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Unpeeling the Onion: Deconstructing the Effectiveness of Two LTA Approaches to Reflective Learning

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ABSTRACT

Selecting the most effective methods of integrating reflective practice into undergraduate nursing programmes remains a challenge for educators. This paper explores two pedagogical approaches of reflective learning in an undergraduate mental health nursing programme, with particular focus on developing the core attributes of self-awareness, empathy and compassion. The discussion is explored within the context of nursing in Scotland, which is undergoing transformative change including adapting to an all degree route to nurse registration. Seismic changes such as these are occurring at a time when the nursing profession generally, and nurses individually, face regular criticism for poor care and lack of compassion. This discussion paper will focus on the necessity of reflective pedagogy in undergraduate nursing programmes in which the expectation is to create both critically aware and insightful individuals who are able to function in a health care culture that is predominately resource poor, time orientated and outcome focused. Although centred on mental health nursing, the paper also comments on the transferability and relevance of the teaching and learning approach to other professions in which human engagement is the key focus. The competing tensions of reflective practice and economically driven health care organisations alongside the significant professional challenges of emotional competency of nursing are discussed. This provides a background to the exploration of the examples of reflective pedagogy that may also be applied to other health and social care professions.

Keywords: Reflection; pedagogy; undergraduate students; mental health.

Introduction

Humanistic principles underpin all of nursing practice and dominate the new standards for nurse education (Nursing and Midwifery Council [NMC], 2010). Nurses are compelled to be 'person-centred', to be 'compassionate', to work in 'partnership', and to involve others in their decision making. At the same time, nursing is criticised for its failure to respond to basic requirements and for its physical and emotional distancing from patients (Care Quality Commission, 2012). The profession is called upon to demonstrate greater kindness, to recognise individual differences and to reorganise its services to better respond to human needs (Patterson, 2012). Further expectations are set by the requirement to base practice on the best available evidence and to ensure compliance with a multitude of local and national policies and guidelines. Lipscomb and Ishmael (2009) describe how the culture of health care in the UK has become so driven by macro-level requirements that the expectation of humanistic educational approaches has become unrealistic. Professional organisations have responded by calling for the establishment of minimum staffing levels as a protector of quality care (Royal College of Psychiatrists [RCP], 1999) at the same time as including an emphasis on reflective practice activities as part of professional training to help support the primacy of relationships within health care.

In Scotland, mental health nursing has been experiencing a level of transformation as the ethos of service-user-led, recovery-focused and values-based practice dominates all policy and strategy initiatives. The Mental Health (Care and Treatment) Act (Scotland) 2003 (Scottish Executive, 2003) was hailed as the most progressive piece of mental health legislation seen in the UK with principles

such as service user involvement and client led care being at the centre of all care delivery. This was followed by the launch of three frameworks, including the National Framework for Pre-registration Mental Health Nursing (NHS Education for Scotland, 2008) and a Capability Framework for Working in Acute Mental Health Care (NHS Education for Scotland, 2009), which called on nurses to engage in principles of recovery focused and values based care (Trueland, 2008). Recent work has begun to explore methods to support the principles in practice (NHS Scotland, 2011), while concerns remain about making the most of the opportunities available in undergraduate programmes to develop these principles. Most recently, the UK-wide Willis Report (Willis Commission, 2012) on nurse education concluded that whilst nurse educators had little to deride themselves over in terms of the education process, there exists a need for a higher level of evaluation of undergraduate programmes and greater rigour in the evaluation of teaching and learning programmes. In terms of reflective learning, there is material to draw on, but how specific this is to the support of the demands of mental health nursing requires further exploration.

Teaching and assessing reflection in nursing: a brief review of the literature

Reflective practice aims to foster a range of skills and attributes that are aligned with humanistic values that nursing espouses (NMC, 2008). Norrie, Hammond, D'Avray, Collington, and Fook (2012), in an exploration of how professions differ in their approaches to the teaching of reflection, identify that much of the nursing literature on reflection is concerned with examining and

