Corkindale, 2004), particularly when spouses are depressed (Field et al., 2006; Morse, Buist, & Durkin, 2000). Coping with their partners maternal postnatal depression can leave new fathers feeling overwhelmed, isolated, stigmatized and frustrated (Davey, 2006). While paternal depression may decrease following childbirth, it can also recur and increase over the course of the first year, again, particularly when spouses are depressed (Bielawska- Batorowicz & Kossakowska-Petrychka, 2006; Dudley, Roy, Kelk, & Bernard, 2001; Goodman, 2008; Matthey et al., 2000; Paulson et al., 2006; Pollock, Amankwaa, & Amankwaa, 2005; Wang & Chen, 2005).

Depressed or sad mood may be less apparent in men (Cochran & Rabinowitz, 2000; Condon et al., 2004; Hausmann, Rutz, & Benke, 2008; Kilmartin, 2005; Marcus et al., 2005; Rutz, von Knorring, Pihlgren, Rihmer, & Walinder, 1995). Depressed men often change their social behavior. Withdrawal from social situations, indecisiveness, cynicism, and an irritable mood are identified as hallmark signs of depression in the adult male (Spector, 2006). Avoidance behavior, drinking, drug use, extra-marital affairs and partner violence can also be signs of male depression (Wexler, 2004, 2005). First occurrences of partner violence have been found to occur 2 months postpartum (Hedin, 2000). Mens affect may present more as anxious or angry than sad (Karp, 1996; Winkler et al., 2005). In the absence of consistent assessment criteria, symptoms of paternal postpartum depression can be misconstrued. For example, a new father's irritable mood may be attributed more to infant crying or feeling excluded from the mother-baby bond rather than to a symptom of depression (Kim & Swain, 2007). Similarly, spending extensive time at work away from the family may be perceived as a need to maintain the traditional male role of provider and breadwinner rather than as an avoidance behavior indicative of depression (Bria et al., 2006). Drinking,

drug use, fighting, partner violence and extra-marital affairs may also be open to interpretations other than signs of depression. And yet, these behaviors can all reflect a mood of sadness.

Marked loss of interest in virtually all activities in both new mothers and fathers is difficult to assess. Sleep and appetite disturbances, anergia or lack of energy and weight loss or gain can be misattributed to the normative changes of pregnancy and postpartum that can accompany a 24 h a day commitment to caring for a new baby (Luskin, Pundiak, & Habib, 2007).

While maternal postpartum hormone changes are well documented, information about paternal hormone changes is less readily available. Kim and Swain (2007) posed five conjectures about paternal hormone fluctuation. First, they noted male testosterone levels decrease during a partners pregnancy and postpartum period. Testosterone can decrease by as much as 33% during the first 3 weeks after birth (Storey, Walsh, Quinton, & Wynne-Edwards, 2000) and evening testosterone levels were lower in fathers than in controls (Berg & Wynne-Edwards, 2001). In healthy families, this lowered testosterone may be partially responsible for paternal behaviors such as responding with sympathy to babies' cries, establishing strong infant attachment, lower aggression and better concentration in parenting (Fleming, Corter, Stallings, & Steiner, 2002). But, Kim and Swain (2007) emphasize how a significant correlation exists between lower testosterone levels and depression. Second, Kim and Swain (2007) noted that male estrogen levels increase during the last month of a partners pregnancy and the early postpartum period, a dysregulation not usually experienced. Higher levels of estrogen have been linked to fathers' experiences of cou- vade syndrome or pregnancy like symptoms such as nausea and weight gain (Storey et al., 2000). Third, Kim and Swain (2007) noted male cortisol levels decrease postpartum. Cortisol regulates physiological responses to stress. However, Berg and Wynne-Edwards (2001) also revealed that cortisol levels in new fathers increase during the week before the birth, and these researchers linked this increase with apprehension preceding the birth, a finding previously noted in male animals. Therefore, when the cortisol levels drop immediately following the birth, new fathers experience a further unusual dysregulation. Fourth, Kim and Swain (2007) noted that male vasopressin levels decrease postpartum. Vasopressin affects the ability of the prefrontal cortex to plan and organize behavior. Lower vasopressin has been associated with lower male aggression towards other males (Young, 2009). Fifth, they noted that male prolactin levels usually increase during a partner's pregnancy and postpartum (Storey et al., 2000). But, if prolactin levels decrease instead of increase, a new father is prone to negative moods. Further study to substantiate these conjectures is warranted. However, a combination of lifestyle changes, increased estrogen and lower than usual levels of testosterone, cortisol, vasopressin and prolactin can influence paternal postpartum depression.

Assessing paternal postpartum depression is not easy. Nevertheless, it is critical for all nurses who have contact with new fathers to remain open to the notion that new fathers are predisposed to postpartum depression, particularly if their partner is afflicted. Delving deeper into understanding behaviors of withdrawing, indecisiveness, cynicism, avoiding, drinking, using drugs, fighting, partner violence, extra-marital affairs and feelings of heightened irritation will reveal important insights. Asking new fathers candidly if they are feeling depressed, anxious or angry can open the door to further exploration of these emotions. Considering conjectures that hormonal fluctuations can impact new fathers may help explain the condition. Creating opportunities for new fathers to use tools such as the Edinburgh Post Natal Depression Scale and the Gotland Male Depression Scale will also begin to shed light on their experiences.

EFFECTS OF PARENTAL DEPRESSION ON FAMILIES

Parents who are struggling with depression are not able to consistently care for their families. Maternal postpartum depression can significantly impact children's emotional, social and cognitive development (Murray & Cooper, 1997a, 1997b; Murray, Cooper, Wilson, & Romaniuk, 2003). Mothers with postpartum depression may feel ambivalent, negative or disinterested in their children. Without experiencing bonding and attachment, depressed new mothers become disconnected and have difficulty responding to their infants cues. Over time the infant becomes less positive in its responses (Feng, Shaw, & Skuban, 2007; Righetta-Veltima, Bousquet, & Manzano, 2003). Children of depressed mothers have been found to be more antisocial, neurotic, having more temper tantrums and being more difficult to control. They were less securely attached to

their mothers and showed less sociability and sharing behaviors (Beck, 1998). Maternal postpartum depression can affect children later in their lives as well. Adolescents whose mothers experienced postpartum depression were found to have higher rates of depression themselves (Hammen & Brennan, 2003). They were prone to violent acts, exhibited tendencies towards oppositional and aggressive behaviors, achieved less than optimal academic success, continued to experience cognitive developmental problems, and were prone to having issues with low self-esteem (Johnson & Flake, 2007). Horowitz (2006) identified an overall maternal postpartum depression prevalence rate of 19.7% 2–4 weeks after delivery and called for adapting research-based screening approaches to clinical care. Current literature supports the assumption that paternal depression may exist in many of their partners as well and research-based screening tools for men are becoming available. As the following discussion of the impact paternal postpartum depression can have on families will emphasize, new fathers must also be included in postpartum depression screening initiatives.

When one or both parents are depressed, the couple may view their child somewhat negatively. When mothers are experiencing postpartum depression, both mothers and fathers may describe their child as having a difficult temperament or that the child is ‘slow to warm up’ (Di Blasio & Ionio, 2003; Edhborg, Seimyr, Lundh, & Widstrom, 2000). When both parents are depressed, they are twice as likely to rate their children as below average or average and to perceive health problems in their children (LaRosa, Glascoe, & Macias, 2009).

Despite the impact depression has on couples, one well parent may compensate for a depressed parent (Paulson et al., 2006). Responsive care provided by the father can buffer a child from being negatively influenced by maternal depression (Edhborg et al., 2000). Fathers who are able and available to provide social support for their depressed partner appear to predict children’s developmental success (Letourneau, Duffett-Leger, & Salmani, 2009).

The negative effects of depression on children are exacerbated when both parents are depressed. Having two depressed parents is associated with worse social and emotional adjustment than having only a depressed mother (Paulson et al., 2006). Having two depressed parents is also associated with undesirable parent health behaviours and fewer positive parent–infant interactions. Maternal and paternal depression each impacts positive parent–child enrichment activities such as reading, playing and singing (Paulson et al., 2006).

Independent of maternal postpartum depression, when new fathers are depressed, the effects on the family can be far-reaching. Fathers with symptoms of depression are twice as likely to have an infant who cries excessively at 2 months of age than fathers who are not depressed (van den Berg et al., 2009). Depression in fathers during the postpartum period was found to double the risk of behavioral and emotional problems in their children at 3 years of age (Ramchandani et al., 2005). Further, paternal postpartum depression in fathers was also significantly associated with psychiatric disorders in their children at 7 years of age, most notably, oppositional-defiant and conduct disorders (Ramchandani et al., 2008). Both of the Ramchandani studies revealed that boys seem particularly vulnerable to the effects of their fathers’ depression. Fathers who are in poor mental health may not be able to provide emotional support to their partners and children. They may not be able to function well at work, compounding the problem by creating financial stress.

Resources for helping depressed new fathers are often limited. Marital difficulties and the stress of responding to a new baby can make it difficult for couples to offer desperately needed support to one another. Healthy fathering role models were not present for many fathers in their own childhood. Social support may be inadequate and discussing emotional concerns may not seem acceptable. While postpartum therapy groups and classes are available for mothers, fathers may not feel welcome. Given the association between paternal postpartum depression and later child psychopathology, nurses have compelling reasons to consider ways to help promote mental health with this vulnerable aggregate.

WHAT CAN NURSES DO TO BEGIN TO HELP?

Few programs exist to address paternal postpartum depression and this gap in services needs to be urgently addressed. Guidelines for assessing new fathers’ mental health may not yet be established, even in areas where midwives and other

clinicians are directly involved with pregnancy and postpartum care. However, as trusted professionals, nurses from a variety of different practice areas can implement practical approaches to promote paternal mental health. Both professionally and personally, family members turn to nurses for advice when a new baby is expected and then arrives. Nurses in physicians' offices, early childbirth education, obstetrics, pediatrics, healthy child clinics and schools are all well positioned to initiate screening and outreach programs for new fathers, perhaps in conjunction with those already in place for new mothers. Advocating for the inclusion of information about paternal postpartum depression into existing programs will begin to stimulate awareness.

Nurses in other areas of practice can also increase public awareness of paternal postpartum depression, provide education about agencies that offer counseling and initiate referrals. Nurses interact with grandparents, aunts, uncles, siblings and friends of expectant or new parents at work, socially and in our own families every day.

Increasing public awareness that a disorder exists, that it affects a significant number of families worldwide, that specific symptoms or behaviors can be expected and that there are tools to measure the disorder can be a powerful initial step in promoting mental health. Quantifying a disorder can begin to decrease the stigma that inevitably accompanies alterations in emotional health. Professional literature, such as the studies presented earlier in this paper, can be summarized and shared with interested individuals.

Waiting rooms in any physicians office or health care agency are opportune venues for displaying information about paternal postpartum depression. New mothers and fathers as well as those who are part of their lives can spend hours in wait areas. Similarly, bulletin boards in hospitals, outpatient clinics, community service buildings, day cares, recreation facilities and public libraries are prime locations for health teaching information. Permission to post material may be needed. Classrooms where childbirth education classes, baby care programs and parenting workshops are offered are also appropriate locations.

Online resources geared to the lay public that would be suitable to display in these venues are available on websites such as the Fatherhood Institute at <http://www.fatherhoodinstitute.org/> and Postpartum Men at www.postpartum-men.com. The term 'sad dads' has emerged to describe paternal postpartum depression and can be used as a search term. Postpartum websites are beginning to include information for new fathers as well as new mothers. Reviewing these sites and then suggesting relevant links may be useful to those who interact with new parents.

Print resources such as a magazine or newsletter article in a plastic sleeve might be fitting on a table display with other reading material. Oversize visual resources such as a poster can be impactful. Print resources can be readily constructed by reproducing information from websites. Often mental health agencies publish pamphlets that have no copyright restrictions and are provided free of cost. Print resources that can be carried out and that include specific contact information for counseling services are particularly valuable.

Student nurses attending practicum placements might be interested in creating mental health promotion materials targeting paternal postpartum depression. Students' assignments may invite them to become involved in agency activities and the idea of having their work viewed by members of the public can be appealing.

Tools such as the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale can be presented as posters or handouts. Construction simply involves reproducing these self report scales, the instructions for completing them and the primary source citation identifying where they were first published. Once again, including accompanying information specifying contact information for counseling services is important.

Whenever possible, nurses are encouraged to discuss the results of a scale. When depression is present, an individual can be referred for help. In some cases, this may mean initiating the process by calling an agency to make an appointment rather than just making a suggestion to do so. It may mean writing a note to a physician that includes the completed and scored scale. In instances where suicidal thoughts are present and an individual seems to be a danger to himself or others, it may mean 'walking with' him to an agency or even an emergency room for immediate help.

Nurses may be most able to help new fathers devastated by postpartum depression when they plant seeds of awareness that the disorder exists, that the young man is not alone and that help is available. Schumacher, Zubaran, and White (2008) called

for more detailed assessments of fathers during the postpartum period, especially when their partners are also depressed. These detailed assessments must be framed from a deeper understanding of how men can express their feelings and how they feel about seeking help for emotional problems. Spector's (2006) review of fatherhood and depression underscored how therapy is effective when it can be initiated and continued, but research has repeatedly shown that men seek out counseling far less than women. So, sensitive and creative mental health promotion approaches, such as a poster of the Edinburgh Postnatal Depression Scale on a waiting room wall for one new father to fill out, may throw a private and non-threatening lifeline towards counseling to someone who desperately needs it.

Conclusion

Paternal postpartum depression is a very real and very serious problem for many new fathers and their families. Men whose partners are depressed are at greater risk and the disorder may be present in as many as 25% of the population. Tools such as the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale have been used by researchers from different countries to measure paternal postpartum depression. Nurses can also use these tools efficiently in a variety of different practice settings as screening instruments.

Although the disorder is only now beginning to be defined and measured, sufficient evidence exists to warrant nurses' attention and concern. Paternal postpartum depression may be reflected in behaviors such as withdrawing, expressing irritation, cynicism, drinking, using drugs, fighting, partner violence and extra-marital affairs. New fathers who are depressed may present with symptoms of depression during their partner's pregnancy and throughout the first year postpartum. The presentation can be expected to be more insidious than the sudden onset usually seen in maternal postpartum depression. An affect of anxiety or anger may be more predominant than sadness.

The burden of these symptoms leaves new fathers with limited ability to offer emotional support to their partners and children. In turn, behavioral and emotional problems, even psychiatric disorders such as oppositional-defiant and conduct disorders, have been found to occur significantly more often among children whose fathers were depressed postpartum (Ramchandani et al., 2008).

Nurses can begin to help by implementing everyday strategies to increase public awareness of the disorder. Including information about paternal postpartum depression in existing programs geared to pre-natal and postpartum families is an important foundational step. Creative strategies to build on this foundation include summarizing professional literature and making tools such as the Edinburgh Postnatal Depression Scale and the Gotland Male Depression Scale available as program handouts or posters and pamphlets in wait areas. Other strategies include constructing visual aids from online resources for postpartum men's health and posting them on bulletin boards. Similarly, using print resources from local mental health agencies will offer valuable direction for initiating support and counseling services. Following up with new fathers or their family members about where to go for help with overcoming depression is critical. As nurses continue to learn about paternal postpartum depression and seek out ways to become involved in screening and treatment initiatives, more opportunities to reach out and help will emerge.

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How to uncover post-stroke depression



[PDF – 1.9 MB]

Citation

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Abstract

Often undetected, post-stroke depression occurs in at least one-third of stroke survivors. Nurses can help by recognizing and responding to patients who become depressed after experiencing a stroke. We fill you in on how to assess this disorder and what treatment options are available.

Emotional disturbances following the trauma of experiencing a stroke aren't unexpected. Survivors often feel angry and fearful, experiencing a deep sense of loss. Rehabilitating from the devastation of paralysis, sensory disturbance, language deficits, and problems with thinking and memory is seldom straightforward. All too often, however, the psychiatric illness of post-stroke depression is overlooked and undertreated within the rehabilitative process.

In this article, I'll identify the incidence and prevalence of post-stroke depression, describe measurement considerations to detect the disorder, and discuss treatment approaches.

Defining depression

The *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (DSM-IV-TR) categorizes post-stroke depression as a mood disorder due to a general medical condition. Major depression and minor depression are the conditions most often associated with stroke.

Major depression lasts longer than 2 weeks. It's characterized by loss of interest or pleasure for most of the day, almost every day, and is accompanied by changes in appetite and sleep patterns, fatigue, psychomotor agitation or retardation, loss of energy, reduced ability to think or concentrate, feelings of worthlessness, recurrent thoughts of death, and even specific plans for suicide. Major depression includes clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Minor depression* also lasts longer than 2 weeks, but involves less functional impairment.

Using DSM-IV-TR criteria, a recent study revealed that major depression was present in 15% of stroke survivors and minor depression in an additional 28%.

Who's at risk?

The prevalence of post-stroke depression ranges from 30% to 50%, according to the American Stroke Association. Clinical depression may occur within the first 3 months post stroke and can last for several years if left untreated. The wide range of prevalence rates is related to methodological differences among studies, inconsistent definitions of depression, the use of different depression screening instruments, excluding stroke patients with physical or cognitive impairments, and assessing depression at different time intervals post stroke. Despite these variances, at least 33% of stroke survivors of all types can be expected to experience diagnosable clinical depression.

Risk factors include a history of depression, increased stroke severity, and poststroke cognitive or physical impairment. Post-stroke depression is more common among patients living in a rehabilitation setting than in the general community. Stroke survivors with aphasia are also at high risk. Despite an abundance of research, the influence of stroke location on the risk of developing post-stroke depression hasn't been determined. Whether the stroke location was ischemic, hemorrhagic, or a supratentorial, infratentorial, lacunar, cardioembolic, cortical, subcortical, or subarachnoid stroke subtype, the severity of a stroke is the strongest predictor of post-stroke depression.

Getting down to brass tacks

The etiology of post-stroke depression isn't well understood. Researchers have hypothesized that increased production of proinflammatory cytokines resulting from brain ischemia in cerebral areas is linked to the pathogenesis of mood disorders. With increased inflammation, particularly in the limbic areas, serotonin can become depleted. Serotonin regulates levels of alertness, the ability to categorize information, and perceptions of well-being. Lack of serotonin or disruption of the serotonergic system when neuronal synapses are injured or destroyed may lead to post-stroke depression.

Post-stroke depression has been associated with poor recovery and rehabilitation response, reduced social functioning, greater use of healthcare services, and increased risk of subsequent cardiac and stroke events. Although the negative impact of depression on stroke survivors is well recognized, healthcare professionals often fail to respond to a patient's distress both at an early stage post stroke and later on in the recovery process when the distress has become established as a mood disorder. This failure to respond may be related to difficulty assessing post-stroke depression and understanding treatment approaches that can help.

By the measure

Assessing post-stroke depression is particularly challenging because vegetative symptoms such as fatigue, psychomotor retardation, and insomnia may be related directly to the stroke disorder but are also part of the DSM-IV-TR criteria for diagnosing depression. One in three stroke survivors will experience aphasia—defined as impaired language comprehension and expressive abilities—and yet aphasic patients are often excluded from research examining post-stroke depression. Aphasia and other cognitive problems make it almost impossible to adequately assess depression with interview questions and observation alone. Despite these challenges, you can invite family members and all staff members who are or have been involved with a stroke survivor's care to share their observations of the patient's mood.

Scales

If your patient is able to speak, you can use scales or questionnaires to assess post-stroke depression. Although scales are used extensively in research studies, they're underused in routine clinical care. Scales can be constructed as self-reporting, with stroke survivors providing answers themselves, or they can be observational, with caregivers recording observations. Note that before implementing any kind of scale, it's necessary to review the original publication in which the instrument was introduced and investigate the kind of reliability and validity testing that has been done on it.

Self-report scales offering reliable and valid assessment of post-stroke depression include the Beck Depression Inventory (BDI), the Hamilton Rating Scale for Depression (HAM-D), the Center for Epidemiologic Studies Depression Scale (CES-D), and the Geriatric Depression Scale (Short Form), or GDS-SF. The BDI was originally developed to assess depression in psychiatric settings; it requires specialized training and is under copyright with the American Psychological Association, so may not be used freely. The HAM-D is often used in clinical trials to measure efficacy of antidepressant medication and is appropriate for adults of all ages. The CES-D is used extensively in epidemiologic research to investigate depression in the general adult population. The GDS-SF is used widely and efficiently with adults over age 65; with a cutoff score of 3, it's currently recommended for post-stroke depression screening (see *The GDS-SF*).

The GDS-SF

Choose the best answer for how you've felt over the past week:

1. Are you basically satisfied with your life? YES/NO
2. Have you dropped many of your activities and interests? YES/NO
3. Do you feel that your life is empty? YES/NO
4. Do you often get bored? YES/NO
5. Are you in good spirits most of the time? YES/NO
6. Are you afraid that something bad is going to happen to you? YES/NO
7. Do you feel happy most of the time? YES/NO
8. Do you often feel helpless? YES/NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES/NO
10. Do you feel you have more problems with memory than most? YES/NO

11. Do you think it's wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES/NO
13. Do you feel full of energy? YES/NO
14. Do you feel that your situation is hopeless? YES/NO
15. Do you think that most people are better off than you are? YES/NO

A score of greater than 3 points is suggestive of post-stroke depression.

A score of greater than 5 points is suggestive of depression.

A score of greater than 10 points is almost always indicative of depression.

Source: Sheikh J, Yesavage J. Geriatric Depression Scale (GDS): recent findings and development of a shorter version. In: Brink TL (ed.), *Clinical Gerontology: A Guide to Assessment and Intervention*. New York, NY: Howarth Press; 1986.

Observation scales that offer reliable and valid assessment of post-stroke depression include the Clinical Global Impression Severity Scale (CGI-S) and the Signs of Depression Scale (SDSS). The CGI-S requires clinicians to have psychiatric experience as they compare the individual being assessed with typical cases. The SDSS, initially developed as a tool for screening depression in elderly medical patients, is now emerging as a relevant, easy-to-complete tool specifically for nurses and caregivers to use in the assessment of post-stroke depression (see *The SDSS*).

The SDSS

1. Does the patient sometimes look sad, miserable, or depressed? YES/NO
2. Does the patient ever cry or seem weepy? YES/NO
3. Does the patient seem agitated, restless, or anxious? YES/NO
4. Is the patient lethargic or reluctant to mobilize? YES/NO
5. Does the patient need a lot of encouragement to do things for him or herself? YES/NO
6. Does the patient seem withdrawn, showing little interest in the surroundings? YES/NO

Score 1 for “yes” and 0 for “no.”

A score of greater than 2 points is suggestive of depression.

Source: Hammond MF, O’Keeffe ST, Barer DH. Development and validation of a brief observer-rated screening scale for depression in elderly medical patients. *Age Ageing*. 2000;29(6):511-515.

Visual analog scales aren’t recommended. Similarly, scales such as the Stroke Aphasic Depression Questionnaire and the Aphasic Depression Rating Scale have been found to have limited reliability and validity. When assessing aphasic patients, you can point to “yes” or “no” choices and record nonverbal responses on more established scales (see *Communicating with an aphasic patient*). Involving family members and staff caregivers is an adaptive strategy for assessing depression even when aphasia is present.

With the exception of the BDI, all of the aforementioned scales are readily available on the Internet. They can be printed out, completed at different times, and included in the stroke patient’s file. Traditionally, universally recognized depression scales

haven't always been included in the assessment process; however, scores from these scales can provide strong advocacy data for treating the debilitating symptoms of poststroke depression.

Crying behaviors

Identifying distinctions among crying behaviors is an important aspect of assessing post-stroke depression. Although crying is an expected coping response, frequent and sustained bouts of crying can also be an indication of depression. Observing crying responses in relation to whether a motivating stimulus or trigger is present is a critical distinction. For example, when crying is congruent with discussion of or private reflection on sadness, the behavior is a reflection of mood. But when congruent crying occurs frequently and continues for long periods, depression is likely present. Facial expressions and the presence of tears may appear similar among all types of crying behaviors, but assessing the congruence between crying and mood or affect of sadness will help distinguish the diagnosis of post-stroke depression.

Other crying behaviors, such as pathologic crying, emotionalism, and catastrophic reactions, are disorders of emotional expression rather than symptoms of a depressive mood disorder. Pathologic crying (or pathologic laughing) occurs without any apparent triggering stimulus and may be related to damage in the motor areas of the cerebral cortex and brainstem. Emotionalism occurs when the patient has difficulty controlling his emotional behavior and may suddenly start crying (or, less commonly, laughing) for no apparent reason; this may be related to damage in the right cerebral hemisphere. Catastrophic reactions are expressed when crying is accompanied by anxiety, aggressive behavior, swearing, or withdrawing and may be triggered by a task made difficult or impossible by a neurologic deficit, such as trying to move a hemiplegic arm. Pathologic crying, emotionalism, and catastrophic reactions often coexist with post-stroke depression, but they're separate conditions that require separate treatment approaches.

Previous coping strategies

Given the difficulty of differentiating features of post-stroke depression from neurologic deficits caused by the stroke itself, the importance of understanding how a patient has coped in previous crisis situations becomes clear. Asking patients who are able to speak to describe situations in which they've tackled overwhelming challenges in the past will illustrate the kinds of coping strengths they value. Similarly, asking family members to paint a picture of how the stroke patient coped with previous difficulties will reveal important insights. Assessment of previous coping strategies must also include inquiring about previous responses to loss and typical expressions of anger and anxiety, as well as patterns of crying. Knowing that patients previously diagnosed with depression are significantly at risk for developing post-stroke depression, assessing previous psychiatric history, including treatments that worked and those that didn't, is critical.

Approaches to treatment

Given the high incidence and prevalence of post-stroke depression, immediate and continued assessment of both major and minor depression using DSM-IV-TR criteria after a stroke has occurred is an essential feature of any treatment protocol. Despite the challenge of aphasia and other cognitive impairments, early interviews with family members can help distinguish expected grief reactions from clinical depression. Completing self-report and observational scales at different times will offer data that can be used to measure the depression, as well as the stroke patient's response to treatment. And, before depressive symptoms develop into a mood disorder, prompt initiation of antidepressant medications, behavioral therapy, and alternative treatment approaches can help.

- Face the patient and establish eye contact.
- Speak in a normal manner and tone.
- Use short phrases and pause between phrases to allow the patient time to understand what's being said.
- Limit conversation to practical and concrete matters.
- Use gestures, pictures, objects, and writing.
- As the patient uses and handles an object, say what the object is. It helps to match the words with the object or action.
- Be consistent in using the same words and gestures each time you give instructions or ask a question.
- Keep extraneous noises and sounds to a minimum. Too much background noise can distract the patient or make it difficult to sort out the message being spoken.

Antidepressant medications

The use of a prophylactic antidepressant medication, such as escitalopram, and problem-solving therapy within 3 months of a stroke has been found to reduce the rate of post-stroke depression. Stroke survivors receiving either kind of treatment were less likely to develop depression compared with those on placebo. For escitalopram, the risk was 4.4 times less than on placebo; for problem-solving therapy, it was 2.2 times less. Escitalopram is a selective serotonin reuptake inhibitor (SSRI). There has been research into the merit of prescribing an SSRI medication as soon as a stroke has occurred.

After post-stroke depression is determined to be present, other SSRI antidepressant medications, such as sertraline, citalopram, and nortriptyline, have demonstrated efficacy. An important consideration with any pharmacologic treatment is that the dosages required to achieve therapeutic blood levels may be lower or even half the usual dose and may take time to titrate in patients who are medically ill. SSRI antidepressants may take longer to absorb, distribute, metabolize, and be eliminated. Common adverse reactions include nausea, sedation, dizziness, somnolence, headache, weight gain, and, when first started, excitability. Taking SSRIs with meals to reduce gastrointestinal disturbances is recommended. Although many stroke survivors respond to antidepressant therapy with a decrease in their vegetative symptoms in about 1 week, others may take longer. Simultaneously monitoring the adverse reactions of antidepressant medication, post-stroke depression symptoms, stroke deficits, and any existing medical conditions isn't easy, but it's necessary.

Behavioral therapy

Therapeutic intervention to address potential or established depression must also become part of any post-stroke protocol. Problem-solving therapy, in which mental health professionals meet with stroke survivors to facilitate awareness of problems and help develop solutions, can help. Similarly, brief psychosocial behavioral intervention, in which stroke survivors are provided with opportunities to interact with educational materials and interventionists, may also be helpful.

One program implemented by a nurse involved giving participants written stroke recovery materials from the American Stroke Association, including information about depression, and meeting with a study interventionist once a week for 8 weeks. Participants completed a medication diary and were encouraged to include family members and caregivers in the

meetings. The intervention, in combination with antidepressants, reduced post-stroke depression significantly and the effect was sustained for up to 2 years.

Alternative therapy

Acupuncture shows promise in treating post-stroke depression with fewer adverse reactions than antidepressants. Repetitive transcranial magnetic stimulation—a noninvasive method of triggering brain activity by exciting neurons with electromagnetic induction—may be an effective and safe alternative for stroke survivors who don't respond to antidepressants. Electroconvulsive therapy may also be an effective treatment. Listening to music during the early post-stroke stage can enhance cognitive recovery and prevent negative mood.

Emotional deficits of stroke cheat sheet

- Loss of self-control
- Emotional lability
- Decreased tolerance to stressful situations
- Depression
- Withdrawal
- Fear, hostility, and anger
- Feelings of isolation

A depression-free recovery

Post-stroke depression is a serious problem that complicates recovery for one-third of stroke survivors. Stroke survivors living in a rehabilitation setting and those who are aphasic are especially vulnerable. Nurses can help by recognizing the condition as a psychiatric illness and responding with an understanding of treatment approaches. DSM-IV-TR criteria for major and minor depression and scales such as the GDS-SF and the SDSS offer reliable and valid measurement and can be readily included in routine nursing assessments. Similarly, working with family and caregivers to distinguish crying that's congruent with a mood of sadness from other crying behaviors is important. Knowing about how patients coped with previous crises will help support their present efforts. Treatments such as antidepressant medications, behavioral therapy, and alternative therapy have all demonstrated efficacy. As nurses continue to learn about post-stroke depression and seek out ways to understand the condition more fully, other opportunities to help stroke patients will emerge.

Learn more about it

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Post-stroke depression: How can nurses help?



[PDF – 196 KB]

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Abstract

Often overlooked and undertreated, post-stroke depression (PSD) can occur in at least one-third of stroke survivors. Nurses and other formal caregivers can help by recognizing and responding to those who become depressed after experiencing a stroke. This article identifies the incidence and prevalence of post-stroke depression, describes assessment considerations to detect the disorder and outlines and comments on a number of treatment and care approaches.

Emotional disturbances following the trauma of experiencing a cerebral vascular accident or stroke are not unexpected. Stroke survivors often feel angry, fearful and experience a deep sense of loss. Rehabilitating from the devastation of paralysis, sensory disturbance, language deficits and problems with thinking and memory is seldom straightforward. All too often, however, the psychiatric illness of post-stroke depression is overlooked and undertreated within the rehabilitative process.

Depression

The Diagnostic and Statistical Manual of Mental Disorders DSM 5 (**APA – American Psychiatric Association, 2013**) categorizes post-stroke depression (PSD) as a mood disorder due to a general medical condition. Criteria include:

- a persistent period of depressed mood;
- diminished interest or pleasure in most activities; and
- significant impairment in social, occupational, or other important areas of functioning (**APA, 2013**).

Sleep disturbances, vegetative symptoms and social withdrawal are especially problematic (**Llorca, et al., 2015**).

Concerns closely associated with the stroke itself, such as hypochondriac issues, lethargy, diminished energy, weight loss, insomnia, poor concentration and psychomotor alterations are often present (**Teasell and Hussein, 2014**).

It has been estimated that major depression is present in 15% of stroke survivors, with minor depression present in an additional 28% (**Roger and Johnson-Greene, 2008**).

Incidence and prevalence

The incidence, or number of new cases of post-stroke depression, ranges from 5% to 63% (**Johnson, et al., 2006**). The prevalence, or number of cases, of post-stroke depression in a population ranges from 25% to 79% (**Thomas and Lincoln, 2008**). The wide range of incidence and prevalence rates is related to methodological differences among studies, inconsistent definitions of depression, use of different depression screening instruments, excluding stroke patients with physical or cognitive impairments, and assessing depression at different time intervals post-stroke. Despite these variances, at least 31% of survivors of strokes of all types can be expected to experience a diagnosable clinical depression (**Hacket and Pickles, 2014**) – with more than half of these neither diagnosed nor treated (**llorca, et al., 2015**).

Risk factors for PSD

Risk factors for post-stroke depression (PSD) include a history of depression, increased stroke severity, and post-stroke cognitive or physical impairment. The condition is more common among those living in a rehabilitation setting than in the general community (**Johnson, et al., 2006**).

Stroke survivors with aphasia are at high risk for post-stroke depression (**Johnson, et al., 2006**), as are those with reduced mobility (**De Ryck, et al., 2013**).

Despite an abundance of research, the influence of stroke location on the risk for developing post-stroke depression has not been determined (**Teasell, Foley, Salter, et al., 2008**). Whether the stroke location was ischemic, hemorrhagic or a supratentorial, infratentorial, lacunar, cardioembolic, cortical, subcortical or subarachnoid stroke subtype, the severity of a stroke is the strongest predictor of post-stroke depression (**Johnson, et al., 2006**).

Etiology

The etiology of post-stroke depression is not well understood. Researchers have hypothesized that increased production of pro-inflammatory cytokines (small proteins known to promote systemic inflammation) due to brain ischemia (blood restrictions) in cerebral areas is linked to the pathogenesis of mood disorders (**Spalletta, et al., 2006**).

With increased inflammation, particularly in the limbic areas, serotonin can become depleted. Serotonin, a neurotransmitter, regulates level of alertness, the ability to categorize information, and one's perception of well-being and happiness. Lack of serotonin, or disruption of the serotonergic system when neuronal synapses are injured or destroyed, may lead to post-stroke depression (**Llorca, 2015**).

