# Experiential Learning

Abstract

This paper sketches some ways in which teachers of nurses may help learners gain more from their practical experience. It aims to demystify the term “experiential learning” without glossing over its subtleties. All the methods described are being practised in nurse education and the reader will be able to identify those which she actually uses. The article will use the pronoun “she” throughout.

James Kilty

In my role as Lecturer in Adult Education at the University of Surrey I contribute to the post-graduate certificate in the education of adults, the majority of whose students are nurses, midwives or health visitors in training as tutors. In this I continue work done whilst in a similar capacity in a previous appointment, jointly with the Royal College of Nursing. I also contribute extensively to continuing education and in-service training in the NHS (for nurses, doctors and others), for other professions, both in the University and elsewhere. I acknowledge my deep sense of gratitude to colleagues and students old and new who have taught and continue to teach me so much about the pleasures and challenges of nursing. This article is one of the ways I can repay the debt I owe for this learning and for the support I have received.

Origins

A considerably shortened version of this article has been published in the ‘Quest’ series entitled Feelings, edited by Charlotte Kratz in the Nursing Times. It was called “Learning from Practical Experience”, and appears in the July 21st 1982 issue.

The paper is based on handouts used in various postgraduate courses and in-service trainings such as study days for doctors and nurse tutors, the postgraduate certificate in the education of adults course and the vocational training courses for doctors and dentists.

Uses

The issues raised in this paper apply, with some minor modifications, to ANY PROFESSIONAL TRAINING, where there is an alternation of “classroom” and practical work, extending over a significant period of time.

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NB I have resurrected this paper from print and OCR and added some dubious arrows to the diagrams. The long diagram near the end is a jpg photo of an original page added in 1987 to augment the text. I hope it is still of use though there has been much change in all areas of training, especially in Nurse Education and Nurse Teacher Education, the latter which was the primary audience of the original.

James Kilty, Hayle 2023.

# Experiential Learning

## LEARNING THROUGH EXPERIENCE

My starting point in this paper and in my current educational work is that all of us have an intrinsic tendency to draw upon our experience to grow in knowledge, develop our values and attitudes and extend our range of skills. We are constantly absorbing information through our senses and digesting it as we act in what is never a static situation. The basic skills to do this are inbuilt in the human organism: these skills are also refined and developed through experience.

Experience does however present its challenges. To meet them we either draw on existing skills or create new ones at the time in an attempt to solve the presenting "problem" Our decision to act is based on our existing knowledge, with all its assumptions (true and false), both conscious and unconscious. In that sense our wisdom is limited by our past experience. Since experience can challenge us to our limits (and beyond) then we attempt to survive in it - that is, to preserve our belief system, our self-images and in extreme cases our lives. We therefore defend ourselves against the challenge. In such cases, learning is temporarily suspended and we store in our memories (more and more) 'unfinished business' to deal with later. This process. happens more or less naturally, but it can be hastened if we can create opportunities to go over the 'unfinished business'.

Thus, a combination of 'here-and-now' learning and reflection on past experience is necessary if we are to gain the most from experience. The nurse is given a great deal of time in supervised and unsupervised practice. The intention is clear and wise: she needs the opportunity to acquire a very wide range of skills to be effective in her profession; technical, inter-personal and personal (1) involving cognitive, affective and behavioural components (2). She needs the freedom to apply her growing skills in the real situation, with appropriate safeguards for herself, her patients and her colleagues, against the inevitable 'errors' in her 'practice makes perfect' or 'trial-and-error process. If the process is not to be too traumatic so that she inevitably defends herself, then she needs careful guidance and preparation, with a graded programme of activities which includes self-initiated 'risk-taking' and caring support from those around her to help her gain the relevant knowledge, attitudes and skills. She needs to create (and have created for her) opportunities to review what she is learning, clarify what she might learn from past and future experience and extend her own skills of learning through experience.

The remainder of this paper amplifies a distinction between *learning by experience* and *learning from experience* and suggests ways in which teachers of nurses may enable these processes to be more effective, both in clinical practice and in informal and formal settings away from the many environments in which nursing care is given.

## LEARNING BY EXPERIENCE

The 'self-actualisation' tendency or 'instinct' is a more or less conscious *and* a more or less unconscious process (3). That is, we may be more or less aware that we are learning *during* an experience; we may realise after an experience (sometimes long afterwards) that we have learned something significant or that we were going through a growth episode using many related experiences and which was unclear at the time. The rough and tumble of professional life. the varying and unpredictable demands and stresses of ever changing situations, tend to leave us preoccupied with what our immediate and future responses should be, rather than on our learning process. For example, in trying to perfect a difficult skill it is sometimes when we *forget to try* that there is a sudden integration and surprise that we can do it after all.

That the process is largely 'unconscious' (and innate) can be seen by sleeping on a problem and finding the solution comes to mind on waking (we can even instruct ourselves to dream about a situation and often do so anyway) or after relaxing in a hot bath or just by leaving the situation and doing something else. *Relaxation* seems to be an important condition for this creative process.

The more data we can draw from the experience, and the more we trust our own self-actualisation tendency, the more completely will we learn. This implies having as much attention for the experience as possible, both for external events *and* for our own internal processes.

Attention for events external to ourselves corresponds with what nurses label “observation skills”. This means not only using the senses of sight, hearing. touch, smell and taste and being open to the incoming information. It also means being aware of how selective this attention is, when concentrating upon aspects of experience such as the non-verbal signals from a patient or colleague, or when *not* looking at someone, thus losing valuable information.

Attention for internal processes and behaviour corresponds to what nurses call “self-awareness” (4). This means noticing thoughts, intuitions, emotions, bodily sensations, intentions (for ourselves and others), needs, what we are doing and how we are doing it and how these all relate.

