TRANSFORMATIVE LEARNING:

UNDERSTANDING AND FACILITATING

NURSES' LEARNING AND USE OF

NURSING CONCEPTUAL FRAMEWORKS

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PROLOGUE

Nursing is in the midst of the most important epoch of its modern history. The epoch, or period of marked evolutionary change, is evidenced by our movement to articulate the nature and purpose of nursing as well as our contribution to the health of people. As Baumgart (1990) noted, in recent years nursing has become more visible, influential and powerful. This epoch is signalling the end of the silencing and devaluation of nurses.

It is impossible for any nurse to remain unaffected by this turning point in nursing's history. We need only to reflect on our own personal histories as nurses to see the dramatic changes that have occurred. One of the significant changes that has occurred in the last two decades has been the development of nursing conceptual frameworks which have prompted many nurses, both individually and collectively, to critically examine their fundamental beliefs about nursing and themselves as nurses. The turning point is signalling the beginning of the assertion of nursing's unique knowledge and identify.

As a nurse living through this period in our history, I have been moved to explore my own perspective of nursing. My developmental journey as a nurse has provided the impetus for writing this paper. One of the critical points along my journey was when, as a graduate student, I began to explore different nursing conceptual frameworks. The

exploration led me to think about nursing, people, health and life in ways that I had not previously known. My journey was profound, but it was not easy. It was emotional and paradoxical. All at the same time I felt despair and elation, powerless and powerful, sad and happy, confused and clear, hopeless and hopeful. The result of this journey was a new awakening to a deep understanding of and commitment to nursing.

From my own journey, I recognized that my own understanding of and commitment to nursing had arisen out of my critical reflection on my perspective of nursing as well as the perspectives that were described in the nursing conceptual frameworks. Learning about the conceptual frameworks acted as a vehicle for the transformation of my own perspective of nursing. I also recognized from my own experience that the process of learning and discovery that I had experienced seemed to be different from other kinds of learning. This learning was deeply moving, emotional and concluded in a major shift in the way in which I saw nursing and myself as a nurse. My thoughts were later confirmed when, as an educator and consultant, I worked with other nurses as they learned and began to use nursing conceptual frameworks in their practice. My personal journey led me to try and understand the process of learning that nurses experience as they learn about nursing conceptual frameworks.

This paper is based on three assumptions. First, critical reflection on our perspectives of nursing is critical to our ability to articulate the unique identity and knowledge of nursing. Second, nursing conceptual frameworks can provide a vehicle to assist in that critical reflection on and articulation of nursing. Third, learning nursing conceptual frameworks is more than merely acquiring knowledge or skill, it is a process that may involve a paradigmatic shift or transformation in the basic beliefs, values and assumptions that nurses may hold about nursing and themselves as nurses. Therefore, this paper is an attempt to illuminate the experiences of nurses as they learn nursing conceptual frameworks and to posit approaches and strategies for facilitating

this learning. My hope in writing this paper is that through greater understanding of nurses' experiences we will be increasingly able to transcend the shackles that have silenced us. Our continuing evolution depends upon our ability to articulate the nature and purpose of nursing. For "silence can never remind those who have forgotten, or inform those who never knew" (Baumgart, 1990, p.27).

PART I
TRANSFORMATIVE LEARNING:
A THEORETICAL PERSPECTIVE

The central purpose of this paper is to provide an understanding of the experiences of nurses as they learn a nursing conceptual framework and to propose strategies for facilitating this learning. In keeping with this purpose, I want to begin by focusing on the theoretical nature of transformative learning. In this part of the paper I will first discuss the philosophical assumptions that underpin the construct of transformative learning. Second, I will present a framework for transformative learning that will then be used to provide the theoretical grounding for the subsequent discussions of nurses' learning of nursing conceptual frameworks.

Throughout the ages philosophers have been compelled to examine the epistemological and ontological questions as to the nature of human knowing and being. How is it that human beings perceive and make sense of their world? How is it that human beings come to act and interact in and with the world? Since learning presumably has to do with human knowing and being, these philosophical questions are important starting points for this discussion of transformative learning.

While there are numerous schools of thought which may be used to explore questions

about human knowing and being, I am choosing to use the philosophical thoughts of Kant (Cobelstone, 1964; Heidegger, 1959) and Polanyi (1962). Both of these philosophers suggest that reality or the world within and outside of ourselves is not something that simply exists, but it is something that we create based on our learning and experiences which begin in infancy and continue throughout our lives. We are creators and re-creators of our own reality. The creation of reality is generated through a mental framework of personal values, beliefs and assumptions about the world and ourselves in the world. This personal interpretive framework, which is usually unconscious, acts as a screen through which we perceive, interpret and make sense out of our experience in the world. Not only do human beings come to know their world through the interpretive framework, but they also act or interact with the world as a result of the perceptions and interpretations of the world which occur through the interpretive framework or personal paradigm.

The fundamental assumption is that every human being holds within his/her mind a framework or paradigm which is comprised of values, beliefs and assumptions which are learned throughout our life experiences. The frameworks act like a highly personalized sets of ocular lens shaping the way a person perceives, understands and makes sense out of his/her experience in the world. Moreover, the lens determine our behaviours or the way we act and interact with the world. As Polanyi (1960) noted, the personal paradigms are such an intimate part of us that "we may be said to dwell in them as we do our own body" (p.60). Thus, the notion of the personal interpretive framework provides one way of responding to the questions of human knowing and being.

The idea that human beings come to know and understand their world through an interpretive framework has provided the philosophical underpinnings of thinking in many disciplines. One example of this is evidenced in work related to the history and

philosophy of scientific thought. Planck (Gernand and Reedy, 1985), Kuhn (1970) and Polanyi (1960) in discussing the nature of scientific thought suggested that scientists hold particular paradigms or world-views which shape the way they perceive and interpret reality. They argue that the paradigms or world views determine scientists' behaviour as enacted in the methodologies that they choose and, in addition, provide the basis upon which validity and truth are established. In the late 1800's Max Planck, following the work of Kant, proposed the notion of the "Weltanschauung" or world-view that scientists held. Later, Kuhn proposed the notion of scientific paradigms comprised of values, beliefs and assumptions which formed the interpretive frameworks of scientists. Both of these philosophers saw the world-views or paradigms as being subject to both evolutionary and revolutionary change. Kuhn, for example, believed that normal science evolved incrementally, with existing knowledge being confirmed or elaborated upon within the same over-reaching paradigm. Revolutionary science, on the other hand, was thought to be the discovery of new knowledge which necessitated an entirely new paradigm. The paradigm shift occurred as scientists faced facts, observations or experience that could not be understood within the prevailing paradigm. In revolutionary science, the world-view was dramatically changed at the fundamental level of basic assumptions, values and beliefs.

The notion of a personal framework or paradigm which is subject to evolutionary or revolutionary transformation has also been widely discussed in the psychological literature. Kelly (1955) proposed a theory of personal constructs in which he suggested that life was experienced and interpreted through people's paradigms or constructs. The discovery of meaning through the transformation of constructs or personal paradigms has been proposed as a framework for understanding human development, some forms of consciousness raising and psychotherapy (Carlsen, 1988; Gould, 1978, Rosenthal, 1984; and Wolfe, O'Conner and Crary, 1990). In this line of thinking, people are seen to have an internal paradigm including beliefs, assumptions, values and

expectations. Most of the time, the paradigm sufficiently helps us to understand and interact with the world. Sometimes, often in the face of a particularly difficult developmental period of crisis, the entire internal structure or paradigm is questioned ultimately leading to a profound re-configuration or personal paradigm shift.

Significant transformations or paradigm shifts appear to be described with increasing frequency in the literature of many disciplines. This kind of change is described in the religious literature related to convictional experiences (Loder, 1981; Staples and Mauss, 1987). As well, paradigm shifts are discussed in relation to social and global transformation (Harman, 1988 and McWaters, 1981). Furthermore, this kind of change is described in the organizational literature (Lefkoe, 1985). The descriptions of the nature of the change process, an assumption is made that personal, professional, organizational or social interpretive frameworks or paradigms can, during certain disquieting circumstances, be fundamentally changed, shifted or transformed. Once the transformations occur, people come to know the world themselves and the world in essentially different ways leading to changes in the way in which they act and itneract in the world.