Post-stroke depression has been associated with poor recovery and rehabilitation response, reduced social functioning, greater use of healthcare services, increased risk of subsequent cardiac and stroke events (**Mitchell, et al., 2009**), and greater mortality rates (**Hornsten, 2013; Meader, et al., 2014**).

Although the negative and distressing impact of depression on stroke survivors is well recognized, health care professionals often fail to respond to this distress, both at an early stage after the stroke and later on in the recovery process when the distress has become established as a mood disorder (**Kearins and Luciano, 2015; Watkins and French, 2009**). This failure by health care professionals to respond may be related to difficulty assessing PSD and understanding treatment approaches that can help.

Measurement considerations

Assessing post-stroke depression is particularly challenging in that vegetative symptoms such as fatigue, loss of appetite, insomnia, or psychomotor retardation may be related directly to the stroke disorder and are also part of the criteria for diagnosing depression (**Berg, et al., 2009**).

One in three stroke survivors will experience aphasia, defined as impaired language comprehension and expressive abilities; yet, aphasic individuals are often excluded from research examining PSD (**Townend, et al., 2007**). Aphasia and other cognitive problems make it almost impossible to adequately assess depression with interview questions and observation alone (**Roger and Johnson-Green, 2009**).

Despite these challenges, nurses can invite family members and all staff members who are or have been involved with a stroke survivor's care to share their observations of the individual's mood. When stroke survivors themselves cannot speak about their feelings of devastating sadness, nurses must speak for them.

Knowing that 10% to more than 50% of individuals who suffer a stroke will experience a clinical depression within the first three months, and that the depression can last for several years if left untreated (**Johnson, et al., 2006**), recognizing and responding to depression is a priority for nurses and formal carers.

Assessment scales

Nurses can use scales or questionnaires to assess post-stroke depression. Although scales, also referred to as instruments, are used extensively in research studies, they are underused in routine clinical care. Scales can be constructed as:

1. Self reporting, where stroke survivors provide answers themselves; and

2. Observational, where caregivers record observations.

Before implementing any kind of scale, it is necessary to review the original publication where the instrument was introduced and to investigate the kind of reliability and validity testing that has been done.

(I) Self-reporting scales

Self-report scales offering reliable and valid assessment of PSD include:

- The Beck Depression Inventory-BDI (**Beck, Ward, et al., 1961**)
- The Hamilton Rating Scale for Depression (**Berg, et al., 2009**)
- The Center for Epidemiologic Studies Depression Scale (**Radloff, 1977**)
- The Patient Health Questionnaire PHQ-9 (**Kroenke, et al., 2001**), and
- Geriatric Depression Scale-Short Form (GDS-SF) (**Roger and Johnson-Greene, 2009.**)

See Table 1, Geriatric Depression Scale – Short Form.

Table 1 Geriatric Depression Scale – Short Form

Choose the best answer for how you have felt over the past week:		
1.	Are you basically satisfied with your life?	Yes/ No
2.	Have you dropped many of your activities and interests?	Yes/ No
3.	Do you feel that your life is empty?	Yes/ No
4.	Do you often get bored?	Yes/ No
5.	Are you in good spirits most of the time?	Yes/ No
6.	Are you afraid that something bad is going to happen to you?	Yes/ No
7.	Do you feel happy most of the time?	Yes/ No
8.	Do you often feel helpless?	Yes/ No
9.	Do you prefer to stay at home, rather than going out and doing new things?	Yes/ No
10.	Do you feel you have more problems with memory than most?	Yes/ No
11.	Do you think it is wonderful to be alive now?	Yes/ No
12.	Do you feel pretty worthless the way you are now?	Yes/ No
13.	Do you feel full of energy?	Yes/ No
14.	Do you feel that your situation is hopeless?	Yes/ No
15.	Do you think that most people are better off than you are?	Yes/ No
A score > 3 points ('Yes' answers) is suggestive of Post Stroke Depression.		
A score > 5 points is suggestive of depression.		
A score > 10 points, almost always indicative of depression.		

Source: Sheikh, J. and Yesavage, J., Geriatric Depression Scale: Recent findings and development of a shorter version. 1986. In: Brink, T L. (ed.), Clinical Gerontology: A guide to assessment and intervention. New York: Howarth Press.

The Beck Depression Inventory – BDI (**Beck, Ward, et al., 1961**), originally developed to assess depression in psychiatric settings, requires specialized training and is copyrighted by the American Psychological Association, so may not be used freely.

The Hamilton Rating Scale for Depression – Ham-D (**Hamilton, 1960**) is often used in clinical trials to measure efficacy of anti-depressant medication and is appropriate for adults of all ages.

The Center for Epidemiologic Studies Depression Scale – CES-D (**Radloff, 1977**) is used extensively in epidemiologic research to investigate depression in the general adult population.

The Patient Health Questionnaire PHQ-9 (**Kroenke, et al., 2001**) is a brief and easy-to-use instrument that nurses found reliable and valid when used with stroke patients who are able to communicate adequately (**De Man-van Ginkel, Gooskens, et al., 2012**).

The Geriatric Depression Scale-Short Form (Sheikh and Yesavage, 1986), is used widely and efficiently with adults over 65, and with a cut-off score of 3, is currently recommended for post-stroke depression screening (Roger and Johnson-Greene, 2008).

Observation scales

Observation scales that offer reliable and valid assessment of PSD include:

- The Clinical Global Impression Scale-CGIS (Berg, et al., 2009); and,
- The Signs of Depression Scale-SOS (Lightbody, et al., 2007). (See Table 2)

Table 2 Signs of Depression Scale

1. Does the patient sometimes look sad, miserable or depressed?	YES/ NO
2. Does the patient ever cry or seem weepy?	YES/ NO
3. Does the patient seem agitated, restless or anxious?	YES/ NO
4. Is the patient lethargic or reluctant to mobilise?	YES/ NO
5. Does the patient need a lot of encouragement to do things for him/herself?	YES/ NO
6. Does the patient seem withdrawn, showing little interest in the surroundings?	YES/ NO

Score 1 for 'yes' and 0 for 'no'.

A score > 2 points is suggestive of depression

Source: Hammond, M.F., O'Keeffe, S.T. and Barer, D.H., Development and validation of a brief observer-rated screening scale for depression in elderly medical patients, *Age and Ageing*; 29(6); p.511-515; 2000.

The Clinical Global Impression Scale – CGIS (Guy, 1976) requires clinicians to have psychiatric experience as they compare the individual being assessed to typical cases.

The Signs of Depression Scale – SOS (Hammond, et al., 2000), initially developed as a tool for screening depression in elderly medical patients, is now emerging as a relevant, easy to complete tool specifically for nurses and formal caregivers to use in the assessment of post-stroke depression (Lightbody, et al., 2007).

Scales such as the Visual Analog Scale, where cartoon characters and symbols are used instead of written questions, were not recommended (Berg, et al, 2009). Similarly, scales such as the Stroke Aphasic Depression Questionnaire and the Aphasic Depression Rating Scale were found to have limited reliability and validity at present (Lightbody, et al., 2007).

When assessing aphasic individuals, nurses can point to 'yes' or 'no' choices and record non-verbal responses on more established scales. Involving family members and staff caregivers as informants is an adaptive strategy for assessing depression even when aphasia is present (Townend, Brady and McLaughlan, 2007).

With the exception of the Beck Depression Inventory, all of the scales mentioned are readily available on the internet simply by typing in the name to a search engine such as Google or Bing, etc. They can be printed out, completed at different times and included on stroke survivors' files.

Traditionally, nurses/formal caregivers have not always included scales in the assessment processes; and yet, scores on universally recognized depression scales can provide strong advocacy data for treating the debilitating symptoms of PSD.

Crying behaviour

Identifying the distinctions among crying behaviours is an important aspect of assessing post-stroke depression (**Melrose, 2010**). While crying is an expected coping response, frequent and sustained crying can also be an indication of depression.

Observing crying responses in relation to whether a motivating stimulus or trigger is present is a critical distinction. For example, when crying is congruent with discussion of, or private reflection on, sadness, the crying behaviour is a reflection of mood. And, when congruent crying occurs often and continues for long periods, depression is likely present (**Melrose, 2010**).

However, other crying behaviours, such as pathological crying, emotional incontinence and catastrophic reactions are disorders of emotional expression rather than symptoms of a depressive mood disorder.

Pseudobulbar affect (PBA) or pathological crying (or pathological laughing) occurs without any apparent triggering stimulus and may be related to damage in the motor areas of the cerebral cortex and brainstem (**Cichoń, et al., 2015; Parvizi, et al., 2009**).

Emotionalism or emotional incontinence occurs when the person has difficulty controlling their emotional behaviour and may suddenly start crying (or, less commonly, laughing) for no apparent reason and may be related to damage in the right cerebral hemisphere (**House, et al., 2004**).

Catastrophic reactions are expressed when crying is accompanied by anxiety, aggressive behaviour, swearing or withdrawing, and may be triggered by a task made difficult or impossible by a neurologic deficit, such as trying to move a hemiplegic (paralytic) arm (**Yudofsky and Hales, 2008**).

Pathological crying, emotionalism and catastrophic reactions all often co-exist with post-stroke depression, but they are separate conditions and require separate treatment approaches (**National Stroke Association, 2011**). While facial expressions and the presence of tears may appear similar among all types of crying behaviours, assessing the congruence between crying and a mood or affect of sadness will help distinguish the diagnosis of PSD.

Previous coping

Given the difficulty of singling out features of PSD from neurologic deficits caused by the stroke itself, the importance of understanding how the individual has coped in previous crisis situations becomes clear. Asking individuals who are able to speak to describe situations where they have tackled overwhelming challenges in the past will illustrate the kinds of coping strengths they value. Similarly, asking family members to paint a picture of how the stroke survivor coped with previous difficulties will reveal important insights.

Assessment of previous coping must also include inquiring about past responses to loss, typical expressions of anger and anxiety as well as patterns of crying. Knowing that individuals previously diagnosed with depression are significantly at risk for developing post-stroke depression, assessing previous psychiatric history, including both treatments that worked and those that did not, is critical.

Treatment approaches

Prevention

Given the high incidence and prevalence of post-stroke depression, including immediate and continued assessment of depression once a stroke has occurred, is an essential feature of any treatment protocol. Despite the challenge of aphasia and other cognitive impairments, early interviews with family can help distinguish expected grief reactions from clinical depression.

Completing 'self report' and 'observational scales' at different times will offer data that can be used to measure the depression as well as the stroke survivor's response to treatment. And, before depressive symptoms develop into a mood disorder, prompt initiation of antidepressant medications, therapy and alternative treatment approaches can help.

Antidepressant medication

Preventing post-stroke depression with prophylactic anti-depressant medication (i.e., Escitalopram), and problem solving therapy within three months of a stroke, has been found to reduce the rate of post-stroke depression (**Mikamin, et al., 2011; Robinson, et al., 2008**). Stroke survivors receiving either kind of treatment were less likely to develop depression compared to those on placebo. For Escitalopram, the risk was 4.4 times less than on placebo; for problem-solving therapy it was 2.2 times less (**Robinson, et al., 2008**).

Escitalopram is a Selective Serotonin Reuptake Inhibitor or SSRI anti-depressant. Robinson and colleagues' seminal work with post-stroke depression has generated considerable interest in the merit of prescribing SSRI medication as soon as a stroke has occurred (**Robinson, et al., 2008**). Similarly, mirtazapine, a tetracyclic antidepressant, has been found effective in preventing and treating post-stroke depression (**Niedermaier, et al., 2004**).

Once post-stroke depression is determined to be present, other SSRI anti-depressant medications, such as sertraline, citalopram and nortriptyline, have demonstrated efficacy (**Starkstein, Mizrahi and Power, 2008**).

An important consideration with any pharmacological treatment of the medically ill is that the doses required to achieve therapeutic blood levels may be lower or even half the usual dose and may take time to titrate. SSRI antidepressants may take longer to absorb, distribute, metabolize and be eliminated (**Austin and Boyd, 2014**). Common side effects include nausea, sedation, dizziness, somnolence, headache, weight gain, and, when first started, excitability (**Ibid., 2014**). Taking SSRI's with meals to reduce gastro-intestinal disturbances is recommended (**Antai-Otong, 2009**).

While many stroke survivors respond to antidepressant therapy with a decrease in their vegetative symptoms in about a week, others may take longer. If antidepressants are found to have no effect after four to six weeks, their discontinuation should be tapered rather than abrupt (**Coggins, 2015**). Simultaneously monitoring side effects of antidepressant medications, post-stroke depression symptoms, stroke deficits and any existing medical conditions is not easy.

Therapy

Therapeutic intervention to address potential or established depression must also become part of any post-stroke care protocol. Actively involving family members early and co-ordinating practical and psychosocial support for both clients and their families is essential (**Vallury, Jones and Gray, 2015**). Problem solving therapy, where mental health professionals meet

with stroke survivors to facilitate awareness of problems and help come up with solutions, as Robinson (2008) and colleagues demonstrated, can be helpful.

Similarly, brief psychosocial behavioural intervention, where stroke survivors are provided with opportunities to interact with educational materials and interventionists, can also help.

One program implemented by a nurse (Mitchell, et al., 2009) involved giving participants written stroke recovery materials from the American Stroke Association, including information about depression, and meeting with a study interventionist once a week for eight weeks. Participants completed a medication diary and were encouraged to include family members and caregivers in the meetings. The intervention, in combination with antidepressants, significantly reduced post-stroke depression and the effect was sustained for up to two years (Mitchell, et al., 2009).

Alternative approaches

Acupuncture shows promise in treating post-stroke depression, an approach that has fewer side effects (He and Shen, 2007; Qian, Zhou, et al., 2015).

Chinese herbs, such as the herbal supplement, *Free and Easy Wanderer Plus (FEWP)*, are tolerated well and show good efficacy and safety in post-stroke depression (Li, Wang, et al., 2008).

Repetitive transcranial magnetic stimulation, or rTMS, may be an effective and safe alternative for post-stroke survivors who do not respond to antidepressants (Jorge, et al., 2004).

Music listening during the early post-stroke stage can enhance cognitive recovery and prevent negative mood (Särkämö, et al., 2008).

Electroconvulsive, or ECT therapy, may also be an effective treatment (Teasell, et al., 2008; 2014).

Conclusion

Post-stroke depression is a very real and very serious problem that complicates recovery for more than a third of stroke survivors. Nurses/caregivers can help by recognizing the condition as a psychiatric illness and responding with an understanding of treatment approaches. Stroke survivors living in a rehabilitation setting and severely impaired by stroke, and those who are aphasic or immobile, are especially vulnerable.

DSM-5 criteria for depression (APA, 2013), and scales such as the Geriatric Depression Scale (GDS), or the Signs of Depression Scale (SODS), offer reliable and valid measurement and can be readily included in routine nursing assessments. Similarly, working with family and caregivers to distinguish crying that is congruent with a mood of sadness is important.

Knowing about the strengths survivors demonstrated when coping with previous crises will help support their present efforts. Treatment such as antidepressant medications, therapy and alternative approaches have all demonstrated efficacy.

As nurses and formal caregivers continue to learn about post-stroke depression and seek out ways to understand the condition more fully, other opportunities to reach out and help will emerge.

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Practical approaches in treating depression: Alleviating the debilitating symptoms of depression in LTC



[PDF – 1.2 MB]

Citation

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Depression is a significant problem that often remains undetected in Canadian nursing homes (Ostbye, et al., 2005). Between 12% and 16% of older adults living in long-term care facilities have major depressive disorder, 50% may have a minor depressive disorder, and up to 70% may at one time experience depressed, sad, or blue mood (AMDA, 2003); and yet, as many as 20 out of 100 residents may not receive formal treatment interventions (Jones et al., 2003).

Prevalence

Depression is not a normal function of aging (Anderson, 2002). In fact, the incidence of depression is higher in a younger demographic. For example, the lifetime prevalence rate of major depression is higher in a younger demographic. For example, the lifetime prevalence rate of major depression in individuals over age 60 was 10.6%. This compares to 19.8% in individuals aged 30-44 years (Kesler et al., 2005), which is almost double that of their elderly counterparts.

The Canadian Task Force on Preventative Health Care (MacMillan, et al., 2005), the U.S. Preventative Services Task Force (U.S.P.S, T.F., 2002), the Registered Nurses Association of Ontario (RNAO, 2003), and the National Advisory Council on Aging (McCourt, et al., 2002) all recommend screening and treating for depression. Instruments such as the Geriatric Depression Scale (GDS) and the Minimum Data Set (MDS) are able to identify residents with depression (Koehler, et al., 2005).

Practical approaches in treating depression: Alleviating the debilitating

Educational resources for assessing and treating psychiatric problems in long-term care facilities are available (Conn, et al., 2001). Further, treatment approaches such as supportive psychotherapy, anti-depressants and, in some cases, electroconvulsive therapy (ECT) are considered appropriate for geriatric patients (Birrer and Vemuri, 2004).

Five Reminders

However, despite recognizing the reality that depression is prevalent among nursing home residents, that it is not a normal function of aging, and that professional groups have created a number of best practice guidelines to address the problem, practical responses to the issue remain elusive in the long-term care environment.

This article presents five brief reminders to help assess and alleviate the debilitating depression so many residents experience. These reminders, itemized in the box below, will be discussed at length.

Assessment and alleviation of depression (Five Reminders)

1. Document the presence of depression using the Diagnostic and Statistical Manual of Mental Disorders, the DSM- IV-TR (APA, 2000).
2. Question whether a physical cause or trigger is present.
3. Question whether an emotional cause or trigger is present.
4. Alleviate symptoms by listening actively, encouraging structured activities and monitoring responses to anti-depressant or electroconvulsive therapy.
5. Care for the care-giver must not be neglected.

I. Documenting the presence of depression

Document the presence of depression using the DSM-IV-TR criteria (APA, 2000). Confirm whether any of the following symptoms have been present for two or more weeks, and if they interfere with daily functioning:

- Depressed mood;
- Anhedonia (decreased attention to, and enjoyment from, previously pleasurable activities);
- Unintentional weight change of five percent or more in a month;
- Change in sleep pattern;
- Agitation and psychomotor retardation;
- Tiredness;
- Worthlessness or guilt inappropriate to the situation (possibly delusional);
- Difficulty thinking, focusing or making decisions;
- Hopelessness, helplessness and/or suicidal ideation.

It is important to note that depression in older adults can manifest differently than in other populations. Since a depressed mood may be difficult to determine, anhedonia is a critical consideration.

Denial

Often, residents will deny feelings of depression and emphasize somatic complaints and non-specific complaints instead. Cognitive difficulties may become apparent and behavioural changes, such as apathy and irritability, may be more accurate indications of depression.

Depression is frequently present in residents diagnosed with Alzheimer's disease. Early morning awakening, while normal for many older adults, is also a symptom of depression.

Alexopoulos (2004) emphasized that depression is markedly increased when elders are medically ill, that psychotic features, such as delusions, are often present and that suicide is a significant risk. Therefore, always ask about suicidal ideation.

2. Presence of a physical trigger

Question whether a physical cause or trigger is present. Although some people experience an endogenous (or metabolic) depression which occurs for no apparent reason, others may have depressive reaction in response to a particular health-related event. Question and confirm whether any of the following have occurred recently:

Changes in current health status:

Some conditions are more of a trigger for depression than others. Conditions such as strokes, certain types of cancer, myocardial infarction, diabetes, Parkinson's disease, early stage dementia and hormonal disorders such as hypothyroidism are examples of illnesses that may be related to depressive disorders. Any condition that produces chronic pain, disability, or dependence, can be depressogenic.

Medications/substances causing symptoms of depression

- Certain antihypertensives
- Benzodiazepines
- Anti-neoplastics (interferons)
- Anti-inflammatories (corticosteroids)
- H2 antagonists
- Antibiotics
- Antipsychotics
- Alcohol

(Adopted from Tariot, 1996)

Changes in medication regime:

Corticosteroids or interferons often cause depressive symptoms as side effects; also, many other drugs can interact or react in unforeseen ways when taken together or singularly and which can cause symptoms of depressions. (See box above)

Changes in sensory abilities:

Loss of sight and hearing can isolate individuals from others and lead to withdrawal and decreased interactions.

Inadequate diet:

Deficiencies in foods rich in omega 3 fatty acids, in folate and the B vitamins can precipitate depressive symptoms. Omega- 3 fatty acids are present in fish and fish oil supplements; folate is present in leafy green vegetables and citrus fruits. The B vitamins – perhaps most importantly, vitamin B12 – are present in liver, other meats, dairy products and eggs.

Since older adults have difficulty absorbing B12 through digestion, regular B12 injections may be necessary; and, since symptoms of dehydration can be similar to those of depression, fluid intake must also be adequate.

Limited exposure to sunlight:

Winter months and extended periods of cloudy, rainy weather can cause some individuals to experience seasonal affective disorder (or SAD). Limited opportunities to spend time outdoors, or even beside windows during the daylight hours, can lead to minor depressive episodes due to the lack of sunshine.

Limited exercise:

Although mobility is clearly an issue for many residents, lack of exercise depletes the body of endorphins, a brain chemical that reduces pain and stimulates a sense of well-being. Other anti-depression benefits can accrue from exercise.

3. Emotional triggers

Question whether an emotional cause or trigger is present. Loss, loneliness and feelings of abandonment can seem more pronounced at certain times. Death or other traumatic events are clear and easily understood examples. Anniversaries of the death of a loved one or other significant occasion can spark a depressive episode. Holidays, a missed visit from a family member, learning of bad news, experiencing any deprivation and even reminiscing about missed opportunities in one's past life can heighten feelings of sadness as well.

Dysthymia

For individuals who suffer with dysthymia, where the depression is more chronic than acute, low self-esteem and hopelessness can appear more debilitating during the daytime. Knowing that this depressing condition can improve markedly during the evening hours, having limited opportunities to socialize and engage in meaningful activities during this time can give rise to inexorable dejection.

For individuals suffering anxiety-related depression, difficulty falling asleep can be troubling. Feelings of worry can seem disproportionate to the perceived cause. Crying may be either prolonged or strikingly absent.

4. Alleviating the symptoms

Alleviate symptoms of depression by listening actively, encouraging structured activities and monitoring responses from anti-depressant or electroconvulsive therapy. When residents do express feelings of sadness or worry, having someone listen and validate feelings is appreciated.

While a natural response to an individual expressing negative emotions may be to offer solutions, advice and good cheer, simply listening actively can offer invaluable comfort. The opportunity to talk and vent feelings without being cut off is affirming. Reflecting back what has been stated acknowledges the hurt and difficulties being experienced by the resident.

Structured activities promote a sense of self worth and adequacy. Setting small attainable goals for residents prone to depression, such as just spending short periods of time in an activity, rather than not attending at all, can support immediate successes. Providing opportunities for residents themselves to maintain control over their daily activities strengthens their ability for self-coping with depression.

If anti-depressant medications have been prescribed, tracking the start-dates and individual responses is crucial. Given that the therapeutic effect of most anti-depressants can be expected around two or three weeks, or longer, after the first dose, this time period is significant.

Award-winning research established link between depression in the elderly and poor blood flow

Beyond a certain point of plaque accumulation in the arteries (atherosclerosis), the flow of blood in the body is restricted and may cause a number of forms of physical decline. Atherosclerosis, and other forms of vascular disease, also increase the risk for depression in the elderly, according to a study by psychologist Benjamin Mast, of the University of Louisville.

Using data from the National Institute on Aging, Mast investigated over 2,100 elderly subjects aged 70 to 79 – with no evidence of depression. They were followed for a couple of years to see if some of them who had vascular disease or related risk factors demonstrated a higher risk for depression.

He found that vascular disease was associated with a 50% to 90% increased risk of depression after three years.

Mast pointed out that the link between vascular disease and depression has broad implications for caregivers and researchers: “There is some suggestion that older adults who have depression are at greater risk for developing dementia syndromes – for example Alzheimer’s disease and vascular dementia.”

Mast presented his findings at the annual (spring, 2005) meeting of the American Geriatrics Society, where he received the Society’s New Investigator Award in recognition of his studies in vascular-depression research.

“Feeling better” – be wary

Paradoxically, when an individual resident’s mood begins to lift in response to anti-depressant therapy, they are most in danger of acting on suicidal ideation. In other words, “feeling better” can actually give residents the energy they need to act on their feelings of wanting to die. Thus, observing vigilantly for behaviours, such as hoarding pills once medications have been initiated, is critical.

If electro-convulsive therapy has been prescribed, re-orienting the resident is helpful when short term memory loss, one of the side effects, occurs. Frequently, forgetting recent events is experienced in the hours immediately following treatment. Thus, prompts and cues are appreciated during these times.

5. Care for the care-giver

Care for the care-giver must not be neglected. Supporting residents through their bouts with depression can lead to compassion fatigue and burn-out for staff and family members.

Might any of the DSM-IV TR criteria be present with members of the health care team?

Could the stigma of depression prevent employees from reaching out for help?

Are services readily available for care-givers who need counseling?

Do family members have respite and relief?

When the physical and emotional triggers that can cause depression emerge for care-givers, is there support for creating strategies to cope with these personal feelings of depression?

Is adequate time away from the facility available so caregivers can experience a sense of renewal?

Balancing efforts to ease depression in long-term care residents, and still maintain self-care is not easy. However, implicit within the process of assessing and alleviating depression in others is the reminder that effective caregivers must also look after their own physical and mental health.

The most important message

“Behavioural interventions decrease depressive symptoms in patients with mild-to-moderate dementia. For clinicians/ caregivers treating or caring for patients with dementia, the most important message is to routinely assess for depression and treat it, because successful treatment can improve many dementia-related outcomes.”

(From: Boustani, M. and Watson, L., The interface of depression and dementia, Psychiatric Times; 21(3); March, 2004).

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Relocation stress in long term care: How staff can help



[PDF – 713 KB]

Citation

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Abstract

Relocating can be stressful and even traumatic for older adults, particularly when the relocation is involuntary. Reports that relocating older people is detrimental to their well being, health and survival are well documented (Holder and Jolley, 2012). For over two decades, relocation stress, previously known as Relocation Stress Syndrome, has been recognized as a real and approved nursing diagnosis (Morse, 2000; NANDA, 1992). And yet, supporting residents through the stress and trauma of relocating remains a challenge. This article defines relocation stress and suggests that gathering resources, extending a minimum four month welcome, and celebrating contentment can help.

Relocation stress was first defined as a syndrome where “physiological and/or psychosocial disturbances [were] a result of transfer from one environment to another” (Manion and Rantz, 1995). Later, the North American Nursing Diagnosis Association (NANDA) specifically connected the condition with admissions to long-term care and transfers between health care facilities, adapting the definition to “the physiologic and psychosocial disturbances caused by change in health care environment” (Carpenito-Moyet, 2007). Relocation stress is also known as *transfer anxiety* or even *transfer trauma* when the move is involuntary and outcomes are negative (Hodgson, et al., 2004).

Defining characteristics

Major defining characteristics of relocation stress are loneliness, depression, anger, apprehension and anxiety, while minor characteristics are changes in former eating and sleeping habits, dependency, insecurity, lack of trust and a need for excessive reassurance (Carpenito-Moyet, 2007). These characteristics are most pronounced during the first four months after arrival (Laughlin, et al., 2007).

Although associations between relocating and stress are well established, researchers have questioned the validity of relocation stress as a nursing diagnosis (Mallick and Whipple, 2000). Critical concerns have been raised that what “appears to be relocation stress syndrome may be a pre-existing, undiagnosed, and untreated endogenous depression, exacerbated by relocation” (Walker, et al., 2007). Clearly a key issue in any discussion of relocation stress is accurate assessment.

Prevalence in LTC

Residents in care facilities experience a high prevalence of endogenous depression (See box below), with the symptoms all too often undetected (Melrose, 2006).

Similarly, residents relocating also experience a high prevalence of adjustment disorders that go undetected (Maercker, et al., 2008). However, it is overly simplistic to assume that expressions of loneliness, depression and anxiety are linked solely to the stress of relocating.

Research reporting the effects of relocating older adults provides varied results. In one study where institutionalized residents were relocated suddenly and involuntarily, 45.8% died within the first year (Laughlin, et al., 2007).

Residents who are particularly vulnerable to mortality are those with low physical functioning (Borup, et al., 1980), women (Hertz, et al., 2008), and those over age 85 (Laughlin, et al., 2007).

Residents relocating from home to LTC found the changes impacted their sense of control, their self identity and their self worth, particularly as they adapted to the lack of privacy and sought to make new friends (Donald, et al., 2009). Sharing space and feeling safe with strangers was stressful (Piekarski, 2008). The psychological transition associated with relocating was highly stressful (Ellis, 2010).

Endogenous depression

Also known as unipolar depression, *endogenous depression* is a sub-categorization of *general depression*. It is based on the belief that the source of the disorder was internal, or endogenous, meaning that it was caused by factors inside the organism. Endogenous depression, therefore, was considered biological depression, as opposed to depression brought on by stressful events, known as *reactive depression*. Reactive depression occurs due to a stressful event, whereas endogenous depression may have no external cause or trigger.

Some of the characteristic features of endogenous depression include insomnia, depleting energy level, inability to focus or poor concentration, problems remembering and memorizing, and lack of interest in any form of physical activity.

“Upsetting and chaotic”

Even when residents and their families perceived the new location as a better facility, many describe the process of relocating as “upsetting and chaotic” (Capezuti, Boltz and Renz, 2004).

On the other hand, researchers have also indicated that the effects of relocating can be minimal, for example, residents experiencing only small changes in cognitive performance, depression, and social engagement (Castle, 2005). However, while reports on the extent of physiological and psychosocial disturbances may not be consistent, relocating can be expected to impact residents’ quality-of-life.

Priority for care staff

Family members are also impacted when their loved ones experience relocation stress (Ellis, 2010; Mintz, 2005). Prior to a long-term care admission, families may have already assisted their spouse or parent with a series of relocations. For example, moving from house to apartment, moving from living independently to an assisted living facility, and moving from unit to unit following hospital admissions.

Family members can be expected to have accompanied their loved one to numerous appointments with health professionals and to have reiterated the presenting of health concerns to a variety of individuals from different agencies.

Remaining connected to family can support residents’ ability to cope with relocating (Iwasiw, et al., 2003; Kao, Travis and Acton, 2004). However, family members also need respite from the stress of relocating their loved one. Helping relocated residents and their families cope should be a priority for long-term care staff.

Gathering resources

An important first step that management can take in supporting staff as they help residents and families cope with relocation is to gather resources geared to both professional caregivers and the lay public.

These supportive resources include:

Professional guidelines:

For professional staff, evidence-informed guidelines such as *Management of Relocation in Cognitively Intact Older Adults* delineate practices that help cognitively intact older adults successfully relocate (Hertz, et al., 2005). A summary of these guidelines is provided in a subsequent publication (Hertz, et al., 2007).

These guidelines are presented in two components. The first identifies risks for ‘relocating and planning for a move.’

The second component targets postrelocation and includes planning and facilitation of adjustment to the move. Useful, practical and efficient flowsheets are included for both components.

While the pre-location or pre-placement flowsheets may not be immediately relevant to long-term care staff receiving a new resident, staff as well as families would value knowing assessment points to consider. Once resources such as these guidelines

with their pre-made flow sheets have been acquired, incorporating them into existing assessment protocols becomes more manageable.

Public/professional fact sheets:

Using bulletin boards to post pre-made fact sheets summarizing the characteristics of relocation stress can be an effective method of raising awareness. For paraprofessional staff, the Wisconsin Board on Aging and Long Term Care Ombudsman Program (WI BOALTC) (2011, April) developed a simple fact sheet that could be posted on a bulletin board in a staff education area. See box below.

Possible symptoms of relocation stress

For some residents, the symptoms of relocation stress may be obvious changes in health, personality or disposition. For others, the changes may be more subtle. It is critical that the receiving facility understand what a resident is usually like, so any changes are potentially recognized as symptoms of relocation stress:

- Depression
- Sadness/Crying
- Despair
- Confusion
- Indecision
- Apprehension
- Anxiety
- Falls
- Restlessness
- Sleep disturbance
- Dependency
- Insecurity
- Distrust
- Withdrawal/Isolation
- Loneliness
- Over-idealizing (Isn't this place wonderful? Everything's perfect!).
- Negative comments about staff
- Resistance/Unwillingness to move
- Anger
- Aggressiveness
- Change in eating habits
- Weight change
- Stomach problems

Edited from the Wisconsin Board on Aging and Long Term Care . . . April 2005, Revised, April, 2011

Similarly, for family members, visually pleasing fact sheets developed by cartage companies and commercial transitioning service companies are readily available on the internet and could be posted in a family education area.

Workshops:

Incorporate the topic of relocation stress into scheduled staff and/or family and resident education sessions. Select a recent publication to frame interactive discussions and elicit comments from attendees about their experiences with moving or relocating. Provide attendees with pen and paper and direct them to write out a strategy they found helpful during their own relocation experience. Collect the responses, transcribe them on colorful paper and post on a bulletin board beside the professional or lay public resources. Follow up by integrating the suggested strategies into practice whenever possible.

With front-line staff, the follow up process is especially important because, as a Canadian study revealed, “nursing staff, including aides, were found to be the primary source for both supportive and nonsupportive behaviours relevant to emotional support and practical assistance for relocated elders” (Donald, et al., 2009).

Involving staff in the creation of strategies to deal with relocation stress from their own successful experiences will strengthen commitment.

Control:

Issues of control, self identity, privacy and making friends are likely to emerge

for older adults during the first four months after relocating to long-term care (Donald, et al., 2009). Therefore, from the moment staff welcome residents to their new home, the process of intentionally sharing control and decision-making will establish a foundation for what the relocation experience will be like. While residents (and family members) are likely to perceive that they have little control over the admission process and facility regulations, they are entitled to control over their personal space. To this end:

- offer choices of where personal belongings will be placed;
- ensure availability of sufficient clothes to encourage choices about what to wear;
- provide menu choices and record favorite foods;
- whenever possible, invite residents to identify the times they wish to receive prn or sleeping medication; and finally,
- include residents and families in care planning, making sure to follow through with their requests or suggestions.