Here thoughts and intuitions include: creative ideas; imaginations, hunches and guesses; images; memories of past meetings, similar situations, learning, teaching; prescriptions, expectations; ‘shoulds’ and ‘wants’; structured and unstructured thought processes such as trying to remember and memorising, ‘brainstorming’, evaluating; problem-solving; rehearsing; visualising; prognosing; planning, empathising.

The balance between being immersed in an experience or being absorbed by it, and witnessing it or standing back from it (which is a form of meditation) is not easy. It is a skill many have acquired (or have not lost!) through life and which can be enhanced through training.

Simple paired training exercises include: “Now, I am aware...”, (in the classroom or practical situation) “I observe ... I imagine …” (5, 27a) describing nonverbal behaviour; role play exercises e.g. feeding a patient, ‘blind walk’ (6), taking a nursing history. Group activities include: describing in detail an event in the classroom or a short film, ‘here-and-now’ group discussion (7) group games e.g. ‘falling leaf’ (7a). Individual activities include relaxation routines, meditation, especially silent ‘witnessing’ of internal processes and of both internal and external events (sitting or moving around, with or without non-verbal interaction (7a). Review of these activities would include quality and selectivity of the attention in order to train learners in observation skills.

Simple interventions by a teacher in the practical situation include: “what are you thinking/feeling/noticing ... now?” “What tensions do you notice in your body?” “What are you imagining?” or encouragement such as “You’re OK” (8), “you’re doing fine” or “relax”, “slow down, notice what you’re doing”, “take care of yourself”. These can help nurses enormously in noticing and observing what is going on in themselves and in the situation.

Observation skills (9) such as those discussed above, are only the beginning of an often complex process of professional decision-making as for example in application of the nursing process (10). Generally speaking, since only part of this process can be discussed in the presence of a patient, much of the teacher’s activity will be to encourage reflection upon past (immediate) experience then it is the second of the two processes which becomes important.

## LEARNING FROM EXPERIENCE

A more deliberate and conscious process of learning through experience is to reflect upon past experience(s) with the aim of puzzling out some significant learning (11). This is used in order to determine some new action or set of actions when returning to the activity. Again, this is a skill to be deployed in a situation - indeed much professional activity involves this kind of silent mental process, although it often must be overtly carried out in negotiations with a patient, so that *both* can learn from the process.

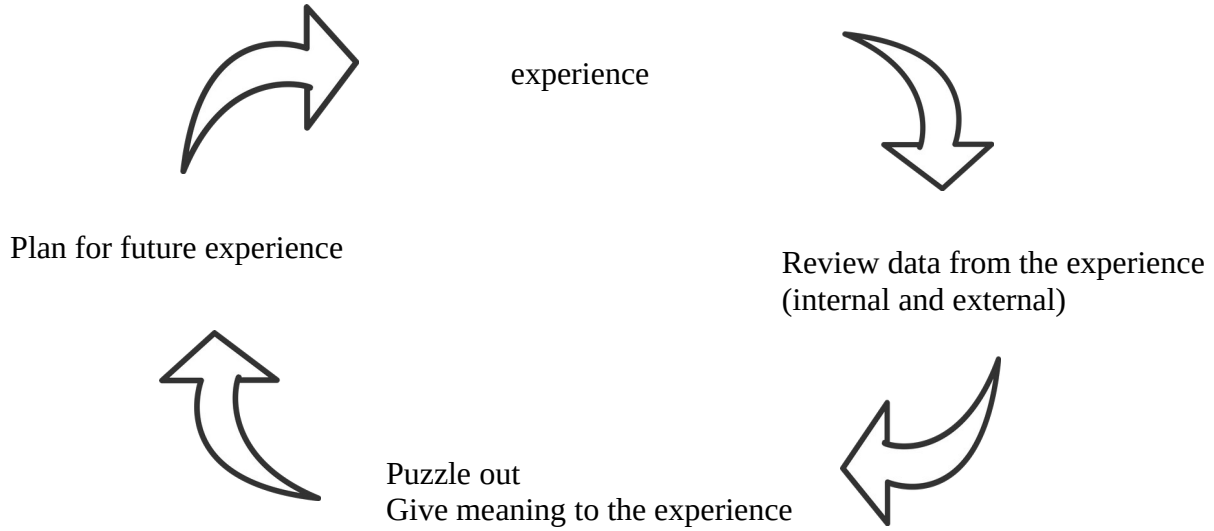
However, it often requires more time than is available and thus needs to be carried out away from the problem situation, in private, or aided by a colleague or teacher.

Clearly much of this goes on *informally* as nurses individually and in ad hoc social groups go over experiences of the day off duty, travelling home and elsewhere. However, though a glance at the diagrams below will surely confirm that we use these processes, further thought will surely confirm that on the whole we are unsystematic either in setting time to review experience thoroughly or in using a logical procedure.

As teachers, perhaps we err in insufficiently encouraging intuition and feeling and as practitioners in insufficiently encouraging logic and deliberate behaviour. The procedures below aim to integrate these more fully.

The basic cycle is as follows:

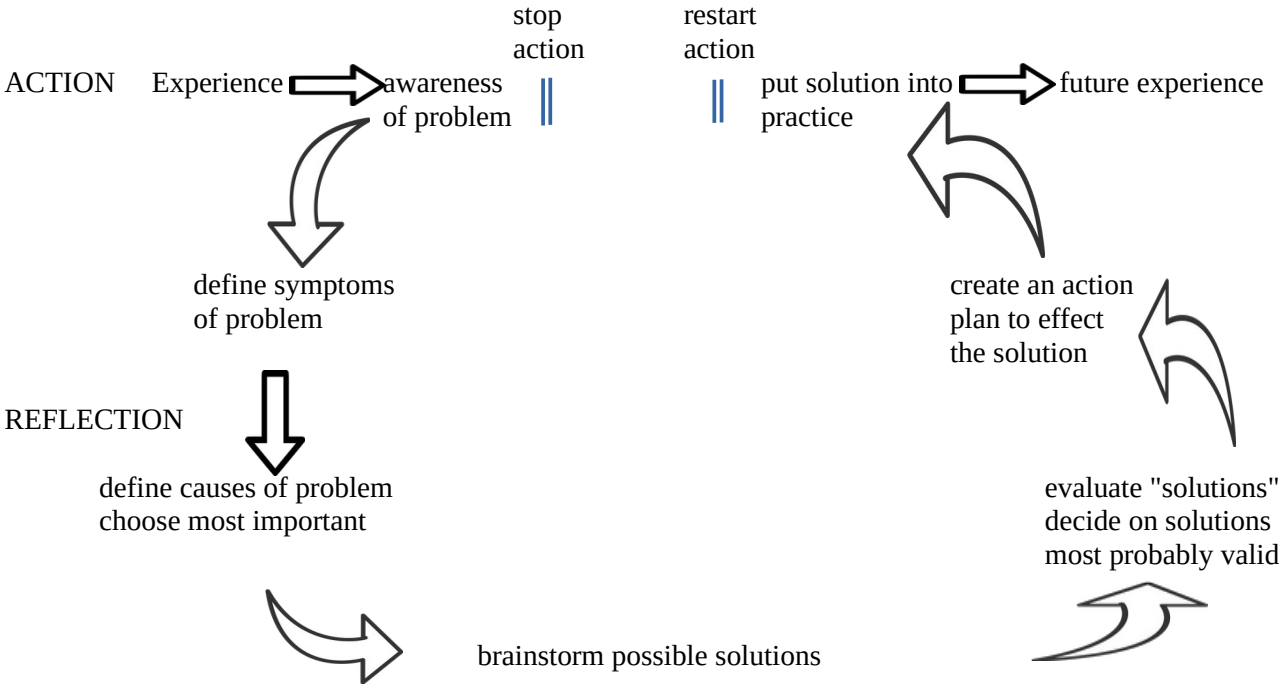
Fig 1: **Experiential learning cycle** *




After Kolb & Fry (12)

* Paradoxically the more aware we are of the experience (self-monitoring or ‘witnessing’) and the more the awareness is balanced between the inner and the outer experience the more accurate and complete will be our “objective” memories of the experience and the more valid will be our creative, intuitive, spontaneous action and the less need we will have of the cycle, which will be easy to use. The less aware, the less accurate and the more subjective will be our remembered *perceptions* of the experience, the more we will need the cycle, the harder it will be to use and the more resistant we will be to taking responsibility for using it.A version of this which is an easy to use practical procedure for solving problems is as follows:

Fig 2: **A Problem solving ‘cycle**



Any step in this cycle may be difficult to complete for lack of information. It will not be begun unless there is motivation to do so and sufficient influence for change (13) The less attention we pay to *ourselves* and the situation, the less information we have and the less likely we will find a valid solution.

This then presents one of the limits to our ability to learn from our experience. The more we are preoccupied with frustrations building up during the ordinary professional day, and feelings of tiredness and trying to keep going, the more energy we use to control our own inner processes, the less attention we have for the immediate reality.

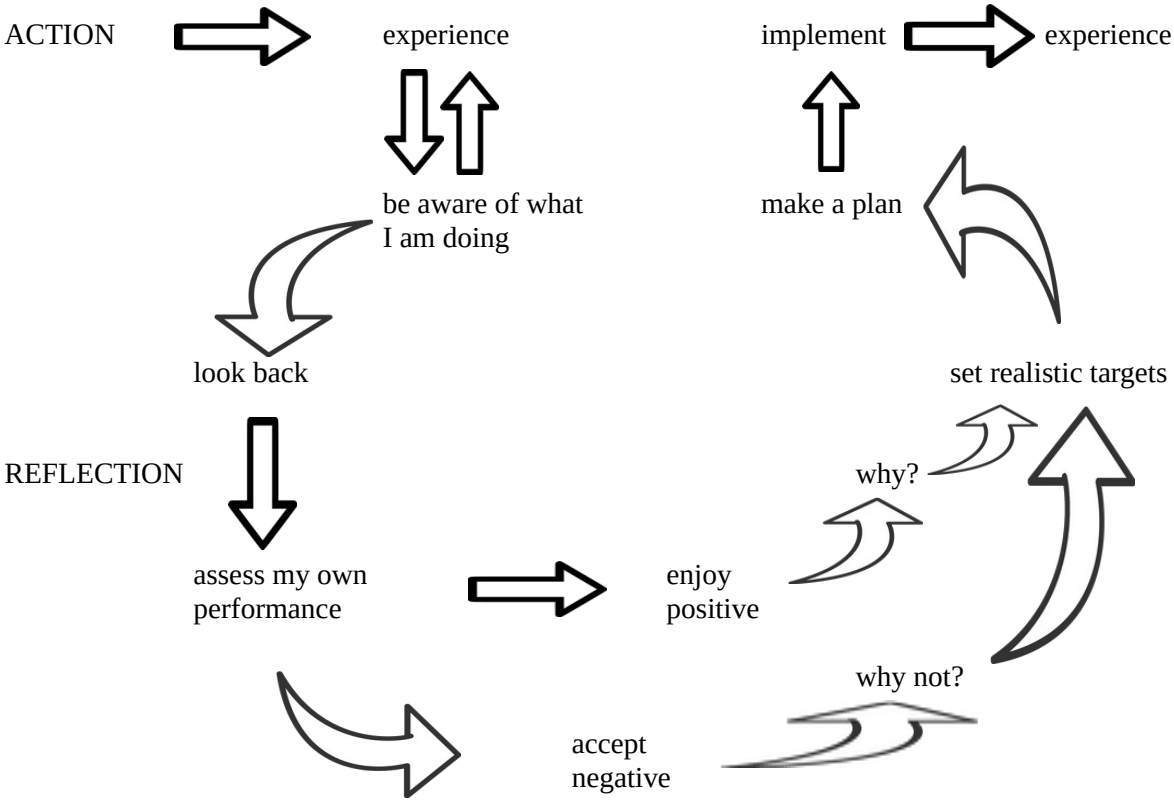
Sometimes we can discover that this is the *main cause* and thus the problem becomes "how can we pay more attention to ...?" Often we are *blind* to this selectivity or to our own responsibility for a problem (14) The process can thus be significantly aided, especially in training, by an appropriate combination of facilitative and authoritative (including confronting) interventions.(15) Some problems are so challenging that they stir up so much emotion in the nurse that cathartic support will be necessary before she can begin to think positively and constructively about them.