From the foregoing discussion, I would suggest that considerable evidence exists which supports the basic philosophical premises upon which this paper is written. Since the focus of the paper is specifically related to learning, I want to turn now to the educational iterature and to an exploration of transformative learning as a further example of fundamental changes in people's interpretive frameworks or paradigms.

Transformative education and learning have gathered the attention of educators in relatively recent years. Education, like all fields of inquiry, has itself evolved in ways that have reflected the dominant paradigms of the day. Transformative learning and its facilitation is only one paradigm or approach to understanding the learning process.

However, I see transformative learning as different f rom some other dominant paradigms in education necessitating facilitative strategies specific to this approach. Let me explain.

For many years, the theory and practice of education and learning were strongly influenced by Tyler (1949). Most of us as educators today were or are affected by the Tylerian approach. One needs only to look at a curriculum in nursing or the structure and process of many in-service or continuing education programs to see the effects of the Tylerian model. In this approach, education and learning were seen to be fairly linear, systematic processes which basically involved; assessment, planning, development, delivery and evaluation. Learning was seen to be incremental in nature with new learning being built upon existing knowledge and skill. Learning was also instrumental, that is to say, it was directed toward the solving of a particular problem or gap between desired and actual performance (Mezirow, 1985 and 1990). In this approach learning was seen to be almost context free in that little attention was given to the political, aesthetic or social dimensions of the environment in which the learning was taking place (Brookfield, 1985). Facilitators were to objectively assess the learning need, develop specific and measurable learning objectives, provide the opportunities for knowledge and skill acquisition and evaluate the performance outcomes (Monette, 1977). The influence of this approach is still seen in some models of program planning (Dick and Carey, 1985) and in the emphasis on competency based learning which occurs in schools of nursing and hospitals today.

The Tylerian model was criticised because of its mechanistic and reductionistic approach to learning (Brookfield, 1985). Two further criticisms were that the approach was seen not to consider the learning environment and the facilitator was seen to be the expert with the learner playing a fairly passive role (Brookfield, 1985 and Monette, 1977). In response to some of these criticisms, a new paradigm was proposed in the

form of self-directed learning.

Self-directed learning, originally proposed by Malcolm Knowles (1975), revolutionized thinking on education nd learning. Knowles believed that adult learners were innately self-directing, recognizing their learning needs and engaging in activities to meet those needs. The role of the educator was seen to be more of a facilitator, assisting the learners through their own learning process. Unlike in the Tylerian approach, the emphasis of self-directed learning was the learner.

While self-directed learning made a positive and prevailing shift towards the centrality of the learner in the learning process, some concerns have been subsequently posited. First, as Brookfield (1985) noted, some initiatives related to self-directed learning became non-directed learning in that the learner was seen to have sole responsibility for learning. In these instances, facilitators tended to opt out of or abdicate their responsibilities in the learning process. A second concern has been raised as to the ability of learners to define all of their learning needs. Brookfield and Monette (1970) suggested that learners define their needs within their own perspective or paradigm. While that is certainly adequate in many circumstances, there are times when the educator may see learning needs that the learners do not simply because they are operating from different perspectives. In other words, sometimes people do not know what they need to know. Brookfield suggested that when this occurs, the role of the facilitator becomes that of simply a technician responding to consumer needs and wants rather than one in which learners are challenged to critically reflect upon themselves or the world in which they live. While Knowles clearly say the role of the facilitator as an active one, many educators interpreted the role as passive where the perspectives, values and beliefs of the facilitators were excluded from the process essentially diminishing their impact on learning.

As perspectives on education and learning have evolved, some changes have emerged. For example, learning is now see by many to be holistic rather than linear and systematic (Griffin, 1983). As well, the environment, whether that be the personal, social or specific learning environment, is seen to significantly affect learning. Moreover, the roles of facilitator and learner are seen to be collaborative and mutually enhancing. Finally, significant learning is thought to involve critical reflection upon basic perspectives of self and the world.

Central to this discussion is transformative learning. This approach is one that incorporates the ideas that both facilitators and learners engage collaboratively in critical reflection upon themselves and the environment. The two most noted originators of this approach to learning are Paulo Freire (1960) and Jack Mezirow (1978, 1985 and 1990). Freire, while working with poor, rural illiterate people, saw that what kept people illiterate was their own perception of themselves and their world. This perception was strongly shaped by an oppressive social environment, creating in learners what Freire called a "Culture of silence". In order for people to value literacy, they needed to liberate themselves from the culture of silence. This he proposed could happen through conscientization in which people would engage in critical reflection upon their perceptions, analyse the social and political forces which were oppressing them and ultimately transform their perceptions of self and their world. The Freirian approach to education and learning which emphasizes liberation and transformation has been widely used in third world, literacy, feminist and social action education.

In keeping with freire's assumptions, Mezirow (1978) proposed the construct of perspective transformation. He believed that people have a meaning perspective which structures the way they existentially experience, interpret and understand the world. The meaning perspectives are comprised of values, beliefs and assumptions which have been learned through life and which have historical and socio-cultural origins.

Like Freire, Mezirow employed critical theory, in this case the theory of Habermas which led him to suggest that the social, occupational or political environment can shape the meaning perspectives of people in an oppressive manner. Learning, therefore, was seen to be directed toward emancipation through the transformation of meaning perspectives including underlying beliefs, values and basic assumptions. The transformative process of learning was seen to involve critical reflection upon the basic structures that shape learners' meaning perspectives and analysis of the historical and socio-cultural assumptions which constitute the perspectives. The critical reflection and analysis would give way to the gradual taking on of a new more inclusive meaning perspective along with new values, beliefs and basic assumptions (Mezirow, 1990). Perspective transformation, like paradigm shifts, occur when, in the face of incongruous situations, the existing meaning perspectives are seen to no longer be adequate for assimilating or making sense out of the world. The transformation process gives rise to the creation of an entirely new perspective leading to fundamental changes in the way in which learners interpret themselves and their personal, social or occupational worlds (Mezirow, 1978; Brookfield, 1985).

Transformative learning is one approach to understanding learning and education. The uniqueness of this perspective lies in what I see as two main areas. First, transformative learning posits that learning is framed by the meaning perspectives or personal paradigms that are held unconsciously in the minds of the learners. The personal paradigms or meaning perspectives are made up of values, beliefs and assumptions which are learned throughout life and through our interactions with the social, cultural, occupational and political environment. Whether the meaning perspectives are affirmed, extended or transformed, the distinguishing feature of transformative learning is that the fundamental meaning perspectives or personal paradigms, along with inherent values, beliefs and assumptions are challenged through critical reflection. The second distinguishing characteristic of transformative learning is

that it is always directed toward liberation; liberation from domination or oppression arising out of the external environment in which we live or work and liberation from the confines of our own internal perspectives.