Self-identity:

Find out the preferred name residents wish to be addressed; ensure that this information is communicated to all staff. While some individuals enjoy the informality of being called by their first name or a nickname, others find that this heightens their feeling of powerlessness. Titles such as Mr., Mrs., Dr., or non-English forms of address may remind residents of their former roles (Melrose, 2004).

Initiate an ongoing biography or ‘life story’ scrapbook-style document and keep it on display in residents’ rooms. Involve family members in the project and ensure that supplies such as paper and glue are on hand when visitors arrive. Include pictures and descriptions of residents, their past and present achievements and their families. Add signatures from greeting cards or bouquets of flowers that are sent in and children’s drawings for color. For many residents and their families, the experience of piecing the collection together during visits can be a positive and relaxing process (Melrose, 2004).

Avoid situations where groups of staff members converse in a language not familiar to residents. When caregivers are within hearing distance of residents, ensure that any conversation is understandable and inclusive. Invite residents into staff banter

using gentle, appropriate humor and positive overtures. Simply being included in friendly, everyday staff discussions can help residents establish their identity in a new place and with a new group.

Privacy:

Shared rooms are a reality in long-term care; but for residents and their families, this proximity to another individual can be overwhelming. Establishing boundaries related to personal belongings, bathroom hygiene, noise from TVs or radios, alone time, and accommodating visitors is essential. Policies related to noise and to the areas where residents in shared rooms can host their visitors must be clear.

Making friends:

Significant losses can delay residents' interest in making new friends. Most have lost their spouse, their previous good health and many of the possessions that once adorned their home. Acknowledging these losses is important. While staff may not always have time to sit and reminisce, opportunities should be created so that residents can connect with volunteers or fellow residents as often as possible.

'Buddy systems,' where well-settled residents are assigned to mentor those newly admitted, may be a useful approach in some areas of long-term care.

Similarly, assigning a 'job' to the newly arrived resident, such as inviting a former librarian or avid reader to organize an area of reading material, may be fitting.

Accompanying new residents to activities and then remaining with them long enough to initiate conversations with others can set the stage for developing quality relationships and new friendships.

Celebrate contentment:

Stress can continue for residents and their families well beyond the first four months after relocating. Some residents who appear to be accepting of their life in long-term care may actually not be content or satisfied at all. Rather, they may simply be resigned (Brandburg, 2007).

Ongoing assessment of stress and other mental health issues, such as depression and adjustment disorder, must continue. However, when times of contentment occur, celebrating these events can go a long way towards increasing their frequency.

According to the Merriam-Webster dictionary, contentment is defined as "*freedom from worry or restlessness, peaceful satisfaction.*" The importance of acknowledging residents' smiles, of genuinely enjoying their conversation and commenting positively on their successes, should not be underestimated.

Likewise, staffs' own contentment and feelings of peaceful satisfaction with their workplace must also be celebrated. Caring for vulnerable elders is one of society's most important jobs.

All staff employed in long-term care contribute to the well being of residents and their families. When staff share their experiences of pride, joy and achievement, residents celebrate these experiences as well. Consistent public acknowledgement of staff or facility achievements can set a subtle but strikingly powerful tone of contentment within the staff/resident group.

Three phases of relocation

According to Kao, Travis and Acton (2004), a resident relocating from a comfortable and familiar home, to a nursing home, experiences a variety of issues at different times. These authors specify that relocating to a nursing home may involve three phases:

1. In the **pre-institutionalized phase**, the relinquishing of personal affects, cause feelings of grief and loss. Advance directives and having to consent to power of attorney can lead to symptoms of depression. Kao and colleagues explain that the choices and decisions required can be an overwhelming experience (Ibid., 2004). They also point out that, “while nursing staff are not usually involved with residents and their families during this chaotic time, it is important to imagine the physical and mental exhaustion that residents and their families go through.”
2. During the time they are in the **transition phase**, residents may experience acute feelings of “abandonment and vulnerability.” Following placement, “residents may respond with anger and a sense of injustice,” with negative responses especially common in those who were involuntarily placed in a facility (Jackson, et al., 2000). These negative reactions, which can endure as long as three months following placement, “. . . are in part related to feeling that staff do not acknowledge their former roles, through which they contributed to their families and society, and this reinforced their loss of social status and role” (Iwasiw, et al., 2003).
3. In the **post-institutional phase**, the adjustment required can last up to one year. “Although residents, family members and caregivers may expect the stress of relocation to diminish once the resident has become oriented to their new home, clinical symptoms may continue throughout the first year” (Melrose, 2004). Psychological issues include establishing a sense of control and identity in a new environment. It has been maintained that it is this loss of control that leads to anger and difficulties with care (Mikhail, 1992). The post-institutional adjustment stage for those with cognitive impairment can be even more challenging as they may find it more difficult to settle in and initiate new social relationships (Melrose, 2004).

Conclusion

Relocation stress is a nursing diagnosis characterized by loneliness, depression, anger, apprehension and anxiety, changes in former eating and sleeping habits, dependency, insecurity, lack of trust and a need for excessive reassurance.

Residents moving into long-term care are at greatest risk for experiencing relocation stress during the first four months. Staff can help residents and their families cope by gathering resources such as professional guidelines, lay public fact sheets and interactive workshops.

Extending a four month welcome emphasizing residents’ control, self-identity, privacy and opportunities to make friends can also help.

Finally, intentionally finding ways to celebrate the times when both residents and staff feel contented and satisfied with their facility can help reduce some of the feelings of stress that residents experience when they relocate to long-term care.

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Reducing relocation stress syndrome in long term care facilities



[PDF - 444 KB]

Citation

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Current literature reflects that relocation stress syndrome is a real (Morse, 2000) and valid (Mallick & Whipple, 2000) disorder where individuals experience difficulty coping with the process of relocating from a familiar secure environment to one that is unfamiliar. Traditionally known as “transfer anxiety” the condition has been an accepted nursing diagnosis in the North American Nursing Diagnosis Association (NANDA) classification scheme (2001) since 1992.

Relocation stress syndrome can be defined as “physiologic and/or psychosocial disturbances as a result of transfer from one environment to another” (Manion & Rantz, 1995, p. 108). According to Brugler, Titus, and Nypaver (1993) all individuals involved in the relocation are at risk of developing this human reaction, including family members.

Dependency, confusion, anxiety, depression and withdrawal are the five defining characteristics of relocation stress syndrome (Mallick & Whipple, 2000). Jackson, Swanson, Hicks, Prokop, & Laughlin (2000) suggested that symptoms of anxiety, depression, apprehension, loneliness and increased confusion occur 80% of the time. Sad affect, withdrawal, sleep disturbances, weight loss and gastrointestinal upsets occur 50% to 70% of the time (Jackson et al, 2000).

When older adults find themselves in the position of requiring institutional long-term care, they arrive at their new home under some of the most vulnerable circumstances of an individual's life (Kao, Travis & Acton, 2004). Seeking to understand what relocation stress syndrome might look like and how staff can help to reduce that stress is an important responsibility for nurses.

What Does Relocation Stress Syndrome Look Like?

Before During and After Relocating

The human dynamics of relocating are complex and different issues emerge for residents and their families at different times. Kao, Travis and Acton (2004) summarized that adults moving to long term facilities progress through three phases; pre-institutionalization, transitional, and post-institutionalization.

Whether residents experienced this phase as a result of transferring from a hospital or arriving directly from their own home, the choices and decisions required can be overwhelming.

Before Admission

In the first, pre-institutional phase, selling a home and relinquishing personal belongings stimulate feelings of loss and grief. Similarly, legal decisions such as advance directives and power of attorney designations can stimulate feelings of depression and powerlessness. Whether residents experienced this phase as a result of transferring from a hospital or arriving directly from their own home, the choices and decisions required can be overwhelming.

Long term care accommodation may not be available in residents' home communities and their request for a particular facility may not have been granted. In addition, family members may also be coping with feelings of stress and guilt due to placement activities (Kao, Travis & Acton, 2004). While nursing staff are not usually involved with residents and their families during this chaotic time, it is important to imagine the physical and mental exhaustion that residents and their families go through.

The First Three Months

In the second phase, a time of transition, older adults' feelings of helplessness, abandonment and vulnerability are the most acute. Immediately after institutionalization and for as long as three months, residents may respond with anger and a sense of injustice (Jackson et al, 2000). Negative responses are especially common among involuntarily admitted residents.

Iwasiw, Goldenberg, Bol & MacMaster (2003) also identified that the majority of residents in their research study appraised the long term care facility the most negatively at three months. Reasons for these residents' negativity, in part, related to feeling that staff did not acknowledge their former roles, through which they contributed to their families and society, and this reinforced their loss of social status and role.

Further, during this time of transition, families may also be disturbed by the physical, social and emotional changes in their loved one and may question the placement decision. Thus, knowing that emotional concerns for residents and their families are expected to be heightened around three months after admission, it is useful to flag this particularly vulnerable time for residents and plan extra time for listening and collaborative problem solving.

The First Year

The third, post-institutional phase is an adjustment expected to last at least one year. Key psychological issues for residents

in this phase include seeking a sense of control over their new environment, establishing an identity in that new environment and remaining connected to family and friends. Mikhail (1992) emphasized how it is loss of control that sustains residents' anger and allows conflicts regarding care to arise. When older adults with cognitive impairment relocate, the process can become even more challenging as difficulties with remembering and making decisions make it hard for residents to settle in and initiate new social relationships.

Offering residents and their families' choices whenever possible is essential. Also, facilitating communication among residents, families and staff is critical. Frequent team meetings and individualized care plans that keep medical and nursing records up to date and well-organized will greatly reduce relocation stress syndrome (Iwasiw et al, 2003; Kao, Travis & Acton, 2004; and Morse, 2000). Modifying the institutional environment in response to individual's usual habits and acknowledging residents' personal histories, values and preferences will help.

Implications for Practice

Settling In

Although many residents, family members and caregivers may expect the stress of relocation to diminish once an older adult has become oriented to their new home, clinical symptoms related to the syndrome may continue throughout the first year. The process of settling in is seldom straightforward. Recognizing and accepting that physical and psychological disturbances are expected to emerge can help. Negative responses precipitated by fatigue and sensory overload are anticipated and nurse responses that reflect patience and compassion are invaluable.

Offering Choices

Most residents will have had limited if any opportunities to tour their new home, meet their new "family" and attend facility activities before they are actually admitted. While choices related to many aspects of the move and the way the institution must be managed are non-negotiable for residents, they are entitled to control over their personal space. Offer choices of where personal belongings will be placed and define physical boundaries to provide privacy.

Offering residents and their families choices whenever possible is essential. Also, facilitating communication among residents, families and staff is critical.

Provide opportunities for residents to exert control by offering opportunities to choose from different selections of healthy food and fluid items. Identify individual likes and dislikes, invite suggestions for meal planning and whenever possible, involve residents in activities such as setting the table and food preparation.

Find out the name residents prefer to be addressed by and ensure that this information is communicated to all staff. While some individuals enjoy the informality of being called by their first name or even a nickname, others find that this practice heightens their feelings of powerlessness. Titles such as Mr., Mrs., Dr., or non-English forms of address may remind residents of their former roles.

Other opportunities to offer choices to residents include inviting them to decide which clothes they wish to wear and which activities they would or would not like to be involved in. Encouraging residents' to assess optimum times for prn medication and then consistently responding to their instruction can reduce anxiety and promote trust.

Promote Personal Identity

Create an ongoing biography or “life-story” scrapbook style document and keep it on display in residents’ rooms. Involve family members in the project and ensure that supplies such as paper and glue are on hand whenever visitors arrive. Include pictures and descriptions of residents, their past and present achievements and their family members. Add signatures and brief excerpts from greeting cards or flower bouquets that are sent in and children’s drawings for color. For many residents and their families, the experience of piecing the collection together during visits can be a relaxing process.

Document past experiences residents have had with loss and abandonment in the assessment area of their chart. It is not necessary for nursing staff to complete comprehensive psychological explorations; issues related to loss and abandonment often comes up during everyday conversation. For example, childhood experiences of “being left,” the deaths of parents, family and friends, divorce or living through catastrophic events such as a war or natural disaster.

What is particularly important about these experiences is to label the processes and strategies individuals used to cope during and after the event. For example, asking: “How did you get through that?” provides important insight into ways of handling stress. Reminiscing about previous success during stressful situations reminds residents of their strengths and in turn illustrates those strengths to caregivers.

When residents express feelings of sadness, loneliness and anger, it can be difficult for family members and caregivers to hear. However, venting emotions, whether they are positive or negative, is a healthy response to stress. Rather than distracting from or invalidating residents’ feelings by trying to cheer them up, it is important to encourage honest discussion. Iwasiw et al (2003) emphasized that listening to residents and providing opportunities to talk about their feelings helped meet their needs to maintain an identity and dignify them as individuals.

Facilitate Communication

Maintaining relationships with family and friends for new residents of long-term care facilities can be stressful. Symptoms of depression, such as withdrawal and disinterest in activities usually enjoyed can precipitate behaviors such as avoiding others, not returning telephone calls and declining invitations to go out. However, friends and family offer emotional strength and motivation, so facilitating communication within these relationships is therapeutic.

Provide hosting areas where residents can offer visitors simple refreshments like tea, coffee or juice. As much as their physical conditions will allow, encourage residents to organize the serving and seating arrangements they prefer for their guests. If the cost of providing light refreshments is an issue, provide a discreet container where guests can drop coins to pay for the supplies. Feeling unable to host guests can be a deterrent to maintaining precious relationships.

Initiate communication with residents’ family members and friends by inviting them to join care planning meetings. Write down comments visitors make about residents’ likes and dislikes as they are shared and later transfer the information to the chart. The process of recording comments while an individual is speaking can be very affirming. When visitors sense that the information they offer is acted on, they are more likely to remain involved.

Similarly, invite visitors to participate in any social activities available at the facility and ask for their help in making the event a success. Sign up sheets for tasks or items to bring promote commitment and increase attendance.

Support groups for family and friends can ease the stress of relocation as well. Establishing a consistent time and place each week where residents’ loved ones can speak freely and discuss their concerns can alleviate anxiety. Often, visitors develop friendships during these meetings, making coming to the facility a pleasant experience.

Listening intentionally; offering choices, promoting personal identity and reinforcing residents’ own coping strategies can significantly lessen the trauma.

Conclusion

Relocation stress syndrome is a potential problem for residents, their families and their caregivers. Both physical and emotional responses attributed to this disturbance may occur throughout the first year after moving to a long term care facility. In particular, new residents and their loved ones may express negative feelings during the first three months. Listening intentionally, offering choices, promoting personal identity and reinforcing residents' own coping strategies can significantly lessen the trauma. Recognizing relocation stress syndrome and providing empathetic, well documented and person centered nursing care is both a challenge and an opportunity for Licensed Practical Nurses.

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Schizophrenia: A Brief Review of What Nurses Can Do and Say to Help



[PDF – 80 KB]

Citation

Melrose, S. (2009). Schizophrenia: A brief review of what can nurses do and say to help, *Journal of Practical Nursing*, 59(2), 3-4.

Over the past several decades, the World Health Organization has consistently cited that schizophrenia affects 1% of individuals around the world (Jablensky, Sartorius, Ernberg, Anker, Korten at al, 1992) and ranks among the top 10 causes of disability in developed countries (Murray & Lopez, 1996). Schizophrenia is associated with a financial burden of over \$62 billion in the United States (Wu, Birnbaum, Shi, Ball & Kessler, 2005) and nearly \$7 billion in Canada (Goeree, Farahati, Burke, Blackhouse, O'Reilly et al, 2005). McGrath, Saha, Chant and Welham (2008, June 14) now suggest that the incidence and costs may well be higher than these seminal estimates and that individuals with schizophrenia have a two- to threefold increased risk of dying. Given the current trend towards admitting patients with psychiatric illnesses such as schizophrenia into flex beds in health care settings, nurses can expect to meet individuals struggling with this devastating illness in all areas of their practice. Nurses who know what to do and say can save lives.

What Is Schizophrenia?

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR), schizophrenia is a persistent, often chronic and usually serious mental disorder affecting a variety of aspects of behaviour, thinking, and emotion. Patients with hallucinations or delusions may be described as psychotic. Thinking may be disconnected and illogical.

Peculiar behaviours may be associated with social withdrawal and disinterest (American Psychological Association APA, 2000). Causes of the disorder are not clear; however an imbalance of serotonin, norepinephrine, an abnormally large number of dopamine receptors, and a faulty neurotransmission process may play a role (Schizophrenia.com, n.d.). Symptoms often present between the ages of 18 and 25 and early intervention when the first psychotic symptoms are expressed is encouraged (Dyer & McGuinness, 2008).

Distinguishing between positive or hard, and negative or soft symptoms is of particular importance with schizophrenia. In this context, “positive” does not mean “good.” Rather, positive symptoms are psychotic and demonstrate how individuals have lost touch with reality. Positive symptoms are those that exist but should not exist such as hallucinations, delusions and disorganized thinking and behaviour.

Delusions fall into several categories. Individuals with a persecutory delusion may believe they are being tormented, followed, tricked, or spied on. Individuals with a grandiose delusion may believe they have special powers. Individuals with a reference delusion may believe that passages in books, newspapers, television shows, song lyrics, or other environmental cues are directed to them. In delusions of thought withdrawal or thought insertion, individuals believe others are reading their mind, their thoughts are being transmitted to others, or outside forces are imposing thoughts or impulses on them. With positive symptoms, understanding that individuals are deeply convinced the delusions are real is essential (Austin & Boyd, 2008; Mohr, 2003; Varcarolis, Carson, & Shoemaker, 2006).

In contrast, negative symptoms are those characteristics that should be there but are lacking. For example, negative symptoms include: apathy (lack of interest in people, things and activities), lack of motivation, blunted affect, poverty of speech (brief terse replies to questions that lack content), anhedonia and asociality (avoidance of relationships). A blunted affect does not reflect an inability to feel emotion. Withdrawing from others is a coping mechanism for those with schizophrenia – not a rejection of those who initiate contact.

What Can Nurses Do?

QUESTION WHETHER A DIAGNOSIS OF SCHIZOPHRENIA BEEN DESIGNATED. Is the presentation of psychotic behaviour associated with a diagnosis of schizophrenia? Or might drugs, alcohol, brain injury or even dehydration be causing the unusual behaviour?

IDENTIFY PRESCRIBED ANTIPSYCHOTIC MEDICATIONS. Individuals diagnosed with schizophrenia can be expected to have antipsychotic medications prescribed for life. Since the side effects can be devastating, patients often stop taking them. However, without antipsychotic medications, the positive and negative symptoms of schizophrenia will return and seriously impair functioning.

Antipsychotic medications are either ‘typical’ (Chlorpromazine/ Thorazine or Haloperidol/Haldol); or ‘atypical’ (Clozapine/ Clozaril, Risperidone/Risperdal, Olanzapine/Zyprexa or Quetiapine/Seroquel). While traditional typical antipsychotics reduce positive symptoms, they can also induce extrapyramidal (EPS), tardive dyskinesia and over sedation (Varcarolis, Carson & Shoemaker, 2006). The newer atypical antipsychotics, which reduce both positive and negative symptoms, can cause significant weight gain, metabolic abnormalities, movement disorders and over sedation (Cullen, Kumra, Regan, Westerman, & Schulz, 2008). While non compliance is understandable, it is vital for nurses to know what antipsychotic medications have been prescribed for individuals with schizophrenia and whether the individual is currently taking them.

ENSURE MEDICATION IS INGESTED. Hallucination and delusion content often includes the belief that anti-psychotic medication is “poison,” and in response to this belief, individuals frequently “cheek” or pretend to swallow pills. Given this inalterable aversion to swallowing pills, long acting medications offering relief from psychosis are often administered IM each month.

What Can Nurses Say?

ARE YOU HEARING VOICES RIGHT NOW? With schizophrenia, it is important to emphasize that nurses are required to know the content of any hallucination or delusion. Posing a clear direct question such as “Are you hearing voices right now?” during each interaction is expected. A hallucination could involve a deep loud commanding male voice incessantly admonishing an individual that he/she is “worthless and must die.” Observe for cues such as eyes darting to one side, muttering to self or looking to a vacant area.

INTERJECT DOUBT. After asking if hallucinations and delusions are present, avoid reacting as if these are real, do not argue back to the voices and set time limits for talking about them. Acknowledge the individuals experience while at the same time offering your own perceptions. For example: “I do not hear these voices, but I understand how scary this must be for you.” Focus on feelings. Present diversions based on reality either through conversations or working together on a simple project. Suggest: “Try not to listen to the voices right now; we’ll walk down the hall and look at the decorations.” Suggest listening to music with earphones. If an individual seems anxious, the symptoms may be increasing.

HAVE YOU BEEN FEELING SUICIDAL? Approximately 10 percent of individuals with schizophrenia (especially younger adult males) commit suicide (National Institute of Mental Health NIMH, 2006; Public Health Agency of Canada PHAC, 2002), so assessing suicide risk is critical. Pose three direct questions. First, have you considered taking your own life? Second, how do you plan to commit suicide? Third, what stops you?

HAVE YOU TAKEN ANY DRUGS OR ALCOHOL TODAY? IN THE LAST WEEK? IN THE PAST? Quantifying specific amounts of substance, such as the number of beers, marijuana cigarettes or grams of cocaine is important. The lifetime incidence of substance abuse occurring in schizophrenia is 60% (American Psychological Association APA, 2000). Substance abuse is associated with negative outcomes such as incarceration, homelessness and violence. Referral to a dual diagnosis treatment program may be needed to address both a schizophrenic illness and substance abuse problems.

Summary

Communicating with individuals who express delusions they believe are real is not easy. And nor is reaching out to engage individuals who present with severely blunted affect. But, those who live with schizophrenia need nurses to understand their illness and help by monitoring medication compliance and asking questions about hallucinations, suicide and substance abuse.

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MENTAL HEALTH (DEVELOPMENTAL DISABILITIES)

Supporting Persons with Developmental Disabilities and Co-occurring Mental Illness: An Action Research Project



[PDF – 593 KB]

Citation

Melrose, S., Wishart, P., Urness, C., Forman, B., Holub, M. & Denoudsten, A. (2013). Supporting persons with developmental disabilities and co-occurring mental illness: An action research project. *Canadian Journal of Psychiatric Nursing Research*, 3, 32-40.

Abstract

This paper presents findings from a naturalistic action research project that implemented a WrapAround mental health promotion activity with six individuals dually diagnosed with a developmental disability and mental illness. The project was framed from a strengths based conceptual perspective and questioned how caregivers could better prepare developmentally disabled clients to anticipate and prevent a psychiatric mental health crisis before hospitalization occurs. Facilitators provided monthly health promotion meetings where clients at risk of experiencing a psychiatric crisis were helped to create a team of family members and paid caregivers to 'wrap around' them. The teams met regularly and facilitators guided discussions to focus on clients' strengths, their goals and strategies for success. Data collected from 13 interviews with clients and members of their teams was analyzed to reveal three themes, our findings. First, regular meetings where clients seek and receive support from individuals they value can help address escalating symptoms of mental illness. Second, constant caregiver turnover heightens client anxiety,

which in turn exacerbates illness. Third, limited paid in-service and networking opportunities are available to caregivers. These findings invite nurses in the psychiatric field to create similar opportunities to support PDD clients and those who care for them.

Mental health promotion activities that efficiently support persons with developmental disabilities (PDD) dually diagnosed with mental illness have been understudied. The co-occurrence of mental illness in PDD, also known as developmental disabilities (DD), as intellectual disabilities (ID) or more pejoratively as mental retardation (MR) is not well understood. According to the National Association for the Dually Diagnosed NADD ([n.d.](#)), dual diagnosis is a term applied to the co-occurrence of the symptoms of both PDD and mental illness. It is important to note that the term dual diagnosis is not used exclusively to identify the co-occurrence of PDD and mental illness. The overarching term dual diagnosis or co-morbidity is a generic term referring to the co-occurrence of disorders suffered by an individual ([Teliás, 2001](#)).

Individuals identified as PDD experience difficulty functioning and adapting. Functionality is evaluated by an IQ score of 70 or below and adaptability by skill mastery in areas such as eating, dressing, communicating, socializing and assuming responsibility ([American Psychiatric Association, 2000](#)). PDD can be mild, moderate or severe. Traditionally, those with PDD were cared for in institutional settings. However, today nurses in the psychiatric field can routinely expect to meet community dwelling PDD clients in a variety of health care settings.

This paper describes a yearlong naturalistic action research project that implemented a WrapAround mental health promotion activity with six individuals dually diagnosed with a developmental disability and mental illness. Participants were drawn from two different Calgary agencies. Insights into the experiences of these clients, their families and the paid staff who care for them can help psychiatric nurses better understand and respond to this understudied group.

Background

Two key issues facing the dually diagnosed and those who care for them are a high prevalence of mental illness and perceived service gaps ([Melrose, 2013](#)).

High Prevalence of Mental Illness

Adults with intellectual disabilities can experience mental illness at a prevalence rate of 40.9%, nearly four times greater than the general population ([Cooper, Smiley, Morrison, Williamson & Allan, 2007](#)). When admitted to psychiatric units, their problems can be more severe and they can receive more interventions than individuals without developmental disabilities ([Chaplin, 2011](#)). They may spend more days in hospital ([Bouras, Martin, Leese, Vanstraelen, Holt et al, 2004; Morgan et al, 2008; Saeed, Ouellette-Kuntz, Stuart & Burge, 2003](#)). The majority are likely to be subjected to chemical restraint ([Webber, McVilly & Chan, 2011](#)).

In Canada estimates suggest that 380,000 Canadians ([Yu & Atkinson 1993, republished in 2006](#)) and between 6,000 and 13,000 Albertans live with a dual diagnosis ([Hughson, 2009](#)). About forty-two percent of all hospitalizations among PDD Canadians occurred for psychiatric conditions ([Lunsky & Balogh, 2010](#)). PDD Canadians are at fifteen times greater risk of receiving a psychiatric admission of schizophrenia ([Balogh, Brownell, Ouellette-Kuntz et al. 2010](#)), and this risk is also nearly four times greater than the general population ([Morgan, Leonard, Bourke & Jablensky, 2008](#)). Further, PDD Canadians are at over four times greater risk of experiencing dementia and at nearly three times higher risk of being depressed than non PDD individuals ([Shooshtari, Martens, Burchill et al. 2011](#)). Fourteen per cent of PDD participants in an Australian study had an incapacitating

anxiety disorder (White, Chant, Edwards, Townsend, Waghorn, 2005). The high prevalence rate of developmental disabilities co-occurring with mental illness is further influenced by traumatic events, challenging behaviors and assessment issues.

Traumatic events Adults whose intellectual disability is mild or moderate, rather than severe, may not have greater prevalence rates than the general population (Whittaker & Read, 2006). However, traumatic events can also play an important role in their psychopathology. In one study, 75% of participants with mild to moderate intellectual disabilities had all experienced at least one traumatic event during their life span, predisposing them to significantly increased probability of a mental disorder (Martorell et al, 2009).

Challenging behaviors Challenging behaviors, although not listed as DSM-IV-TR psychiatric diagnosis, have consistently been identified as a reason for admission to hospital (Cooper et al 2007; Cooper, Smiley, Allan, Jackson, Finlayson et al, 2009; Cooper, Smiley, Jackson, Finlayson, Allan et al, 2009; Whittaker & Read, 2006). Challenging or problem behaviors such as aggression, self-injury, and destructive, disruptive or non-compliant behaviors often precipitate hospitalization (Lowe, Allen, Jones, Brophy, Moore & James, 2007). However, while challenging behaviors coexist in some people with intellectual disability, disturbances in psychiatric functioning are not believed to underpin the majority of these behaviors (Allen & Davies, 2007).

Assessment issues Assessing mental illness among persons with intellectual disabilities is not straightforward. Limited training is available to professionals (Quintero & Flick, 2010). In turn, mental illness may go undetected in PDD. Many diagnostic criteria include self reports of thoughts, feelings, physiologic states, past events and reactions to these events. This requires a level of language discrimination and memory skills that may not be present in adults with intellectual disabilities (Bouras & Holt, 2007). Diagnostic overshadowing, or ignoring mental health problems because the symptoms are judged to be “just” part of the developmental disability, can occur (Reiss & Szyszko, 1983). The social isolation often accompanying PDD can leave individuals with distorted perceptions of whether what they are experiencing is ‘normal’ (Silka & Hauser, 1997). Hospital emergency department staff reported a lack of knowledge related to intellectual disabilities (Lunsky, Gracey, & Gelfand, 2008) and paid caregivers need training in the early detection and warning signs of mental ill health (Smiley, Cooper, Finlayson, Jackson, Allan et al, 2007). Canadian online resources such as the text: *Introduction to the Mental Health Needs of Persons with Developmental Disabilities* (Griffiths, Stavrakaki & Summers, 2002), and the guidelines: *Planning Guidelines for Mental Health and Addiction Services for Children, Youth and Adults with Developmental Disability* (BC Ministry of Health, 2007 March) begin to offer important direction.

Perceived Service Gaps

Deficiencies In a national survey examining the range of mental health services available to individuals with a dual diagnosis and perceived service gaps across Canada, respondents identified that generic mental health providers were poorly equipped to meet the needs of these individuals, that wait lists for specialized services were typically four months or longer and less than half of the respondents affirmed that expertise or specialized services existed in inpatient treatment or emergency room facilities (Lunsky, Garcin, Morin, Cobigo, & Bradley, 2007). Aggression/challenging behavior was the main reason for admission to and barrier to discharge from hospital (Lunsky & Puddicombe, 2005, December). An inability to access appropriate mental health services in a timely manner leads to crises resulting in hospital emergency room visits, warranting intervention to correct the deficiencies at both the clinical and systems levels (Lunsky, Gracey, & Gelfand, 2008).

Beyond medication Researchers continue to question the efficacy of psychotropic medication treatments for dually diagnosed clients who present with challenging behaviors (Antonacci, Manuel & Davis; Benson & Brooks, 2008; Tyrer et al, 2008) and yet, as many as half of the adults in this population have been prescribed psychotropic medication (Lunsky, Emery, & Benson, 2002). They may not believe they have either choice or involvement in their medication regime (Crossley & Withers, 2009). Services that include but are not limited to prescribing medication are needed.

Clearly, high rates of psychiatric unit admissions are occurring among this population and gaps in service are perceived. Our research aimed to implement and evaluate an alternative approach that focused on health promotion.

Approach and Methods

Our project was framed from a strengths based conceptual perspective (Rapp, Saleebey & Sullivan, 2005; Saleebey, 2006) and a naturalistic action research design (Kemmis & McTaggart, 1990). Action research implements and then evaluates new ideas in practice and asks the question ‘what can we do better?’ (Kiener & Koch, 2009). Our research posed the question: What can we do better to prepare PDD clients to anticipate and prevent a psychiatric mental health crisis before hospitalization occurs. Participants were recruited from two Calgary agencies serving PDD clients.

Ethical approval was obtained from Athabasca University. Ten clients identified as dually diagnosed by agency staff were invited to participate and four declined. As Clements (2012) emphasized, participating clients’ capacity for in-formed consent was assessed and obtained throughout the project and all participants were given the opportunity to discontinue their involvement at any time.

Modeling the action research intervention on a ‘Wrap-Around’ approach, facilitators provided monthly health promotion meetings to six PDD clients at risk of experiencing a psychiatric mental health crisis. Individually, each client was helped to create a team of family members and paid caregivers to “wrap around” them. Throughout 2012, the six teams met regularly and facilitators guided discussions to focus on clients’ strengths, their goals and individualized strategies for success.

The WrapAround approach is an intensive, holistic method of engaging with individuals with complex needs so that they can live in their homes and communities and realize their hopes and dreams (National WrapAround Initiative, n.d.). The approach is a client driven, team oriented planning model. Typically used with children, youth and their families, this project is unique in adapting the model to PDD clients. The approach espouses:

“a philosophy of care beginning from the principle of ‘voice and choice,’ which stipulates that the perspectives of the family—including the [client] — must be given primary importance ... Values ...[emphasize] supports that are individualized, family driven, culturally competent, and community based. The process should increase the ‘natural support’ available to a family by strengthening inter-personal relationships and utilizing other resources available in the family’s network of social and community relationships. It should be ‘strengths based,’ including activities that purposefully help the [client] and family to recognize, utilize, and build talents, assets, and positive capacities” (National WrapAround Initiative, n.d. ¶3).

Table 1 presents indicators of some of the goal progression and barriers the teams identified and that led to the creation of the themes.

(Pseudo)Name	Goal Progression	Barriers
Cassandra	-moving from elderly Mum's home to live with a supportive roommate -quit smoking (electric cigarettes) -dental cleanings without freezing -trusting relationship with support worker after 5 years -joined sister at scrap booking	-constant staff turnover heightens anxiety. Not sure if she will 'like' new caregivers. Obsessive behaviors increase when new staff assigned
Ashley	-employment/volunteer search shifted from childcare to office environment -less calling in sick for programs -more consistent attendance at gym -coped with fear of knives through caregiver support with cooking	-limited understanding of mental illness decreased early recognition of escalating symptoms of schizophrenia: e.g.: hearing voices -weight gain a medication side effect
Gord	-debt repayment plan in place -recognizing addiction triggers more	-impaired social interaction associated with autism makes employment overwhelming
Garry	-anger management strategies helping to decrease outbursts of rage -created resume for part time work	-limited understanding of mental illness decreased early recognition of escalating symptoms of autism, leading to police involvement -few opportunities for supportive roommate to network with peers and learn more about mental illness
Kurt	-strategies in place to promote hygiene, e.g.: mirror and wastebasket -seeking opportunities to make friends -arriving at program on time more consistently	-limited understanding of mental illness decreased early recognition of escalating symptoms of schizophrenia: e.g.: withdrawal -expectations of existing friendship programs geared to the mentally ill considered too high
Will	-despite declining to continue with WrapAround, achieved success by risking trying a new activity	-constant staff turnover heightens anxiety. Reluctant to engage in new activities when staff continually 'leave'

Table 1: Participants' Goal Progression and Barriers

Facilitators closed the project by reviewing the efficacy of the intervention (the WrapAround team approach) and exploring barriers that participants experienced. Each client and at least one member of their WrapAround teams were interviewed by a researcher not involved with their teams or with the agency providing their care. Transcripts of the interviews were used as data sources. The interview transcripts were analyzed using line by line coding to create categorizations that led to themes. QRS International's NVivo 10 was used to organize the data collection and analysis. Trustworthiness was established by member checking with the participants to ensure authenticity.