Regular problem-solving during clinical practice, with peers, colleagues, teachers and problem-solving groups in study days or at the beginning of each study period (e.g. the final week of a module) can help nurses not only to learn from their experiences but also to improve their *problem-solving skills*. In this way they will be able to do it more and more effectively on their own, and thus achieve what is an increasingly recognised goal of nurse education (16).

In continuing education, practitioners, managers and teachers welcome the opportunity to generate their own agenda of concerns and address them using the above or other relevant procedure (16a,17).

A second version of this cycle is as follows.

Fig 3: **Self-assessment cycle**




adaptation by Bond M (18). of a cycle created by the author
see also a fuller, more elaborate version following references.

This cycle may be used in full or in part during clinical practice, or alone, with peers, colleagues or teachers. Even a momentary “what was the best thing I (you) did?” or “what have I (you) learned from that experience?” or “what different thing might I (you) do next time round?” can be helpful.

In carrying out self assessment, most individuals report greater ability to think positively and constructively about change or learning programmes to acquire the necessary skills, attitudes and knowledge if they start by going over the good aspects, the successes, the pleasures or an experience (whether short of prolonged). Teachers need to curb their tendencies to put the learner right, to tell them where they went wrong, and to interrupt learners’ self-punishment by enabling them first to identify their many successes (however simple!) in an experience, and determine for *themselves* what they need. This is essential if *self-directed learning* is to be encouraged. Again, these skills are increasingly being recognised as crucial to the fully professional nurse.

They may be further developed by beginning a classroom period with self-assessment, and encouraging learners to contribute to the design of the curriculum. This requires teachers to be flexible in responding to the learning needs raised (19).

Elements of these cycles may be used profitably to enable more to be got out of clinical practice. After any self-contained episode of teaching, learners may be invited, after clarifying what they have learned, to identify activities they *will* aim to carry out in the next period of clinical practice or to clarify any practice or *learning goals* together with action plans (or planned learning programmes) for their achievement. (This process may be continued at the beginning of their next practical allocation, negotiating with sisters/charge-nurses. These targets and plans may be kept under review, and renegotiated from time to time (20).

***Anticipated problems*** and difficulties in applying knowledge may be examined using free discussion or a systematic problem solving procedure. Initially this may be in whole class discussion, later in small groups, and as nurse learners gain confidence and skill in problem-solving and self-assessment, in pairs and individually. Pairs and small groups provide the advantage that individual plans may be treated as promises (to self) - peer support may be continued, with peers helping each other check how well these promises are kept. The whole business can be aided by the use of checklists and other tools for self-monitoring and self-assessment, whether provided by the teacher or devised by learners. (21)

***Experiential teaching*** involves teachers raising issues about practice for : learners to consider; asking questions about ethics, principles and values in nursing or about norms of good practice applied to specific (perhaps hypothetical) situations, about learners’ experience and learning related to the topic taught and about what they intend to apply. (22)

Indeed, this paper aims to trigger reflective processes in you, the reader, by sharing ideas to stimulate you to consider how *you* use your own experience to learn - by yourself, with and from others and in ever changing situations. You are left to discriminate among the values expressed those which concur with your own or which make sense in the light of these reflections. If this paper helps you to confirm that you are *already* doing much which is presented in *your own* creative way, then it will be a success, and help to remove some of the mystique around experiential learning.

***Games, simulations and role play***, methods which are being increasingly used are useful ways of presenting situations which resemble real life practice, simplified appropriately so as to enable learners to concentrate on certain aspects of nursing. In addition to those mentioned, sitting in waiting areas (as if patient); role playing patients being admitted, spending time in wheel chairs or in bed in the ward; role playing typical problem situations such as resistant, depressed, belligerent or frightened patients (or colleagues!) in hospital or home, role playing patients and their families, or typical emergencies, all provide creative opportunities for both teachers and learners to design (23). Ward management games are becoming increasingly popular as are case-load simulations in community nursing and health visiting (24).

***Interpersonal skills training*** can use not only many of the above but also structured exercises in which learners practice selected skills with each other: listening; skills of eliciting information; supporting skills; skills of managing conflict, of assertiveness are just a few examples (25). Video recording *can* be used to *add* to learners’ recollections of events with care (26).

An example of a simple and enjoyable set of activities of the above kind is to brainstorm channels of communication (under the headings of voice, speech, body), and spatial regulators (relative position, proximity) followed by non-verbal (27a) inquiry in pairs into the effects of firstly varying proximity and secondly relative position. Such simple activities lead to heightened awareness of the importance and subtlety of non-verbal communication even from unconscious patients.

***Self-role play***, one factor which is usually missing from the more rational procedures mentioned above is the learners' affective response. In the situation it is often feelings (aware or unaware) which determine the response. In addition, much data is lost or unavailable through forgetting or lack of awareness at the time. A useful way of dealing with these factors is to recreate the situation as if it were a play, an excerpt from the drama of real-life, in which the author, script-writer and principal actor is the person who wants to solve the problem (28).

As with any learning method which involves a person disclosing their weaknesses and sharing their human vulnerability, an atmosphere of trust, openness, honesty and support is essential. This is not a method for the 'I'm here to put you right', heavy brigade. No nurses will venture to role play themselves in a real problem situation unless they anticipate acceptance by the others and support in their *inquiry*. This does not mean that they will not feel uncomfortable as they confront themselves or as others confront them with what they experienced (20). It requires the same basic ingredients of effective nursing care, empathy, unconditional caring and genuineness (30) between and among teachers and learners.