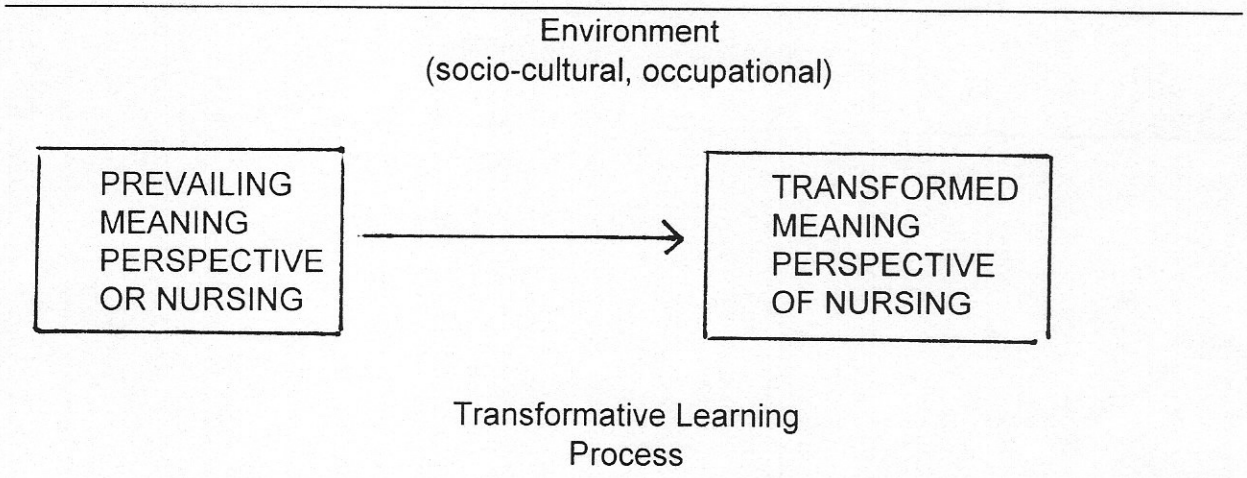
In summary, a framework for transformative learning has as its basic philosophical assumption, the belief that all human beings have a personal interpretive framework. The interpretive framework, paradigm or meaning perspective determines how we come to know and understand ourselves and our world as well as how we act and interact in and with the world. Transformative learning occurs through our meaning perspectives or personal paradigms in some cases resulting in the affirmation or extension of the perspective while in other cases resulting in a complete transformation of the perspective or paradigm shift. In all cases, I have suggested that transformative learning is emancipatory in that it challenges learners to critically examine the values, beliefs and assumptions which underlie their meaning perspectives. In the second part of this paper I will apply the framework of transformative learning in an attempt to illuminate the experiences of nurses as they learn nursing conceptual frameworks.

PART II
UNDERSTANDING NURSES' EXPERINCES
IN LEARNING
NURSING CONCEPTUAL FRAMEWORKS

To this point, I have suggested that nursing is in a period of radical change and part of that change has to do with fundamental shifts in our images of the way in which we see nursing and ourselves as nurses. In this part of the paper I want to situate the model of transformative learning in the nursing context as I believe it is particularly useful in understanding the nature of the learning experience of nurses as they learn a nursing

conceptual framework. To aid the forthcoming discussion, I have depicted a model of transformative learning in Figure I, below.

FIGURE I
Model of Transformative Learning in the Nursing Context



Extrapolating from the model of transformative learning, I would argue that nurses hold professional meaning perspectives comprised of fundamental beliefs, values and assumptions which have historical and socio-cultural origins. The professional meaning perspectives are formed through our personal life experiences as well as our professional education and socialization in our work settings. To a large extent our professional meaning perspectives have remained private, unconscious images of nursing. We rarely publicly discuss our basic beliefs and values, yet the perspective effect all that we think about and do in the course of day-to-day practice. They determine the focus of our nursing assessments and interventions, the nature of our interactions with patients, colleagues or managers and they strongly influence our feelings of worth as nurses. Although we may not be aware of them, our professional meaning perspectives are continuously shaping the way we act and interact in and with

the world of nursing.

Unveiling the Prevailing Meaning Perspectives of Nursing: The Private Images

In order to understand the experience of nurses as they learn a nursing conceptual framework, it is first necessary to fully explore the existing meaning perspectives of nurses. To accomplish this task I want to examine what I perceive to be the four main historical and socio-cultural forces that have shaped the perspectives of nurses today. By examining the four forces, it is possible to shed light upon the values, beliefs and assumptions that have been incorporated into nurses' images of nurses and nursing.

Nursing's Religious Heritage:

Modern nursing was deliberately shaped by Florence Nightingale to resemble a religious order (Donahue, 1985). During the early and mid 1800's nurses were primarily nuns or street-women who were given food and shelter in payment for their work in hospitals. Nightingale saw the need to reform hospitals and thought that nurses were the key players in the reformation. In order to attract young women from the middle class to nursing, it was necessary to create an image of nursing that would be socially acceptable. Thus, the original image of nursing was modelled after a religious order of sisters.

Nursing was seen to be a calling where women could devote themselves without compensation to the care of those less fortunate. There were strict rules of conduct imposed on nurses which included dress, social manners and relationships with persons of the opposite sex. Nurses were cloistered away like nuns. If nurses became engaged to be married, they were obliged to resign. The motto of nursing was "I see and am silent" which reflects the passive, quiet and subservient roles that nurses

played (Donahue, 1985).

The religious heritage of nursing has affected almost every nurse who is alive today. The image of a nurse as a young, innocent, angelic-looking woman, devoted to the care and nurturance of the sick is one that society held for many years. Having graduated from nursing only fifteen years ago, I, like no doubt countless others, was influenced by the beliefs, values and assumptions of the religious heritage. In nurses' residences no male visitors were allowed and curfews were strictly enforced. Uniforms were prescribed with dresses and slips hemmed at the knee. Hair was to be worn above the collar and jewellery was not allowed. In the hospital it was expected that nurses would have a quiet presence and show respect to superiors including head nurses, administrators, instructors and doctors. I can recall a nurse being suspended for running in the hospital parking lot: Running was undignified and was therefore seen as legitimate grounds for punishment. Any nursing documentation in the patients' charts was prefaced by "appears to be ....". Declarative or diagnostic statements even of simple facts was prohibited. Examples such as these provide evidence of the nature of the beliefs, values and assumptions that were incorporated into the prevailing meaning perspectives of nursing arising out of the religious heritage.

The Medical Model:

In Florence Nightingale's view, described in her book Notes on Nursing: What Nursing Is and Is Not (1860), nursing was distinct from medicine. She believed that only nature could cure. It was the role of medicine to remove obstacles which prevented nature from curing. It was the role of nursing to create a healing environment so that nature could act to cure. The focus of nursing was providing a clean, quiet, safe environment and ensuring that the patient received an adequate amount of fresh air, sunlight, nutrition and rest. This focus of nursing revealed its healing power during the Crimean War where, as a direct result of nursing's presence, the mortality rate of soldiers was

reduced from 42 to 2.2 percent (Marriner-Tomey, 1989).

The clarity of Nightingale's vision or meaning perspective of nursing allowed her to gather considerable social and political strength. This power enabled her to muster support for the commencement of schools of nursing. Although Nightingale believed that only nurses could teach nursing, she was unsuccessful in achieving this goal (Donahue, 1985). As nurses were women and women were not admitted to universities, nursing education was structured in an apprenticeship model in hospitals. Physicians, who were university educated men, played a primary role in nurses' education because they were deemed to have more knowledge. This hisorical sequence of events was the beginning of the strong long-lasting presence of the medical model in nursing education.

Many nursing curricula today continue to be structured around the medical model emphasizing disease, pathology and medical interventions. Let me provide an example. In my initial nursing education which I believe is rather typical, the curriculum was organized in the following manner: First, we learned about a disease entity or pathological process; second, we learned about how the medical diagnosis was made; third, we learned about the medical treatment which might be surgical or pharmacological; and fourth, we learned about the nursing interventions required for a patient who was receiving a particular medical treatment for a medically diagnosed disease. While this curricular structure may seem innocuous enough at first glance, there were salient beliefs, values and assumptions about both nursing and medicine that were gleaned from this learning and were unconsciously incorporated into nurses' meaning perspectives of nursing.

The not so subtle message embedded in medically structured nursing curricula was that nursing actions and therefore nursing knowledge was dependent on medical treatment,

medical diagnosis and medical knowledge. Physicians were seen as having expert knowledge and it was the role of the nurse to ensure that the medical plan of care was provided effectively while conveying a caring attitude toward the patient. Nursing was seen as a subset of medicine.

Not only have nurses been educated in schools where the medical model perspective dominated, but they have worked in hospitals that have also embraced the same perspective. Nurses were quick to see that physicians had considerable power and status within the hopsital system. I, like many other nurses, learned that if I wanted to be seen as good and to achieve status, I needed to emulate physicians. I would acquire as much knowledge as possible about diseases and medical diagnoses so that I could make the diagnosis before the doctor. Naturally, I would never whisper the diagnosis aloud, but simply present the doctor with all of the data in such a way that there could be little doubt as to the diagnosis. Not only did I want to emulate physicians, but I looked to them for approval and reward. Seeing physicians as having expert knowledge and power were aspects of my meaning perspective of nursing.