Key Findings

Three themes emerged from discussions with both PDD clients who are at risk of experiencing a mental health crisis; and the family members and/or paid caregivers on their Wrap Around teams.

1. Regular meetings where clients seek and receive support from individuals they value can help address escalating symptoms of mental illness.
2. Constant caregiver turnover heightens client anxiety, which in turn exacerbates illness.
3. Limited paid in-service and networking opportunities are available to caregivers.

Table 1 (page 34) presents indicators of some of the goal progression and barriers the teams identified and that led to the creation of the themes.

Discussion

This action research project illustrated a nurse led health promotion approach that participants found helpful. The researchers provided participants with monthly meetings where support teams ‘wrapped around’ clients and supported them towards success. Rather than responding to clients in crisis, the monthly meetings created opportunities for family and paid caregivers to support well clients. The regular meetings created opportunities to address clients’ escalating symptoms of mental illness when they first appeared, thus preventing costly hospitalizations. As a psychiatric nursing intervention, monthly health promotion meetings illustrate valued support for at risk PDD clients.

Discussions with clients and their WrapAround team members revealed the impact that constant caregiver turnover has on clients’ health. One caregiver identified a

40% yearly staff turnover in her program. A family member explained how adjusting to 18 to 20 new caregivers in a three year period heightened her loved one’s anxiety. Clients, family members and caregivers all agreed that this anxiety in turn exacerbated illness.

Constant staff turnover is an unresolved issue for those who care for the developmentally disabled. Reports emphasize how funding cuts, limited staff training and poor working conditions result in high staff turnover in other Canadian jurisdictions as well (Casey, 2011; Hendren, 2011, July; Hensel, Lunskey & Dewa, 2011, February; Li, 2004). The present study contributes to a growing body of knowledge indicating that constant staff turnover is clearly a problem in the field.

Most caregivers interviewed in this project noted that they are paid only for face to face time with clients. Therefore, professional development opportunities such as in-services, workshops and networking opportunities with colleagues and other professionals are not available to them. Several had no pre-service education and/or training in either developmental disabilities or mental illness. They often felt that they did not know what to do when clients presented with challenging behaviours. They expressed that recognizing escalating symptoms of mental illness was difficult and indicated their willingness to learn more.

Responding to clients’ challenging behaviours leave direct care staff, particularly those who are untrained, feeling emotionally exhausted and burned out (Chung & Harding, 2009; Jenkins, Rose, & Lovell, 1997; Thomas & Rose, 2010). Some resolution of staff’s emotional exhaustion has been achieved through training focusing on understanding the psychiatric conditions underlying clients’ challenging behaviours (Costello, Bouras & Davis, 2007; Rose, Rose & Kent, 2012; Werner & Stawski, 2012). Knowing that this training may help resolve the issue of constant staff turnover, opportunities for psychiatric nurses to contribute their expertise become apparent. Creating individually accessible educational resources for paid caregivers is an area where psychiatric nurses can provide much needed support.

Conclusion

Persons with developmental disabilities and co-occurring mental illness benefit from long term, scheduled health promotion

meetings and their paid caregivers are often uninformed about escalating symptoms of psychiatric illness. Resources to help paid caregivers recognize and understand mental illness within this client group are urgently needed. Psychiatric nurses are well positioned to initiate health promotion activities such as the WrapAround intervention presented in this paper. Psychiatric nurses are equally well positioned to create individually accessible resources for clients' paid caregivers. In contrast to other studies emphasizing psychotropic medication and hospital based treatment, this project illustrates an alternative intervention focusing on crisis prevention. We invite readers to consider similar opportunities where psychiatric nurses could provide support to dually diagnosed clients and those who care for them.

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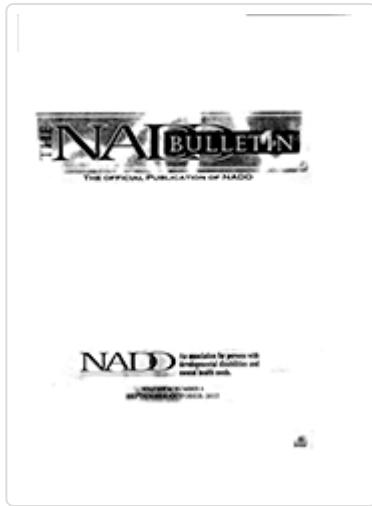
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Beyond Physical Inclusion: A Grounded Theory of Belonging



[PDF – 2 MB]

Citation

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Abstract

We used *grounded theory* to analyze interviews with support workers evaluating a program for individuals with dual diagnosis. Our *grounded theory* research started with the question, “What is going on in the data?” From our data analysis, our grounded theory of *belonging* emerged. There are two components to our grounded theory that conceptualize what is going on in the data. The first is the main concern, which is *stopping short*. The second is the core variable, which is *belonging*, and resolves *stopping short*.

Stopping short is the main concern, and is the process that accounts for making resolution difficult. Several underlying concerns reinforce *stopping short*. These are *being left out*, *(limiting) inclusion*, *logical elaboration*, and *turnover*. A lack of awareness of the influence of these concerns can reinforce *Stopping short*. Awareness of them and their influence is part of the contribution to resolving *Stopping short* through the core variable of *Belonging*.

The process of *belonging* is supported by increasing Awareness and an emphasis on *relationship*. *Reciprocity* and *support(ing) relationships* and *awareness* provide the meaning and relevance of belonging for people supporting those

living with dually diagnosed. The significance of using *grounded theory* for our analysis and the contribution *belonging* makes for those supporting and working with individuals with dual diagnosis are discussed.

Grounded Theory

Grounded theory is a general research methodology used to generate relevant theory through the analysis of data. Grounded theory can be used on any data (Glaser, 2007). Often grounded theory research starts with the question, “What is going on in the data?” (Glaser, 1998). Instead of traditional approaches, where preconceived theories or patterns drive the analysis, with grounded theory the analysis is guided by the many rigorous steps of grounded theory noted below, woven together by the constant comparison process (Becker, 1993; Glaser, 2002a). Through constantly comparing codes to codes, generating a concept, and comparing codes to concepts to generate categories, the analysis generates similarities, differences, and degrees of meaning which inform the properties and dimensions of the emerging theory (Glaser, 1978b). It is through the constant comparative method and memoing that the grounded theory acquires its grab, fit, and ability to work the data (Glaser, 1978b). Grab, fit, and work imbue the theory with relevance and meaning, so that there is a high probability that it will make a difference within the area from which the data was acquired (Glaser, 1978b).

The Research Approach

In our re-examination of interview data from our primary research project, two aspects of classic grounded theory methodology, the package and the product, were of particular value. The package explains how a grounded theory is generated. The product clarifies how to recognize the core attributes of a grounded theory.

I. The Grounded Theory Package

Glaser (1998) refers to the essential components of grounded theory as the grounded theory package. Using the package helps researchers develop their theoretical sensitivity and increases the probability of generating a meaningful grounded theory. There are several components we used in generating our theory of *belonging*:

a. Coding

Coding is the fracturing of the data into the smallest pieces of meaning, selecting words, phrases, or stories “that contain a single unit of meaning” (Schreiber & Stem, 2001, p. 69). This is the analysis stage where the researcher defines what he or she sees in the data pieces (Charmaz, 2006).

b. The constant comparative method

The constant comparative method, or constant comparison, is one of the most important components of GT (Glaser, 1978b;

Glaser & Strauss, 1967). Glaser explains the sequence: first the researcher compares indicators (incidents or codes observed in the data) to other indicators. Once a conceptual code (a repeated idea that becomes apparent) is generated, the indicators are then compared to that emerging concept or idea. Constant comparison forces the analyst “into confronting similarities, differences and degrees of ... meaning between indicators” (Glaser, 1978b, p. 62).

c. Memoing

Writing theoretical memos is the core stage in the process of generating theory. “Memos are theoretical notes about the data and the conceptual connections between categories. ... If the analyst skips this stage [of writing theoretical memos] by going directly to sorting or writing up, after coding, he/she is not doing GT” (Glaser, 2004, para. 61).

d. Theoretical codes

Theoretical codes are important in generating a grounded theory as they provide the organizational foundation for the emerging theory. “The final theoretical code is the one that emerges, through the coding process, and serves to integrate all of the substantive categories with the core category” (Hernandez, 2009, p. 52).

e. Sorting and writing up

This is the final component of GT, which involves sorting theoretical memos into piles and writing them up in a manuscript or book, to disseminate the findings. “Sorting is essential—it puts the fractured data back together” (Glaser, 2004, para. 67).

2. The Grounded Theory Product

a. Relevance and meaning

Glaser asserts that a grounded theory must be relevant and meaningful, rather than just interesting. And not just to those from whom the data was acquired. Relevance and meaning drive the generalizability or transferability of the grounded theory. A good grounded theory is applicable to a wide, multidisciplinary audience.

b. Grab, fit, and work

A relevant grounded theory consists of the following attributes: it must grab, fit, and work the data (Glaser, 1978b, 2001). A grounded theory is also able to be modified (Glaser, 1978; 1998). Note that these criteria are in contrast to an oft mistaken goal of a grounded theory, that it is accurate (Glaser, 2002b, 2007) and a proof (Glaser, 1978b). A grounded theory is not accurate as it does not describe nor is it a proof; it is a theory, a hypothesis.

To clarify, grab (Glaser, 1978b, 2001), the theory has clear and grabbing implications, it makes sense. It grabs the reader’s attention. Fit (Glaser, 1978b, 2001) is where there is a close connection of the theory with the incidents the theory is

representing, that it connects. Work (Glaser, 1978b, 2001) is where the theory deals with real concerns of participants and captures attention. A grounded theory works when it explains how a meaningful concern for the participants is resolved. Therefore, a grounded theory that has grab, fits, and works the data has a high probability it will be relevant, that it will be applied, and that if necessary it will be modified (Glaser, 1978; 1998).

3. Data

In his well-known article “All is Data”, Glaser (2007) emphasized how data from a variety of sources can be used to generate a grounded theory. Commonly, interviews, observations and documents are used. In our work, our data consisted of interviews with caregivers who support individuals with dual diagnoses. Throughout our analysis and as new concepts emerged, we reviewed additional literature and discussed our project with experts.

Our Results

The results of our analysis are presented below, in Table 1. There are two components to our grounded theory of *belonging*, the patterns of Basic Social Psychological Processes (BSPP) which explain what is going on in the data. The first component is the main concern, which is *stopping short*. The second component is the core variable of *belonging*. *Belonging* is the core concept which resolves the main concern of *stopping short*. Both *stopping short* and *belonging* emerged from our Grounded Theory analysis of the data. In addition, there are several relevant components of the GT package that were indispensable in generating our grounded theory of belonging. These are addressed in the Discussion section in this article (Glaser, 1978a).

Table 1: The relevant concepts of our grounded theory of Belonging

Results of our GT analysis	
Main Concern	Stopping short
Underlying concerns	· Being left out · (Limiting) inclusion · Turnover
Core variable (resolving the main concern)	Belonging
Theoretical codes	· Relationship · Awareness
Substantive codes	· Reciprocity · Support(ing)

In the section which follows, we discuss our conceptualization of the relevant concepts from our analysis and how they connect to both the main concern of *stopping short* and the core concept of *belonging*. Together, *stopping short* and *belonging* constitute our grounded theory of *belonging*, a Basic Social Psychological Process.

Discussion

Our grounded theory of *belonging* is a conceptualization of what is going on in the data. We will discuss our grounded theory of *belonging* from the perspective of two key aspects of the process: the main concern of *stopping short* and the core variable of *belonging*, which resolves the main concern of *stopping short*. Both concepts emerged from the data and together form our grounded theory of *belonging*.

1. The Main Concern Is Stopping Short

Stopping short is our conceptualization of the process which blocks or prevents people from feeling involved in their environment, that is, from feeling a sense of belonging. Several significant concerns emerged from our analysis which support and reinforce *Stopping short*. These are *being left out*, *(limiting) inclusion*, *logical elaboration*, and *turnover*. It is important to see how these concepts relate to *stopping short* of belonging. *Stopping short* links them as the main concern. Understanding their influence, one can see how they impact *stopping short*; either reinforcing *stopping short* or resolving *stopping short*, as they influence the core variable of *belonging*.

Stopping short is a conceptual representation of the difficulties in realizing the goals of care and support of individuals who have a main concern and the underlying concerns that support the process can cumulatively hold back or prevent caregivers from realizing their goals of caring for their clients who have a dual diagnosis. In this context it is the lack of awareness of the process that prevents or obstructs the caregiver from reaching the goal of care and support for their clients. Awareness will be discussed later in the context of theoretical codes as part of the conceptualization of the core variable of *belonging*.

These concepts underlying *stopping short* will be discussed later as they relate to the main concern of *stopping short*, followed by how *stopping short* relates to *belonging* as a BSPP and the concepts that undergird *belonging* which leads to the resolution of *stopping short*.

a. *Being left out*

Being left out was the first concept that emerged as we began our re-examination of interview data from our primary project. *Being left out* is a very strong concern that emerged from the data analysis, one which was shared by support staff, their supervisors, and family members caring for and supporting the individuals with a dual diagnosis who participated in the project. The data yielded many indicators of the profound impact *being left out* had on clients. Two examples, below, illustrate this impact particularly well.

The first indicator is a client carefully dressed in clothes, newly purchased in anticipation of attending a family event. The client stood waiting, alone, on their apartment doorstep. They were waiting for a previously arranged pickup by a family member, a pickup that never came. This person was *being left out* of their family event.

The second indicator comes from a client living with a supportive roommate. Although the roommate made meals and provided clean living arrangements, the client was not invited to join the roommate to join in shopping trips for food, making meals, or watching TV in the evenings. Consequently, the client withdrew to their designated room, coming out only to eat prepared meals. The client's behavioral regression was noticeable, attributed to the consequences of *being left out*.

These two examples of *being left out* speak to the emotional charge associated with the experience of being and feeling left out, as well as the negative contributions made to health and well-being. *Being left out* is certainly not just a consideration or concern for individuals who have a dual diagnosis.

b. The Basic Social Psychological Process (BSPP) of being left out

In our analysis, we identify being left out as a relevant, basic social psychological process not only relevant for support workers and staff supporting individuals who have a dual diagnosis, but also for families and the clients themselves. Being left out impacts individual and collective well-being, and lack thereof. Initially, with the prevalence and impact of *being left out*, it appeared to be the main concern emerging from the data.

c. *Inclusion* resolving *being left out*

Once we identified the impact of *being left out*, we discovered a complementary process that seemed to fit as though it might be a pattern that resolved being left out. This process is *inclusion*. *Inclusion*, or simply including people, seemed to be an excellent process for resolving the disturbing experience of *being left out*.

Interestingly, inclusion, or creating opportunities for clients to participate in community activities, is well represented in the data. There are numerous illustrations in the interviews of how paid support staff, and family members too, collaborated in ways to include clients enrolling them in programs such as swimming, exercise, scrapbooking, and others. However, further conceptualization of inclusion ultimately led us to conclude that the main concern was in fact, *stopping short*. Next, we elaborate on the limiting aspects of simply viewing inclusion as a process of creating opportunities for clients to attend activities.

d. *(Limiting) inclusion*

The complementary nature of *being left out* and *Inclusion* could be viewed as representing a grounded theory. A significant concern emerged from the data, *being left out* and *inclusion* could be the core variable that resolves *being left out*. In other words, creating opportunities for clients to participate in community activities and programs would seem to resolve the concerns and difficulties they experienced when they felt as though they were being left out.

However, as we continued our analysis, we explored the various dimensions inclusion might have. It turned out that one of these dimensions, the physical one, was much more prevalent than any other dimensions Inclusion might encompass, to the exclusion of any other (at least within our data). It was at this point that the emphasis in our analysis shifted from dimensions of inclusion to discovering what was being left out. This shift led to the discovery of a key property of inclusion, its limitations, which we conceptualized as *(limiting) inclusion*.

(Limiting) inclusion is a concept that connects. Too often, we know, have heard, or perhaps have even experienced this personally situations where we have been physically included but have felt something missing, tangibly or intangibly (maybe even that we may feel we don't "belong"?). Although physical inclusion, or physically attending an activity is extremely important, physical inclusion is often actually "*stopping short*" of meaningful support as a relevant contributor to well-being. The resources and network may be there, but people may not feel they are involved or genuinely part of the environment they are in.

This *(limiting) inclusion* contributes to our grounded theory of *Belonging* by pointing us to the concept of "*stopping short*." And *stopping short* explains (conceptualizes) what is going on in the data thus far, by connecting the underlying concerns of *being left out* and *(limiting) inclusion*. As we illustrate, this concept also connects to the concept of *turnover*.

e. *Turnover* – a multidimensional concept

Turnover emerged as a significant concern in the primary project (Melrose et al., 2013). An increase in anxiety in clients who have a dual diagnosis was attributed to the constant turnover of support workers. Increased anxiety correlated with escalating symptoms of mental illness (Melrose et al., 2013). Increased anxiety was caused by both the lack of continuity and a lack of consistency in client care (Melrose et al., 2013).

Turnover remained relevant in our retrospective Grounded Theory analysis. Studies over the past several decades indicate that *Turnover* affects many areas of support staff well-being. In addition to changing jobs frequently (Casey, 2011; Hendren, 2011; Hensel, Lunskey, & Dewa, 2011; Melrose et al., 2013), staff who work with individuals who have a dual diagnosis feel burned out (Devereux, Hastings, & Noone, 2009; Jahoda & Wanless, 2005; Jenkins, Rose, & Lovell, 1997; Thomas & Rose, 2010) and emotionally drained (Mascha, 2007; Reinders, 2010; Schuengel, Kef, Damen, & Worm, 2010).

In addition, other areas of staff support are affected by turnover. *Turnover* occurs with clinicians who work with the clients and their families. A scarcity of resources exists, in part due to funding cuts, and this contributes to turnover. Further, clinical and supervisory personnel who provide support and educational opportunities to the front line support workers are impacted by a lack of resources, leading to a loss of support for clinical practice and continuing education for support workers.

Lastly, an interesting dimension of *turnover* emerged during our analysis, a paradigmatic one. This is in connection with the paradigm shift away from caring for people in institutions and towards providing support services in their communities (Lunskey et al., 2013). This paradigmatic dimension of *turnover* has implications for programming and support. As one interviewee astutely noted, the paradigm of care may be changing, but an institutional model of governance may still be directing services provided.

f. Stopping short – summary

In summary, the main concern (or what people find most difficult in a situation) in our grounded theory analysis is that current approaches geared to including people stop short of resolving this concern. Thus, the main concern is *stopping short*. *Stopping short* was the pattern that connected several underlying concerns in the data: *being left out*, *(limiting) inclusion*, and *turnover*. Below, we discuss the core variable, and grounded theory, of *belonging*.

2. The Core Variable Is *Belonging*

Belonging is the core variable, the Basic Social Psychological Process that emerged from our grounded theory analysis. *Belonging* is the process resolving the main concern of stopping short. Both concepts, *belonging* and *stopping short* were derived from the data.

So how does *belonging* resolve *stopping short*? The previous section provides the conceptual basis for *stopping short*, the main concern. This section on *belonging* builds upon the foundation laid by the main concern. *Stopping short* informs the core variable of *belonging* and the underlying concepts that support *belonging*.

Belonging owes its relevance and meaning to one of the key components of grounded theory – theoretical codes. *Belonging* relies on two theoretical codes which support resolving the main concern of *stopping short* and provide the grab, fit, and work of the grounded theory for people living with a dual diagnosis as well as for those who support them. Two substantive codes also contribute to the area of dual diagnosis.

a. *Support(ing)* and *reciprocity*

Support(ing) is one of two substantive codes generated from our analysis. With the emergence of *belonging* as a core concept, we conducted a literature search on the subject. One of the discoveries we made was the work of Peter Block (2009). Block's work provided us with the relevant distinction between *supporting* and *helping*. From Block's work, care can be viewed conceptually as *helping* or *supporting*. In our conceptualization of *belonging*, *supporting* is distinct from *helping*. *Supporting* conveys more of a dialogical nature to *relationship* and identity. Whether a client or a support worker, *Helping* is most often directed in unilateral direction; the health care professional or support worker helps the client or patient; the client or patient receives the proffered help. There is little opportunity to consider another dimension or reciprocal direction to the *relationship*. With *support*, other dimensions and directions of *Relationship* are opened up. Becoming aware of other directions or dimensions of *relationship* facilitates our movement beyond *Stopping short* to *belonging*. Perhaps *Supporting* is the means to greater resilience and sustainability than *helping*?

Reciprocity is the second of two substantive codes generated. As we see it, *reciprocity* involves the possibility of mutual exchange. *Reciprocity* provides a relevant distinction between *Supporting* and *Helping*. How often might we focus on *helping* as a default over *supporting*? How often might we lose *reciprocity* in our *relationships* through our default to *helping*? How often in our insistence on *helping* might we lose the opportunity of being *supported*? How often might we be *stopping short* in this matter of *helping* and miss the opportunity to move beyond *helping* to *supporting*, to *belonging*?

An indicator of *reciprocity* is recounted in an interview with a client's support worker. Her client was a young woman who experienced heightened anxiety around knives, who, despite this fear prepared a dish containing chopped vegetables for her neighbor who was ill. This unexpected *reciprocity* speaks to the essence of *belonging*, of the client not only receiving, but in giving as well. *Reciprocity* here speaks to opening up unexpected dimensions *relationship* for meaning and purpose emerge and for them to be cultivated *supported* through *belonging*. *Reciprocity* speaks to the essence of *belonging*; of client unexpectedly providing support others as well as receiving it from the support worker.

b. *Relationship* and *awareness*

Relationship and *awareness* are two theoretical codes that emerged near the end the analysis, during the memo sorting an writing up phase.

Relationship as a process involves connections and connecting. *Relationship* is something we cultivate (Simmons, 1993). The concept of *relationship* also serves as a reminder during our analysis; our foci was conceptualization and process, connections, and connecting. This is in contrast to when the emphasis might be on description and describing a phenomenon within the data.

Awareness, the concept, emerged during the write up of our sorted memos. Glaser and Strauss discovered the concept of *Awareness* in their original study on dying, the study that led to their seminal publication of *The Discovery of Grounded Theory* (Glaser & Strauss, 1967).

Awareness is not a static description but a process that contributes to increasing *Awareness*. In the naming of *stopping short* there is an opportunity for our *awareness* to shift from where we are *stopping short* as a pattern or interaction to *belonging*.

Awareness and *relationship* tie the process of *belonging* together as an integrated conceptualization. *Awareness* and *relationship* contribute to our "seeing" where *being left out*, (*limiting*) *inclusion*, *logical elaboration*, and *turnover* are *stopping short* of *belonging*. Without *awareness*, the probability of meaningful movement beyond *stopping short* and (*limiting*) *inclusion* is diminished.

Conclusion

This conceptualization of *belonging* and the main concern of *stopping short* provides us a finger pointing, not an accusatory one, but a finger pointing in the direction of resolution, of *belonging*, which is the process through which *stopping short* is resolved and greater well-being is achieved for those involved supporting, living and working with individuals with a dual diagnosis.

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Developmental disabilities co-occurring with Mental illness



[PDF – 69 KB]

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Objective

To provide a snapshot of current knowledge related to developmental disabilities co-occurring with mental illness.

Background

The co-occurrence of mental illness in persons with developmental disabilities (PDD), also known as developmental disabilities (DD), as intellectual disabilities (ID) or more pejoratively as mental retardation (MR), is not well understood. According to the National Association for the Dually Diagnosed NADD (n.d.), dual diagnosis is a term applied to the cooccurrence of the symptoms of both PDD and mental illness. It is important to note that the term dual diagnosis is not used exclusively to identify the co-occurrence of PDD and mental illness. The overarching term dual diagnosis or co-morbidity is a generic term referring to the cooccurrence of disorders suffered by an individual (Telias, 2001). An alternate example of a dual diagnosis refers to the co-occurrence of substance abuse disorders and mental illness.

Individuals identified as PDD experience difficulty functioning and adapting.

Functionality is evaluated by an IQ score of 70 or below and adaptability by skill mastery in areas such as eating, dressing, communicating, socializing, and assuming responsibility (American Psychiatric Association, 2000). PDD can be mild, moderate, or severe. Two key issues facing the dually diagnosed and those who care for them include a high prevalence of mental illness and a perceived lack of services.

Key Issues

1. High Prevalence of Mental Illness

Adults with intellectual disabilities can experience mental illness at a prevalence rate of 40.9%, 3 to 4 times greater than the general population (Cooper, Smiley, Morrison, Williamson & Allan, 2007). When admitted to psychiatric units, their problems can be more severe and they can receive more interventions than individuals without developmental disabilities (Chaplin, 2011). They may spend more days in hospital (Bouras, Martin, Leese, Vanstraelen, Holt et al, 2004; Morgan et al, 2008; Saeed, Ouellette-Kuntz, Stuart & Burge, 2003). The majority are likely to be subjected to chemical restraint (Webber, McVilly & Chan, 2011).

In Canada estimates suggest that 380,000 Canadians (Yu & Atkinson 1993, republished in 2006) and between 6,000 and 13,000 Albertans live with a dual diagnosis (Hughson, 2009). About forty-two percent of all hospitalizations among PDD Canadians occurred for psychiatric conditions (Lunsky & Balogh, 2010). Canadians with PDD are at fifteen times higher risk of receiving a psychiatric admission of schizophrenia (Balogh, Brownell, Ouellette-Kuntz et al. 2010) and this risk is also 3 to 4 times greater than the general population (Morgan, Leonard, Bourke & Jablensky, 2008). Further, PDD Canadians are at 4 to 5 times higher risk of experiencing dementia and at nearly 3 times higher risk of being depressed than non PDD individuals (Shooshtari, Martens, Burchill, et al. 2011). Fourteen percent of PDD participants in an Australian study had an incapacitating anxiety disorder (White, Chant, Edwards, Townsend, Waghorn, 2005). The high prevalence rate of developmental disabilities co-occurring with mental illness is further influenced by traumatic events, challenging behaviors and assessment issues.

Traumatic events Adults whose intellectual disability is mild or moderate, rather than severe, may not have greater prevalence rates than the general population (Whittaker & Read, 2006). However, traumatic events can also play an important role in their psychopathology. In one study, 75% of participants with mild to moderate intellectual disabilities had all experienced at least 1 traumatic event during their life span, predisposing them to significantly increased odds of a mental disorder (Martorell et al, 2009).

Challenging behaviors Challenging behaviors, although not listed as DSM-IV-TR psychiatric diagnosis, have consistently been identified as a reason for admission to hospital (Cooper et al 2007; Cooper, Smiley, Allan, Jackson, Finlayson et al, 2009; Cooper, Smiley, Jackson, Finlayson, Allan et al, 2009; Whittaker & Read, 2006). Challenging or problem behaviors such as aggression, self-injury, and destructive, disruptive, or non-compliant behaviors often precipitate hospitalization (Lowe, Allen, Jones, Brophy, Moore & James, 2007). However, while challenging behaviors coexist in some people with intellectual disability, disturbances in psychiatric functioning are not believed to underpin the majority of these behaviors (Allen & Davies, 2007).

Assessment issues Assessing mental illness among persons with intellectual disabilities is not straightforward. Limited training is available to professionals (Quintero & Flick, 2010). In turn, mental illness may go undetected in PDD. Many diagnostic criteria include self reports of thoughts, feelings, physiologic states, past events and reactions to these events. This requires a level of language discrimination and memory skills that may not be present in adults with intellectual disabilities (Bouras & Holt, 2007). Diagnostic overshadowing, or ignoring mental health problems because the symptoms are judged to be “just” part of the developmental disability, can occur (Reiss & Szyszko, 1983). The social isolation often accompanying PDD can leave individuals with distorted perceptions of whether what they are experiencing is ‘normal’ (Silka & Hauser, 1997). Hospital emergency department staff reported a lack of knowledge related to intellectual disabilities (Lunsky, Gracey, & Gelfand, 2008)

and paid carers need training in the early detection and warning signs of mental ill health (Smiley, Cooper, Finlayson, Jackson, Allan et al, 2007). Canadian online resources such as the text: *Introduction to the Mental Health Needs of Persons with Developmental Disabilities* (Griffiths, Stavrakaki & Summers, 2002), and the guidelines: *Planning Guidelines for Mental Health and Addiction Services for Children, Youth and Adults with Developmental Disability* (BC Ministry of Health, 2007 March) begin to offer important direction.

2. Perceived Service Gaps

Deficiencies In a national survey examining the range of mental health services available to individuals with a dual diagnosis and perceived service gaps across Canada, respondents identified that generic mental health providers were poorly equipped to meet the needs of these individuals, that waitlists for specialized services were typically 4 months or longer and less than half of the respondents reported that expertise or specialized services existed in inpatient treatment or emergency room facilities (Lunsky, Garcin, Morin, Cobigo, & Bradley, 2007).

Aggression/challenging behavior was identified as the main reason for admission to and barrier to discharge from hospital (Lunsky & Puddicombe, 2005, December). An inability to access appropriate mental health services in a timely manner leads to crises resulting in hospital emergency room visits, warranting intervention to correct the deficiencies at both the clinical and systems levels (Lunsky, Gracey, & Gelfand, 2008).

Beyond medication Researchers continue to question the efficacy of psychotropic medication treatments for individuals with intellectual deficits who present with challenging behaviors (Antonacci, Manuel & Davis; Benson & Brooks, 2008; Tyrer et al, 2008) and yet, as many as half of the adults in this population have been prescribed psychotropic medication (Lunsky, Emery, & Benson, 2002). They may not believe they have either choice or involvement in their medication regime (Crossley & Withers, 2009). Services that include but are not limited to prescribing medication are needed.

Conclusions

In summary, the co-occurrence of developmental disability and mental illness is termed dual diagnosis. Persons with developmental disabilities experience a high prevalence of mental illness, particularly schizophrenia, dementia, depression, and incapacitating anxiety; as many as 75% of them can be expected to suffer a traumatic event during their lifetime. Challenging behaviors, including aggression and self-injury rather than DSM diagnostic criteria, often precipitate their admissions to psychiatric units. Assessment is complex; professionals may have limited training and treatment may seem focused on psychotropic medications, leaving dually diagnosed individuals and those who care for them with the perception that existing services are deficient.

Recommendations to remediate these deficits are not clear cut. Given the high prevalence of hospital admissions among this group, health professionals can expect to encounter individuals dually diagnosed with PDD and mental illness. Increased funding for research and increased training for health professionals will begin to help. Educational opportunities where family members and paid carers can learn about managing mental illness and strategies they can implement to deescalate challenging behaviors will also begin to help. Creating these opportunities is both a challenge and opportunity to support and advocate for these vulnerable individuals.

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Action research: Supporting the developmentally disabled and their caregivers



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Abstract

In 2012, I worked with agencies serving the developmentally disabled to implement and evaluate a mental health promotion intervention. Responding to the problem of managing clients' mental illness mainly through crisis intervention, we hoped to improve practice by trying an alternative approach. Previous studies indicated the problem was also occurring on a national and international level and solutions were urgently needed. Our yearlong intervention involved monthly meetings with clients and teams of their staff and family members. We evaluated our intervention by analyzing interviews with clients and team members. By framing our project from a strengths based world view and an action research design we were able to integrate practical wisdom, published literature and critical reflection.

This case study illustrates challenges and setbacks that can occur in busy practice settings where precarious funding and staff turnover are a reality. Research with vulnerable populations requires deliberate attention to ensuring

consensual, respectful and ethical participation. Ethical considerations must be magnified with populations such as the developmentally disabled and even more so when co-occurring mental illnesses are present. Communication with participants is critically important and explanations of practical strategies that work are presented.

Learning outcomes

- This case illustrates an everyday example of an action research project undertaken by busy healthcare practitioners who work with the developmentally disabled. Reading the case will provide a snapshot of methodological challenges that can occur.
- To appreciate the role of establishing a common philosophical orientation among the research team and following through with this guiding orientation during communication with participants.
- To analyze jurisdictional regulations that guide research with vulnerable populations in relation to protection, recruitment and retention in potentially helpful projects.
- To critique small scale action research projects as a viable approach to strengthening practice knowledge among disciplines who work with the developmentally disabled.

Action Research: Supporting the Developmentally Disabled and Their Caregivers – Project Overview and Context

Persons with Developmental Disabilities (PDD), who are also known as individuals with intellectual disabilities (ID) or more pejoratively as mental retardation (MR) are a vulnerable, marginalized and often poorly understood group. As a nurse specializing in the psychiatric area, I did not feel well equipped to care for those with PDD, particularly when they presented with a co-occurring mental illness. When a local Canadian funder, the Collaborative Research Grant Initiative (CRGI) issued a call for projects addressing the complex needs of those with PDD, I reached out to two agencies who serve this population, Calgary Alternative Support Services (CASS) and Progressive Alternatives Society (PASC). Working together, and with the goal of improving practice, we created a project where we could offer a mental health promotion activity to clients and then evaluate the effectiveness of our intervention. The yearlong project was implemented throughout 2012.