understanding the teaching approaches used to develop students as reflective practitioners. Fowler (2008) highlights the importance of the link between the methods used to develop reflection and the meaningfulness of the reflection itself. The creation of a learning approach to reflection needs to consider how best to motivate students to achieve the best possible outcome. Russell (2005) emphasises the importance of learning the benefits of reflection through experience rather than didactic expositions on its benefits. He goes on to outline how creating a reflective dialogue with students can help achieve this. Cook and Matarasso (2005) outline a range of positive benefits when integrating reflective practice into a problem based learning module where therapeutic engagement skills are developed. The challenges posed to the students' levels of self-awareness are a key part of the learning gained from this approach. Kennedy (2009) calls for a judicious use of reflection and an avoidance of too casual an approach in its implementation. Further, he advocates forms of collaborative reflection, where learning can be generated through interacting with others. Pryce (2002) provides an interesting insight into the paradox of reflective practice where the focus on individuals' experience and practice limits the outcomes of reflection. Pryce argues for a greater emphasis on the practitioner as a 'social actor' operating within a particular social context which needs to be understood before real change can be initiated. O'Donovan (2006) acknowledges the importance of context and the support that needs to exist for reflection to take place.

Reflective practice aims to be transformative and emancipatory through a critique of established thinking and behavioural patterns (Pryce, 2002). Institutional forms of reflection, however, have now come to represent a confessional and surveillance type discourse, less concerned with the liberating ideal of reflection and more with ensuring conformity with established norms (Nelson, 2012). Students' need to confirm their career choice early in their programme (Eraut, 2004) and the requirement to learn and integrate professional behaviours (Fowler, 2008) can limit engagement in the more radical ideals of reflective practice. The design of teaching approaches needs to take cognisance of students' position within the professional socialisation process. The approaches to reflection described here derive their ethos from a programme philosophy that reflects the direction set by national policy in Scotland. Rights, Relationships and Recovery (Scottish Government, 2006), which was succeeded in 2010 by Rights, Relationships and Recovery: Refreshed (Scottish Government, 2010), sets out a new direction for mental health nursing where the ability to develop positive relationships is seen as the starting point for all interventions with service users and carers. Reflective activities are designed to help students know themselves better and, by doing so, to increase their skills and confidence to work more effectively with clients. A willingness to commit to the uncertain nature of this type of work is a requirement from teaching staff. The relationship basis of mental health nursing reflected within this policy supports a liberal, person-centred approach towards reflective practice. This avoids the restrictive and overly conservative agenda that has recently affected the teaching of reflective practice.

Assessment of reflection remains a contentious area. Criticism centres on the impact of complying with standard marking criteria on the student's reflection, questions about how personal thoughts and feelings can be subjected to appraisal, and doubts about the validity of subjective experience in the assessment of knowledge and understanding (Plack, Driscoll, Blissett, McKenna, & Plack, 2005). Furthermore, assessment can be seen as a barrier to personal growth and development that nursing programmes often espouse (Hargreaves, 2004). Coward (2011) argues that the use of reflective models as part of an assessment process simply does not work. The requirement to comply with marking criteria dilutes the students' often complicated experiences of practice where personal shortcomings, knowledge gaps, and uncertainty are typical of real world engagement and central to meaningful

reflection but are removed from reflective accounts for fear of being judged as indications of professional inadequacy. The arguments in favour of assessment centre on two areas. One is the obvious concern with establishing if a student has or has not developed the skills of reflecting. If we do not assess, how can we tell (Wong, Kember, Chung, & Yan 1995)? Equally, how can a student be helped to develop or deepen skills in reflection without establishing their current competence? The other one is that, as reflective ability has become a requirement of professional accreditation, evidence of proficiency needs to be demonstrated. If reflection is important enough to be included in a programme, then it should be important enough to be assessed.

The teaching of reflective skills, however, remains difficult with variations in how reflection is organised and integrated, different understanding and approaches by teaching staff, and difficulty engaging students in the process. Fleming (2007) states that at the core of reflective learning is the integration of both the professional and personal self. The seminal work of Carper's four ways of knowing, described by Johns (1995), demonstrates the importance of reflective practitioners being able to work through and across the four levels of knowing (aesthetic, ethical, professional and personal). This requires two conditions: a high level of insight and a safe and secure environment in which to explore and process experiences. Finally, Higgins (2011) reminds us of the centrality of practice to reflection, the need to ponder what has happened, to understand its meaning and consider where this new learning takes us.

The two teaching approaches described in this paper aim to foster the first condition though the provision of the second, creating a secure environment. Example One explores reflection learning in student groups, whilst Example Two explores the effectiveness of reflective learning through a two-stepped approach of taking a video recording of a role play to inform a piece of reflective writing. Formal evaluation of reflective groups (Example One) occurs at programme completion, while informal monitoring of each group's effectiveness is ongoing. Evaluation involves both a written element and a structured conversation with combined groups to establish those components that assist or hamper group functioning. In Example Two, the role play contributes to the module summative assessment that allows judgements to be made on both the students' reflective ability and the depth of understanding enabled by the approach.