The medical model perspective which was implicitly and explicitly taught in schools of nursing and reinforced in the work context has strongly shaped nurses' images or meaning perspectives of nursing. Nursing knowledge as a subset of medical knowledge and a focus on disease or medical treatment are substantially different beliefs than Nightingale's notion of nursing as a distinct discipline which focused on the creation of the healing environment. The historical dominance of the medical model in nursing educational and occupational contexts as well as in society at large has meant that nurses' perspectives of nursing have, to a marked extent, been authored by the pens of physicians in a patriarchal and oppressive fashion. (Allen and Hall, 1988; Perry, 1985; Roberts, 1983; and Watson, 1990).

The Militaristic/Bureaucratic Heritage:

The third force that has shaped nurses' meaning perspectives arises out of nursing's historical connectedness with the military and the more recent bureaucratization of nurses' work contexts. From the time of Florence Nightingale, nursing has been affiliated with a military model. The structure of hospitals and of nursing service, established by Nightingale, may have been influenced by her own experiences with the military during the Crimean War. Beyond that time, nursing continued to play an important role in the wars of this century. More recently, during the 1950's hospitals beame increasingly bureaucratic. The military and bureaucratic models emphasized rules and regulations, a hierarchy of authority, division of labour and a task orientation.

In nursing, the values, beliefs and assumptions inherent in the militaristic/bureaucratic perspective have been evident in several ways. First, the perspective is evident in the language nurses have used. For example, terms such as 'being in training", "wearing civies", "being on or off duty" or taking up "a post" are reflective of the military-style language. The second piece of evidence lies in the hierarchy of authority within schools of nursing as well as hospitals. Nurses were taught, even as recently as the 1960's, that they were to obey the directives of superiors. They were to stand if a superior entered the nursing station and they were to get off an elevator to make room for a superior. The non-questioning posture of nurses was simply something that was accepted until they were able to rise up through the "ranks".

The Feminine Heritage:

Perhaps the strongest force shaping nurses' meaning perspectives has arisen out of our feminine heritage. Nursing has throughout its modern history continued to be a significantly female dominated profession. Consequently, nursing as well as nurses have been influenced by the social and cultural mores that surrounded the role of

women in society. In Nightingale's time, the fact that nurses were women created the original need to shape the profession in a way that was akin to a religious order. The fact that nurses were women meant that nursing education could not take place in universities. The fact the nurses were women meant that nursing knowledge, as women's knowledge was and still is seen as simply women's common-sense knowledge which is primarily genetically endowed. The fact that nurses were women meant that nurses, until recently, stayed in nursing only until they married and left to fulfil their ultimate roles as wives and mothers. The nurses did not question their subservient role as handmaidens to physicians. One need not be an ardent feminist to see that our perspectives of ourselves as women have dramatically shaped our own, as well as, society's meaning perspectives of nursing.

As I reflect on my own history, I can see the influences of the feminine heritage. I chose nursing, not because I saw it as a life-long caree, but because it was seen to be an honourable profession that would allow me to care for people while preparing me well for my future roles as homemaker and mother. I saw an important part of my role as being the physicians' assistant which meant anticipating and responding to their every need. My interactions with physicians demanded all of my female prowess. I would feel pleased when I could get the physician to "order" what I knew the patient needed in a way that left the physician thinking that it was 'his' idea in the first place. I manipulated interactions and tolerated verbal outbursts because I believed that was simply the way it was. While some might argue that this kind of male-female interaction is a reflection of the pre-feminist era, a recent conversation with a group of young, newly graduated nurses sent home the message to me that this way of interacting still prevails today. The nurses in this group described situations in which they had been "yelled at" or verbally abused by physicians in front of peers and patients. What was disturbing was the fact that from the nurses' perspective, the problem was seen to be their own limitations in dealing with an embarrassing and hurtful situation rather than

the inappropriateness of the physicians' behaviours. Though many nurses would have been changed through the feminist movement, there can be no denying that the beliefs, values and assumptions of the feminine perspective have in the past and perhaps continue to be part of nurses' meaning perspectives of nursing.

To summarize, I have suggested that the meaning perspectives of nursing that prevail in the minds of many nurses today have been, to a greater or lesser extent, shaped by four main historical and socio-cultural forces. The role of women, dominance of the medical model along with nursing's religious and militaristic/bureaucractic heritage have generated certain values, beliefs and assumptions that fit together to form our professional meaning perspectives. It is my contention that the prevailing meaning perspectives of nursing are substantially different from the meaning perspectives of nursing which are articulated through nursing conceptual frameworks. The difference between the perspectives explains why learning a nursing conceptual framework is not simply a matter of acquiring new knowledge which would occur within the existing perspective. Rather, the learning involves for many nurses a fundamental shift or transformation from one perspective to another. In order to explore my thesis further, it is necessary to examine nursing conceptual frameworks and the meaning perspectives of nursing that they imply.

Nursing Conceptual Frameworks: Unveiling the Alternative Meaning Perspectives of Nursing

Nursing conceptual frameworks are, at the most basic level, some nurses' images or perspectives of nursing which have been made conscious, public and more formalized than private images in terms of their structure. By definition, nursing conceptual frameworks have a structure which includes certain elements. Each framework describes values, beliefs and assumptions associated with the key concepts that are

believed to be of central importance to nursing. These concepts are human beings, the environment, health and nursing. The concepts are then linked together through propositions or relating statements to form a whole, meaningful configuration (Fawcett, 1989). While each nursing conceptual framework may vary in terms of their philosophical and scientific assumptions, values and beliefs, they nevertheless provide a comprehensive and unique perspective of nursing.

FIGURE II
Elements of Nursing Conceptual Frameworks

HUMAN BEINGS

NURSING HEALTH

ENVIRONMENT

Despite the fact that each conceptual framework taken separately offers a unique perspective of nursing, taken collectively at the level of a meta-analysis, I believe they have common beliefs, values and assumptions that posit a meaning perspective of nursing that is fundamentally different from those that are more privately held. Where the prevailing meaning perspectives of nursing have been shaped by the four identified historical and socio-sultural forces previously discussed, the meaning perspectives of nursing as described through nursing conceptual frameworks have a different set of values, beliefs and assumptions. To illustrate the point, in the following summary I have attempted to capture the core values beliefs and assumptions of the prevailing meaning perspecives of nursing and contract them with those of the meaning perspectives described in the nursing conceptual frameworks.

SUMMARY OF CORE VALUES, BELIEFS AND ASSUMPTIONS OF THE MEANING PERSPECTIVES OF NURSING

Prevailing Meaning Perspectives: Private Images

Religious Heritage

- Nursing as altruistic calling.
- Nurses as passive, caring women.
- Nurses as acute observers but not as decision-makers.
- Nursing as an occupation until marriage.
- Relationships with physicians as subservient.
- Patient as needy, passive recipient of care and nurturance from nurse.

Medical Model

- Nurses as facilitators of the medical plan of care but ensuring that the plan was carried out in a humane and caring fashion.
- The focus of medicine and therefore nursing was on the disease or pathology of the patient.
- Nursing's knowledge as a sub-set of medical knowledge.
- Nursing dependent on medical knowledge and intervention.
- Relationship of nurses to physicians is dependent, where nurses were seen as handmaidens.
- Patient as passive recipient of care, because doctors and other care providers were seen as experts.

Militaristic/Bureaucratic Heritage

- Focus of nursing on rules, regulations, efficiency and standardization of care within hierarchical authority structure.
- Emphasis on procedural and technical knowledge.
- Patients as objects moving through system, having common needs.

Feminine Heritage

- Nursing as occupation which prepared women for more important roles as homemakers and mothers.
- Women's knowledge and therefore nurses' knowledge as intuitive and genetically endowed.
- Women as quiet, behind-the-scenes supporters of men and therefore nurses as

supporters of doctors.
- Patients as recipients of care and nurturance by 'motherly' nurses.

Meaning Perspectives: Through Nursing Conceptual Frameworks

- Nursing as profession and life-long career.
- Nursing knowledge is distinct body of knowledge which focuses on human response to health and illness.
- Nurses as autonomous professionals, accountable and responsible for decision-making and problem-solving within their scope of practice.
- Focus of nursing on healing and health.
- Patients as holistic, unique beings interacting with their environment.
- Patients as active decision-makers and equal participants in healing and health.
- Relationship with doctors and other health care providers is collaborative.