We chose to frame our project from an action research design because we wanted to learn more about both the topic area and the research process. Practitioners at the agencies wanted to be involved in research, but their high caseloads and hectic schedules left little time for activities not directly related to helping clients. Thus, an action research design, with its emphasis on implementing and then evaluating a client intervention was an excellent fit.

One ongoing priority we attended to throughout our project was to situate our research in relation to existing publications. From the design through to the dissemination stages of our work, we consistently turned to the literature for guidance. We made a point of incorporating seminal works by established authors in the field as well as any recent work. Our reading led us to understand that a high prevalence of mental illness existed in the PDD population and that a gap in services for this population is a national as well as an international concern. Further, we learned that working conditions for caregivers are problematic. These insights supported our contention that our project was significant and that reporting our findings would contribute new ideas.

Another ongoing priority we attended to throughout our project was to ensure that any research involvement with our vulnerable participants was consensual, respectful and ethical. We made certain clients' capacity for informed consent was

assessed and obtained during all stages of the project and all participants were given the opportunity to discontinue their involvement at any time. We obtained approval from my employing university's ethics board and we reviewed relevant policies on research ethics. In Canada, a key policy is the Tri Council Policy Statement (TCP 2, 2010), which states:

“Respect for Persons implies that those who lack the capacity to decide for themselves should nevertheless have the opportunity to participate in research that may be of benefit to themselves or others. Authorized third parties acting on behalf of these individuals decide whether participation would be appropriate. For the purposes of this Policy, the term “authorized third party” (also known as “authorized third party decision makers”) refers to any person with the necessary legal authority to make decisions on behalf of an individual who lacks the capacity to consent to participate or to continue to participate in a particular research project. These decisions involve considerations of Concern for Welfare and Justice” (p.27).

Incorporating this key policy into our project, we included ‘authorized third party decision makers’ in our consent process. Although specific policies will differ among jurisdictions, researchers working with vulnerable groups must always seek out and then incorporate the ethical review regulations specific to their area. For example, in the United States, Katherine McDonald offers important guidance to action researchers working with the developmentally disabled (McDonald & Keys, 2008; McDonald, Keys & Henry, 2008; McDonald, 2012; McDonald, Kidney & Patka 2013).

We implemented our mental health intervention, which consisted of twelve monthly health promotion meetings with six clients (diagnosed with PDD and co-occurring mental illness) and a team of individuals who they chose to support them. Then, we evaluated our intervention by interviewing these clients and their team members. The interviewers were not associated with the agencies serving the participants. Thirteen interviews were transcribed and analyzed for themes. Overall, our participants did find the intervention was helpful. But, we were prepared for the possibility that our intervention might not be as effective as we imagined. We reasoned that an action research design would give us the flexibility to critically reflect on our work, find value in what worked as well as what did not and if necessary, go on to try other approaches.

Research Practicalities

Our research group included busy practitioners from the disciplines of nursing, spiritual care, social work, psychology and education. Our group shared a common commitment to advocating for persons with developmental disabilities and it was this commitment that sustained us through a series of challenges. These challenges, mainly stemming from regulatory requirements, are discussed below.

Challenges

From Proposal to Implementation and Dissemination – Dealing with Delays

In line with a worldwide recession, precarious CASS and PASC funding left agency employees and clients feeling uncertain whether contracts for services, programs and even staff jobs would be renewed. From proposal to implementation and dissemination, we faced delays. In particular, attendance at face to face research planning sessions where researchers came from two agencies and two universities posed a challenge. When assessing priorities, overwhelmed agency staff often had to re-schedule our planning sessions to provide crisis intervention for clients. Assigning research project tasks such as scheduling/re-scheduling meetings, record keeping and coordinating client interventions, to one member of the group, in our case, the Primary Investigator (PI), helped our project progress. Also, working online whenever possible was also helpful.

Another delay occurred with our research funding. Our research proposal, initially submitted in 2010, was not immediately selected by the CRGI funders. It was not until later the following year, in 2011, when additional funds became available, that we were invited to re-submit our proposal. Thus, two years after its inception, our proposal was accepted, allowing us to begin implementing our intervention in January 2012. By this time, all but two of the original eight member research team had left the agencies and a new research group needed to form. However, as we reflected on our project, we considered the impact staff turnover had on our research process. In turn, these reflections opened our thinking to the impact staff turnover has on clients.

Respectful Recruitment and Retention-Overcoming Disinterest and Attrition

Throughout our recruitment and retention processes, we grounded our project in an abiding respect for our participants and we were careful to adhere to jurisdictional policies governing research with vulnerable populations. Our ethics approval board and our funding requirements all emphasized that our participants must understand the research project and feel free to discontinue their involvement at any time. But, these requirements also had a negative influence on our ability to recruit, retain and overcome disinterest and attrition in our project.

For example, our consent form was two pages long. This was in accordance with university ethical approval board requirements. A series of explanatory points had to be included. Despite using simple language and having agency staff or family members explain the forms, the experience of obtaining informed consent was confusing for clients. At the beginning of the project, we invited and hoped to include ten participants. But, only six consented to the intervention, only five attended consistently and only two consented to tape recorded interviews.

Similarly, in accordance with funding requirements, our inclusion criteria for our PDD participants stipulated that they present with accompanying complex needs, specifically a mental health concern. Our exclusion criteria stipulated that clients in crisis would not be included. Many agency clients with complex needs (our target population) lived reclusive lifestyles, were reluctant to engage in new activities and had consistently withdrawn from previous programs. Ameliorating our responsibility to both sustain client participation in an activity we believed was helpful and to respect clients' decisions to discontinue was particularly difficult.

In both these instances, we overcame these challenges by including participants' staff and their family members in the project. Staff transported participants to intervention meetings, families hosted meetings in their homes and these caregivers were more comfortable than clients when it came to sharing their views about the project in tape recorded interviews.

Research Design

As we crafted a research design for our project, we first established that we would approach our work together and with our participants from a strengths based world view. That is, rather than focusing on disabilities and deficits, we were more interested in abilities, clients' strengths and approaches that could and would work.

Next, we reviewed established definitions and explanations of action research methodology. We consulted general research texts, action research texts, journals devoted to action research and publications addressing action research with PDD individuals. Through this review, we were introduced to seminal authors, and we acquired their original publications (primary sources).

Defining Action Research

We developed a definition of action research that worked for our project. In our view, action research is a reflective, spiral process where practitioners use research techniques to examine their own practice carefully, systematically and with the intention of applying their findings directly to their own and others' every day practice. Kemmis and McTaggart (1988) offered the seminal explanation that action research is deliberate, solution-oriented investigation that is group or personally owned and conducted. It is characterized by spiraling cycles of problem identification, systematic data collection, reflection, analysis, data-driven action taken, and, finally, problem redefinition. The linking of the terms "action" and "research," first coined in the 1940's by social psychologist Kurt Lewin, highlight the essential features of this method: trying out ideas in practice as a means of increasing knowledge about or improving practice.

Kemmis and McTaggart (1990) also suggested that the participatory nature of action research, where researchers collaborate with participants in order to understand and improve events, can reduce the distance between researchers and participants and the "... problems they intend to solve, or the lived experience they intend to interpret" (p. 28). Rather than being 'researched on,' in action research, service users can be included appreciably more than in traditional research (Koshy, Koshy & Waterman, 2011). Finally, in our definition, we incorporated educator Steven Corey's (1949) emphasis on how the change action research can initiate in everyday practice is more important than the quantitative goal of generalizing findings to a broader audience. Developing a definition of action research that worked for our project helped us sort through the plethora of information available on this methodology and gave us the direction we needed to move forward.

Implementing the Project

Knowing our goal was to improve practice and that services were not adequate for PDD clients with mental illness, our research question emerged as we imagined what we could do better. Simply hospitalizing clients once a crisis occurred was not working. Our research posed the question: What can we do better to prepare PDD clients to anticipate and prevent a psychiatric mental health crisis before hospitalization occurs? Our objective was to implement and evaluate a mental health promotion intervention (monthly meetings with clients and those who cared about and for them) that could potentially prevent unnecessary hospitalization. Findings not only indicated that our intervention was helpful, but also that constant staff turnover was exacerbating clients' mental illnesses. We also discovered how paying staff only for face to face time with clients left them no opportunities for professional development and networking. By disseminating our findings in reports, conferences and refereed journal articles we may have extended the influence of our project beyond just our own locale.

A Strengths Based Worldview – What Does That Look Like?

Throughout our project, we reflected on our strengths based worldview. A philosophical orientation emphasizing what worked, what was going well and what we could do to celebrate success guided our thinking. But how could we translate this thinking into our connections with participants? In the following section we share strategies that helped us communicate our worldview into action.

First. Establish Time for Client Concerns

Our research design afforded us the opportunity and the privilege of spending considerable time communicating with persons with developmental disabilities, their staff and their family members. Our health promotion intervention meetings were held in coffee shops, agency rooms and private homes. On a personal level, our engagement with our participants was

critically important. Co-occurring PDD and mental illness can leave some individuals feeling discouraged when they are unable to understand lengthy explanations. Everyday literacy tasks such as reading notices, financial statements, bills, and forms that must be filled out can be very frustrating. Solutions to problems with contacting legal aid or food insecurity services such as a community kitchen can seem overwhelming. Knowing these client concerns, the intervention meetings established time to address them. For example, one participant living in a subsidized apartment set aside notices he received from his landlord and brought these to his meetings.

Second. Intentionally Attend to Our Own and Our Participants Nonverbal Cues

We found that few elements of communication were as important as non verbal cues when working with our participants. In one instance, when a researcher less familiar with the field inadvertently used words that were difficult to understand, a participant seemed comfortable enough to roll her eyes and sigh. When the researcher responded to this with laughter at the mistake, the participant also laughed. But, in another instance, when a family member frowned while describing a concern, our participant clearly showed her feelings of hurt and belittlement by lowering her head, drawing her knees up and sinking into her seat. We did not feel the content of the message was as harmful as the non verbal expressions of disappointment that seemed to accompany it. Simple attending behaviours of smiling, leaning forward, affirmative head nodding and allowing sufficient time for clients to respond served us well in engaging our participants.

Third. Articulate and Enjoy Achievements

Following through on our commitment to approach interactions with participants from a strengths based worldview, the experience of articulating and enjoying achievements took centre stage in our intervention meetings. Problematic behaviour was acknowledged, but researchers promptly shifted the focus away from admonishing the client and toward problem solving strategies. We strategically brought up past achievements and examples of what clients had done well. In one instance, a participant's goal of laundering his clothes was not achieved. When a family member began iterating other issues related to laundry, researchers commented that the goal was ongoing and moved the discussion to how he had accomplished additional exercises at the gym. The participant was invited to explain the exercise and what was involved. Researchers made sure that more time was spent articulating and enjoying the achievements than on goals not yet accomplished.

Some staff and family members found this modelling helpful while others did not. A sibling of one participant privately expressed frustration to researchers that the meetings “weren’t changing anything.” However when encouraged to view the meetings through the eyes of his sibling, he indicated an openness to the approach. In conjunction with ensuring time was available for client concerns and remaining mindful of non verbal cues; we believe articulating and enjoying achievements were key communication strategies for engaging participants. We hoped the intervention meetings were safe, pleasant times where participants looked forward to enjoying what they had done well with people in their lives who cared about them.

Action Research with Persons with Developmental Disabilities: Practical Lessons Learned

Action research is not for everyone. As the preceding sections have illustrated, the realities of practice, especially practice with vulnerable clients, can leave little time for formalizing a process of implementing and then evaluating an intervention. Practitioners in all areas of health care are likely to have no shortage of problems in practice that are in immediate need of research attention. Any yet, carving out time to seek funding, review literature, write proposal(s) for review by rigorous ethics

boards and disseminate findings, in addition to framing out a workable project design can seem daunting. The following practical suggestions represent lessons learned during our project:

- Before beginning any research project with vulnerable clients, identify the approvals that will be needed in your jurisdiction. All research in health care requires proposal submissions to agencies employing the researcher and/or providing services to participants. Proposal submissions to agency or academic ethics boards are also routine. When working with vulnerable clients, further submissions may be required. Carefully review policy documents, such as the Tri Council Policy Statement (TCP2, 2010) in Canada for specific direction. Include excerpts from these policies to strengthen the proposals.
- Work with like minded research collaborators. Action research is often implemented by multidisciplinary, multiagency teams. Teams may form in response to opportunities provided by employers or funders and individuals may not know one another. It's important to take time initially to establish common beliefs and come to an agreement about the philosophical orientation or worldview that will drive the project.
- Expect delays. Issues such as precarious funding, overloaded work schedules and staff turnover are expected in healthcare. Expect and prepare for them in research. When the primary investigator assumes responsibility for record keeping, scheduling and delineating tasks, it becomes easier to sustain the project when members leave the team and new researchers come on board.
- Anticipate and plan to address challenges recruiting and retaining participants. Clients who are members of vulnerable groups such as those with PDD or PDD and co-occurring mental illness can seem difficult to engage. Establishing trust takes time. Designing the project to include participants' staff, family members and friends can help. Attend to non verbal as well as verbal communication.
- Researcher –participant contact time can be fun. Too often researchers are preoccupied with project issues that are not relevant to clients during their time together. For PDD clients, time with a friendly and attentive researcher can be meaningful. Certainly any presenting crisis must be addressed by notifying appropriate staff. But, in the role of researcher, practitioners are in a unique position to genuinely enjoy and appreciate clients in new ways. Find out what participants' interests are. If both of you are interested in scrapbooking, consider ways to scrapbook together while collecting data. If both of you are interested in hockey, talk about favourite teams and players when opening research discussions and closing interactions.
- Celebrate setbacks. Interventions implemented to solve practice problems may not work as well as researchers hope they will. Student researchers bound by academic timelines and practitioner researchers bound by employer or funder deadlines can feel immense pressure to have projects succeed. It is important to note that success in action research is not just about what went well. Action research is a spiral process where problems are identified and interventions are implemented and evaluated. Throughout the process, researchers reflect critically and deeply on their actions. Without setbacks, reflections would simply be superficial. The importance of celebrating setbacks should not be underestimated.

Conclusions – Action Research Supporting the Developmentally Disabled and Their Caregivers

Our project illustrated a yearlong action research project where a multidisciplinary multiagency team of researchers implemented and evaluated a health promotion intervention with persons with developmental disabilities. We situated our work in relation to existing literature and we were careful to adhere to ethical guidelines in our jurisdiction. At the beginning of our work together, our team agreed we would approach the project from a strengths based worldview. We faced challenges such as delays, disinterest and attrition. All but two of our original research team members left the agencies and we recruited fewer participants than we hoped. Including participants staff and family members helped sustain our project.

Following through with our commitment to a strengths based worldview, we believed three strategies were helpful during our communication with participants. First, we ensured time was available for clients to express their concerns. Second, we intentionally attended to our own and our participants' non verbal cues. Third, we emphasized articulating and enjoying

achievements. A key practical lesson that resonated with us when we closed our project was the importance of expecting and even celebrating setbacks. Action research calls researchers to reflect deeply and critically on their actions, and setbacks nourish critical reflection.

Exercises and Questions

1. This project described a health promotion intervention that provided an alternative to responding to PDD clients mainly when they experienced a mental health crisis. In your field or workplace, are there activities you could engage in that might prevent problems before they become a crisis? How could an action research project explore these activities?
2. Jurisdictional requirements related to ethical treatment of vulnerable populations can require researchers to include a series of points on consent forms. This project used a lengthy consent form and participants found it confusing. What accommodations could be made to conventional consent forms to suit the needs of developmentally disabled people?
3. Findings from action research projects are not intended to be generalized. And yet, findings can yield important practice knowledge. How can researchers 'defend' the trustworthiness and authenticity of their action research findings?
4. Sample size for this project included only six participants. Each participant included a further group of staff and family members, thus enlarging the sample size nominally. However, the sample was small. What role do you think sample size plays in action research? What influence does sustained contact, such as meeting monthly for a year have on making sampling decisions in action research?
5. This action research implemented and evaluated an intervention. Action research can serve as a beginning or starting point for researchers. Certainly the methodology extends well beyond the relatively simple process of intervening and evaluating. How could a small action research project serve as a starting point for a research project you are interested in? What other action research approaches could you incorporate to extend your project (for example, participatory action research)?

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MENTAL HEALTH (ADDICTIONS)

Understanding and Supporting Adults with Fetal Alcohol Spectrum Disorder - Strategies for Health Professionals: an Opinion Piece



[PDF – 185 KB]

Citation

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Abstract

Fetal alcohol spectrum disorder (FASD) is a non-diagnostic umbrella term used to describe the spectrum of lifelong physical, mental, and intellectual disabilities that can result from prenatal exposure to alcohol. FASD is preventable when pregnant women abstain from drinking any type or amount of alcohol at any time during pregnancy. One in 100 children worldwide are affected. Prompt diagnosis and treatment referrals for infants and children improve functionality. Yet, conditions related to fetal alcohol exposure frequently remain unrecognized and untreated. Adults with both diagnosed and hidden FASD experience significant cognitive, behavioral, and executive functioning deficits. Co-morbid physical and psychiatric disorders are common. This editorial presents health professionals with

information to understand and support adults with FASD. Specific strategies related to initiating referrals to community services, communicating intentionally, and responding positively to behavioral challenges are discussed.

Key Words: Fetal Alcohol Spectrum Disorder, FASD, adults with FASD, supporting adults with FASD

INTRODUCTION

Fetal alcohol spectrum disorder (FASD) is an umbrella term used to describe the myriad of lifelong physical, mental, and intellectual disabilities that result from exposure to alcohol during pregnancy.^{1,2} FASD is not a clinical diagnosis, however, and includes within its spectrum the following diagnoses: fetal alcohol syndrome (FAS), partial fetal alcohol syndrome (pFAS), alcohol related birth defects (ARBD), alcohol related neuro-developmental disorder (ARND), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE).³

Out of all the substances of abuse, alcohol has the most serious effects on a developing fetus, and FASD is considered the leading cause of preventable developmental and cognitive disabilities.^{3,4} In the United States, 1 in 10 expectant mothers reported consuming alcohol in the past 30 days, and 1 in 33 reported binge drinking.⁵ In South Africa, where the highest rates of FASD occur in the world, more than 20% of women reported drinking alcohol during their pregnancies.⁶

In 2010, the World Health Organization (WHO) endorsed a global strategy to prevent the use of alcohol during pregnancy.⁷ Following the example set in Scandinavian countries, the Chief Medical Officers for the United Kingdom (UK), the National Health and Medical Council of Australia, and the American Academy of Pediatrics in the United States (US) have all asserted that there is no safe time, no safe amount, and no safe type of alcohol during pregnancy.^{3,8-10}

However, despite continued educational efforts advising against drinking during pregnancy, expectant mothers continue to imbibe, which results in negative outcomes for the affected children.¹¹⁻¹³ Further, many of these children go undiagnosed, resulting in lifelong impairments without recognition of needed care and treatment.¹⁴

FASD has emerged globally as a significant burden on economic, social, and public health systems.¹⁵ At the systems level, direct costs include high use of health care, law enforcement, special education, and care services.¹⁵ At the individual level, indirect costs to people living with FASD include loss of productivity, increased morbidity, and early mortality.¹⁵ One in every 100 children worldwide are born with FASD.¹⁶ The prevalence of FASD among special populations, such as Aboriginal peoples, children in foster care, and those who are incarcerated or receiving psychiatric treatment has been estimated to be even greater, ranging from 5 to 68 times higher than the general population.¹⁶

The effects of FASD influence how people function for the rest of their lives. Those affected frequently experience co-morbid conditions. For example, lifelong impairments related to language, auditory, visual, behavioral, and mental problems are common in 50% to 91% of the FASD population.¹⁷ Physical defects, adaptive functioning deficits, and congenital anomalies, such as malformations and dysplasia of the cardiac, skeletal, renal, ocular, auditory and other systems, are common.¹⁵ Approximately 90% have mental health concerns, and in adulthood, one of the most severe characteristics of FASD is the presentation of a major mental health diagnosis.¹⁸⁻²⁰

Health professionals from a variety of different settings can expect to encounter adults with FASD in their practice. Existing information for preventing FASD, supporting women who consume alcohol during their pregnancies, and interventions for infants and children with FASD is widely available. However, the condition may go unrecognized and untreated in many adults. Increasing understanding of FASD among all members of health care teams can make an important difference in initiating appropriate support. Geared to a multidisciplinary audience, this editorial presents practical and supportive strategies health care providers can readily implement.

UNDERSTANDING FASD

FASD in Children

Diagnosing conditions along the FASD spectrum, which include FAS, pFAS, ARBD, ARND and ND-PAE, is a complex process that usually requires physical and neurodevelopmental assessments from a multidisciplinary team.¹⁴ Agreement on a universal diagnostic system for FASD is lacking among investigators in the field. In infants, it is generally accepted that in addition to indications of growth deficiencies and developmental delays, the following are expected: documentation of significant prenatal alcohol use, smaller than normal head circumference, short palpebral fissures (small eye openings), smooth philtrum (rather than the usual raised vertical groove between the base of the nose and the border of the upper lip), and thin vermilion border of the upper lip.²¹ It is important to note that many infants and children with FASD manifest the characteristic developmental delays yet lack the growth impairments or clearly abnormal facial features expected.²²

Children who present with recognizable symptoms of FASD and who are promptly diagnosed and referred to social services, special education programs, and specialized medical care, can improve their chances of functioning well in life.²³ Unfortunately, studies regarding the prevalence rates of diagnosis indicate that only 1% to 10% of individuals with FAS are identified and receive a diagnosis, and those with pFAS and ARND, diagnoses are made even less frequently, leading to a large proportion of affected individuals without support of any kind.²⁴⁻²⁶

Many children with FASD have IQ scores of less than 70, difficulties with communication, poor social skills, and problems with daily living skills.^{1,25,27,28} Children who have characteristics of FASD but who achieve IQ scores greater than 70 are less likely to be recognized as needing support, putting them at high risk for delinquency, school failure, and other negative life outcomes.^{20,29}

FASD in Adults

As children age, diagnosing FASD becomes increasingly more complicated. The risk of head trauma, violence, and drug and alcohol abuse increases, and older children and adolescents can lose the abnormal facial features present at birth.³⁰ Further, validating documents from childhood indicating growth restrictions, facial features, and records confirming maternal drinking may be unobtainable. For children who were adopted or whose mothers are unwilling to disclose alcohol use, this information is often difficult for affected individuals to acquire.

Adolescents and adults with unrecognized FASD can establish patterns of inappropriate behavior, emotional problems, poor school functioning, and negative family interactions.³¹ Unrecognized FASD is often seen in high-risk settings, such as psychiatric hospitals, the child welfare system, and juvenile detention and correctional facilities.³¹ People who do not meet diagnostic criteria for a disorder on the FASD spectrum yet still present with cognitive and behavioral deficits are often termed as “hidden,” and it is estimated that these manifestations are 6 to 8 times more common than FAS.³²

The deficits that people living with both diagnosed and hidden FASD experience are profound. Executive functioning (higher level cognitive abilities, such as thinking abstractly, planning ahead, solving problems, and being flexible), social skills, memory, learning, frustration tolerance, ability to pay attention, and activity/hyperactivity levels are all affected to varying degrees.^{26,29,33,34} These deficits prevent individuals with FASD from leading successful, independent lives, delay academic achievement, increase the need for supported living, and may put the individual at risk for poverty, abuse, and violence.^{27,29} Individuals with FASD are at a higher risk than the general population to come into contact with the law.^{30,35,36}

SUPPORTING PEOPLE WITH FASD

People with FASD use health, educational, and social services at rates exceeding both the general population and those with chronic illnesses.³⁷ They have 3 times as many hospitalizations, oftentimes for mental health concerns, such as depression, mood disorders, anxiety disorders, attention deficit hyperactivity disorder (ADHD), and substance misuse.^{28,37,38} Physical concerns, such as vision and hearing loss, are also common.¹⁷ Additionally, rates of rheumatoid arthritis, celiac disease, lupus, early onset dementia, and chronic ear infections are also higher than the general population.³⁷

Given the range of co-occurring mental and physical disorders that cause people with FASD to seek medical help, health practitioners can expect to encounter adults with diagnosed and hidden FASD in most clinical areas. Yet, many health professionals are not able to identify that they ever worked with a patient/client with FASD or suspected FASD.³⁸ Many feel ill-prepared to work with this group of people and may misinterpret behaviors as “willful” or defiant, rather than manifestations of the cognitive and behavioral deficits associated with FASD.³⁹

When health professionals are unaware that people with FASD need enduring and long-term support, they may discontinue services when they observe progress. However, this progress may not be maintained without continued contact and guidance.^{30,32} Care providers may attempt to teach patients/clients new skills without consideration for their problems with comprehension, memory, and processing new information.⁴⁰ Even professionals in specialized mental health care areas expressed difficulty differentiating among symptoms of psychiatric illness, brain injury, and FASD.⁴¹ In the following section, strategies drawn from existing literature as well as our own experiences that can help practitioners effectively support adults with diagnosed and hidden FASD are presented.

STRATEGIES FOR HEALTH PROFESSIONALS

It is important to emphasize that although people with FASD can be expected to face similar challenges, each individual will present with a wide range of cognitive, behavioral, and executive functioning deficits. Fetal development can be affected by alcohol in differing amounts and at any stage. As a teratogenic substance, alcohol crosses the placenta with ease and, depending upon sensitivities of the mother and child, causes dissimilar effects, depending on the exposure.⁴² Functional assessments in which specific deficits and capabilities are identified yield important information that professionals can use to create intervention plans tailored to individuals' needs.^{26,27,29} Bearing in mind the diverse range of FASD clinical presentations, the strategies suggested below must be adapted to the unique needs of individual patients/clients.

Initiate Referrals to Community Services

Long-term support. For people with FASD, connections with community services can make a crucial difference in their ability to cope and succeed with the challenges of everyday life.⁴⁰ At a foundational level, health practitioners can initiate referrals that ensure their patients/clients have access to long-term support from employment services, vocational rehabilitation and social services and, when necessary, mental health care, Aboriginal support groups, substance abuse programs, and correction facilities programs.³²

Practical assistance that health professionals can offer include accompanying people to appointments with the services they need; making follow-up appointments; and noting these appointments on calendars, day-timers, or Smartphones. One can suggest scheduling appointments on the same day and time each week or month. People may find it easier to remember to attend an appointment every Monday afternoon at 2 PM, than if the appointments were scheduled at different times each week.

Diagnosis

When feasible, family members should be encouraged to participate in programs the community services offer. One can invite family members, friends and other advocates to gather data that may assist clinicians in diagnosing a disorder on the FASD spectrum, such as indications of prenatal exposure to alcohol, infant facial characteristics associated with FASD, growth deficiencies, developmental delays and special education needs, assessment, and supports at school. A confirmed FASD diagnosis will help patients/clients receive essential long-term support.

Social Support. Community service programs may host support groups and social activities that people with FASD can benefit from. Those affected by FASD have difficulty in social situations and often do not have reciprocal friendships or peer relationships. They may view a casual acquaintance as a true friend. Feelings of inadequacy and social disconnection can be present. Many feel as though they do not fit in in social situations yet are at a loss as to how to behave appropriately. Events guided by trained facilitators can help people learn more about appropriate social interactions.

Because adults with FASD likely fell behind their peer group growing up, they may have immature and under developed social skills. They may have been repeatedly taken advantage of, teased, and bullied. As a result, in adolescence and adulthood, they may turn to negative peer groups in order to experience a sense of belonging. When these groups are involved in criminal activities, those with FASD may be goaded into committing crimes and then scapegoated when caught. Because of their lack of adequate supports and strong desire to be accepted by peers, they often do not recognize they are being used.

Although community service agencies and programs cannot be expected to meet all the varied needs for social support that adults with FASD have, they may be able to provide alternatives to negative peer group influences. Sessions with counsellors can help people search for ways to find positive activities and relationships that are genuine and reciprocal.

In our view, initiating referrals that result in establishing a network of community services and supports for people, especially before they are discharged from a care facility, will equip them to continue working on the skills they learned and may help them feel more connected to their communities. The support networks associated with community services will provide a foundation for people to stay well and possibly avoid future physical and mental health crises.

Communicate Intentionally — Comprehension

When people with FASD have difficulty hearing words, processing information, expressing themselves, interpreting social cues, paying attention, and remembering points made during conversations, health professionals are not able to provide them with information relevant to their care. In some instances, rather than stating they do not understand, people with FASD may comment superficially, smile, and nod an affirmation.

Therefore, in order to verify comprehension, consider asking patients/clients at different times to reiterate the information they have heard in their own words. Key information can be repeated a number of times over the course of multiple interactions to assist in information retention. Limit the amount of information given to the patient at any one time.

Communicate Intentionally — Language

Use simple nonmedical terms and concrete language whenever possible. Vague terms, such as “maybe” and “sometimes if” can be confusing. Abstract questions may elicit inaccurate responses. For example, in response to the question: “Do you feel alone?” a response might be “No” because the patient/client is currently sitting with the professional. This response indicates a concrete rather than abstract understanding of the word “alone.”

Communicate Intentionally — Stimulation

People with FASD often experience sensory overload and overstimulation. One can help patients/clients recognize triggers that cause them to feel agitated and explore ways they can develop coping skills. Florescent lights; computer screens, uncomfortable clothing, and overly crowded spaces and background noises, such as coffee pots, ticking clocks, and humidifiers, can be very distracting to people with FASD; therefore, it is better for these patients to ensure conversations take place in quiet spaces and away from any glaring lights. One can role model strategies for coping, such as dimming lights and appropriate ways of sharing feelings of frustration.

Perhaps most importantly, patients/clients should be guided towards developing realistic plans for dealing with feeling overwhelmed. Realistic plans are especially important in social situations. People need to know their limits, who they can call, and even where they can go to manage their distress. Writing down the plan and inviting patients/clients to share it with professionals and family members is useful.

Communicate Intentionally — Emotions

One needs to recognize when people are struggling with identifying emotions. Finding the right words to describe feelings can be hard. Charts and pictures can be used as illustrations. Similarly, providing sufficient time for people to share their concerns is important.

Respond Positively to Behavioral Challenges

The cognitive impairments associated with FASD can heighten impulsivity and decrease cause-and-effect reasoning. Those who are affected may take things that do not belong to them, interrupt others, behave inappropriately, and appear as though they do not take responsibility for their actions. They may also have trouble with time management. For example, a patient/client may arrive late for a 1 PM appointment because s/he left home at 1 PM, forgetting to allow time for travel. Problems with money management and coping with change are also common.

In these instances, rather than assuming people are deliberately defying social conventions or being thoughtless, it is important to remember that FASD affects brain development in utero. People with this condition have not been born with the same capacity to reason as the general population. Finding ways to direct people toward that which needs to be done and how to behave, rather than focusing on that which does not need to be done or how not to behave can be effective. Providing too many instructions or too many “should nots” can feel overwhelming, resulting in people simply not committing the information to long-term memory.

Problem behavior cannot be ignored and negative consequences must be imposed when necessary. In order to establish connections with the behavior, these consequences should be imposed immediately and consistently by all those involved in providing support. On the other hand, frequent, immediate, and consistent positive feedback that recognizes appropriate behavior should also be offered. Predictable structured routines can help prevent behavioral challenges from developing into problem behaviors.

CONCLUSION

In summary, this editorial presented an overview of FASD, explaining how the term refers to a spectrum of devastating

disabilities caused by prenatal exposure to alcohol. People with FASD live with the physical, mental, and behavioral disabilities all their lives. Consequently, the support and care they need must also continue throughout their lives. When infants and children are diagnosed early and connected with specialized social, educational, and medical programs, they are better equipped to deal with the ongoing challenges they face. However, for a significant number of affected people, deficits related to FASD go unrecognized, undiagnosed, and unsupported. The many physical and mental co-morbid conditions they struggle to cope with often bring them into contact with health professionals, many of whom have only a limited understanding of FASD. Effective strategies that practitioners can implement include initiating referrals to community services. For those adults whose FASD is unrecognized or hidden, connections to agencies and programs that will provide the long-term support they need can make a crucial difference. These connections can help people find clinicians who are able to confirm a diagnosis on the FASD spectrum.

When communicating with people with FASD, another important strategy is to intentionally consider their level of comprehension. Rather than assuming that smiling, nodding, and superficial responses indicate understanding, asking patients/clients to re-iterate any instructions in their own words is a more accurate measure of comprehension. Similarly, using concrete rather than abstract language, minimizing environmental stimulation, and providing extra time for expressing emotions are worthwhile.

Finally, strategies that help practitioners respond positively to behavioral challenges, such as offering positive feedback and giving clear direction about the actions people should take are helpful. We call for health professionals to continue developing an understanding of the disabilities associated with FASD in adulthood and the kinds of supportive strategies that can begin to make life easier for the many people affected.

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"It was worse than my son passing away." The experience of grief in recovering crack cocaine addicted mothers who lose custody of their children



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Abstract

Grief could be considered to be the universal experience notwithstanding the cause. For addicted mothers, grief is a constant companion after losing custody of their children often leading them to attempt suicide and engage in self-destructive behaviors. Little is known about the processes and symptoms of grief in these mothers. This hermeneutic study explores the grief of four crack cocaine recovering mothers who lost custody of their children. Thematically, three nonlinear stages were identified that the mothers passed through in an iterative manner: betrayal, soul-ache, and reclamation. Posttraumatic growth was identified as an outcome once the mothers entered recovery. It is imperative that clinicians from all disciplines recognize and respond to the grief that addicted mothers who lose custody of their children experience, through the offering of grief support and grief counseling.

Keywords

crisis, grief, loss, trauma, comparative death, bereavement workers, counseling

Grief could be considered to be the universal human experience. All human beings have or will experience grief at one or multiple points in their lives through death or loss (Simon, 2013). For crack cocaine-addicted mothers who lose custody of their children, grief can be a constant companion (Janzen, 2010). This can cause extensive pain and distress spiritually, emotionally, and physically (Janzen & Melrose, 2013) and may have features of pathological grief (He et al., 2014). Losing custody could be likened unto the worst possible imaginable thing that could happen to a mother (Janzen & Melrose, 2013).