Example One: facilitated peer group reflection

Reflective groups are established within the undergraduate programme and take place six times during each of the three years of the programme. Students meet only during practice placements but away from the clinical area. Simply having time set aside to talk with and get to know colleagues is an identified benefit of group work (Graham, 2000, Oloffson, 2005, Platzer, Blake, & Ashford, 2000). Students are required to present an account of a practice experience and its significance to them. The group is then facilitated to engage with the identified issues. The groups have a number of key characteristics. While they are embedded within mentor-assessed practice modules they are not a component of assessment. The cohort has a half-day introduction to reflection before placements start. Students are made aware of reflective models and are encouraged to adhere to a structured approach in year one. However, there is not a rigid adherence to a reflective model. Coward (2011) warns of the 'interrogating' nature of nursing models and how their use can lead to a mechanistic and de-motivating understanding of reflection. Dyer and Taylor (2012) have also highlighted how the teaching of models of reflection promotes the creation of 'technicians' and a belief in students that they must conform with universal rules of good practice achieved through adherence to fixed models of practice.

The sharing of noteworthy personal experiences of practice within a largely self-regulated group (students develop and monitor their own ground rules) is often sufficient to allow an explorative discussion of professionally significant issues. The strong emotions experienced during practice find an outlet in reflective groups and can help reduce feelings of isolation while confirming understanding of practice. (Stoddart, Cope, Inglis, McIntosh, & Hislop, 1996, Gould and Masters 2004, Manning, Cronin, Monaghan, and Rawlings-Anderson, 2009). Furthermore, an emphasis on the here and now allows the group to respond to current challenges arising from practice. The groups gain their legitimacy by remaining responsive to context and an evolving health care culture. Finally, groups are facilitated by a lecturer who also acts as the students' personal development tutor (PDT) for the duration of their programme. The reliability and trust aimed for are consistent with Carper's second condition (Johns, 2005) and are fundamental to a model of group reflection that is person centred, tolerant, and welcoming of uncertainty.

The positioning of reflective groups during clinical placements helps establish the link between practice and learning from practice through consideration of student experiences. The outlining of significant events engages group members while highlighting the complexity of contextualised relationships. Dewey (1933) described reflection as a desire to investigate circumstances that have triggered a moment of doubt. The greater the uncertainty and puzzlement created by events the more potential they have to deepen student learning. Brookfield (1990) (as cited in Mezirow, 2009) explains how the recounting of personal experiences of practice allows the group to enter another's frame of reference and to engage with their understanding and interpretation of events. Small-group work allows students to experience a collegiate approach to creating understanding, an important aspect of mental health nursing. Bulman and Shultz (2004) emphasise the social nature of learning and how well-run groups can avoid the creation of 'false certainty'. Simplistic explanations are challenged by engagement with others, and students are compelled to consider alternative perspectives. Furthermore, an ongoing self-assessment of professional understanding and competence is facilitated by students comparing their progress with fellow group members and making adjustments in attitudes and behaviour. Talking and listening helps alter and adapt thinking and behaviour, leading to growth and change, and with this new capacity personal efficacy is increased (Manning et al., 2009).

Increases in self-awareness are achieved through acknowledgment of emotional and attitudinal responses to direct clinical contacts. Taylor (2010) describes how insights raise awareness and how this awareness can bring about changes. These changes can be small, but openness to the experience of change is an important component of learning. The creation of personal knowledge, particularly insights gained into one's own beliefs, values, and behaviour, is what differentiates reflection from other forms of mental activity (Bulman & Schutz, 2004). Self-knowledge is essential to effective relationships, more so in mental health nursing, where the therapeutic relationship is central to the role. A clear sense of self is also an important professional attribute. White, Fook, and Gardner (2006) outline how self-knowledge can empower people to see themselves as active social agents rather than powerless individuals. Self-knowledge can increase confidence in one's own abilities and judgements while helping people to self-manage through complicated and imperfect services. However, an honest self-awareness is difficult to achieve as deeply held beliefs and attitudes are often challenged and strong feelings exposed. What can be surprising is the degree of openness and candour displayed by students. This is complex, variable and dependent on group cohesiveness, but can be attained if attention is given to Carper's requirement for safety and security within reflective activity. What successful groups seem to have in common is a tolerant and non-

judgemental atmosphere but within a clear set of group boundaries that include a negotiated set of rules, a clear focus on the practice experiences of the participants, and a willingness to challenge and question each other.