From the summary, it is evident that the meaning perspectives of nursing as described through nursing conceptual frameworks is different from the meaning perspectives that may be unconsciously held in the minds of many nurses today. The differences are primarily related to the beliefs and assumptions that nursing and nursing knowledge are distinct rather than a subset of medicine and that the focus of nursing is directed toward the health of holistic, unique and self-determining human beings rather than on disease, medical treatment, tasks or the system. I believe that the differences in the perspectives is sufficiently profound that learning about nursing conceptual frameworks may, for some nurses, involve a paradigm shift or transformation in how nurses view nursing and themselves as nurses.

If one accepts the premises that nurses hold unconscious meaning perspectives of nursing and that nursing conceptual frameworks provide a distinctly different perspective of nursing, the question remains as to why this is of any importance. Why is it important to make conscious the private images of nursing that nurses hold and to learn about the public images described through nursing conceptual frameworks? The answers to these questions seem important as they provide some justification for

engaging in the process of transformative learning.

The rationale for the need to make conscious the meaning perspectives of nursing that are held by nurses and to learn about nursing conceptual frameworks is four-fold.

First, as Argyris, Putnam and Smith (1985) pointed out, when beliefs, values and assumptions are not conscious in the minds of practitioners, there is a high degree of probability that the actions of the practitioner may be incongruous with the espoused perspectives. In other words, practitioners may behave in ways that are in fact inconsistent with what they say they believe and value. For example, a nurse may say that she/he believes that patients have the right to make decisions that affect their health and health care but when a patient refuses a particular treatment, the nurse may attempt to convince the patient to reverse his/her decision. When the values, beliefs and assumptions of meaning perspectives are not conscious, it is next to impossible to critically reflect upon their validity or to evaluate practice behaviours against them to ensure congruence.

Second, in most nursing settings, nurses work together so that any given patient would be cared for by several nurses even if one was designated as a primary nurse. Often nurses make the assumption that 'because we're all nurses, we see the world the same way'. This assumption is likely fallacious. It would be like asking a group of builders to build a house without giving them a set of blueprints. Despite the fact that all people were builders, their images of the house to be built and the approach to the house-building process would be very different if they did not share a similar set of blueprints. Thus, when meaning perspectives of nursing are not conscious and openly discussed, there is a risk that the consistency of care may be compromised.

Third, it is also possible that when meaning perspectives are not conscious they may lack internal consistency reducing the nurse's ability to positively affect the health of the

patient. Wardle and Mandle (1989) studied the perspectives of nursing that were held by nurses working in a psychiatric unit. One finding about which the researchers expressed considerable concern was their observation that many nurses had unconsciously built their nursing perspectives from psychiatric theories espoused by other health care providers in the work context. However, because the perspectives were taken in without critical examination, they were substantially lacking in internal consistency and logic.

The fourth and last point to be made is that when meaning perspectives of nursing are not conscious, nurses are open to what I call the "chameleon effect". The phenomenon occurs when, in the absence of a clearly articulated meaning perspective, the nurse unconsciously takes on the meaning perspective including dominant values, beliefs and assumptions of the environment in which he or she works. Evidence of this phenomenon was revealed by Field (1983) in an ethnographic study of the perspectives of nursing which were held by public health nurses. She pointed to the fact that the nurses' perspectives of nursing were determined by the program in which the nurses worked. There was little indication of any uniformity in the perspectives. Perry (1985) also suggested that the work environment shapes the perspectives of nursing that nurses hold resulting in the fact that nurses tend to operate from a set of beliefs and values that are derived from a medical or institutional model. She proposed that this has resulted in nurses' inability to define and describe the connotative meaning of nursing and thus to see the unique value of their knowledge or work. Further, as Roberts (1983) suggested, in nursing the dominance of the medical model perspective in hospitals and the health care system generally has been a major source of oppression for nurses. When meaning perspectives remain in the unconscious realm, they are subject to being shaped and moulded by the environment and, most importantly, they may become highly oppressive.

To summarize then, meaning perspectives of nursing that often lie in our unconscious minds have been shaped by several historical and socio-cultural forces. When they remain unconscious, they may negatively impact on the consistency and quality of care and may act as sources of domination and oppression, negatively impacting upon our own professional identity and self-esteem. Nursing conceptual frameworks provide a meaning perspective of nursing that describes nursing as an autonomous profession, having its own body of knowledge and making its own unique contribution to the health of people. While we may not agree with all of the values, beliefs and assumptions made explicit in the nursing conceptual frameworks, they nevertheless stimulate important critical reflection upon and discussion about our perspectives of nursing and ourselves as nurses. Most importantly, because nursing conceptual frameworks define the uniqueness of nursing, they also provide a vehicle for nursing's emancipation both from the oppression that we impose upon ourselves through unquestioned assumptions and from the environmental forces that have been major accomplices, albeit sometimes unconsciously, in that oppression.

Given that my assumptions are first that there is value in learning nursing conceptual frameworks and that learning may involve a transformative process from the prevailing meaning perspectives to a more emancipated meaning perspective, let me know turn to discuss the nature of the learning process in detail. Based on my own experience as well as the experience of many nurses with whom I have worked, I am convinced that learning a nursing conceptual framework is for many a highly complex process. It involves more than simply acquiring new knowledge and skill. At the basic level, it is a process that at the least, challenges our fundamental beliefs, values and assumptions, perhaps confirming them or extending them. At the most, learning a conceptual framework can create a paradigm shift or transformation in the way in which the nurse sees nursing and her or himself as a nurse. In order to apprehend the experience more fully, I want to turn now to discuss the nature of the learning process of nurses as they

learn a nursing conceptual framework.

Learning A Nursing Conceptual Framework: The Process of Transformative Learning

The Process of transformative learning as it is experienced by the learner has not been well described in the literature. Brief references to steps which may occur for the learner have been proposed in psychology (Gould, 1978), religious conversion (Loder, 1981) and social transformation (Ferguson, 1980) and others but the authors do not provide the depth of discussion which is necessary to apprehend the full subjective nature of the process. Perhaps the most comprehensive description of what would be considered a transformative learning process was provided by Taylor (1979) who studied adult learners in an emergent group. Although no descriptions of transformative learning can be found in the nursing literature, the work of authors and researchers in other fields can augment an understanding of nurses' experiences as they learn a nursing conceptual framework.

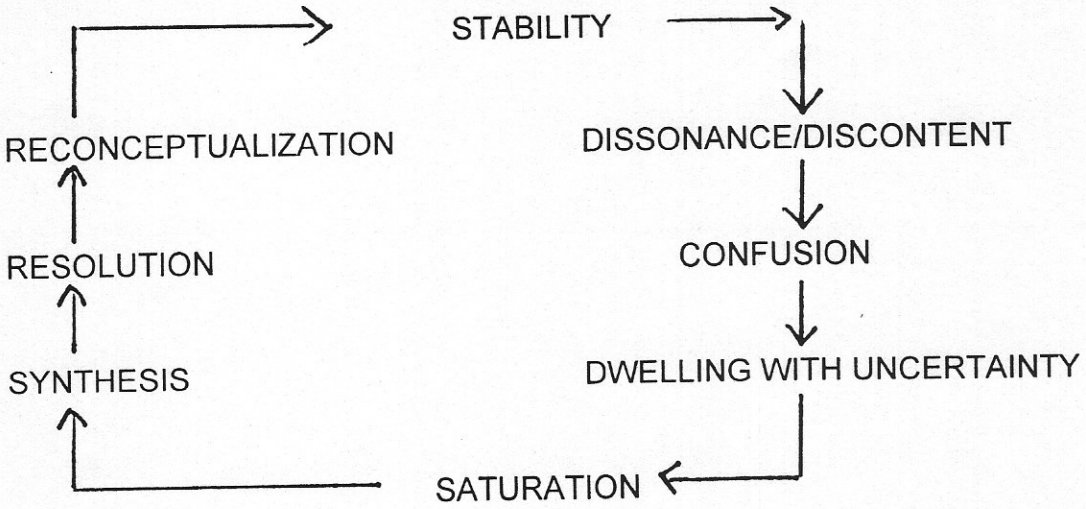
The following description of the transformative learning process is based on actual reports of nurses which I studied over a one year period (Rogers, 1989) and also on my observations and interactions with many nurses as they were engaged in a process of learning a variety of nursing conceptual frameworks. One of the basic assumptions upon which this discussion is based is that when nurses learn a nursing conceptual framework for the first time, their existing meaning perspectives of nursing are challenged and often substantially changed. The reason the change occurs is that the meaning perspective of nursing inherent in all nursing conceptual frameworks is fundamentally different from the meaning perspectives of nursing that nurses tend to hold in their unconscious minds. Therefore, regardless of the specific framework being learned, the process of learning any nursing conceptual framework may be

transformative in nature.