In our research exploring the lived experiences of four mothers recovering from addictions (Janzen & Melrose, 2013), we were struck by the profound and persistent grief that impacted our participants. In this article, we extend our work to examine the experience of grief in the context of child custody loss in four recovering crack cocaine-addicted mothers. We do this by linking our findings to the constructs of grief and bereavement, categories of grief, disenfranchised grief, grief in the context of child custody loss, and hope. Methodology is delineated. Results of the research are outlined. A discussion is presented and limitations are explored. We issue a call for the provision of grief support/counseling for addicted and recovering mothers who lose custody of their children.

Literature Review

Grief and Bereavement: Theoretical Foundations

Theoretical foundations related to grieving have evolved considerably since the time of Freud in 1917 who felt that the ultimate task of grieving was emotional detachment (Rothaupt & Beckner, 2007). Neimeyer and Currier (2009) see the goal of bereavement as one of adaptation or meaning making where “adaptation after death of a loved one oscillates between orientation to the loss . . . and restoration of contact with a changed world” (p. 355). There are two tracks that are associated with bereavement, the first being a biopsychosocial track which focuses on overt symptomatology and a relational track which looks at predeath and postdeath relationships with the deceased (Neimeyer and Currier, 2009). Neimeyer sees that working through a constructivist framework, grieving is attended to as an active, effort-bound process in order to reconfirm or reconstruct meaning which has been threatened by loss.

Moules, Simonson, Fleiszer, Prins, and Glasgow (2007) note that grief itself is ambiguous: “grief is universal and individual; benign and malignant; life giving and life requiring, active and passive, heart and head; inarticulate and poetic; celebration and bereavement” (p. 122). As Niemeyer (2005) and Moules et al. note, grief is a lifelong experience—using the metaphor of a healing wound to better understand grieving.

With a physical wound, it is cleansed, sutured, and bound up and usually heals within a prescribed period of time. Instead, Moules et al. (2007) note that bereavement wounds remain open and jagged. Further, they cite that these wounds are painful and problematic as healing time is delayed, often resulting in considerable scarring. In essence, bereavement wounds heal from the inside out instead of the outside in (Moules et al., 2007). Shear et al. (2011) also use this metaphor to describe grief as being complicated in that symptoms interact and duration is prolonged.

Considering the work of Niemeyer (2005), Moules et al. (2007) look at this adaptation as “not the ground that changes but it is our location on the ground, our appreciation of it” (p. 133). The bereaved “live with the dead” where they struggle to construct a coherent account of their bereavement that pursues a sense of continuing with how they have been while also integrating the reality of a changed world into their conception of who they must be now (Neimeyer, Prigerson, & Davies, 2002, pp.

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236–237). This is supported by Florczak (2008) who sees that the process of bereavement is in finding healthy, symbolic relationships and roles with the deceased.

Acute Grief

Acute grief is a normal human response to loss or death as death is considered as a common life event (Shear et al., 2011; Wittouck, Van Autreves, De Jaegere, Portzky, & van Heenden, 2011). Mourning and grief are considered to be natural responses to loss (Simon, 2013). While the acute grief process usually results in a life that is changed and restorative, acute grief processes do not normally need intervention (Shear et al., 2011, p., 103). Shear et al. note that psychiatrists emphasize that acute grief should not be treated as being pathological in nature. Acute grief is grief that occurs shortly after learning of a loss or death and involves a separation response as well as a response to stress (Shear, 2015). Most individuals move through the mourning process without the presence of severe mental or physical problems (Wiltouck et al., 2011). However, bereavement can trigger mental or physical disorders (Shear et al., 2011). The early bereavement period can exacerbate a risk for myocardial infarction, cardiomyopathy, or both (Shear, 2015). Further, Shear outlines that the risk is increased for the development of mood disorders, anxiety, or substance abuse as bereavement can trigger physical or mental disorders (see Table 1 for symptomatology of acute grief).

Table 1. Symptomatology of Grief and Loss

(Baum & Negbi, 2013; Boss & Yeats, 2014; Currier et al., 2012; Davidson, 2010; Gilbert, 2007; He et al., 2014; Holland & Neimeyer, 2011; Horowitz, Siegel, Holen, Bonaano, Milbrath & Stinson, 1997; Prigerson et al., 1997; Shear, 2015; Shear et al., 2011; Simon, 2013; Wittouck et al., 2011; Zisook & Shear, 2009)

Symptomatology of grief and loss	
Acute grief	-Shock or disbelief, intense separation distress, longing and sadness, preoccupation with thoughts, memories and images of deceased, focusing on loss; Shock, anguish, loss, anger, guilt, regret, anxiety, fear, loneliness, unhappiness, depression, intrusive images, depersonalization, overwhelmed; decrease in usual activities
Prolonged grief/complicated grief/traumatic grief	-Sleep disturbances, substance abuse, suicidal ideation, and behavior, immune function alterations, nonadherence to therapeutic regimes for disease, mood, anxiety, or substance abuse disorders, emotional trauma/traumatic distress, headache, flu, eating changes, numbness, bitterness, anxiety, isolation, personal emptiness, avoidance of others, sleep interference, loss of interest of activities of daily living, intense yearning/longing, pain, impairment in social and personal functioning, activity restriction, insomnia, cardiac dysfunction, cancer, meaninglessness, hopelessness about future, anger, disconnection from others, depression, hypertension, cardiac problems, social impairment, psychotropic drug use, reduced quality of life
Disenfranchised grief	-Hidden sorrow, difficulty in mourning, anger, guilt, powerlessness, loneliness, generalized isolation, embarrassment, secrecy, restrained or stifled emotions, frustration, delayed grief reactions, chest pain, isolation, shame, disbelief, shock, numbness, guilt, regret, anger, sadness, anxiety, and depression; insomnia, chest pain, shortness of breath, fatigue, sleeplessness, nervousness, stomach problems, intensely emotional, tearfulness, depression, relief, loneliness, guilt, anxiety, and sense of disbelief; increased use of drugs and alcohol
Ambiguous loss	-Feelings of ambiguity, confusion, and ambivalence, immobilization, frozen grief, wounded or lost self-esteem, rupture of close relationships, sadness, doubt, anxiety, while at the same time preserving hope for return of lost person; increased conflict, relational rifts and alienation, depression, trauma, anxiety, helplessness, identity issues, stressrelated illnesses, substance abuse, interpersonal violence to self or others; dialectical thinking

Abnormal Grief: Traumatic, Complicated, Prolonged, and Disenfranchised Grief

For the past 20 years, there have been various definitions of abnormal grief (Lobb et al., 2012; Rosner, Pfoh, & Kotoučová, 2011). The term abnormal grief or pathological grief has evolved over time and is now termed as prolonged grief disorder (Lobb et al., 2012). Prolonged grief disorder encapsulates traumatic grief, complicated grief, and prolonged grief. Rosner et al. (2011) note that the terms complicated grief and prolonged grief have been, and still are, used interchangeably. The term complicated grief is more prevalent in the overall literature (Bryant, 2014; Rosner et al., 2011; Seirmarco et al., 2011; Shear, Ghesquiere, & Glickman, 2013; Simon, 2013; Zetumer et al., 2015).

Armed with the outcomes of robust randomized controlled trials (RCTs), prolonged grief has been widely studied (Rosner et al., 2011). Despite intensive lobbying and research presented to the American Psychological Association, the term prolonged grief disorder was rejected and is not currently found within the 2013 edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychological Association, 2013) nor the World Health Organization's (2015) *International Classification of Diseases Revision 10* (ICD-10; Bryant, 2014; Prigerson et al., 2009, 2008; Rosner et al., 2011). We now explore traumatic grief, complicated grief, and prolonged grief.

Traumatic Grief

Traumatic grief has its roots in the work of Prigerson et al. (1997) and Shear et al. (2011). The term traumatic grief is associated with loss that occurs through a traumatic event such as a car accident, domestic violence, homicide, or suicide (Neimeyer et al., 2002). Traumatic grief is now encompassed within the sequelae of prolonged grief disorder and termed as traumatic

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distress (Holland & Neimeyer, 2011; Rosner et al., 2011). Traumatic distress is differentiated between separation distress (which is relational in nature) as it is “influenced by more situational factors surrounding death” or the cause of death (Holland and Neimeyer, 2011, p. 254).

Complicated Grief

Complicated grief was first identified by Horowitz and colleagues (Horowitz et al., 1997, 2003; Prigerson et al., 1995; Rosner et al., 2011). Complicated grief refers to an abnormal grief process lasting greater than 12 months (Rosner et al., 2011) and encompasses two clusters of symptoms (Rosner et al., 2011; Wittouck et al., 2011). The first cluster is seen in terms of a “strong yearning” for the individual who has died (Rosner et al., 2011, p. 79). Rosner et al. and Wittouck et al. describe the second cluster as being composed of a number of factors related to cognition, emotion, and behavior (see Figure 1 for symptomatology of complicated grief).

The incidence of complicated grief is estimated by country to be between 2.4% in Japan, 3.7% in Germany, and 4.2% in Switzerland (Rosner et al., 2011). The estimations of those who have acute grief that will go on to develop complicated grief vary. Shear et al. (Shear, 2005; Shear et al., 2011) indicate that 10% of those who have acute grief go on to develop complicated grief. Overall complicated grief is approximated to be anywhere from 5 to 10% (Zetumer et al., 2015) to 20% of the bereaved population (Rosner et al., 2011). Shear et al. (2013) cite that approximately 7% of the bereaved older adult population develop complicated grief.

Prolonged Grief

The term prolonged grief was coined by Prigerson et al. in 2009. Prolonged grief occurs when traumatic grief and complicated grief are both present with features of separation distress (from main attachment figure) and traumatic distress (situational factors around death/cause of death; Currier, Holland, & Neimeyer, 2012). The incidence of those bereaved who are likely to develop prolonged grief is 10 to 15%. Worldwide, the incidence of complicated grief leading to prolonged grief disorder is 2 to 3% of the population (Shear, 2015). Shear notes a rise in incidence with the death of a romantic partner from 10 to 20%.

Disenfranchised Grief

Disenfranchised grief, as a concept, is identified to be effectively established within literature, research, and practice (Robson & Walker, 2013). Disenfranchised grief was first identified by Doka (1989). It is defined as a “grief that people experience when they incur a loss that is not or cannot be openly acknowledged, physically mourned or socially supported” (Boss & Yeats, 2014, p. 86) or a type of grief “where there is no social acknowledgement of the mourner’s relationship to the deceased, or the mourner’s loss, or the mourner’s ability to grieve” (Doka, 1989, pp. 98–99). Noting there are differences within and between cultures, ethnicities, religions, and society (Gilbert, 2007; Robson & Walker, 2013), Doka (2002) cites that there are many expectations on how bereaved are expected to mourn or grieve. The *rules of grieving* result in a wide range of accepted behaviors which may be met with apprehension, annoyance, or even censure (Gilbert, 2007).

Disenfranchisement has ties to subjugation as well as the political (Robson & Walker, 2013). Robson and Walker suggest that disenfranchised grief is not linear, but rather pyramidal in nature, suggesting a hierarchy of loss which differs from the normative notions of loss. The pyramidal nature of disenfranchised grief is felt to expansively affect primary attachment figures such as spouses and parents as they represent the top stratification of the pyramid (Robson & Walker, 2013). Primary

attachment figures are felt to *suffer* the most in terms of disenfranchised grief (p. 103) (see Table 1 for symptomatology of disenfranchised grief).

Ambiguous Loss

An additional grief experience that is referenced in the literature is known as an ambiguous loss (Betz & Thorngren, 2006; Boss, 2004). Ambiguous loss is defined as an “unclear loss that continues without resolution or closure” and considered to be relational in nature (Boss & Yeats, 2014, p. 63). Ambiguous loss is a loss that does not fit within the traditional notion of death (Betz & Thorngren, 2006).

Boss and Yeats (2014) define two classifications of ambiguous loss: physical and psychological. Ambiguous loss is typologized to be either loss where there is physical presence but psychological absence or physical absence but psychological presence (Betz & Thorngren, 2006; Boss & Yeats, 2014). Examples of ambiguous loss are child custody loss, foster care, adoption, a significant other experiencing dementia, lost at sea, a significant other leaving without saying goodbye, loss of a pet, perinatal death, infertility, murder, and so on (Betz & Thorngren, 2006; Boss & Yeats, 2014; Gilbert, 2007).

Ambiguous loss presents itself as a situation where there are no rituals for meaning and that the loss is socially stigmatized (Betz & Thorngren, 2006). In our North American culture, Betz and Thorngren describe talking about or dealing with death as a process to be largely avoided, restrained, and denied or at the very least involve a quick turnaround. Boss and Yeats (2014) describe the perils of ambiguous loss as “living with someone who is both here and gone—or gone and not for sure—[as being] a bizarre human experience” (p. 63) which leads to significant symptomatology. The effects of ambiguous loss are considered to be trifold: immobilization, relational, and individual (see Table 1 for symptomatology of ambiguous loss).

Boss and Yeats (2014) cite that those who experience ambiguous losses are at higher risk of developing complicated grief. This is due to there being little possibility of resolution of the loss or bereavement. In essence, grief is frozen through the spaces of time (Boss & Yeats, 2014). Further, ambiguous loss is considered to be a type of disenfranchised grief and especially seen as negated by media, legal, and religious institutions that are intolerant of that ambiguity.

Grief in the Context of Child Custody Loss

There is very little literature related to grief in the context of child custody loss. A search of Google Scholar, Academic Search Complete, Research Library JSTOR, Omnifile Full Text Select, SAGE, and Scopus using the search term, “grief in child custody loss,” revealed only five studies. Four of these studies involved mothers (Askren & Bloom, 1999; McKegney, 2003; Novac, Pardis, Brown, & Norton, 2006; Wells, 2010) and one involved fathers who had lost custody of their children (Baum & Negbi, 2013).

Askren and Bloom’s (1999) study of 12 mothers who had relinquished custody of their children revealed that mothers experience initial acute grief reactions which often lead to pathological grief. Pathological grief is more particularly noted in mothers who involuntarily give up custody.

Novac et al.’s (2006) research centered on young, homeless mothers and custody loss of their children from the perspectives of 18 health and social service providers who engaged with this population. The outcomes of this study were primarily seen in recommendations for counseling related to bereavement and child custody loss.

The study of Wells (2010) focused on narrative analysis of custody loss and reunification with one participant. Wells did not center on grief but rather the associated rage and gendered shame that come from a motherhood ideology that is prevalent in America. The conclusions of this study note that motherhood identity is reconstructed through the processes of loss and regaining custody.

McKegney (2003) interviewed four mothers who had their children removed from them at birth and highlighted their loss of
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self-worth, isolation, and stigmatization. She noted the suffering (most often silently) that these mothers endured and the disenfranchised grief that they experienced. There is no known literature to date that explores grief through the lens of addicted mothers who lose custody of their children.

Grief and Hope

While grief and hope may be seen as opposite ends of a continuum, there is a relationship between them that Attig (2004) emphasizes cannot be discounted. Attig describes that at the very heart of grieving, constructive labors of love and hope are omnipresent through both soul work (related to motivation), spirit work (related to challenging with the unfamiliar or unexpected), and resilience. Moore (2005) contends that it is possible to choose hope, even in bereavement and loss. Hope is felt to effect healing both emotionally, physically, and spiritually (Feudtner, 2005; Snyder, 2000).

Moore (2005) describes hope as an elusive concept—one which is not easily defined. Feudtner (2005) concurs stating that a plethora of definitions exist. Much of the seminal literature, however, is related to hope is found in the work of Feudtner (2005; 2010) and Snyder (2000). Theories related to hope arose in the 1960s and 1970s and generally defined hope as “having positive expectations” (Snyder, 2000, p. 12) According to Snyder, hope is conceptualized as the triad of goals, agency, and pathways (thoughts and motivations) which culminates in hopeful thought. Further, Snyder (2002) defines hope as “the perceived capability to derive pathways to desired goals, and motivate oneself via agency thinking to use those pathways” (p. 249).

Hope is felt to be a combination of thoughts, feelings, decisions, and actions by individuals within a wider social and cultural milieu (Feudtner, 2005). Hope relates to positive performance, adjustment, and health (Snyder, 2000). Additionally, hope is believed to extenuate positive affect and decrease negative affect and has positive effects on goal setting (Feudtner et al., 2010). In the context of child custody loss, hope is felt to be a mainstay in recovering mothers with addictions who have lost custody of their children (Janzen, 2010; Janzen & Melrose, 2013).

Methodology

Our research utilized an interpretive theoretical framework and phenomenological hermeneutic approach based upon the work of van Manen (1997). The research question was, “What is the lived experience of mothers in recovery who have lost custody of their children?” The purposive sample included four recovering crack cocaine-addicted mothers who had lost custody of their children. Ethical approval was obtained by the university’s Research Ethics Board and the facility of origin where the sample was drawn. The mother’s age ranged from 18 to 30 years. Two had lost custody permanently and two were in the midst of court proceedings, attempting to regain custody. All of the mothers had coexisting mental health disorders and a history of abuse or interpersonal violence. Participants were recruited through advertisements which were placed in a longterm residential addictions treatment center. Pseudonyms were chosen by the mothers for themselves and their children. Digitally recorded, semistructured interviews lasted between 45 minutes and 1g hours. Interviews were transcribed verbatim. Nvivo8 (QRS International Dupuy Ltd., 2009) software assisted the researcher by maintaining and organizing the data.

The 68 pages of single-spaced data were analyzed for themes (Cresswell, 2013; Denzin & Lincoln, 2011; Ritchie, Lewis, Nicholls, & Ormston, 2013; Silverman, 2013). Specifically, a three-layered analysis based on the work by Perry (2009) was undertaken which included analysis of stories/researcher perspectives, member checking, and the reader of the research being invited to engage in their own analysis. Three themes and nine subthemes were identified: betrayal (substances, self and other betrayal; child welfare) soul-ache (the moment of loss, accountability; living with loss), and reclamation (learning to live again, a perfect day; reaching toward the future).

Throughout our analysis, our participants’ experiences with overwhelming grief stood out. In reviewing and reflecting further

on the experiences of the addicted mothers who lost custody of their children, grief was identified as a major finding in our research. In response, themes and subthemes were subsequently recoded for references to and descriptions of grief and symptomatology. Therefore, in this article, we present a further explanation of the study of grief within the context of the three themes originally identified. Symptomatology is derived from the participants' descriptions of grief.

Results

Betrayal

The multifaceted sources of feelings of betrayal that each of the women felt after custody loss led them quickly down a spiral of entering an ever-deepening relationship with their addiction that they saw no reprieve from. Charlotte painfully recounted:

And because I believed my life was going to revolve around my addiction and my drugs and the lifestyle that I had, that's my thought to myself and I even said, I tried convincing myself for so many years, that's the way I wanted to die [silence] [crying] That's the way I wanted to die.

This resulted in "giving up on life" and actively seeking to "just sit aside and kill [themselves] slowly." Their grief was played out through their addictions. Hannah related: "I'm going to kill myself. I push the envelope and I push it." Each woman recognized that their addictions and the pain they felt from the loss of their children were destroying them—not only physically, but mentally and spiritually. Cristal sadly recounted, "I was destroying that out there. Destroying my soul."

Each of the women experienced intense pain, hurt, and depression. Cristine related that her drug use abated that pain even if just for a little while. "I was feeling depressed. I just wanted the pain to go away. I didn't want to hurt. I wanted to be okay and I guess I felt I was okay when I was high."

Crack cocaine became their way of coping with loss, grief, and extreme loneliness.

Charlotte expressed that loneliness. "I thought they understood. They didn't understand. I felt so alone at those times. Although my family was there for me, I still felt so alone."

Cocaine became the only friend they felt they had and giving up cocaine would be like losing a best friend. Hannah explained,

Ultimately that's our coping skill. That's our friend. Because, yeah I lost my best friend. When anything was going wrong, who was there for me? By continuing [with cocaine], by going down the road after my kids [were] gone, like with Clara being apprehended, I didn't pick up the phone and call my treatment centre. I picked up the phone and called my drug dealer.

The judgment they felt from others was severe. Hannah related

I find society views mothers that use as write offs, that there's no going back or coming back from it . . . society is so judgemental when it comes to . . . even if they find out you've been clean for 10 years. It doesn't matter. You still have, you're tainted or something.

The loss of their children combined with the judgment of others affected their self-esteem.

Cristine noted, "I just felt that I wasn't good enough."

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Soul Ache

Soul ache for the mothers was a space where they were not living nor dead . . . they were just existing. Intense grief was their constant companion. It was not only their hearts that were broken, but it was also their very souls.

The moment of loss for the mothers was something that haunted them for many years and broke their hearts. They could vividly describe the events of that moment. Charolette talked about when she gave up custody voluntarily as a result of her cocaine use.

I walked into the courthouse and I still remember the look on my mom's face. I didn't even tell my mom and I share a lot with my mom. A lot. I didn't even share with her that morning when I made the decision to give up on my kids. And then, the thought of my mom's face. I think about it. How she looked at me. It still haunts me. It broke my heart. I didn't want to face the reality [long silence] that I was part of the problem of giving them up.

Feelings of violence and hate toward child welfare workers involved in apprehending their children surfaced followed by a sense of powerlessness and hopelessness. "I wanted to get violent," recalled Cristine. "I really felt I guess betrayed a little bit, misled for sure, and . . . but at the end of the day there was nothing I could do." Hannah angrily expressed,

I hate them so much, and I don't like using that word hate. [crying] It's such a strong word. I know I had a part in it, I know I had a part in what I did. I know. But it—what they said to me, I will never, I will never, I will never forget it. Never.

Grief was expressed through the mother's tears and at times panic-stricken crying. "I've never cried so hard in my life. Like nothing breaks my heart more. I went home and cried and I cried." Hannah described her tears as "hysterical." Relational difficulties were frequent especially with partners or family members were involved in the loss of custody.

Feelings of failure were predominant in each of the women to the point where one mother tried to bring solace to herself through denial by thinking "they're not really my children. I just brought them into the world." Cristine related, "I had failed. To a certain extent I had failed. If anything I felt sorry for myself for you know, being allowed to bring children into the world that I couldn't keep." Regret was commonplace. Cristal recounted,

But yeah, it's been—it's been like, I have a lot of regrets. I do, but you know, I know that there's a way that I could always have made, and I think about it now there's things I would have been able to change if I would have, I mean I know it's not possible . . .

Self-blame, denial, shame, guilt, and anger were also experienced. Charolotte explained her feelings in continuing to live with loss.

"I blamed myself. I was in denial with it. I had so much shame, guilt, anger. I had all of it. It's what kept me stuck in my addiction because I didn't want to face the reality of it; I had to give up my boys."

Mothers yearned for their children. Their children were omnipresent in their thoughts and hearts. One mother talked to the pictures of her children every night. For Hannah, the loss of custody of her son was worse than if he had died. She recounted . . .

Like especially when I lost my first son, like he passed away when he was a month old in my arms. That's all I could think and it was worse than my son passing away because at least I knew he was gone. Knowing Jason was out there and I couldn't be with him was horrible [crying] Sorry . . .

The loss of hope was perhaps one of the worst things the mothers experienced.

I felt that all hope was gone. What did it matter? I might as well just go and die and that's what I tried to do. Like

honestly, that's why I ended up in the hospital because I tried to kill myself. My mom took me to the hospital and told them, "You don't put her somewhere; she's going to be dead."

Feelings of loss permeated their lives. "Just that loss . . . for me was the hardest thing in my life I've had to cope with. I've lived through hell, you know. I've lived through hell and been there and back many times, more than I can count."

Reclamation

Despite the grief and struggle that these mothers still felt after many years of losing custody, there came a point where they chose to reclaim their lives. This reclamation was centered on recovery and the hope that their ongoing recovery gave them. In essence, they were learning to live again. This learning to live again was centered within the residential recovery center and its staff, an increase in spirituality and dependence upon God as their higher power, the return of hope of reunification at some point in time with their children, and the desire to give back.

The recovery center was instrumental in regaining hope. Charolotte explained the impact of the staff at the recovery center.

When I came into [Recovery Center] and as I started breaking down my walls, breaking down my guard, and started believing in the staff, starting to trust the staff, and knowing the staff wasn't going to hurt me or tell me things that weren't right I started to believe in that. Let us love you until you can love yourself. For me, they gave me that love. I didn't believe it, you know, when I heard in rooms, let us love you until you can love yourself, I didn't believe it because I had such low self-esteem. I was so down on myself. I was so negative about who I was. I didn't believe it because it was too good to be true, right? But when I came to [Recovery Centre] they gave me that love. They gave me that part of me I didn't know I still had because I buried it; I hid it away from myself.

Cristal recounted her dependence upon God as her higher power in her life. "I depend on God for everything today. I do have hope." Charolotte expressed, "I know God hears me. He sees the tears I cry for them, but I have to meet him half way in order to see them." Hannah made sense of losing custody of her children through her belief in God.

How do I make sense of it? Like, God is really big in my life now. That's my higher power, that's how I choose to define it and everything happens for a reason. There's not one thing I don't think, that goes on in anybody's life that isn't meant to happen. These are ultimate lessons for me.

Even when custody loss was permanent, the women held onto the hope that one day they would be able to be reunited with their children. Some of them were cognizant that reunification would happen when their children were adults. Others hoped that time would come sooner. They each could visualize an ideal or perfect day with their children. The greatest wish of all the mothers was to *just hold* their children and be *alone with them*. Cristine said, "Yeah. I'd go and I'd touch the face of my kids and feel their energy and their love." Charolotte lovingly related:

What would I do? I'd cook for them. I would hold them [crying] I would do anything they wanted. Anything! If they wanted one day with me, I would do anything. Anything! I would be reasonable. I would cook for them, like I said. If they wanted to watch a movie, I'd watch a movie with them. The one thing I would want to do is just hold them. That would be one big thing for me, just to hold them. The rest would be up to them, anything they wanted to do. Anything. We'd do it.

Each of the women expressed a desire to give back—to help other women who found themselves in similar circumstances or give back to society. Cristal recounted,

I'm going to be like this person that helps other people. Not only my children, my family, but just, people, you know? And I will continue to work with homeless people and addicts and that's one of the reasons why I want to go into social work. I want to specialize in something like that.

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Charolotte wanted just to make a difference. At the time of the interview, she was painting rooms in the recovery center.

I belong in life and I can, I can make a difference, even if it's just little. The painting I'm doing right now, it's like I think about it. Who knows, if they're going out in that room for a girl who's going to be part of here, who needs that room. She's probably still suffering right? She's still hurting. What keeps me going is knowing that I gave to that girl, just something little like that. The painting in her room. Because I was hurting too, and helping that, for another lady that probably is going to come in here needing the room that I paint, she can use it. Little things like that with my recovery that keep me going, for another person, to help them out, that is much more.

Cristine summarized the hope that all the mothers had . . .

For a long time I thought I was powerless, but you know what? For the first time in forever I finally feel like I can do this because before I became overpowered by crack, I was an amazing person. I worked two jobs. I had my own place. I took care of my friend. Like I could do it, you know? I could function and I could make it happen because I was that person that was strong and able. Well, I finally feel that way again, so I can do it and I will, you know? I will, for me and for my kids because without my kids I don't have me and without my me, I don't have my kids.

Discussion

Grief in the Context of Child Custody Loss

There is a paucity of literature related to grief in child custody loss. The loss of child custody creates an ambiguous loss. This is especially true for mothers due to the “lost person [being] in fact alive and difficult to mourn” (Baum & Negbi, 2013, p. 1684; Boss, 1988, 2004). The loss of child custody also results in disenfranchised grief in mothers (McKegney, 2003).

McKegney (2003) notes that mothers suffer intense and often silent grief over the loss of their children despite the reason the children were apprehended. Weiss (1998) echoes this, describing the grief as “so intense and painful” (p. 1012) that child custody loss creates feelings of desperation. This desperation enacted itself out in an ever deepening spiral with each of the women's addictions as well as feelings of violence toward those who apprehended their children.

Recovering mothers who lose custody of their children appear to fit into the latter category of ambiguous loss where the child is psychologically present but not physically absent (Boss, 2004; Boss & Yeats, 2014). This type of loss can be compared with a child that has been abducted, but in this case, the child is apprehended. When a child is abducted, the child often is taken against his or her will despite the mother–child relationship (Spilman, 2006). As in nonfamily abduction, apprehension or the taking or detaining of a child without parental consent is felt to be one of the most disturbing and emotionally distressing parental experiences that a parent can encounter in their entire lives (p. 150). Spilman describes vicarious trauma of both child and parent.

With this trauma, apprehension could be considered an emotionally violent loss and more so if the child is taken unexpectedly. Lichtenthal, Niemeyer, Currier, Roberts, and Jordan (2013) note that in situations where the loss has been violent in nature that traumatic grief is an outcome. Although in abduction there is much support in terms of family, friends, police, and attorney (Spilman, 2006), there seems to be little support for mothers who lose custody of their children. Mothers could be considered to live through the trauma of losing custody largely on their own. Price, Jordan, Prior, and Parkes (2011) refer the loss of a child as “living through [a] nightmare” (p. 1391).

Grief Reactions

Askren and Bloom's (1999) analysis of 12 studies of mothers who resigned custody of their children reveals that initially mothers experience acute grief reactions. Acute grief gives way to chronic, unresolved grief and often results in pathological grief. When custody is lost involuntarily, mothers experience enduring psychological distress (Novac et al., 2006; Wiley & Baden, 2005). Comparing and contrasting the symptomatology of acute grief, the mothers in the study appear to initially experience acute grief reactions which give way to long-term psychological distress.

When mothers experience concurrent mental illness, their grief is described as extremely distressing (Seeman, 2012) which leaves them bewildered and confused (Sands, Koppelman, & Solomon, 2004). All of the women in this research experienced co-occurring mental health disorders, addiction, and a history of abuse/domestic violence. This could be considered to complicate the loss of custody of their children as mothers have to deal with mental health, addictions, and interpersonal violence as well as the loss of their children.

Rostila, Saarela, and Kawachi (2011) found that the probability of a mother's mortality after the death of a child to be 31%. This increased mortality is supported by an earlier study by Winngaards-deMeij et al. (2007). The active attempts of suicide in which death did not result are consistent with the increased probability of mortality.

Parental loss of a child is considered to have the greatest risk for and prevalence of complicated grief (Kersting & Wagner, 2012). Shear (2015) estimates the prevalence of complicated grief in child loss to be greater than 20%. The mothers in this study exhibited many of the symptoms of complicated grief/prolonged grief.

Prolonged Grief

Prolonged grief does not singularly occur in bereavement but also can occur with other psychological conditions that are related to loss (Currier et al., 2012). Prolonged grief disorder is "characterised by intense, severe, and functionally impairing grief symptoms which have been shown to be distinct from bereavement related depression and anxiety" lasting for "at least 6 months to several years" (Litchtenthal et al., 2013, p. 7). For the mothers in this study, their grief was still present at the time of the interview—from 1 to 10 years after losing custody. This speaks to the long-term effects of child custody loss.

Mothers exhibited much emotion during the interviews, often crying as they spoke of their loss and grief. The impact of losing custody of their children can be understood as occurring long after the acute phase of grieving and could be considered as prolonged grief with characteristics of prolonged grief disorder (He et al., 2014; see Table 2 for symptoms of prolonged grief disorder vs. grief in child custody loss).

Table 2. Symptomatology of Prolonged Grief Disorder/Pathological Grief Versus Grief in Child Custody Loss in the Literature and Study.

Symptomatology of prolonged grief disorder versus grief in child custody loss	
Prolonged grief disorder= Pathological grief + traumatic grief + complicated grief (He et al., 2014)	-Longing or intense yearning, pain, sorrow, or grief, avoidance of reminders, shock, dazed, confusion regarding role in life, trouble accepting the loss, difficulty in moving on, numbness, emptiness, meaninglessness, depression, PTSD, anxiety (Horowitz et al., 1997)
It is noted that separation distress as well as traumatic distress can cause symptoms of prolonged grief disorder (Holland & Niemeyer, 2011)	-Separation distress, traumatic distress, major depression, generalized anxiety disorder, PTSD, invasive thoughts about lost relationship, meaninglessness, functional impairment in activities of daily living, trauma like symptoms (Holland & Niemeyer, 2011) -Problems accepting loss, unable to trust others, excessive anger, disconnection from others, hopelessness regarding the future, life becomes meaningless (Currier et al., 2012) -Cognitive, emotional, and behavioral symptoms (Wittouck et al., 2011)
Grief in child custody loss (Literature)	-Initial acute grief response of anger, guilt, and depression. -Denial, despair, atypical responses, headaches, sleep disturbances, appetite disturbances, lack of energy, fantasies, searching behavior, relational problems in family, long-term physical, social, and psychological problems. -Symptoms of chronic, pathological grief. (Askren & Bloom, 1999) -Magnification of previous trauma, despair, disempowerment, numbness, loss of self-esteem, loss of desire to live (Novac et al., 2006) -Substance abuse, psychiatric problems (Hoffman & Rosenheck, 2001) -Shame and rage (Wells, 2010) -Guilt, feelings of betrayal, humiliation, anger, worry, and grief (McKegney, 2003) -Difficulty sleeping, weight loss, diminished appetite, nightmares, explicit dreams related to child apprehension, or searching for lost child (Chalton, Crank, Kansara, & Oliver, 1998)
Grief in child custody loss (study)	-Intense grief and pain, desire to numb pain through addictions, substance abuse, anger, denial, self-blame, shame, guilt, negative self-talk, bitterness, hurt, feelings of failure, loss of hope, feelings of acting violent toward those apprehending child(ren), cutting everyone out of life, loss of self-esteem, betrayal, feelings of being misled, hysterical crying, suicidal ideation, active attempts of suicide, loss of self, self-neglect, relational difficulties especially with family members who have been involved with custody loss, extreme longing, giving up, frustration, discouragement, powerlessness, hate, feeling alone, separation distress, traumatic distress, depression, intense yearning

Note. PTSD = posttraumatic stress disorder.