A simple procedure is as follows:

**Self role play (basic psychodrama)**

1 invite volunteers to role play themselves
- i. outline scenario
- ii brief other 'actors'

2 arrange the environment to simulate the original scene

3 re-enact the activities just before and during the critical incident
- i keep other actors to the 'script'

or ii improvise the characters

4 stop: principal 'actor' reviews *all* available data

5 other 'actors' share information about their experience

6 observers contribute *observations* overlooked

7 the teacher (who is the 'director') *may* add *observations*

8 the principal reviews the data, identifies what she learned

(this may be refined further, and any new strategies identified played out to build up skills - others may act as principal).

Again, the memory of a challenging situation includes its affect, which may block creative thinking. Occasionally too, the self-confrontation and the supportive confrontation of others may require cathartic interventions (13) to help the nurse deal with her emotional response.

As values in nurse education increasingly incorporate notions of self-image/self-presentation and personality development (31) so this approach will be used increasingly to encourage more in depth examination of personality constraints on good practice, by nurse educators who have been trained to do so. Initially, however, the method can be kept light and be used to train nurses to gain the skills of doing their own self-role play.

Easy ways of introducing the method include asking nurses what they said or did which might have caused the ‘problem’ then inviting them to repeat it as nearly as they can remember themselves doing so in real life - with the associated postures, movements, tone, facial expression etc. - then inviting review by themselves (and others).

When groups are confident in the method, dealing with imagined difficult situations or *anticipated problems* can be a remarkably effective way of enabling ‘transfer of training”.

Those facilitating should however, as always, ensure that those participating do so voluntarily, having the first chance to review and identify what they have learned and can determine the kind of feedback they receive from participating group members and that any comments are given supportively.

***Co-counselling***, (32) which involves reviewing experience in pairs, can incorporate many of the above (self-assessment, problem-solving, role play and self role play). It can also aim to help us to release some of the stresses accumulating from the inevitable demands of nursing. It is an approach which has been introduced not only into the continuing education of nurses, but also into basic training. It can be (and has been) used informally as a basic tool of peer support by nurses (16a).

In the full co-counselling model each person takes equal time as helper and helpee.

The helpee instructs the helper on the helping strategy desired which never includes prescribing, informing or confronting. When review highlights a stressful memory, of an event in which fear, grief, anger, guilt, embarrassment or other emotion was suppressed, then concentration by the helpee on the emotion using simple techniques (and associated cathartic interventions) allows these emotions to be felt and expressed fully. This process removes the blocks to learning erected in order to ‘survive’ during the experience. It allows new insights and realisations about the experience and underlying processes to form as well as new intentions for the future and new self-appreciations.

Many nurses ‘counsel themselves’ in private (e.g. sobbing the grief of attending those in suffering and death) or seek one-way informal counselling (Note: the expression of intense emotion is best done with another, safe friend or colleague, to help more completely finish the unfinished business). Co-counselling is a systematic tool, not only for dealing with day-to-day stresses, but for personal growth. By this is meant allowing in the review process, associated previous experiences to be reviewed in the same way and thus enabling the individual to acquire even deeper insights into motivation and behaviour and identify the basic needs which may be being projected into difficult situations and indeed into nursing in general. Regular co-counselling thus deals with the unfinished business of the past and is a personality development and self-actualisation strategy.

Other strategies include massage to de-stress, self-affirmation, and meditative approaches.

When very experienced, a co-counsellor can select a strategy which includes emphasising very regressive material originating around birth or before,and thus deal with major chronic personality tendencies.

All nurses would in the opinion of the author and many nurses who co-counsel regularly, if willing to use the approach, find co-counselling of great value. Those nurses who have been able to arrange a short session to deal with a specific stressful situation have been able to return to the situation with increased confidence and a creative way of dealing with it. Those who co-counsel regularly find that their self-confidence increases and their experience of stress reduces over time, leading to increased ability to handle the many demands of nursing.

Because of the nature of the work of these nurses, midwives, health visitors and psychiatric nurses might find co-counselling on very early ‘material’ particularly illuminating. A strategy has been suggested for introducing it into basic training and peer support groups (16a).

***Self and peer assessment*** (33) This is an approach which recognises the ultimate responsibility of the professional to assess her own competences and draws on others' wisdom and support to counter tendencies to inflate or deflate self-rating. It is informally carried out by every trainee or qualified professional to some degree. The informal process can be made substantially more effective if certain aspects are highlighted and training established. Teachers introducing the approach are recommended to explore the issues involved in managing its introduction into basic training and continuing education by carrying out self and peer assessment of their competences as teachers.

Basically it is a form of collaborative experiential inquiry (34) and involves agreement within a group of the following:

(1) a domain of practice to explore

(2) criteria against which to judge competence

(3) standards of good practice

(4) means of self-monitoring and self-assessing in clinical (or other) practice, recording the assessment and together with relevant evidence

(5) appropriate procedures to manage the peer assessment

The full model involves in addition:

(1) reporting to the group on individual self assessments

(2) constructive peer feedback to express agreement and disagreement or doubt further positive and negative feedback

(3) individual review of self assessment and forward planning

(4) group evaluation and revision of the inquiry in all its aspects

The skills involved in carrying out the full model have been found to substantially enhance self-confidence and human relations skills. They do often highlight difficulties in both of these which need to be handled sensitively and at an appropriate pace if all the relevant values are to be upheld (35).

***Peer Support Groups*** (36)

Nurses may be trained in all the above and in other techniques for peer self-help. One example, the 'feedback circle' is for a person to state a problem, hear from each person in turn (once only) and review and summarise what they had learned - each person presents a problem. A less structured strategy involves group members drawing the helpee out before offering suggestions and inviting considered reaction.
The more self-directing nurses become the more they can request a particular counselling approach. The reverse follows only if nurses are trained in the use of different strategies and continue to practice the relevant skills, at least as helpers.