Before describing the phases of the transformation process, I want to make some general comments. First, the process of learning a nursing conceptual framework is highly emotional. This results from the fact that our values, beliefs and assumptions about ourselves as nurses are tightly entwined with our perspectives of self as people. Thus, any learning process that challenges us to critically analyse our basic perspectives of nursing is ipso facto challenging our views of self as people. Second, since the process of learning is far more than the mere acquisition of new knowledge or skill, learning a nursing conceptual framework takes considerable time. In a study of the learning processes of nurses as they learned a nursing conceptual framework, the researcher found that nine to twelve months were necessary for nurses to internalize the framework (Rogers, 1989). The emotionality of the process and the length of time that the learning process takes have implications for facilitation which will be discussed later.

The transformative learning process appears to occur in general phases which are depicted in the model below. I want to underscore the point that the phases need to be seen as fluid and dynamic rather than linear and sequential.

LEARNING A NURSING CONCEPTUAL FRAMEWORK: PHASES OF THE TRANSFORMATION PROCESS



PHASES OF THE TRANSFORMATION PROCESS:

The process begins when the learner is in a phase of stability. That is to say that the existing meaning perspective is operating, generally at a preconscious level, and is providing an adequate interpretive framework for perceiving, thinking about and working within reality, in this case, working as a nurse in day-to-day practice.

The second phase is that of dissonance and discontent when the existing meaning perspective begins to become inadequate in the face of new information or events which cannot be assimilated within the existing meaning perspective. During this phase nurses begin to become aware of the underlying beliefs, values and assumptions that have shaped their view of themselves and their nursing world. With this awareness

they begin to see discrepancies between the current reality and a potential reality in which they would see themselves as autonomous professionals with a unique knowledge base and having a distinct power to affect the health of their patients. During this phase as well as the phase of confusion in which nurses find themselves lying in limbo between perspectives, they describe feeling tremendously anxious, sometimes angry and report a sense that they can't seem to think any more. In part, the anxiety seems to arise out of the grieving of a loss of an intimate part of the self. The existing meaning perspective no longer makes sense, yet the new perspective is not sufficiently internalized to provide resolution.

The next phase of the transformative process represents the time in which the learners "dwell with uncertainty". During this phase some confusion continues but, there is an acknowledgement that the confusion is not a result of some personal inadequacy. With this acknowledgement comes reduced anxiety as well as a feeling of freedom to critically examine old ways and explore the new perspective. The essence of this phase was captured in an editorial on nursing theory written by Smith (1988). She described this phase as a time of wallowing in obscurity and uncertainty while waiting for the fog to lift and understanding to coalesce. She suggested that through wallowing there emerges a sense of tacit knowing as to a direction to be taken and a personal awareness of making deep connections of meaning despite the apparent fog.

Sooner or later, nurses experience a phase of feeling saturated. They feel that they cannot think about or learn anything more about the nursing conceptual framework. From an outsider's point of view may be erroneously interpreted as resistance. In fact, the need to separate from the difficult process of transformation is part of the natural ebb and flow of the learning experience.

The phase of saturation is often followed by a significant synthesis experience. For

some, this is a moment of profound insight when everything seems to come together and the new framework finally makes sense. For others, the insights come in a series of smaller "ah hahs". In both cases, the experience is often accompanied by increasing tension followed by exhilaration when the synthesis occurs. Taylor (1979) and Lodor (1981) in their accounts of similar learning experiences, suggest that the synthesis process marks a significant turning point in the learning experience, one in which there is fusion of self with that which is being learned. Interestingly, the philosopher Polanyi (1962) in describing human knowing, provided an insight into the sequence of the saturation-synthesis events. He described knowing as occurring focally at a conscious level and subsidiarily at a pre-conscious level. To illustrate the point, he described the phenomenon of trying to remember a person's name that has been forgotten. The harder one tries to recall the name through conscious efforts, the more difficult it seems to remember the name. When the person simply lets go and doesn't think about the name consciously, suddenly the name will burst forth to consciousness. Polanyi explained that while it would appear that the person was no longer thinking about the name, in fact the mind was working at the subsidiary or pre-conscious level. His analysis seems to be highly consistent with the experiences that nurses describe as they come to know the nursing conceptual framework that they are learning.

The last two phases of the transformative learning process are resolution and reconceptualization. During the resolution phase nurses describe a feeling of comfort with the new nursing conceptual framework. The feelings of dissonance and discontent experienced at the beginning of the process are resolved and the anxiety is dissipated. Nurses describe themselves as changed, as seeing the world differently and feeling a distinct sense of empowerment. In the final phase of the transformative process, nurses begin to consciously reconceptualize their practice using the nursing conceptual framework or new meaning perspective. They are able to identify situations that are structured by the old perspective and deliberately engage in plans to reconceptualize

their thoughts and actions. For example, nurses would see that their shift reports were reflective of the medical model and they would begin to reshape the reports to reflect the nursing conceptual framework. Or, they would see that during team conferences nurses played a passive role often assuming responsibilities of recorder. They would consciously begin to change their behaviour within the context of the meetings so that they were confidently presenting a nursing perspective in the planning of care for patients and suggesting that recording duties be shared by all health team members.

Learning a nursing conceptual framework involves a process of transformative learning. This process, as described above, is one that appears to have several phases which occur over time. As the existing meaning perspectives of nursing begin to be challenged and changed many nurses experience a sense of loss followed by an ultimate sense of liberation and empowerment. While there can be no question that cognitive changes occur, I believe that it is crucial to appreciate the deeply emotional nature of the transformative learning experience. The complex nature of the transformative learning process that accompanies the learning of nursing conceptual frameworks creates many challenges for those who are facilitators of learning.

PART III
FACILITATING NURSES LEARNING OF NURSING CONCEPTUAL FRAMEWORKS

Transformative learning not only provides a way of understanding the learning experiences of nurses as they learn a nursing conceptual framework, but it also portends approaches to its facilitation. In this segment of the paper, I will describe strategies that may be used to facilitate nurses' learning of nursing conceptual frameworks. Before discussing specific strategies I want to posit some general

comments about the role of the facilitator and the facilitative environment in transformative learning.

The Role of the Facilitator

Transformative learning has as its primary objective the emancipation of learners. In nursing, learning a nursing conceptual framework acts as a vehicle for nurses' liberation from meaning perspectives that are oppressive to meaning perspectives that are emancipatory and empowering. There must be an authentic desire on the part of nurse administrators, educators and all other facilitators to foster nurses' development and emancipation through the use of nursing conceptual frameworks. If nursing conceptual frameworks are imposed upon nurses, they will become vehicles of oppression rather than liberation. Therefore, it is important that facilitators critically examine their own motives and ensure that in the process of learning a nursing conceptual framework nurses have freedom to choose and to be critical.

The role of facilitators in transformative learning is to engage with the learner in what Brookfield (1985) calls a transactional dialogue. Within the dialogue the learner is challenged to examine his/her existing meaning perspective and to critically examine the underlying values, beliefs and assumptions. The perspective of the facilitator, despite the fact that it may be strongly held, must be open to the same kind of critique as are the perspectives of learners. The process is one of mutual exploration and discovery for both learners and facilitators.