Posttraumatic Growth

In ambiguous loss, the loss of role is mourned and creates a situation where a redefinition of relationship, roles, and responsibilities presents itself to the bereaved. Benkel, Wijk, and Molander (2009) also support this finding in that roles and relationships change with bereavement. Moules (1998) notes that “grief is . . . a journey of relationship. It is a relationship that searches for meaning” (p. 152). Lichtenthal et al. (2013) note that bereaved parents who experience prolonged grief disorder often report posttraumatic growth. The evolution of meanings surfaces over a period of months and years. This is consistent with the findings in this study.

The women in this study experienced meaning of their loss in their efforts to learn to live again despite the loss and symptoms of prolonged grief disorder. This occurred as they worked to reclaim their lives. One of the findings of this study was that the women moved through three nonlinear phases, in which the themes of betrayal, soul ache, and reclamation

represent. Meaning was found once the mothers accepted accountability for their part in the loss of their children which often took years to occur after custody loss (see Table 3 for comparison and contrast of bereavement and associated themes in study).

Table 3. Contrast and Comparison of Bereavement Literature and Themes in Study.

Comparison and contrast of bereavement literature and themes in study

Concept	Literature	Study
The experience of loss Traditional loss or ambiguous losses (Betz & Thorngren, 2006; Boss & Yeats, 2014; Douglas, 2004)	- Emotional pain, physical pain, suicidal ideation, loss of control, feelings of being lost and without purpose, loss of identity (Boss & Yeats, 2014; Douglas, 2004) - Anguished suffering within a devastating emptiness (Florczak, 2008; Lichtenthal et al., 2013) - Loss of heart and soul - "soul-stirring, soul-changing, and soul-calling" (Moules et al., 2007, p. 137) - Loss of identity (Moules et al., 2007; Meert et al., 2015)	- Emotional, physical, and spiritual pain, suicidal ideation, loss of control, loss of self-identity, and loss of purpose - Sense of self as mother remains, sense of self being separate from addictions - Place of soul ache is a place of this anguished suffering in what could be considered to be a devastating void - The nature of custody loss is where one loses their soul and then finds it again in a process of moving through soul ache to reclamation. Their soul is called back from the space of soul ache - Identity as mother intact, loss of child disrupts self-role concept
Complicated grief Struggle to adapt to loss over a period of months or years by 10 to 15% of bereaved population (Neimeyer & Currie, 2009)	- Intense and persistent yearnings for the deceased - Intrusive thoughts regarding the death - Sense of inner emptiness - Hopelessness about the future - Difficulty acknowledging the reality of the loss - Vulnerability, functional impairment, substance abuse (Neimeyer & Currie, 2009; Shear et al., 2011) - Increased risk of mortality (Rostila et al., 2011; Winngaards-deMeij et al., 2007)	- Intense and persistent yearnings for the child who has been lost - Troubling thoughts about the apprehension - Sense of inner emptiness (living and yet dead) - Hopelessness about the future - Trouble accepting the reality of the loss - Functional impairment, going deeper into addiction - Self-destructive path post custody loss (substance abuse) - suicidal ideation/suicide attempts
Traumatic grief Loss of an individual through death by trauma (Neimeyer et al., 2002; Neimeyer, 2011).	- Traumatic death interrupts natural order in families - High arousal - Unintegrated sensations, perceptions persisting for years - Altered sense of security, predictableness, trust, and optimism overpoweringly and perhaps forever undercut by traumatic experience - Compelling struggle for explanation (Currie et al., 2012; Holland & Neimeyer, 2011; Neimeyer et al., 2002). - Haunted by images and thoughts of death (Neimeyer, 2012; Tedeschi & Calhoun, 2008).	- Loss of custody traumatic for mothers - Violates natural order of motherhood - High arousal - Loss/sensations/perceptions persist for years - Altered sense of security, predictability, trust, and optimism (betrayal) - Explanation becomes apparent when mother comes to grips with her own accountability in custody loss - Haunted by images of moment of custody loss/apprehension
Posttraumatic growth Highest form of change associated with grief; distress may be still present (Tedeschi & Calhoun, 2008)	- Making sense of the death; meaning making (Michael & Cooper, 2013) - Discovering existential benefit/life lesson in loss (Currie et al., 2012; Neimeyer et al., 2002) - Transformation, positive adaptation, meaning construction (Michael & Cooper, 2013; Neimeyer, 2005) - Transcendence, transformation (Currie et al., 2012; Michael & Cooper, 2013; Moules, 1998) - Process of re-identification undertaken - New understandings about life and death, a deeper appreciation and understanding of others - A wish to help others who are suffering - A sense of being a better person - Solid identification with others who have undergone bereavement (Douglas, 2004; Meert et al., 2015) - Enduring pain modulated with growth - Expansion of new possibilities, changes in relationships with others, augmented sense of personal strength, an increased appreciation for life; changes in existential and spiritual positioning (Currie et al., 2013; Tedeschi & Calhoun, 2007) - Nonlinear in nature (Currie et al., 2012)	- Life lessons found in coming to terms with loss - Meaning found in relationship with higher power - Positive adaptation and transformation through recovery as well as progressing through the three places/spaces that mother finds herself in (betrayal, soul ache and reclamation) - Identity as mother stable - Sees role as mother differently - Desire to help others who are suffering - Sense of being a better person - Strong identification with other mothers who have lost custody - Pain still is present but able to move through despite the pain - Growth seen in moving into the space of reclamation where we can reach toward the future - Life is valued and appreciated in reclamation - Change in spiritual orientation with relationship with higher power - Increased sense of being in control of future/self - New possibilities emerge for life and living - Mothers move back and forth between and through spaces of betrayal, soul ache, and reclamation

"It was worse than my son passing away." The experience of grief in recovering crack cocaine addicted mothers who lose custody of their

Currier et al. (2012) found a curvilinear relationship between prolonged grief and posttraumatic growth which resulted in both interpersonal and intrapersonal changes. With intermediate symptoms of prolonged grief, there is found the greatest probability of post traumatic growth (p. 68). With lower or higher symptoms of prolonged grief demonstrates less post-traumatic growth (p. 69). The symptoms of prolonged grief, although many, seemed to decrease in recovery. With the mothers' commitment to their recovery, their desire to give back could be demonstrative of posttraumatic growth. Talbot (1998) supports this in that when those who are bereaved make a mindful decision to live, they choose to assist others in the capacities of volunteering or employment in a helping profession.

A move toward religiosity has been found to be related to greater posttraumatic growth (Calhoun, Cann, Tedeschi, & McMillan, 2000; Currier, Mallot, Martinez, Sandy, & Neimeyer, 2013; Milam, Ritt-Olsen, & Unger, 2004). Each of the mothers exhibited a great reliance on their higher power and emphasized a move toward both increased spirituality and religiosity. This may explain their ability, in part, to start to reclaim their lives.

Rumination is also found to have ties to posttraumatic growth (Triplett, Tedeschi, Cann, Calhoun, & Reeve, 2011). Triplett and associates describe two kinds of rumination: that which is deliberate and that which is intrusive. Deliberate rumination is found to result in constructive results and is associated with managing the emotional distress associated with the loss (p. 2). For years, the mothers ruminated about custody loss. During this time, the mothers seem to experience intrusive rumination. Once in recovery, the rumination appears to be more deliberate in nature as the mothers try to make sense of the loss of their children.

Hope remains central to recovering mothers who lose custody of their children. Even despite permanent custody loss in two of the mothers, they still maintained hope that one day they would be reunified with their children. This speaks to the power of enduring hope and the power of the human spirit.

Implications

In the words of John Reynolds (2002),

Disenfranchised grief is as political as it is clinical. Enfranchisement is a political term meaning to . . . set free, to liberate . . . The utility and clinical efficacy for Doka's invention of a political term such as disenfranchisement is that it suggests and action or mobilization. (pp. 352, 384)

This action and mobilization begins with those who have positions of power in society: judicial systems, social workers, psychologists, nurses, physicians, and addiction counselors. To set free or liberate mothers with addictions who have lost custody of their children from stigmatization, marginalization and disenfranchisement in relation to their experience of grief can be a first step in reducing the disenfranchised grief of child custody loss.

The findings of this research demonstrate that mothers who lose custody of their children experience profound grief which can extend up to 10 years past the apprehension of their child(ren). It becomes imperative that treatment interventions such as grief counseling or grief support be provided to these mothers at the time of custody loss and be ongoing in nature—even after posttraumatic growth has been observed. This may assist in the prevention of the development of prolonged grief and prolonged grief disorder. This can start with social work agencies who can refer these mother's to grief support programs as part of mandated options.

While the mothers' suicide attempts did not result in death, it is clear that the risk of mortality can be great. Almost one third of mothers who experience child loss through death lose their lives (Rostila et al., 2011). In the words of Hannah, if child custody loss can be seen as "worse than if [a child] had passed away," then the risk of mortality could be considered to be substantial. Regular contact with mothers by social workers and mental health professionals postcustody loss and regular suicide risk assessments and subsequent treatment can become life-saving actions.

Mothers who have concurrent addictions are 8.4 times more likely to experience death particularly through suicide and overdose (Hser, Kagihara, Huang, Evans, & Messina, 2012). Early mandated referral through the judicial system to addiction treatment centers may be the difference for these mothers. It is emphasized that grief support and grief counseling also be made available to mothers within addiction recovery programming.

Strengths and Limitations

As this research is a qualitative study, the results are not meant to be generalizable but transferable (Glesne, 2015). The small sample is mediated by the assertion that even a sample of one can result in a rich source of data (Crouch & McKenzie, 2006). A sample of at least three participants is considered adequate in qualitative research (Cresswell, 2013). A limitation could be seen within the notion of cause and effect. While through previous research some aspects of grief in mothers who lose custody are known, the paucity of prior research represents a limitation in determining cause and effect which may have been more representative in a quantitative study rather than a qualitative study. Nevertheless, this qualitative study is felt to have resulted in rich data for consideration.

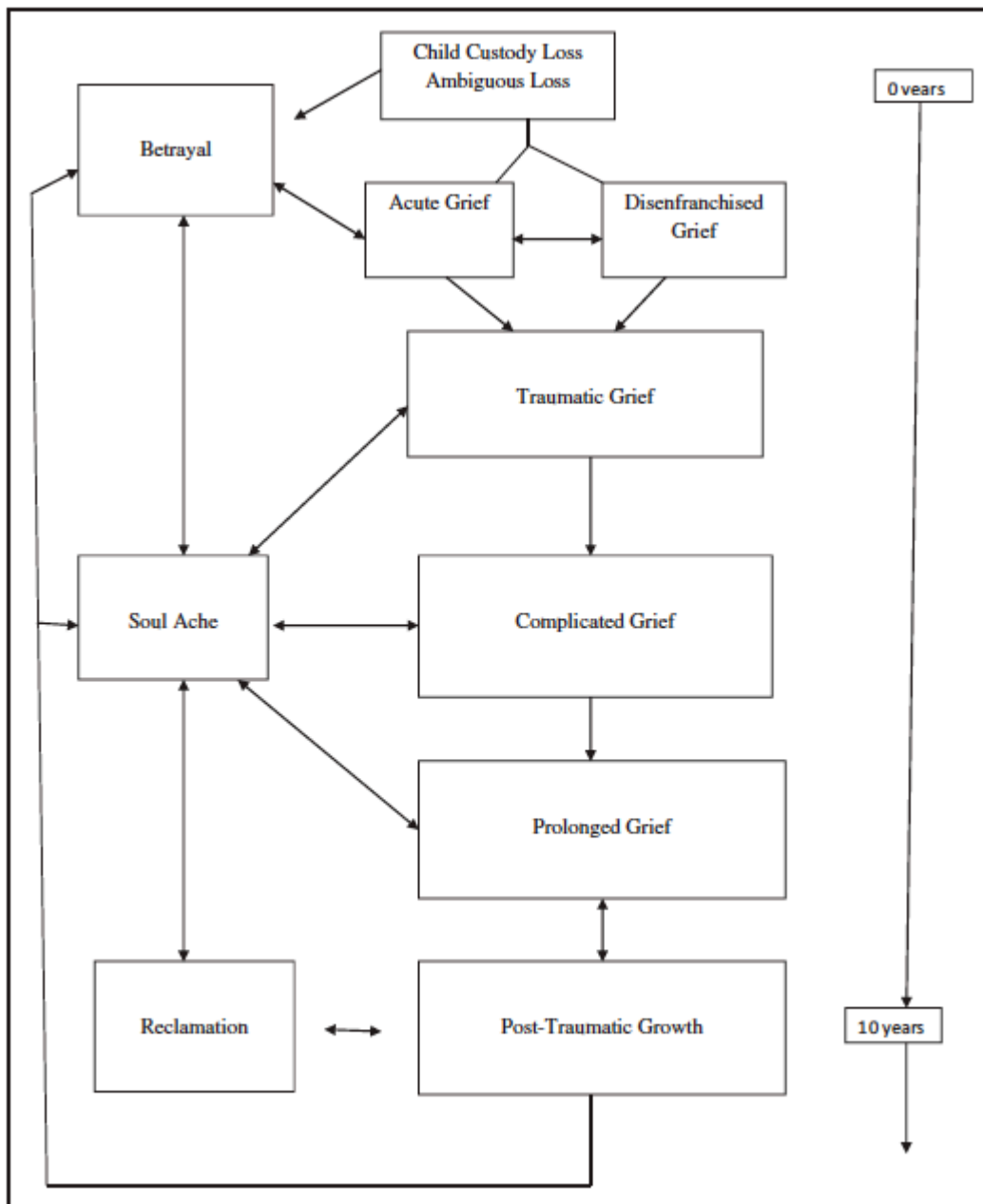


Figure 1. The child custody loss grief model.

Conclusion

In this article, we explored the constructs of grief, bereavement, and loss from the standpoint of the literature. Results of the research were presented. A discussion surrounded ambiguous loss, grief, and posttraumatic growth in recovering mothers who have lost custody of their children. Limitations were outlined.

To date, there has been no known research which has centered specifically on the experience of grief in recovering crack cocaine-addicted mothers who lose custody of their children. This research adds to the knowledge base surrounding not only

a mother's child custody loss but also their experience of grief. As a result of this research, more is known about the symptomatology of the grief that is experienced by mothers and the processes that the mothers progress through: betrayal, soul ache, and reclamation. Although posttraumatic growth has been identified as an outcome of the mothers' loss of custody and the grief that they bear, grief can continue past observations of posttraumatic growth. Much more research is needed to further understand these processes.

Although the mothers in this study did not succumb to their suicide attempts post child custody loss, the risk of mortality is great in this population. If even one life can be saved from suicide due to the devastating effects of child custody loss through the provision of grief counseling, the voices of the mothers in this research will not have been spoken in vain. We leave a call for grief support/ counseling to become an ongoing and standardized practice within all disciplines that are involved with addicted and recovering mothers who lose custody of their children.

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"It was worse than my son passing away." The experience of grief in recovering crack cocaine addicted mothers who lose custody of their

When the Worst Imaginable Becomes Reality: The Experience of Child Custody Loss in Mothers Recovering from Addictions



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Abstract

This article describes findings from a qualitative study that investigated the lived experiences of four mothers recovering from crack cocaine addictions who lost custody of their children. The project was guided by feminist interpretive inquiry, van Manen's approach to hermeneutic phenomenology, and involved thematic analysis of in depth interview data. By telling the stories of these women and using their own words as well as interpretive poetry written by one of the authors to describe their suffering, our research offers important insights to professionals involved in the field of addictions.

For many women, becoming a mother is seen as one of life's most rewarding experiences—one that they may look toward from their own very childhoods. Having children changes not only how women view their own personal lives, but also how

they see themselves in a broader social context (Stenius, Veysey, Hamilton & Anderson, 2005). For the addicted mother, this role becomes a source of ambiguity, strain and conflict when she finds herself trying to choose between being a mother and using substances (Brady, Black & Greenfield, 2009). According to the Canadian Mental Health Association (2011) and Streetworks (2011) (a harm reduction/needle exchange program), child custody loss has been described by mothers with mental health issues and addictions as the worst imaginable outcome of substance abuse. To date, the voices of recovering mothers who have lost custody of their children are not represented in existing literature. In this article, we advocate for this group of marginalized women by sharing their experiences with the worst possible outcome of their addiction, losing custody of their children.

This article is a culmination of the quest to (1) give 'voice' and, perhaps hope, to women who find themselves grappling with child custody loss, and to (2) provide insight into the complexity of these mother's experiences for professionals who treat and come in contact with them.

To provide context for the mothers' stories, we begin by presenting background literature that explores the ideology of motherhood; constructs a composite picture of the addicted mother; delineates child welfare and court practices; discusses trends in addiction treatment and ramifications of child custody loss; and comments on resilience in recovering mothers. This literature underscores the no-win situation addicted mothers can experience. Next, we describe our research approach and emphasize three themes. First, mothers experience feelings of betrayal; second, soul-ache; and third, reclamation when they experience child custody loss. By representing our data with interpretive poetry arising from the transcripts written by Katherine Joyce Janzen (KJJ), one of the researchers as well as participants' verbatim comments to tell the mothers' stories, we are able to depict the richness of their experiences. Finally, we discuss the implications of our findings.

The following poem, written by KJJ, is addressed to our research participants and expresses our commitment to advocacy, to providing context, to giving voice, and to allowing them to find their own strengths.

QUEST

You have shared
Your life,
Your story,
Your soul.
I now act
As an advocate
For you.
I will be your voice.
Your story
Will live on
Beyond the borders
Of your spoken words;
Touching others
With its
Profoundness.

Literature Review

The Ideology of Motherhood

The ideology of motherhood holds a variety of different meanings. For almost all mothers, the attempt to navigate the 'road of

motherhood' can be filled with potholes and fissures as motherhood is both glorified and demeaned (Dunlap, Sturzenhofecker & Johnson, 2006) in a carefully constructed "gender system" of social and cultural roles (Haddock, Zimmerman & Lyness, 2003). While becoming and being a mother is often romanticized, for centuries society has pathologized, demonized and demeaned mothers and presented them as failures as they reach to fulfill impossible expectations (Caplan, 2001; Dunlap et al., 2006; Irwin, Thorne

& Varcoe, 2002; Litzke, 2004). Patriarchal systems, including those of law and custom, have judged and controlled mothers in terms of extensive idealization, scrutinization and denigration in their roles and behaviours (Reid, Greaves & Poole, 2008). Choices in motherhood are further constrained by power imbalances (gender, class, and ethnicity) and social roles which offer a perplexing medium where there exist many choices— none of which are easy (Dunlap et al., 2006). These include being/not being a mother, lesbian mothering, whether to use reproductive technologies, issues of balancing work with the constraints of extended families, being a single mother/parent, and potential poverty (Glenn, Change & Forcey, 1995).

The distance between the polarities of 'ideal mothering' and 'real mothering' further constricts the rights of mothers; significant conflict arises between legal and social responses to mothers who are deemed by society to "behave badly" (Reid et al., 2008) such as addicted mothers or mothers who neglect and abuse their children (Chelsler, 2011). Mothers who fail to live up to the stereotypical ideals and roles that society assigns, especially in terms of femininity and motherhood, exacts severe social stigma (Beck, 2006). This social stigma is further typified in the labels that addicted mothers are given.

A Composite Picture of the Addicted Mother

In our review of the literature we observed a pattern where mothers tended to be polarized into either "good mothers" or "bad mothers" (Brown, 2006). In North America, the stereotypical image of a "good mother" as is severely challenged and delegitimized when mothers abuse substances such as illicit drugs and alcohol (Caplan, 2001; Litzke, 2004).

[A good] "mother is one who is expected to perform a limited number of tasks all of which are never ending. Mothers are not allowed to fail any of these obligations. [This] ideal of motherhood is sacred; it exposes all mothers as imperfect. (Chelsler, 2011, p. 48).

This imperfection is even more pronounced with the addicted mother. Not only does substance use conflict with the traditional female role, it is also considered to be deviant (Powis, Gossop, Bury, Payne & Griffiths, 2000). This deviance is perpetuated and socially constructed in popular media (Meyers, 2004) and within the medical and nursing profession (Marcellus, 2003). Mothers with addictions have been stereotyped as "she devils" or "sexual... Jezebel[s] who [threaten] the lives and safety of [their] born and unborn children" (Meyers, 2004, p. 194). This has resulted in substance using mothers being given various labels including "good, bad, thwarted, [and/or] addicted" as they strive but often fail to meet the 'ideal' of mothering (Reid et al., 2008, p. 211).

Thus the addicted mother eventually is forced to see herself as either a 'good mother' or a 'bad mother' (Brown, 2006). An addicted woman's view of being a 'good mother' often is tied to "trying to do the right thing for their children" (Reid et al., 2008, p. 231). Reid and colleagues support our observation by noting that these women are "very aware of the powerful social forces that have clear images of 'good mother' and 'bad mother' and often [try] to position themselves as mothers attempting to do good in a system and society that does not value or assist them" (p. 231). In her attempts to continue mothering her children, she may live with very high levels of shame, guilt, and self-blame due to her own perceptions of being an inadequate parent (Coyer, 2001). Even with emerging research which supports the presence of adequate parenting skills in addicted mothers (Doris, Meguid, Thomas, Blatt & Eschenrode, 2006; Huxley & Foulger, 2008), these mothers are further marginalized by social service and health care professionals (Brown, 2006), who deem them "unfit" (Powis et al., 2000; Smith, 2006). Shackled by these constraints, the addicted mother often eventually sees herself as being "weak" and "morally corrupt"— paralleling society's view of her (Litzke, 2004).

Social pressures and situational constraints often create conditions where addiction becomes a tool for survival. Intense

poverty, homelessness, social isolation, violent relationships, inadequate food/provisions, and a lack of care for their children often perpetuate addiction (Dunlap et al., 2006). Substance abusing mothers are often further impacted by intergenerational patterns of substance abuse, mental illness, and physical and/or sexual abuse (Cash & Wilke, 2003) which results in further societal stigmatization (Suchman, McMahon, Slade & Luthar, 2005). These significant constraints are felt by society to be solely the problem of the mother and have no bearing on the 'system' or society at large further victimizing and vilifying the addicted mother (Reid et al., 2008). Litzke (2004) aptly describes addiction as "dehumanizing;" mothers are "hailed as addicts" instead of human beings (Aston, 2009, p. 611).

Despite all the barriers and constraints that these mothers face, the role of motherhood provides a sense of stability in recovery (Hiersteiner, 2004). Addicted mothers struggle with feelings about having and keeping their children (Suchman et al., 2005). These feelings result in the presence of considerable conflict which centres on their drug dependence and the fear of losing custody of their children (Powis et al., 2000). Giving up her children is seen as a mother's last possible resort (Coyer, 2001). Clearly, mothers are significantly impacted by the fear of losing custody of their children in their experiences with courts and child welfare agencies.

The Courts and Contemporary Child Welfare Practices

In the United States and Great Britain, 25% to 69% of addicted mothers see their children being placed in foster care or kinship programs (Kovalesky, 2001; Litzke, 2004). In the United States 33% of child welfare cases result in permanent custody loss while Canada's 2004 statistics reveal 62% of all children taken into care have permanent guardianship orders (European University Association, n.d.) which is an increase of five percent from 1999 (Human Resources Skills Development Canada, 2000). In multi-national studies, Canada has the highest rate of child placement (Mulchay & Trocmé, 2010). Rural areas in Canada see children placed at twice the rate of those in urban communities (Budeau, Barniuk, Fallon & Black, 2009). Canadian statistics portray 32% of children being removed from homes led by single mothers with alcohol or drug/solvent use (Trocmé et al., 2005). There has been a shift in which pregnant women now make up 30% of the overall cases mandated in court (Terplan, Smith, Kozloksi & Pollack, 2010).

Rigid restrictions have been in effect for over 10 years in the United States that cause permanency hearings (for permanent guardianship by the State) to be enacted after 12 months, and parental rights terminated if a child is in foster care for longer than 15 months (Smith, 2006; Semidei, Radel & Nolan, 2001). In Canada, children can spend up to three years waiting for a permanency decision which arguably creates a scenario where the children are literally in "limbo" and constrains the development of secure attachments (Knoke, 2009). Given this situation, in the authors' jurisdiction, when three temporary guardianship orders have been in place, the child(ren) are either placed permanently or returned to their parent(s) (Alberta Children's Services, 2007). In both the United States and Canada, there has been a move in the judicial system to shorten these timelines in an effort to enforce quicker permanency decisions (Alberta Children and Youth Services, 2009; Semidei et al., 2001).

Despite the presence of adequate parenting capabilities, mothers who become totally abstinent are still considered to be high risk by the child welfare system (Reid et al., 2008). Social workers' professional relationships with addicted mothers are often strained, even confrontational, with social workers enforcing their own agenda, and paying little attention to the concerns of the mother (Forrester, McCambridge, Waissbein & Rollinick, 2008). The understanding of both the court and child welfare agencies related to addictions/addictions treatment is deemed lacking which translates into a lack of a "just and equitable standard" for working with recovering mothers (Burman, 2004; Kruk, 2008; Smith, 2006). Risk assessment remains a contentious issue but there have been attempts to use a strengths-based harm reduction model (Weaver, 2009). This model sees recovery as a continuum where social workers meet addicted mothers "where they are at" (Kullar, 2009, p. 10). It is of note that advances in addictions treatment programs are beginning to act as a bridge between child welfare and the courts.

Trends in Addictions Treatment

Recovery from addictions is not a straightforward process. While the medical model (complete abstinence) continues to guide many treatment philosophies, advances have been made in addiction treatment. The harm reduction model (relapse being a temporary condition) is increasingly gaining acceptance on a global level (Burman, 2004; Snow & Delaney, 2006).

Gender-responsive treatment is another trend that has emerged since the 1990's, and this model attempts to mediate the complexities of addiction in the context of gender roles, sexism, poverty, and other environmental issues (Grella, 2008). Before 2004, however, models which involved mothers and their children had not yet emerged (Cash & Wilke, 2004).

Models of treatment that include not only family members, but also children, have become more common (Werner, Young, Dennis & Amateri, 2007). This shift in thinking reflects the profoundly negative impact that occurs when, in order to gain access to treatment, mothers are separated from their children (Barry, 2006a; Beck, 2006). In recent years, residential recovery programs have been offering programs and services that allow children to stay with their mother while she engages in recovery (VanDeMark, O'Keefe, Finkleseing & Gampel, 2005; Worley, Conners, Williams & Bokony, 2005). A call for multi-disciplinary teams that can share their expertise in terms of child welfare requirements and issues while concurrently treating the mother's substance abuse remains (Knoke, 2009). Once again, this reflects a pattern in the literature where the voices of women themselves are not represented.

The Ramifications of Child Custody Loss

Child custody loss has profound ramifications. There is very little known about mothers who are recovering from addictions who lose custody of their children. For mothers, the consequences of court-mandated treatment can leave them feeling powerless and victimized (Burman, 2004). Experiencing being labelled an "unfit mother" similarly results in intensified levels of stress, denial, depression, anger, and intense emotional pain (Barry, 2006b; Concoran, 2001; Shillington, Hohman & Jones, 2001). This emotional pain can become even more pronounced when a mother loses custody (Barry, 2006b). Further, the emotional turmoil often triggers increased impulses to seek relief through substance use (Schleuderer & Campangna, 2002) and feelings of traumatisation intensify (Rockhill et al., 2008). Custody loss severely undermines a recovering mother's hope that her children will ever be returned to her (Rockhill et al., 2008). Irwin et al.'s (2002) research revealed that having children physically with her gives mothers the strength to make difficult decisions. The children act as a major motivator to continue recovery (Grella, 2008; Kovalsky, 2001) and as such custody loss can have a significant impact on mothers' efforts to recover.

Resilience in Recovering Mothers

There are only a handful of studies addressing resilience in recovering mothers. Despite the paucity of research, the results of these studies offer more insight into these women's' lives. Recently, Sutherland, Cook, Stetina & Hernandez (2009) looked at problem solving skills and coping strategies as a measure of resilience in addicted and non-addicted mothers. They found that recovering women overall are less resilient than their counterparts who are not chemically dependent. However these researchers also found that the very custodial status of a mother's children seemed to be protective: recovering mothers who had custody of their children had greater treatment completions and decreased substance use in the post-recovery period.

In an earlier study, Hardesty and Black (1999) also identified that the presence of children became the marker of successful recovery where "motherhood served as a survival strategy" (p. 609). Children consistently remained a central focus in the lives of their mothers—even when custody was lost permanently. The emotional bonds created a sense of permanency as the mothers focused on what they viewed as a temporary physical separation. The primary motive of recovery then became a

regaining and re-claiming of their children. Consistently, the mothers in this study reported that the worst possible outcome that could occur was having their children taken away permanently.

Paris and Bradley (2001) found mothers who had lost custody of their children told stories of “hope and resilience” (p. 663). Both Hardesty and Black (1999) and Paris and Bradley (2001) cited that a fundamental task of recovery was re-negotiating a maternal identity. Mohatt, Rasmuss, Thomas, Allen, Hazel and Marlatt’s (2007) study reaffirmed Hardesty and Black’s (1999) conclusions that resilience in addicted mothers was tied to a sense of interconnectedness with family/kin. Despite this interconnectedness, mothers are still ultimately positioned within a no-win situation.

Both the courts and addiction treatment centers desire early reunifications, but reunifications are hampered by the short timelines that currently exist within the judicial system (Hohman & Butt, 2001). Mothers feel substantial pressure to improve their parenting abilities and to stabilize their lives. But the very requirements for programs and services that are meant to help addicted mothers are “ambiguous, incomprehensible, or put [the mothers themselves] at risk” (Reid et al., 2008, p. 224). The social services system for addicted mothers is “all-powerful,” and a source of “constant surveillance” as mothers live under the relentless “threat of having their children apprehended” which results in a “constant source of fear which instilled distrust and powerlessness in the face of” social services (p. 224).

Attempts to use their identities as mothers to drive their recovery may become focused on constantly renegotiating the meaning of what it means to be a ‘good’ mother. There exists a platform where the labels of ‘good mother’ and ‘bad mother’ exist almost simultaneously in the literature. Hardesty and Black (1999) explain that an addicted mother needs to retain a “view of self as a good mother despite the addition... as a self-survival tool” (p. 609) and without this image she falls into a “numbing surrender to self-destruction” (p. 607). The literature is divided on the parenting capabilities of addicted mothers as well as the presence/ absence of healthy relationships with their children (Doris et al., 2006; Huxley & Foulger, 2008). Thus, creating a definitive and accurate portrait of a typical addicted mother is difficult. Despite inconsistencies among research findings, existing literature does provide us with a picture of recovering mothers who have lost custody of their children as women who feel deeply ambiguous. The aim of our study was to expand understanding of this ambiguity and for us to provide a platform to give voice to recovering mothers who may have been ‘silenced’ as a result of losing their children. As Davis and Dodd (2002) assert, ‘silence’ remains a significant barrier to understanding women’s experiences, especially in sensitive-topic research. In sum, this literature review reveals much professional dialogue rather than the women’s own voices.

The Research Approach

Feminist Paradigmatic and Theoretical Assumptions

The feminist paradigm is considered to either fall beneath the umbrella of the interpretive paradigm (Jansen & Davis, 1998), deemed as a theory (Creswell, 2007), or stand on its own as a distinctive worldview (Wilkinson & Morton, 2007). As a paradigm, feminist ontology theorizes “being” and in doing so rejects Cartesian duality and instead focuses on body, mind and emotion (Stanley & Wise, 1993). Stanley and Wise (1993) describe reality in this sense as the ‘self’ where reality is “relationally and interactionally composed”, having historic, contextual, and cultural influences where reality “subtly change[s] in different interactional circumstances” (p. 195). In relation to epistemology, the most central concept relates to there being a “situated knower” and therefore “situated knowledge” (Stanford University, 2009). The relationship between the known and the knower therefore, is one of establishing a mutual conversational relationship of trust where the ‘known’ discloses his/her own personal experiences in an effort to be transparent, and the ‘knower’ in reciprocity is empowered, validated, and strengthened as she shares her experiences (Jansen & Davis, 1998).

Key assumptions of an interpretive-feminist paradigm are: the acknowledgement of the pervasive influence of gender, a primary focus on “consciousness raising”, a rejection of a separation of subject/ object, denunciation of the “assumption that most personal experience is unscientific”, an unwavering concern for ethical implications of one’s research, and unequivocally (through research) women can be empowered and transformed (Milojevic et al., 2008 p. 8). Frisby et al. (2009) further add that

as “multiple sources of oppression are embodied and experienced on a daily basis” (p. 19-20) by women, an assumption exists that a feminist paradigm creates a meaningful framework for making “sense of the physical, spiritual, and social worlds and for envisioning meaningful actions for social changes” (p. 15). Finally, Milojevic et al. (2008) cites that the feminist worldview is a means for “altering” the human condition.

Feminist Interpretive Inquiry

Feminist interpretive inquiry has an end result of a conscious mindfulness of power in terms of gender, but also promotes trust, creates a platform for individual stories to be told, and allows for holistic findings that are not necessarily captured by qualitative research (Elmir, Schmied, Jackson & Wilkes, 2009; Jansen & Davis, 1998). One of the key strengths of feminist inquiry as the giving of voice to voiceless silenced populations (Frisby et al., 2009; Oakley, 1998) who have lived under a “framework of invisibility, marginalization and powerlessness” (Jansen & Davis, 1998, p. 294). Jansen and Davis (1998) cite other strengths of feminist interpretive inquiry such as: supplying the context of the experience, focusing on the strengths of the participants, diminishing hierarchy, de-emphasizing hierarchy, promoting an atmosphere of mutual understanding by allowing the participants to share in the experiences of the researcher, and signalling a non-judgemental stance.