Reflective groups are subject to the same dynamics as all groups, and attention to resistant behaviours by members is required from the facilitator. Difficulties in exposing professional shortcomings to peers are a shared phenomenon of both approaches. Students consistently provide positive evaluations of their group experiences, emphasising the importance of support, peer learning, and the opportunity to check that personal understanding fits with professional requirements. The shared process of negotiating the transition into the prescribed values, knowledge, and behaviours of an evolving profession is an important catalyst to the group's success. Harnessing this dynamic can be achieved by creating clear structure and welcoming difference.

Example Two: a staged approach to reflective learning

This example is taken from a core second year undergraduate mental health module that focuses on building knowledge and understanding of therapeutic skills in mental health nursing. The deconstruction of the assessment into three stages provides the opportunity to explore the effectiveness of the learning experience. The three stages are (i) students participating in simulated role-play that focuses on developing therapeutic relationships in a clinical context. This role-play is then video recorded (ii) and provides material for (iii), a written analysis of the experience incorporating a model of reflection into the account. This analysis is then submitted for assessment.

Role-plays provide vignettes based on real life events that challenge students to develop their skills in managing complex interpersonal scenarios. Used for some time in the education of medical students, role-play provides a form of experiential learning that enables students to capture "an essence and a representation of an experience" (Spalding & Phillips, 2007). In the first three weeks of the module, students' exposure to role-play and filming of role-play was gradually increased. The small group size and the familiarity of the facilitator served to provide a secure ambience in which students' confidence in revealing the personal self grew and sharpened until a collective sense of the shared group objective – to each make a film – provided a place of unity. The presence of consistency and dependency within the group relationships became visible. Shattell, Starr, and Thomas (2007) highlighted the need for personal attributes such as dependency and consistency in therapeutic relationships. It is attributes such as these that enhance trust among group members and provide the soft feathers to the quality of the human experience.

The use of video as a medium for teaching and learning reflective practice is well supported across a range of disciplines and for a variety of purposes (Raingruber 2003, Koole et al., 2013). However, the presence of the camera also initially produced a sharp resistance from the students. Self-consciousness provided a justification for delay – the fear of 'letting down the professional mask' already at play, even at such an early stage in their nursing career. To some extent, this was overcome through the facilitator introducing activities that fostered collaboration. Students were encouraged to handle and 'play with' the 'object of horror' – the flipcam. Opportunities were available to 'pair up' or work in triads and use other rooms for 'trial runs' of the film. 'Change occurs when individuals feel in control' was the maxim used to overcome the initial resistance to filming.

Students were initially reluctant to participate in role play activity with cries of "it's just acting – not like real practice at all" and "it's a false environment" or "I would do much better in the real situation". The latter protest provided the initial surface reason for many students choosing to take the part of the service user rather than the nurse.

There was a clear preference to risk revealing personal vulnerabilities rather than risk revealing professional inadequacies – despite the early stage of their training. The power of simulated learning has been described as enhancing the authenticity of the learning experience in which the simulated role becomes closely aligned to ‘self’. In some of the more powerful role-plays, the wounds of the healer became self-evident. In mental health nursing, as in many other health professions, this is a common phenomenon (Heron, 2001) and one that clearly became ‘visible’ during the more effective role-plays when students indicated an ‘enlightening moment’ of insight and/or understanding. The second stage of the assessment, making the film, aimed to support this insight to be more than simply transitory.

Writing is one of the most frequent learning mediums for reflective learning, with reflective diaries and portfolios being top of the list of populist learner tasks. Moon (2010), among others, discusses the complexities of assessing reflective writing. These include the constraints of being able to express ‘self’ in academic format, the concern that attaching a mark will reduce the authenticity of the submission, (the student may sense that and say what he/she thinks he/she ought to be saying), as well as the difficulties for assessors in maintaining objectivity and consistency in the marking process. In addition, the skill of reflective writing is seen to be a developing one with time and experience and can be taught with practice opportunities built into the curriculum (Russell, 2005). In this assignment, attempts were made to address potential writing difficulties. Students were asked to build their analysis around a reflective framework. They were also freed from the obligation to reference work to maximise the opportunity to bring the ‘I’ to the front of the analysis. In addition, the marking criteria were built around Moon’s (2007) scale of reflective writing.