This is essential if the peer support group is to function well. 'Ordinary' discussion is full of limitations - misguided, but well-intentioned interventions from others, often spring from the helper's own 'unfinished business' which really needs attention and limit how far any member can explore their own needs in the time available. Clear contracts, decided on at the onset of each episode, can facilitate speedy resolution of individual issues and make it easier for others to take their turn.

Some *contracts* include the following:

(1) helpers are asked only to listen silently, with all their attention which is free from distraction by environmental stimulation by the helper's own internal preoccupations or thoughts triggered off by the worker. Silent '*free attention*' can be conveyed as encouraging (without demand), supportive (without judgement), empathic and emotionally warm (without unctuousness).

(2) helpers are asked to *restrict* their *interventions* only to those which draw the helper out: examples include:

echoing; selective reflection; checks for understanding; (empathic building); open questions.

Examples of open questions are: "What are you thinking?", "How do you feel about it?" "What did you imagine might happen?" "What were you feeling at that point in the situation?" "When have you experienced this kind of situation before?"

(3) As (2) with the addition of supportive interventions designed to validate the helpee's work. :

(4) as (3) with the addition of cathartic interventions designed to promote emotional expression and release in the helpee.

The problem-solving cycle in this case is different; after any"abreaction" of suppressed emotion, the helpee is encouraged to form her *own insights* into how it was she had to manage herself at the time and into the qualities in herself she needs to express more fully in the future and allow to emerge and strengthen. With these insights, she can now more readily re-examine the problem.

This is the full co-counselling model, in which workers allow themselves to feel and express their emotional responses to problem situations e.g. frustration and anger through 'storming', grief through sobbing, embarrassment and fear through laughter and trembling. Releasing the distress bottled up at the time removes barriers to clear thinking about the situation and liberates creativity in planning for the future. (Note: it may be sufficient to communicate the emotion felt without catharsis, to discover that such emotions were active and influential but not recognised at the time.)

The method may be used to identify and work on strongly held projections or to specific patients or colleagues in order to be better able to relate to them. If we have chronic difficulty with particular people, assume a projection exists. A simple procedure is as follows (helper asking these questions):

(i) "Who does she remind you of?" (identify)
(ii) "How does she remind you of that person?" (detail)
(iii) "How did you feel towards that person?" (say)
(iv) "What's left unsaid between you?" (discharge the bottled-up feelings).
(v) (When sufficient discharge has been completed)
"How is she *not* like that person?" (detail - to remove the projection)

(Steps i - iii & v may be carried out in silence in the real situation, on meeting).

Since many emotional issues are deep-rooted, skills are required to manage the process, and especially if time is a limitation. Such skills can be learned in courses with this aim especially the 'fundamentals of co-counselling' .now being offered increasingly in professional education.

(5) as (3) plus confronting interventions designed to highlight areas of doubt or inconsistency

(6) helpers are given permission to *range freely* and intuitively over the whole range of categories and sorts of interventions at their disposal (15).

(7) helpers are invited to take the helpee around a *problem solving cycle* using one of (2) - (6) above. (See Appendix I for an elaboration).

If two or more of a group have experienced a similar problem or type of problem, then stages (i) to (iv) *may* be applicable to each individual's own situation. However, at stage (v) each person may choose different solutions or combinations of solutions to suit her own circumstances. In this case,rather than referring back to the persons who generated the problem, group members may be invited to pair and take equal time to listen silently to their colleagues whilst they clarify and justify their own action plans (e.g. five minutes each way). This light co-counselling method inevitably raises individuals' level of motivation to develop, as well as improving efficiency in use of time.

A large group may divide into smaller groups to work through a series of similar problems or work on one particular problem which is representative of a common concern. This ensures that individuals are working on problems of greatest concern to them so that their motivation to change is highest. They may also form small groups to work through their own different agendas. In this case, reporting back to the whole group on the essentials of their work allows them to compare and contrast different approaches.

(8) Helpers are asked to take the helpee around a *self assessment cycle* using one of (2) - (6) above.

(9) One person is appointed as director while the other helpers role play with the helpee, a situation using *basic psychodrama*. A variety of methods is available to enhance the basic approach, for which training is recommended in order to grasp the subtleties of the method and develop the sensitivities required (see Appendix II for an elaboration).

(10) the group contracts to use the *self and peer assessment* strategy. Individuals contract to contribute to some minimum agreed extent.

(11) ***Feedback circle***: this is a quick and efficient method which assumes a participant is sharing a problem because she doesn't know the answer.

i. Participant describes her problem as she sees it in all relevant detail and defines what she need from the group who listen in silence.
ii. Each member of the group in turn gives their reaction, offering a suggestion or two, information or confronting her, or passing' No comment is allowed from anyone else.
iii. The originator talks through her reaction by selecting one or more of the options; creating a new option or deciding what she needs to do to find an acceptable option.

The process is repeated for all participants. If no catalytic interventions are used, participants may learn to define problems more quickly and completely.

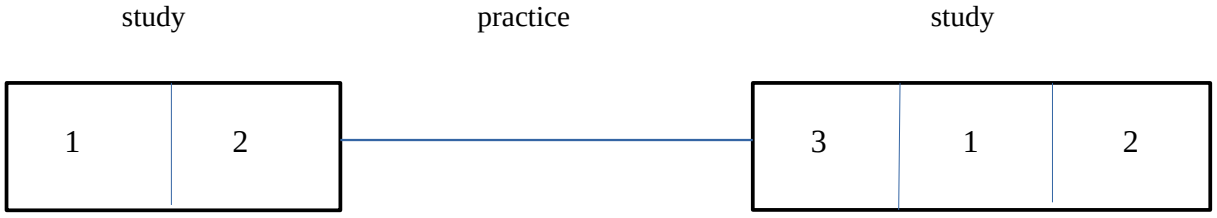
Summary

Training in peer support strategies and skills is a training to take responsibility for dealing with the many issues which face the nurse during her course and is thus a training for independence and self confidence. It is also a training for cooperation and teamwork skills. Nurses can be encouraged to form their own peer support group outside the classroom and continue after qualification, forming and reforming such groups in response to staff changes and training new members themselves. This process is beginning, and can be expected to be a considerable aid in the development of the profession.