Oakley (1998) cites that the primary limitations of the feminist paradigm are bias and validity. Although the intentions of qualitative research exclude generalizability, a small sample size can signal bias in terms of false inferences when viewing the placement of the story in a wider social and political context (Oakley, 1998; Skene, 2007). Validity can come into question in terms of the veracity of the participant’s stories (Oakley, 1998; Porter, 2007). Feminist researchers “challenge detachment and objectivity” which may be seen as a bias within itself where the researcher seeks to understand the ways that a research topic is “autobiographical” (Glense, 2006, p. 119).

Hermeneutic Phenomenology

Hermeneutical Paradigmatic and Theoretical Assumptions

Hermeneutics is grounded in the interpretive paradigm (Rapport & Wainwright, 2006) which encompasses distinctive assumptions related to ontology, epistemology, and methodology (Koch, 1996; Shah & Corley, 2006). The ontology of hermeneutics is a conviction that truth is founded on relativism where truth is “composed of multiple local and specific realities” (Weaver & Olson, 2006, p. 462). Epistemologically, reality is established intersubjectively or with a “shared subjective awareness and understanding” (p. 462). Methodology reflects the progression of constant revision where theory emerges inductively and the principal goals are understanding and change in a social world that esteems the promotion of practical knowledge.

Key assumptions of interpretive inquiry include: understanding as a key outcome, a acceptance that the world is contextual, holistic inquiry, narrative description, investigation as context laden, theory and practice being interactive and specific, and the presence of a participator- researcher relationship (Bridges, n.d.). Assumptions that are explicit to hermeneutics are: the existence of a distinct interpretation (Shah & Corley, 2006), common life experiences presenting a fertile medium for the study of meaning, a focus on human experience rather than conscious understanding, and the “presupposition of expert knowledge on the part of the researcher” being a “valuable guide to inquiry” (Lopez & Willis, 2004, p. 729).

Melding Hermeneutic Phenomenology with Feminist Interpretive Inquiry

A melding of hermeneutic phenomenology with interpretive feminist inquiry complements hermeneutic phenomenology in several ways. “Hermeneutic phenomenology [from the perspective of van Manen (1997)] is quite amenable to feminist forms of knowing, inquiry and writing” (p. xviii). Both are based upon the construct of “being” (Stanely & Wise, 1993; Heidegger, 1962). Ceci (2003) describes that “facets of feminist thought...have drawn attention to the politics of knowledge through theorizing the significance and the situatedness of knowers and knowledge” and thereby by viewing our characters as “meaning-constituting [it stresses] the interpretive nature of our being in the world” (p. 63). Hermeneutical phenomenology as a “philosophy of actions” has the potential to not only “radicalize thought” but make a difference in the world (van Manen, 1997) by giving voice to the women who may feel “silenced” as a result of losing their children (Davies & Dodd, 2002). This is highly congruent with the aims of feminist thought where “feminism is a program for social change... and [offers an] alternative vision [for] the future” (Milojevic et al., 2008, p. 1).

Rather than the theoretical, abstract detachment that is characteristic of empirical research, hermeneutics is both a science and art form where the researcher and the researched, as co-creators, intimately engage with each other in the “pragmatic and poetical” (Barnacle, 2001; Litchman, n.d.). Interpretive feminism enhances this view where researcher and researched meet on equal ground. “Trust is built not just for the purpose of collecting meaningful data, but for a human purpose in relationships” which sees the participant and the researcher “enrich each other’s lives” (Jansen & Davis, 1998, p. 308). Finally we believe, as did Heidegger (1962), that it is impossible to bracket one’s own life experiences, values and assumptions— a conviction that the writers’ own “life-worlds” can enhance the study as the research process unfolds—a precept held in high regard within the interpretive feminist paradigm.

Additional Considerations of Research Researcher Subjectivity

When choosing a phenomenological tradition for this research, immediately the question of researcher subjectivity arose. In the Husseralian tradition, the researcher brackets his/her pre-understandings and in effect ‘divorce’s’ the research from these influences (Smythe, Ironside, Simms, Swensen & Spence, 2008). We felt it was impossible to tell the ‘story’ without recognizing that we are both mothers and that being a mother and caring for our children is at the heart of all we do. Deciding to use van Manen’s (1997) method was conducive to this end as our experiences are honored and valued in this phenomenological tradition. Investigating the experience as it was lived involved using our own personal experience as a point of departure. Personal experience is considered by van Manen to contribute and not detract from the research process as possibilities were opened up and kept open. This allowed us, as researchers, to exact ‘clues’ for orientating ourselves to the phenomenon and further connection with all the other phases or steps in the research process (van Manen, 1997).

Sensitive topic research “creates a space for self-disclosure by the researcher that might not be appropriate in other types of research” (Dickson-Swift, James, Kippen & Liamputtong, 2006, p. 857). The purposes of self-disclosure “level[ed] the playing field” (p. 857). For us as researchers, it also “level[ed] the power relationship between researcher and participant” (Shields & Diccio, 2011, p. 496).

Li (2002) explains that “by being able to share with others our own feelings, experiences and secrets in this world, we also encounter the other person’s secrets and vulnerabilities of which we must be respectful” (p. 94). By sharing our ‘sacred’ experiences, the women were invited to share their ‘sacred’ experiences. This potentially allowed a deeper sharing of experiences, feelings, and meaning.

The Use of Interpretive Poetry

For van Manen (2007) telling the ‘story’ becomes balanced and enhanced by the use of literature (phenomenological and otherwise), the arts (such as poetry), etymological sources of words, and biography. Utilizing these sources of data, results in more reflective depth, promotes dialogue, and assists the researcher and reader of the research to potentially see beyond (their) “limits” and to “transcend beyond the limits of (their) interpretive sensibilities” (van Manen, 1990, p. 74-76). Perry suggests that “to provide a hermeneutic analysis...[poems express] the nucleus or heart of the narrative” (p.134). Kockleman (1987) supports this view:

In the human reality there are certain phenomena which reach so deeply into a [person’s] life and the world in which [they] live that poetic language is the only adequate way through which to point to and make present a meaning which we are unable to express in any other way. (p. ix)

“Poetry [then becomes] appropriate medium of analysis as it bridges non- verbal and verbal expression and it allows for communication in succinct and creative ways... expos[ing] the tacit, which is difficult to express otherwise” (Perry, 1994, pp. 134-135). Interpretive poetry, written by researcher Katherine J. Janzen, became an integral part of the research process where “together the narratives, poems and literature provide[d] an [enhanced] understanding” (Perry, 1994) of the mothers’ experiences where words alone would at times fail to capture the experiences and feelings of the participants.

Research Question

Our research asked the question: *What is the lived experience of mothers in recovery who have lost custody of their children?* We used a hermeneutic phenomenological approach based on the work on Canadian phenomenologist Max van Manen (1997). Methodology includes elements of (1) philosophic structure, (2) essential assumptions of that framework and (3) the features of the human science perspective. Van Manen saw that phenomenology was a retrospective “study of the lifeworld—in the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize or reflect on it” (p.9).

The purpose of human science is to provide “plausible insights” to our everyday life experiences in terms of discovering the very “essence” of a phenomenon rather than pursuing explanations or control (van Manen, 1997). Rigour, exactness and precision are distinguished by human science’s own criteria. Objectivity is realized in the researchers being “true” and “oriented” to the “object being studied” and subjectivity exists in terms of the researcher perceptiveness, insightfulness and discernment “in order to... disclose the object in its fullest richness and greatest depth” (p. 20). As a result, “grasping and formulating thematic understanding” becomes “a free act of ‘seeing’ meaning” rather than a “rule-bound process” (p. 79). Six research activities guide van Manen’s human science research:

(1) Turning to a phenomenon which seriously interests us and commits us to the world, (2) investigating the experience as it is lived rather than as we conceptualize it, (3) reflecting on essential themes which characterize the phenomenon, (4) describing the phenomenon through the art of writing and rewriting, (5) maintaining a strong and oriented pedagogical relation to the phenomenon, and (6) balancing the research context by considering both the whole and the parts. (p. 30-31)

Sampling

Participants were selected from a purposive sample of English speaking mothers living in Western Canada who had a crack cocaine addiction. Inclusion criteria included: currently living in a residential addictions treatment centre and having one or

more children who were not in the participant's custody during a period of active addiction. Mothers with severe mental health issues, and participants who were heavily medicated were excluded from the sample. A recruitment poster was placed in the host facility and participants contacted the researcher through the agency. All participants gave informed consent. The study protocols were approved by the University Research Ethics board and the Board of Directors at the host recovery institution. No compensation was given for participation in this study.

Data Collection

In-depth semi-structured interviews with four recovering mothers were undertaken over a five month period. Out of the four women who were interviewed, two had lost custody of their children permanently, one was still trying to regain custody, and one had recently received temporary custody while still facing imminent court proceedings related to custody issues. Face-to-face interviews with each participant lasting 45 minutes to one and three quarter hours were recorded on a digital recorder. Other sources of data which are consistent with van Manen's (1997) approach included the researchers' reflections, journal entries, etymological sources of words tied to the research, phenomenological literature and descriptions outside the context of the research such as readings and poetry. These additional representations of data were incorporated to provide context and support for the data.

Data Analysis

A combination of manual and computer-assisted coding was undertaken utilizing QRS NVivo8 qualitative data analysis software (QRS International, 2009) to ascertain themes from the data. Using a dual method of analysis was advantageous as it did not estrange us from the data and allowed the data to be examined with both closeness and distance from the data which is essential in hermeneutic phenomenology. NVivo8 complemented this process with its excellent capabilities to cross-reference, annotate, and index the data. The data analysis as a result was richer and served to enforce analytic strategies that methodologically guide the hermeneutic research process (Seale & Gabon, 2004). Lincoln and Guba's (1985) techniques for operationalizing trustworthiness were employed in the process of data analysis. Member checks affirmed authenticity of the themes. Katherine Joyce Janzen wrote the poems. Van Manen's (1997) hermeneutic reduction strategies guided the data analysis.

Findings

Staying true to van Manen's (1997) philosophy of "thematic understanding" being a goal of hermeneutic research (p. 79), three themes, each with three sub-themes emerged from the data. The three themes represent scenes or dimensions that the mothers passed through as they moved through the experience of child custody loss. These scenes—betrayal, soul-ache, and reclamation—represented key stages in their experiences. Each scene was further divided into three sub-scenes which add additional filters to understand the elements of the scenes. The four stories of the women that were interviewed—Charolette, Crystal, Cristine and Hanna (all pseudonyms which the mothers chose themselves)—are described with illustrative quotes from the mothers which embodied their experiences. Interpretive poetry written by KJJ was used to provide another layer of depth and breadth to their stories (Perry, 2009).

Scene One: Betrayal

Estés (2003) describes betrayals taking many forms... “roads not taken, paths that [are] cut off, ambushes.. or [even] deaths” (p. 365). Betrayers (*bitrayens*) mislead, deceive, and act as traitors (*tradres*) to what and who individuals believe in and people and things accepted as truth. Betrayals and betrayers took many forms—both animate and inanimate. The betrayers of the four mothers we interviewed were not always bodily betrayals but always betrayers of the soul and represented small deaths—*las meurtes chiquitas* and large deaths—*las meurtes grandotas* (Estés, 2003). The primary betrayers became substances, self and others, and child welfare. Each betrayer exacted a price—a price that came as a result of the mother’s implicit trust in the betrayer. The following betrayals are explored using the mothers’ own words and interpretive poetry.

Substances

While each mother described crack cocaine as being her “best friend” in a life that “revolved around [their] addiction,” mothers’ were also very aware that over time crack was “slowly destroying [their] soul.” Their relationship with crack was understood as a progressive, destructive relationship. Charolette knew how deeply the addiction took over her life. “I was so addicted. So addicted. And my addiction was so strong and intense and the negative talk, and it really weighed out, like really took over.” Mothers were pinned between both lives—that of a recovering mother and that of an addict. Said Crystal, “I’ve been clean for periods of my recovery...but it’s always been like okay, my body would be in the door but my foot would be sticking out...” Cristine sadly explained that conflict. “But it’s hard when you feel stuck, right? Like what choice do you make? Do you make a choice to say goodbye to the addict or goodbye to your kid? It’s not as simple as making that choice.” Despite this conflict each women knew that the “ultimate” outcome of being “on the streets [and using cocaine] was going to be death.” While cocaine held the elusive promise of coping with their worlds, cocaine in the end would result in a last final betrayal—the loss of their very lives.

REALIZATION

The first time I met you
It was so good
The feeling I had
That I lost years of my life
Making love to you;
needing you before all others.
Somehow you mocked me
As I turned to you to solve life’s problems.
I realize you have betrayed me
With elusive promises
My best, old friend—cocaine.

Self and Others

Even with the presence of multiple betrayers these mother’s single most significant betrayer was the mother herself. Charolette knew that she had betrayed herself. “I fed into it. I made it more believing. I convinced myself about it. So I gave up

more to life.” Hanna knew that her decision making process was faulty when her children were apprehended. She relates, “I didn’t pick up the phone and call my treatment centre. I picked up the phone and called my drug dealer.”

There were also other multiple betrayers. Christine experienced this with her boyfriend, his parents and even her own parents thinking that they were 100% behind her and realizing this was not the case. Crystal was extremely surprised when her children were told she was their aunt. Hanna identified that others betrayed her with their attitudes about addiction. She felt she was shunned, even if others knew she was in recovery. Hanna explained that even her own mother was reluctant to hug her once she started using again...

Yeah, what’s that in the Bible? The disease you give, leprosy, you know that you’re just contagious. And actually when I started using again I used to say that to my Mom. “Don’t worry, if you hug me, you’re not going to catch an addiction.

TREATCHERY

While you betray me
With thoughts
With words
With actions
The worst betrayer of me
Is me.

Child Welfare

These women described valiant efforts to stay “clean” and adhere to the requirements of their child welfare worker in the belief that they would have their children returned to them. When they completed requirements, however, there were always more conditions imposed on them, which left them feeling confused, alone and discouraged. Charolette sorrowfully described the implicit trust she put in child welfare— “I trusted them with my life and [the] lives [of my children] because I thought they were there for me. They didn’t understand. I felt so alone at those times.” Hanna described the process with child welfare as “jump[ing] through hoops” and then being given “10 more.” The decision to be honest about drug use was always a difficult one. Cristine knew the pain of betrayal... “It was tough, you know, like when they stepped in and it was like I was the bad guy because I was honest with them... I told them the circumstances, everything. It didn’t matter.” Charolette summarized the feelings of the mothers amid the tears that she cried—“They won. They got what they wanted... Not once did I have a worker that supported me, that was there for me or that encouraged me to keep going to get my kids back. Not one. So I gave up.”

CIRCUS

I don’t see it coming
As I jump through hoops
Placed before me
Each one higher
And in the end I fall.
Do I tell the truth
When it leaves me imprisoned;
Trapped Without an advocate?

Scene Two: Soul-ache

GIVING UP

A terrible sadness comes in May
With too much light and unreal green;
A sadness like a jail cell
With no corner left to hide.
Clearly I see a little face.
Soft eyelashes shade her cheeks
And she has such a trusting smile;
Beryl runs forever on a lawn-starred with dandelions.
And always she is six years old.
Again she's asking what I cannot give,
The pain, the tenderness is there once more
The old reproach of selfishness.
While other people raised my child
I sought sanctuary in madness.

(M.C. Jones, 1970, used with permission)

Madness comes in many forms when trying to live with loss: seeking relief in continued use of substances, trying to end one's life, and falling into deep depression while struggling with living itself. Madness was found within the spaces of accountability—where blame was situated for events that had happened. Eliot (1969) described this madness as “the pain of living and the drug of dreams,” where one is “neither living nor dead.” (p. 38). This was the true space of soul-ache.

The Moment of Loss

The very moment that the mothers' lost custody of their children represented a death for the women who remained—deaths without funerals or spaces to mark them. This ‘death without death’ was considered worse than if their children had physically died. In many ways the mothers felt that they had themselves died right along with their children. Each woman could recall the moment of loss vividly.

Charolette experienced the loss of her children in a court room where she voluntarily gave up custody. She had been battling her addictions and came to the point where she believed that there was no hope left for their return. She saw the decision as one of “giving up,” a decision which “broke [her] heart.” Crystal abandoned her children when she was 18 and left for another city when she didn't have enough food for her children and didn't know where to go for help. She felt she had “failed” and “couldn't give [her] kids what they deserved.” Cristine lost her son when he was 11 weeks old. She was trying to deal with post-partum depression and couldn't manage a little baby and the emotions that were surfacing related to the death of her first infant son. Hanna lost custody of her new born daughter in a hospital room. She related, “I've never cried so hard in my life. Like nothing breaks my heart more.”

WHITE CROSSES

I mark the spaces of soul-ache.
One for each time my heart broke.

Accountability

Each mother had great difficulty coming to terms with how accountable they were for the loss of their children. Crystal had no food for her children; Cristine was suffering from post-partum depression. Charolette had been beaten so badly by her husband that she had a brain injury; Hanna thought she would be able to make a decision of where her children were placed. Despite this, each woman came to accept her role in the loss of her children.

Charolette relates that although she knew she “was a part of the problem of giving them up... all [she] knew was to use drugs.” Cristine knew that her cocaine use was the direct reason for losing her two daughters, both of whom were born addicted to cocaine. She stated, “It cost me my life and my kids.” The most difficult part of losing custody was, as Hanna explained, “to know that [she] did it to [herself].”

Living with Loss

After the mothers lost custody of their children they went through a period in which they engaged more deeply with their addictions. It was a period of indifference in their lives—lives which ceased to have meaning except by that defined by cocaine. For the women it was a downward spiral into “losing everything” and “cutting everyone out of their li[ves].” Crystal described herself as being “broken.” The depth of despair was overwhelming. Charolette knew in her heart that she totally “gave up” to the point she knew she would “die out there.” Hanna described the deadly effect of losing her children...

No. I didn't feel like [living]. I felt that all the hope was gone. What did it matter? I might as well go die and that's what I tried to do. Like honestly, that's why I ended up in [hospital] because I tried to kill myself. My mom took me to the hospital and told them. You don't put her somewhere, she's going to be dead. And I probably would have been.

THE VOID OF NOTHINGNESS

Her loss, like death, changes me
For a time the very jaws of hell gape open
And I fall into darkness
Until there is nothing
No words
No thoughts
No soul.

Scene Three: Reclamation

If soul-ache was the place of the soul that hovered between living and dying, then reclamation represented a place of rebirth where life was declared once more. This dawning hailed an entrance into a new stage in their lives—one where hope began to exist again. Reclamation consisted of three areas: learning to live again, the perfect day, and reaching toward the future.

Learning to Live Again

Learning to live again was a process for the mothers. Their hearts and souls began to be expanded. They began to feel hope which came from a place where each woman refused to believe that the separation from her children was permanent. They looked toward a both a future where that they would have relationships and contact with their children, and a present where they still saw themselves as mothers.

Each mother emphatically and assuredly stated that “[she] would always be their mother.” Crystal firmly stated, “Nobody’s going to change that, no matter what. Your children will always come back. Will always come back.” Charolette held on to the belief that in the future, she would be able to have contact with her sons: “Another thing that keeps me going is that, knowing I’m gonna—that I can possibly one day see my boys. See my boys and talk to them, or even get a letter from them. It’s a start.” The mothers’ fervent belief in God as their higher power had helped them and continued to help them regain not only their lives but their children.

Part of learning to live again was coming to terms with the role that child welfare had in their lives. Charolette expressed a sense of thankfulness for child welfare when she said, “ But yet I thank them. I thank them for the person I am now... I thank them because they’re there. They gave me that push in life.” Hanna summed it up this way—

I can’t hate the system forever for wanting better for my children and taking them out of a negative environment... A child in an addictive atmosphere where there’s drugs and alcohol going on is not a good place for them. So I can deal with that...

A Perfect Day

Each woman was able to describe a perfect day with her children which provided the motivation that carried her forward into her recovery. These days were of normal activities, but were profound for the mother herself. For Cristine and Crystal it would have been just in the act of “being with” them and “feeling of their energy and love.” The perfect day would be one of absorbing all the actions of their children as the children simply played around them.

The power of touch was something that was sacred to these women and represented the greatest gift that they could be given on a perfect day with their children. Cristine’s wish was just “to hold” them, while Crystal would simply want to “touch [their] faces.”

Hanna’s description of what a perfect day would be for her was filled with a longing that was bittersweet:

I think I would just hold her. So I would just hold her, and you know, I talk to their pictures every night. Clara...Clara she’s just... my mom says she’s just like me and it’s true...with Clara I would just hold her, I think. I would just want to be alone with her. The same with Izzy. And just do what she wanted to do.

THE VISIT

I touch your face
And you are real;
You are here.
I cry
Tears of heartache past,
Tears of present;
Tears of future hoped.

Reaching Toward the Future

Each of the mothers represented individuals who didn't just go on trying—they were able to both conquer and reconcile a past that otherwise may have crippled them and to reach toward a future that had promise. Without the shackles of addiction their life had new freedom—a freedom to dream; a freedom to become that which was in their imaginations. Many of the women's dreams centered on what most people take for granted: having a nice house, a good job, and spending time with their families. Charolette's dreams revolved around employment and her family with the resolve that she needed a secure job to "become a mother again." Crystal's motivation was found in her children. "Everything I do is because I want a better life for my children. In all instances... it's hope for my kids and grandkids." Cristine firmly recounted a simple truth—

For a long time I thought I was powerless, but you know what? For the first time in forever, I finally feel like I can do this because before I became overpowered by crack, I was an amazing person. I worked two jobs. I had my own place. I took care of my friends. Like I could do it... I could function and I could make it happen because I was strong and able. Well, I finally feel that way again so I can do it and I will... I will, for me and for my kids because without my kids, I don't have me and without me, I don't have my kids.

Hanna echoed this when she said, "I have my recovery. And with my recovery is going to come life, and with life comes my kids."

RECLAMATION

Once imprisoned
I have broken free.
Before me lies
My children...
My future.

Discussion

Motivation to Remain in Treatment

Thoughts of their children remained a primary motivator for the mothers to remain in treatment. Even when mothers permanently lost custody, they looked to a day when their children would surround them. This is consistent with Ferraro and Moe's (2003) study where they found that "even when women's rights were terminated and [mothers] were prohibited from

interaction with their children believed that they would be reunited one day..." "This connection [with their] children helped [them] to survive and look toward the future with hope" (pp. 34-35). A 'perfect day' was conceptualized as a dream that she held close to her heart and soul and motivated her work not only toward recovery, but also how she lived her life. This dream provided a tangible foothold which brought forth the strength and "faith... [to] pursue a new direction (Jones, 2007, p. 207).

The power of 'touch' was a concept which permeated each interview. Each woman dreamed of simply holding her children—touching their faces. This image seemed to be healing for each of the women. Touch is considered to be both discriminative and emotional (McGlone, Vallbo, Olausson, Loken & Wessberg, 2007). Through touch emotions are communicated (Hertenstein, Holmes, McCullough & Keltner, 2009). It has been demonstrated that the sight of touch as well as the thought of touch light up the same areas in the brain in Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scans as if touch was occurring physically (McCabe, Rolls, Bilderbeck & McGlone, 2008; Seung-Schik, Freeman, McCarthy & Jolesz, 2003). Touch, therefore may be both emotionally protective and simultaneously acting as a source of motivation for the mothers to continue in their recovery.

Redefining Life Without Children

This study adds to the determination of what constitutes intense emotional pain (Barry, 2006b) in recovering mothers. The women in this study felt that custody loss was worse than if their children had died. This represents an ambiguous loss for these mothers (Betz & Thorgren, 2006).

Ambiguous loss is a loss that doesn't fit within the traditional notion of death and are felt to be either loss where there is physical presence but psychological absence or physical absence but psychological presence. Recovering mothers who lose custody of their children fit into the latter category. This type of loss can be compared to a child that has been abducted, but in this case the child is apprehended. In this loss "the natural processes of their lives stop the day the child is" apprehended (Betz & Thorgren, 2006, p. 360). These losses find mothers "stuck [in an] uncertainty of what their role is" with subsequent feelings of "powerlessness, insecurity in their future... and examining [their] values and beliefs... calling into question who one truly is" (p. 360). In addition, in ambiguous loss, the loss of role is mourned and creates a situation where a redefinition of relationship, roles and responsibilities presents itself to the bereaved.

Ambiguous loss presents itself as a situation where there are no rituals for meaning-making and the loss is socially stigmatized (Betz & Thorgren, 2006). "For years [the mothers] may go through the cycle of hope only to be disappointed once again" (p. 361) where the "grief can be exhausting" (p. 362). Betz and Thorgren note that "with [this] ambiguous loss the [mothers] cannot simply move on. Their immobility or inability to deal effectively with the situation becomes a combination of... feelings of failure [and] the impossibility of the situation that... leave[s] them powerless" (p. 362).

The death of a child is considered to be catastrophic (Craighead and Nemeroff, 2004) and the outcome for these women was indeed catastrophic. "I felt that all hope was gone. What did it matter? I might as well just go and die..." This wish to 'go and die' was acted upon as each of the mothers engaged deeper with their addictions—consciously attempting to end their own lives with increased crack use.

Carlson, Matto, Smith and Eversman (2006) describe mothers who lose custody of their children as experiencing "intense emotional reactions" where mothers may surrender to feelings of desperation. Wijngaards-de Meij et al. (2007) notes that outcomes of parental loss of a child can be parental mortality. Jiong, Precht, Mortensen and Olsen (2003) cite that mothers are particularly vulnerable in the first three years after a child's death and are at much higher risk of suicide than fathers. The loss of hope appears to be omnipresent whether the loss occurs because of custody loss or child mortality (Roberts, 1999).

A grieving process ensued which was consistent with Florczak's (2008) notion of finding meaning in the loss of their children. The strength and courage to go onward could be considered to be "post- traumatic growth" which is the "highest form of change associated with grief" (Tedeschi & Calhoun, 2008, p. 31). Resilience was a demonstrated outcome where maladaptive

coping (Sutherland, 2009) gave way to behaviours consistent with not only life and living, but also living well, which seemed to be tied to the ability to have hope, goals, and dreams.

Re-conceptualization of Life and Role

While the literature points to recovering mothers re-conceptualizing their identity as mothers (Paris & Bradley, 2000; Sutherland et al., 2009) our study supported that it was their *role* as mothers that was reconceptualized. Each of the women had a firm belief they were still mothers despite the loss of their children. This kept their identities as mothers intact. Hence it was not their identity that was relinquished when they lost custody but a process of renegotiation of role and what that role looked like. This role was primarily influenced by what having contact with their children would look like in terms of capacities and activities.

Making Sense of Losing Children

Frankl (2006) found that finding meaning is integrally “unique and specific” to those that seek it. A recovering mother appears to make sense of losing custody when she accepts accountability for the loss of her children. Part of making sense was accepting that “mistakes” were made and moving onward despite those mistakes. Cristine said, “Whatever I have to live today, I can’t worry about yesterday... I know that what I did yesterday is going to affect my tomorrow, but right now I can just be here.”

A solid relationship with their higher power was a lifeline for these women. The concept of a higher power is synonymous with recovery programs (McGee, 2000; Ronel, 2000). Brome, Owens, Allen and Vevania’s (2000) study revealed that a relationship with a higher power resulted in “more positive self-appraisals, more positive relationships with others, and an empowering coping stance” (p. 482).

Courage in the Face of Social and Societal Adversity

The presence of the kind of social and societal adversity these women experienced is supported in the literature (Aston, 2009; Poole & Greaves, 2009). The mothers faced considerable mixed messages from both society and the institutions that served them. These conflicting messages had a significant impact when one considers the recovering mother’s efforts to use motherhood as a driver to recover. These ambiguities left them with a considerable burden to carry—furthering feelings of being lost, confused, and alone. These mothers valiantly tried to change their lives in the face of complex ever changing ‘rules’—always hoping that adherence to these conditions would result in the return of their children.

As Powis et al. (2000) note there is a definite struggle between using drugs and keeping custody of one’s children. What this study adds is that there comes a time when mothers ultimately make this decision. This ‘giving up’ could be understood as a process of deliberation which is influenced on many fronts but primarily by the betrayals they experienced. The literature is clear that child welfare workers have an impact on recovering mothers who lose custody of their children (Poole & Greaves, 2009; Reid et al., 2008). What emerged from our study was that betrayal was not framed singularly from child welfare workers. Rather, betrayal was multidimensional and included substances, significant others, and the mother herself. While the findings support that literature which describes addicted women as seeing themselves as thwarted and punished (Reid et al., 2008) what is further gained from this study is the magnitude of the impact that others have upon them. In Charolette’s words, “A mother will lose her life.”

While Aston (2009) notes that addicted women learn to “hail” themselves as addicts, what gave the women the courage to persevere despite the reactions of others was a central belief that, in the words of one of the women in this research, they were “not the addiction” but the “person behind the addiction.” They were first and foremost human beings. This adds to current knowledge that even in their darkest moments, their identity was not solely reflective of their addiction.

As we listened to our participants’ stories about their children and their treatment, we were struck by their courage in both the very thoughts of their children and in the philosophies of the addiction treatment center which they resided. Each woman felt she had been loved and supported as she progressed through recovery. All of the women noted they were “loved” until they could once more love themselves. This is consistent with what Kearney (1998) saw as “truthful self-nurturing” and what Aston (2009) described as recovery assisting mothers to see themselves differently. The mothers experienced truthful *other*-nurturing until they could truthfully *self*-nurture. What this adds to current knowledge is that Maslow’s (Boeree, 2006) basic human needs—even in recovery—extend beyond physiological and safety needs and are seen within the seeds of being esteemed, belonging, affection, and most importantly being loved.

Strengths and Limitations

Although generalization is not an aim of qualitative research, a limitation of this study is a lack of generalizability. However, the goal of this research was not generalizability, but transferability (Glesne, 2006). Studies which have small samples are thought to “...deepen understanding and build breadth into their investigation through mindfulness of other work in the field. Thus... just one ‘case’ can lead to new insights... if it is recognized that any such case is an instance of social reality” (Crouch & McKenzie, 2006, p. 498). Although this study had a small sample, with any study there are considered to be tradeoffs between depth and breadth (Patton, 2002). With this in mind, the aim of our study was to explore in detail the lived experience of recovering mothers who had lost custody of their children, or in other words, to seek depth. The breadth of this study could be reflected in the provision of associated literature and first examining disciplinary knowledge in the form of a literature review and then, situating findings in the context of that literature.

Recommendations

There are several recommendations that arise from our research. For mothers in recovery, the ability to hold or touch their children, even if only in their minds, embodied motivation for the mothers. Guided imagery that simulates the experiences of holding or touching their children may be valuable as a modality to sustain both well being and motivation in recovering mothers.

Tedeschi and Calhoun (2008) note that “the encounter with major losses teaches the bitter lesson that the individual is vulnerable to experiencing great suffering” upon the death of a loved one (p. 33). For mothers, this represented a figurative death. Losing custody can be viewed as an ambiguous loss resulting in disenfranchised grief in a society that does not recognize the immense suffering of mothers who lose custody of their children (Betz & Thorngren, 2006; Hazen, 2003). Grief counselling represents a viable strategy that could be easily undertaken as part of treatment in addictions recovery. Given the course of self-destruction that mothers engage in after losing custody, this may act as a buffer and provide new strategies to cope with the loss of their children and potentially decrease the risk of suicide.

The loss of custody has a profound impact on mothers. Hope is both lost and regained through the belief of others. Those who occupy positions of power, such as physicians, nurses, child welfare workers and addictions counsellors are called upon to promote and communicate a sense of belief in an addicted mother to recover. Utilizing a strength-based perspective, examining personal belief and value systems as human beings and as professionals, as well as negotiating the underlying philosophies of their professions may do more to assist these mothers than any other single force in the recovering mother’s

lives. Perhaps only then will society and social institutions begin to create a “just and equitable” system (Kruk, 2008) that meets recovering mothers “where they are at” (Kullar, 2009, p. 10).

This begins with giving voice to mothers who have lost custody of their children and providing opportunities for dialogue. Instead of viewing these mothers as ‘good’ or ‘bad’ perhaps it is time to see addicted mothers as human beings with strengths and frailties—and the capacity to change their lives given appropriate supports and resources. Examining personal and professional belief systems may help professionals and institutions realize inconsistencies between their practices and values which may have served to penalize and subjugate addicted mothers in the mother’s efforts to recover. The single phrase, “believe in me,” spoken of by one the mothers in this research, may have more power to change lives when acted upon by those who can and should enact change in our societal structures than any other phrase these mothers could utter.

SHERPA

Believe in me.
I am not the addiction.
I am the woman behind the addiction.
I laugh. I cry.
I hurt.
I need you
To be my guide
As I climb
Over mountains
That rise above me.
Without you I falter.
Without you I fail.
Believe in me.

Conclusions

Human suffering can take many forms. For mothers with addictions the loss of custody of their children represents a dark, deadly period in their lives where there is intense suffering and pain. From a humanitarian perspective, this research has invited the reader to vicariously experience, through the stories of the mothers, the experience of child custody loss. While the reader may find this paper disturbing and unsettling, a bird’s eye view of the pain, grief, and loss of recovering mothers becomes very ‘real.’ Perhaps more importantly, the message—that recovering mothers can recover from this loss—is paramount. Ultimately, the use of our findings has the potential to be influential as professionals consider their own practices, identify their beliefs and values surrounding addicted mothers in recovery, and perhaps as a result, take the first steps towards enacting social and disciplinary change.

Our research underscores the multiple contextual factors that are associated with substance abuse in mothers as well as their journeys to recovery. There exists a need to look at recovering mothers who have lost custody of their children in a holistic sense while trying to ascertain influences that affect their drug use and subsequent custody loss. Examining the experiences of recovering mothers who have lost custody provides further insights that identify the needs of recovering mothers and the processes they go through in their journey to reclaim their lives. We hope that with further research, these processes will become better understood and assist in the progressive determination of policy and treatment options.

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