Constraints of the staged approach

Learning through the narrative form is increasingly popular, and when the narrative belongs to self, the learning is even more significant. Moon (2012) refers to this as “personal storytelling” and an opportunity to develop affective perspective in personal and professional development. The major constraining factor to such development is the presence of assessment, which may result in students feeling vulnerable and uncertain about the quality and value of their writing. As described above, efforts were made to minimise this, particularly by removing the usual obligation to reference the academic writing. The results from the assignment have been higher than in previous modules, and the feedback from the students about the reflective journey within the module has been positive.

Discussion

Both examples described are integrated within the same nursing programme in which (and as with the national approach) person-centred nursing is a core principle. The examples have demonstrated the wealth of learning opportunities that can be obtained if learning is continuous and built into the curriculum objectives. The inclusion of both individual and group reflection enhances the students’ capacity for reflection. Moon (2001) suggests that a range of learning approaches offers students a variety of processes of “relating, experimenting and exploring” from different viewpoints and within a range of contexts.

Assessment of reflection-based assignments remains controversial, but the details in Example Two demonstrate that if assessment is tailored to support and encourage self-analysis without prejudice or malice, it can be important learning.

A whole programme approach to reflection increases the likelihood of students achieving insight into and confidence in reflective practice. Horton-Deutsch, McNelis, and O’Haver Day (2012) describe the introduction of a reflection-centred curriculum as one that adds depth to learning in both practice and theory components.

Reflection supports students to integrate personal and professional qualities. However, beliefs about professional roles and responsibilities, emotional vulnerability, and issues of group dynamics can restrict participation in reflective activities. Furthermore, students can struggle to see the relevance of reflection within a bureaucratic health care system that sometimes disengages practitioners while risking undermining the humanistic values central to good health care. Reflective practice, at its best, deals with the evolving professional self; it encourages the recognition of difference, welcomes uncertainty and, in doing so, places human dignity and experience at the core of health care. Nevertheless, precision about the long-term benefits of reflection remain unclear. What we can say is that reflective pedagogy, with a set of clear aims and philosophy, can help prepare students for those inevitable moments in mental health nursing in which the personal and professional collide.

The approaches to reflection described here are incorporated into an undergraduate course where socialisation into a profession sits alongside the development of critical thinking. A programme approach to reflection should value the adoption of more than one method, particularly where professional competence in establishing effective and meaningful relationships is central to the work of that professional group. The adoption of reflective practice by any discipline requires a deep understanding and commitment that goes beyond rigid application of a method and relies instead on a belief in people’s innate desire to understand and learn.

Conclusion

In a review of literature exploring the evidence for employing reflective writing as a teaching tool in undergraduate nursing programmes, Epp (2008) concludes that nurse educators are correct to pursue reflective learning but that a range of tools and strategies is required to facilitate growth and development. Williams (2013), in the meantime, argues for the importance of “reflective spaces” within professional education to help negotiate the potential dissonance between the personal and professional. The intention of reflective teaching is to deepen and expand understanding of the role of ‘self’ in building therapeutic relationships. Reflective learning can enhance the capacity, the confidence, and the resilience of the individual to be emotionally sensitive and responsive to the complex needs of vulnerable people, particularly if teaching strategies are tailored and varied to respond to a range of learning styles. The tension of who is to blame for poor care – the system or the individual – continues to rankle. Nonetheless, student nurses who experience meaningful reflective learning are more likely to be culture carriers of values based, positive, and person-centred, care that is so sought after.

Whilst many negative media reports focus on the alarming levels of dispassionate nurses, perhaps the headlines should instead be on the systemic and organisational components of the health care system that fail to nurture its most valuable of resources – the nurses themselves.

Biography

Margaret Conlon is a lecturer in the undergraduate mental health nursing programme of Edinburgh Napier University. A practice background working in children and young people’s mental health services then led onto her developing an interest in widening student nurses’ experience in practice. Margaret’s interest in inter-professional working grew through leading a pilot for organising practice placements in a way that extends student learning beyond acute care placements.

Brian Gould is a lecturer in mental health nursing at Edinburgh Napier University with an interest in pedagogical approaches that engage students in developing a clear professional identity. Interests also include reflective practice, problem based learning, curriculum evaluation, mental health nurses’ responsibilities under mental health legislation, and the devolvement of clinical leadership.

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