The final point I wish to make about the role of the facilitator in helping nurses to learn nursing conceptual frameworks relates to the emotional nature of the transformative learning process. Learning a nursing conceptual framework can at times be exciting and exhilarating. However, as previously discussed, the process may also be highly

emotional involving feelings which are associated with loss and grieving such as anger, frustration nd sadness. For this reason, facilitators need to be very sensitive to the emotional experience of the learners.

The Role of the Environment

Much of the time, learning a nursing conceptual framework occurs in an organisational context. As most nurses tend to work in organizations, I want to discuss the nature of the organizational context and its role in transformative learning. Nursing organizations are made up of nurses who assume a variety of different roles such as managers, educators, clinical specialists or staff nurses. Regardless of their roles, nurses hold meaning perspectives of nursing which have been subject to the same historical and socio-cultural forces previously described. Just as the meaning perspectives of nursing that are held by staff nurses shape the clinical practice of nursing, the meaning perspectives of nurse managers and educators shape their administrative and educational practice. This means that in many instances management and educational structures and systems have been created over the years based on the values, beliefs and assumptions of the dominant meaning perspectives of nursing that were held by managers and educators. Since the structures and systems send both implicit and explicit messages to nurses as to what the organization expects and values then it is essential for managers and educators to critically examine and change the administrative and educational structures and systems to ensure that they explicitly support nursing practice which is based on the chosen conceptual framework(s). In transformative learning where emancipation is one of the fundamental goals, the organizational environment can never be regarded as neutral. The environment either supports or be regarded as neutral. The environment either supports or suppresses nurses' emancipated practice using nursing conceptual frameworks.

The following presents some of the structures and systems within nursing organizations that need to be examined and modified so that they reflect the values, beliefs and assumptions of the nursing conceptual framework(s):

Nursing Management Systems:

- Nursing Philosophy
- Nursing Mission statements
- Standards of Nursing Practice
- Job Descriptions
- Performance Planning and Appraisal Systems
- Patient Classification Systems
- Quality Monitoring System
- Organizational Structures i.e. decentralization, shared governance
- Clinical Advancement Programs

Nursing Educational Systems:

- Orientation Programs
- In-service Education Programs

Clinical Nursing Systems:

- Nursing Care Delivery Systems
- Documentation Systems
- Systems of Verb al Communication i.e. Inter-shift Reports
- Patient Assignments
- Patient Education or Discharge Planning Programs
- Team or Nursing Care Conferences
- Clinical Consultation by Clinical Nurse Specialists

Strategies for Facilitating Nurses' Learning of Nursing Conceptual Frameworks

In order to develop strategies for facilitating nurses' learning of nursing conceptual frameworks, I have drawn upon the work of Mezirow (1978; 1990), Friere (1970) and on

my own work and research related to how nurses learn a nursing conceptual framework.

Illuminating Nurses' Existing Meaning Perspectives:

To begin the transformative learning process nurses need to become aware of their existing meaning perspectives and the underlying values, beliefs and assumptions which form those perspectives. Facilitators may simply initiate discussions about current issues in nursing or they may use structured group exercises which focus on having nurses describe and discuss their beliefs and values. I have observed that it is often difficult for nurses to verbalize their beliefs, values and assumptions probably resulting from the fact that they tend to be lying in the preconscious mind. Consequently, I have found that using symbols or images may at times be more effective than words. For example, the facilitator may ask nurses to image an image that represents nursing to them. Some nurses may envision a nurse's cap while others may envision a book. The images provide fertile ground for discussing the underlying meaning perspectives that nurses hold. Whether the exercise is verbal or symbolic, the objective is to raise to consciousness the deeply held values, beliefs and assumptions that nurses hold about nursing, people, health and themselves as nurses.

The role of the facilitator is to engage in socratic discourse by asking provocative questions that will help learners to explore their beliefs and values with progressive depth. Because there is often a difference between the values and beliefs that people espouse and those that are evident in practice, there is a need to assist nurses to look deeper than first initial statements. For example, a very typical statement of belief that a nurse might state is that nurses care for people. The facilitator may then ask: What does caring mean? How would I see caring if I were to observe the practice of a nurse? How is the caring a nurse provides the same as or different from caring that

might be provided by family members or other health care providers? What would happen if patients did not receive care from nurses? Questions such as these stimulate nurses to explore their values, beliefs and assumptions in depth and thus begin to illuminate their existing meaning perspectives.

Fostering Critical Reflection of Nurses' Existing Meaning Perspectives:

Once the existing meaning perspectives are made conscious, there is then a need to promote critical reflection upon the underlying values, beliefs and assumptions. The critical reflection should reveal the historical and socii-cultural forces that have shaped nurses' perspectives of themselves as well as others' perspectives of nursing. One approach that may be used is to provide an historical journey of nursing from pre-Nightingale to modern times. I use slides which include evocative images of nurses throughout history. These images provide the basis for discussing influencing factors such as nursing's feminist, religious and militaristic heritage. It is also effective to ask nurses to reflect upon their own education, early nursing experience and their experience today. The facilitator may ask nurses to describe what would be considered the most important knowledge, rules of practice and expectations that were implicitly or explicitly conveyed to them at different points along their own professional journey. Through discussions such as these, nurses may become consciously aware of the impact of the medical model and the hospital system on their own images of self as nurse as well as others' images of nursing.

Revealing the Discontinuity Between the Ideal Nursing Practice and the Reality:

One key phase in the transformative learning process is the learner's conscious awareness of the discontinuity between the way things are versus the way things ought to be. This is what Friere (1960) referred to as "problematization". Learners begin to

see how their existing meaning perspectives as well as others' perspectives of nursing which are held by those in the occupational context have acted to constrain or oppress. This awareness creates an "essential tension" (Kuhn, 1970) that is necessary for a transformative shift to occur.

One strategy for illuminating the discontinuity is to have nurses develop a vision of the ideal nursing world, a world in which they would be able to provide the best care that they can imagine. Nurses should be asked to include in their vision such things as what they would and would not be doing, how they would feel about themselves, how they would articulate the unique knowledge and contribution of nursing to the health of people and how others would see nursing. I have found that most nurses can easily create an ideal vision and that the visions and that the visions they do create have a great deal of consistency. I would hypothesize that many nurses have repressed their ideal images in order to accommodate to and survive within their work environments.

Once nurses have developed and explained their vision of the ideal, then the facilitators can ask the learners to compare the ideal with the reality of their nursing world. The facilitators should, in a provocative manner, ask nurses to describe the differences between the real and the ideal and identify the factors or forces that prevent them from realizing the ideal. For example, nurses will often say that in the ideal world nurses would not be doing any non-nursing tasks such as cleaning, portering or clerical work. The facilitator might ask why it is that in today's reality, nurses do so much non-nursing work. Through this line on questioning it may be revealed that there is often a discrepancy between nurses' definition of nursing and others' definitions of nursing. While part of the issue is others' meaning perspectives of nursing, a major contributing factor is nurses' difficulty in articulating a clear perspective or definition of nursing and the scope of nursing practice.

Through the process of revealing the dissonance between the real and the ideal, nurses experience a sense of growing tension along with feelings of frustration, sadness and anger. Facilitators need to be sensitive to the feelings of the nurses and avoid getting into a defensive posture justifying the actions and inactions of the system or those working within the system. It is of equal importance for the facilitator to assist the nurses to move beyond this point so that they are not left with a feeling of hopelessness and powerlessness to affect change.

Linking Nursing Conceptual frameworks to Nurses' Meaning Perspectives: A Vehicle for Transformation:

The primary objective of the facilitator in this phase of the process is to help nurses feel empowered to effect change which is directed toward the realization of their ideal vision. One of the keys to affecting the change lies in nurses' abilities to articulate their perspectives of nursing. It is through this ability that they will have a stronger sense of collective power, be able to facilitate others' understanding of nursing and therefore begin the process of needed change. Facilitators can explain nursing conceptual frameworks and suggest that they provide a way of articulating a more ideal perspective of nursing. Therefore, nursing conceptual frameworks can provide one potent vehicle for transformation.