***A caution***:

Teachers interested in developing these skills of facilitating experiential learning methods are advised to **experience them** with selected colleagues as a peer learning inquiry. Some of the methods do invite learners to re-consider some of their more deeply held characteristic ways of being. This requires skill and sensitivity on the part of teachers and peers and must be a voluntary process if it is to be effective. Such a change process often involves triggering emotional 'work' and requires cathartic skills. These issues can only be understood ***experientially***. Experiential knowledge is NOT the propositional knowledge of text books! Experiential knowing involves cognition, affect and conation and not just the restricted cognition of the most traditional sorts of education.

***Relationship between classroom learning and practical learning***




Generally speaking classroom work will involve three main elements (separated in the diagram for clarity):

1. New information presented and assimilated in a variety of forms (lecture, film, self teaching packs, video, demonstration, small group discussion etc.)

2. preparation for clinical practice: games, simulations, role play, structured exercises; self assessment, goal setting and action planning; problem solving of anticipated difficulties, pro-active psychodrama

3. review of practice-based learning: self assessment; problem solving, retro-active psychodrama, co-counselling

Practical work will involve:

supervised and unsupervised .practice; creative responses in new situations; risk-taking, ‘trial and error’, intentional learning programmes; meditation, ‘unconscious’ learning; self-monitoring and self-assessment, structured and unstructured problem-solving, goal setting, planning of learning opportunities; (co) counselling, peer support.

It is widely believed that the only place where skills are learned is in the clinical setting, that is for nurses, ‘at the bedside’. This, albeit an oversimplification which teachers of nurses often have to overcome, suggests a positive direction. Since much of the curriculum is devoted to practical experience (in nursing, about 80%) any energy expended in improving the quality of learning through clinical experience will pay off disproportionately well. This paper has suggested some ways this energy may be profitably expended.

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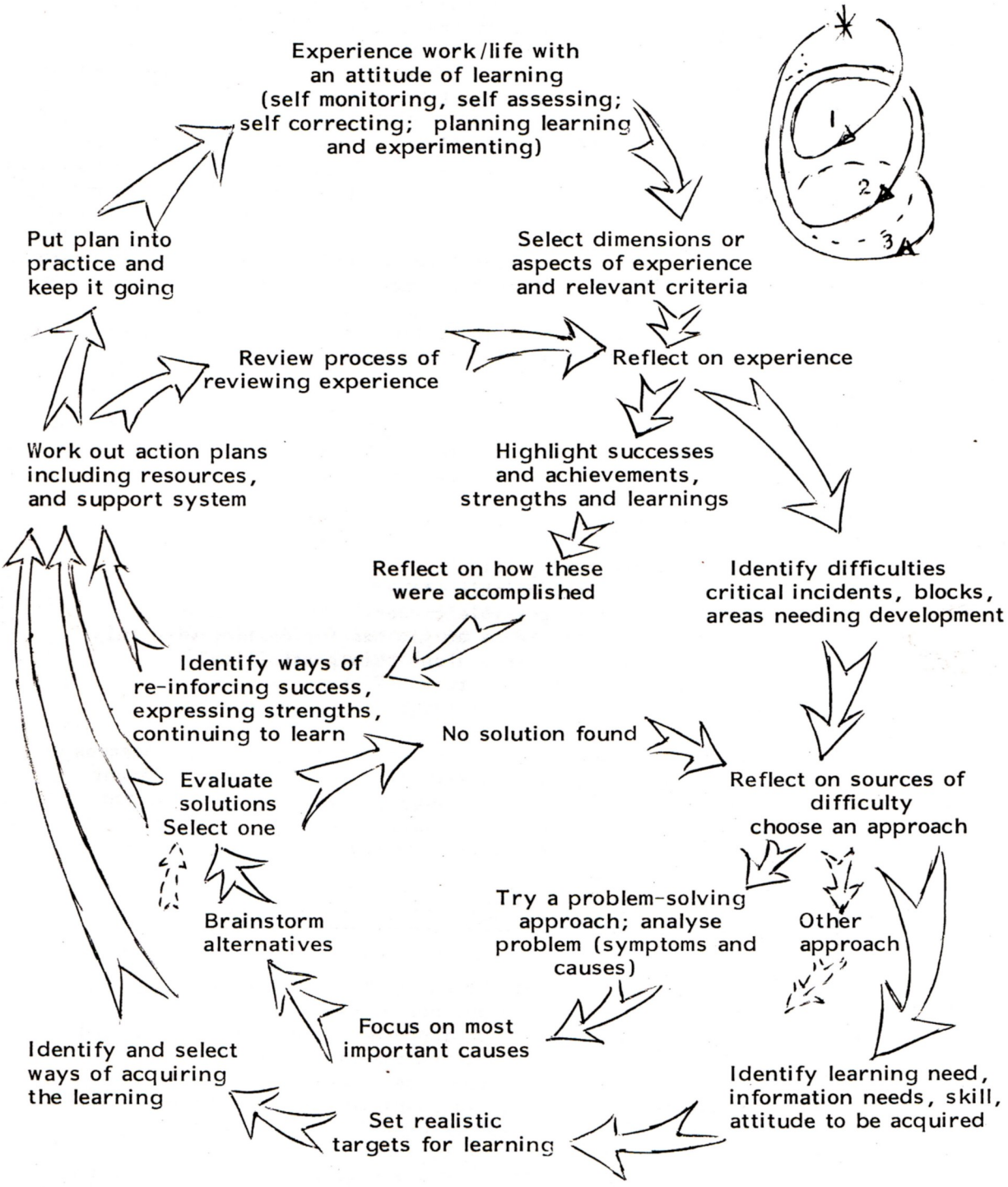
FOSTERING SELF ASSESSMENT SKILLS (individualised review)

Facilitator helps individual, using any appropriate intervention (prescribing, informing, confronting, cathartic, catalytic or supportive) to:




J.M.K. - 13.1.87

Appendix I : ***Further on Problem-Solving***

A. An elaboration of the simple procedure described earlier is as follows:

(i) Symptoms - describe the problem event in all relevant detail, including the specific concerns which brought the problem into awareness

(ii) Causes - identify possible causes (brainstorm if necessary)and limit these to the most probable

(iii) Possible Solutions - brainstorm a list of possible solutions without initial regard for feasibility or discussion

(iv) Assessment of Alternatives - evaluate each solution in terms of feasibility, or by discussion or by identifying advantages and disadvantages of each in turn, whether these are in the short or long term.

(v) Best Solution - select the course of action which is judged most likely to succeed (more than one may be required)

(iv) Action Plan - plan the action in sufficient detail and set a target for implementation and possible further review.

The object is to help the person working on a problem to do so systematicallyby interventions designed to elicit all relevant information for each step inturn, moving on to the next step at an appropriate time.

Examples of Open “client-centred” questions for each stage are: .

> “What makes you choose this particular problem?”
> “Have you said all you need at this stage?”
> “Can you think of any more possible causes?”
> “Will you throw out as many ideas as you can for dealing with this?”
> “What are the best (worst) things about this possibility?”
> “Which option has made most sense to you?”
> “Are you willing to set yourself a target for doing that?”

In working through a problem thoroughly, understanding inevitably deepens. This may mean that new information or new ideas are generated relevant to earlier stages in the process. For example, a worker may add a new potential solution whilst at stage (v) or a group may realise it has not sufficient grasp of the problem at stage (iv) and thus go back to review stage (i).

B. An alternative problem-solving cycle is as follows (13):

1. Describe the problem
2. Restate the problem in terms of the change that is desirable e.g. improved sensitivity to my nurse and her needs
3. Define the forces which push toward improvement (driving forces) and the forces which resist improvement (restraining forces)
4. Decide which of these forces are the most important
5. For each important force, brainstorm possible action steps which will increase the effect of driving forces or reduce the effects of restraining forces (the latter must be done)
6. Review all the action steps generated and select those most promising
7. For each action step, list all the resources which are required;review all the steps and resources in terms of a comprehensive action plan. :
8. Before implementing, decide on how to evaluate the overall action programme.

Appendix II - ***Psychodrama (self-role play)***:

In this method, an individual is invited to reconstruct and re-enact an event as she recalls it happening, with a small group of peers who behave as if they were the others present in the real event. This serves to stimulate her memories (sensory data, feelings through and intuitions), enables colleagues to 'react as if they were the others'. Their own shared reactions, especially their immediate feelings, will enable the individual to gain insight into herself, into others and into how she affects and is affected by others. Such events can be replayed after alternative ways of behaving are generated by the individual and her group and by any teacher present (in that order). Group members may themselves demonstrate and experiment with alternative approaches, whether tactical or strategic, taking over from the individual or try these out in practice. It is usually best to keep such replay short (say two minutes), as otherwise significant data is lost from memory. As with problem solving, it is useful for people with experience and interest in similar problems to group in fives and sixes. In this case, the principal role players should be those with immediate experience of and most concern for the problem. They will thus gain in empathy for the others involved in the real critical incident.

A simple learning procedure is as follows:-

i. Form an agenda of problems, rank them in order of importance, decide which method is most suitable, form groups and structure the time available.
ii. Invite participants to volunteer in turn for self role-play:they outline the scenario, select and brief other role players who initially seek to clarify details of the type of character to be portrayed. Such others may be chosen because they resemble in some way the real-life person or because they had experienced similar problems.
iii. Arrange the environment to simulate (psychologically) important conditions as far as possible.
iv. Re-enact the transactions leading up to and just after the critical point of the interaction. The individual should act and react as herself in that situation, as well as she remembers - words, gestures,posture, tone of voice, relative position, etc. Her colleagues should react as themselves, immersed in the role, living as their imagination of the other's world takes them, but being ready to follow the direction of the individual.
v. The individual assesses herself by recalling what she noticed about herself and the other persons, her thoughts, feelings and intuitions about what she might do and her guesses about the other persons' motives and reactions.
vi. The other players give feedback as to their impressions and insights,sharing their thoughts and feeling responses to the situation and providing any data which the individual may have overlooked. (Observers may be asked to contribute, as also may any teacher present).
vii. The individual reviews the activity in terms of what she might do if she met the situation again.
viii. Players (observers and teachers) give their reactions to the proposal and offer suggestions as to alternatives and engage in discussion.
ix. The individual selects those actions which seem most relevant to her and commits herself to experiment with them in future.

This procedure is not intended as a rigid format to follow under all circumstances, but rather as a guide for teachers and workers to experiment with. The order of review is however especially important, as is the manner of giving feedback.

When an impasse is reached workers may be encouraged to express a higher degree of emotion, repeating more loudly what they were saying, expressing body movement more vigorously, or saying what they really needed to say, but didn't. This is sometimes called "surplus reality".

***Role reversal***: it can be very effective to play the other person in an inter-personal conflict - another group member standing in for the main actor, at an 'impasse' or to generate information about the other person involved.

***Monodrama***:
(i) Both sides of an interpersonal conflict may be played with great effect by the person involved. Various strategies can be tested out.
(ii) Both (or all) sides of an inner conflict may be worked on by playing all the parts in turn - on different seats - speaking from each as the drama unfolds.