For facilitators, there are a couple of points that need to be considered. First, nursing conceptual frameworks should be offered not as the sole vehicle of transformation, but as one option. Nurses must feel they have a choice in electing or not electing to learn a nursing conceptual framework. Their freedom to choose must also be legitimate. The second point has to do with the way in which facilitators explain nursing conceptual frameworks. As nursing conceptual frameworks are theoretical constructions, their language may be foreign to many nurses. In order to help nurses understand the

nature of the frameworks, I have found it effective to use analogies or metaphors from outside of the nursing context and keep theoretical jargon to a minimum. For example, analogies for explaining nursing conceptual frameworks might include blueprints that would be used by a builder, nautical charts or the north star that would be used by sailors or maps that would be used by an explorer. Facilitators may also wish to ask nurses to create their own analogies, metaphors or simple explanations of nursing conceptual frameworks. This can be very useful for two reasons. First, it provides nurses with mechanisms for explaining nursing conceptual frameworks to other people in language that they understand. Second, creating their own analogies, metaphors or explanations moves nurses' understanding from the abstract to the concrete which is essential for learning.

Taking In the New Meaning Perspective: Learning the Nursing Conceptual Framework:

Part of the transformative learning process is the taking in of the new meaning perspective. In this case, the vehicle to the new meaning perspective is provided through one or more nursing conceptual frameworks. Only after nurses have chosen to open themselves to learning about a nursing conceptual framework is the timing right to teach the specific content of the framework. The beliefs, values, assumptions and propositions related to the framework can be taught through a variety of mechanisms such as in-service education programs, workshops, self-directed learning materials, videos or group presentations. Regardless of the structure that is selected, it is extremely important for the facilitator to continuously link the concepts of the conceptual framework to the realities of nurses' worlds. The critical role of the facilitator is to act as a conduit, converting the theoretical to the practical and the practical to the theoretical. One approach that may be used is inductive in nature whereby nurses describe real-life patient situations and the facilitator helps learners to create links between the situation

and the theoretical concepts inherent in the conceptual framework. The capacity of the nurse to take in the new meaning perspective depends heavily on the facilitator's ability to ground the theoretical notions of the conceptual framework in the real day-to-day practice of the nurse.

Letting Go of the Old Meaning Perspective:

As previously discussed, transformative learning necessarily involves the letting go of parts or the whole of the old meaning perspective as the new one is taken in. Letting go of the old often results in a grieving experience for nurses. It is therefore of critical importance that the facilitators be acutely sensitive to this and to provide opportunities for nurses to express their feelings, whatever they may be, as they move through the learning process. It may be helpful to discuss the grieving that many nurses experience and to explain some emotional reactions to learning a nursing conceptual framework. In this way, nurses' feelings associated with the loss can be verbalized and legitimized which will in turn ease the letting go process.

Reconceptualization Using the Nursing Conceptual Framework:
Moving to the New Meaning Perspective:

The last phase of the process of learning is the shift to the new meaning perspective. As the learners move toward the internalization of the new perspective, it is likely that they will also begin to see themselves and their world in substantially different ways. As the learning unfolds, nurses will begin to move from seeing the nursing conceptual framework as something that is external to themselves, requiring conscious use, to something that is internal, requiring less effort for use. The phenomenon is somewhat analogous to learning to ride a bike. At first, all the movements require considerable effort and concentration. Eventually, the motions become fluid and easy, requiring little

conscious effort.

At this time, as nurses begin to apply the nursing conceptual framework, they will begin to reconceptualize or re-frame almost everything that is thought about and done in the course of daily work. As Maser (1978) noted, this internalization process is best accomplished when the facilitator acts as a guide in helping the learner to begin to truly see from the new meaning perspective. The facilitator of nurses' learning must be bi-lingual, being able to see through the lens of the nurses' perspective as well as those of the nursing conceptual framework. In this way, the facilitator can help the nurse to translate from the old to the new meaning perspective. The translation can best be accomplished on a one-to-one basis, perhaps by working along side of the nurse or on a small group basis where patient situations are discussed. It may also be useful toa sk nurses to list the activities that they would do in a normal day and discuss those which could be reconceptualized using the nursing conceptual framework. The facilitator can then help nurses explore strategies for effective translation or reconceptualization.

As nurses begin to internalize the nursing conceptual framework, they themselves will begin to see clinical and administrative structures and systems that are currently inconsistent with the values, beliefs and assumptions explicated in the nursing conceptual framework. It is important at this point in the process for facilitators to encourage nurse managers and educators to critically examine the work environment of clinical nurses and to re-frame structures and systems so that they are congruent with the nursing conceptual framework. As clinical nurses will have considerable knowledge about the nursing conceptual framework they should therefore be actively involved in reconceptualizing the work environment so that it is supportive of them.

The strategies described above represent some approaches that I have found to be effective for facilitators of nurses' learning of nursing conceptual frameworks. They

cannot be considered as entities unto themselves, but rather as one dimension of the facilitation of transformative learning. Transformative learning occurs within a context, whether that is a hospital, school of nursing, community agency or other occupational setting and it is the context as well as those in positions of authority that must be committed to the emancipation of nurses through the use of a nursing conceptual framework. There must be a commitment to critically examining the structures, processes and systems within the environment and to explicitly supporting nurses' evolutionary development.

EPILOGUE

THE JOURNEY UNFOLDS:

We are in a remarkable epoch of nursing's evolutionary and revolutionary unfolding. It is a time of rapid change and tremendous challenge. Part of that challenge lies in our individual and collective search for our professional identify and the articulation of the unique knowledge that lies embedded in the art and science of nursing. One of the significant points along our path of discovery has been the development of nursing conceptual frameworks which have presented alternative perspectives about nursing. One of the tenets of this paper has been that the development of nurses and nursing depends upon our ability to critically reflect upon our private images of nursing. This tenet holds true in relation to the nursing conceptual frameworks that we choose to learn and use. Learning one or more nursing conceptual frameworks should not be viewed as a destination, but rather as an important phase in our evolutionary journey.

Our journey demands that we acknowledge and value all of nurses' efforts to explore the meaning and contribution of nursing. Diversity is a value that must be cherished. Although there have been critics of the theorists and the extant nursing conceptual frameworks, we must at the very least, appreciate their courage and foresight in publicly

presenting their images of nursing. They, more than most nurses, have had the courage to put their private images to the test in a public arena. They have stimulated nursing research and theory development, evoked controversy about the nature and purpose of nursing, and they have made a difference in the minds and practice of many, many nurses. The theorists and their frameworks have played a crucial and laudatory role in the larger picture of nursing's epistemologic and ontologic unfolding.

For those of us who choose to engage actively in this journey, we will seek to understand nursing and ourselves as nurses in increasingly broad ways. We will be critical of our own perspectives, as well as those of others and we will be critical of the environments in which we work. The more clearly we see and understand ourselves and the world about us, the greater our understanding will be of the phenomenon of nursing. Through that clarity of vision, we will discover the knowledge and power of nursing to affect the health of people which is our ultimate social and moral imperative.

REFERENCES

Alan, J. And Hall, B. (1988). Challenging the focus on technology: A critique of the medical model in a changing health care system, Advances in Nursing Science, 10, (3), 22-34.

Argyris, C., Putnam, R. And Smith, D. (1985). Action science. San Francisco: Jossey-Bass.

Baumgart, A. (1990). Celebrating nursing. Canadian Nurse, September, 24-50.

Boyd, R. And Byers, J. (1988). Transformative education. International Journal of Lifelong Education, 7 (4), 261-284.

Brookfield, S. (Ed.) (1985). Self-directed learning: From theory to practice. San Francisco: Jossey-Bass publ.

Candy, P. (1982). Personal constructs and personal paradigms: Elaboration, modification and transformation. Interchange, 13, (4), 56-69.

Carlsen, M. (1988). Meaning making: Therapeutic processes in adult development. New York: W.W. Norton and Co.

Cobleston, F. (1964). A history of philosophy. Modern philosophy: Kant. (Vol. 6, Part II). Garden City: Image Books.

Dick, W. And Carey, L. (1985). The systematic design of instruction (2nd ed.). Glenview, Illinois: Scott, Foresman and Co.

Donahue, P. (1985). Nursing the finest art: An illustrated history. St. Louis: C.V. Mosby Co.

Donley, R. (1982). Editorial. A community of scholars. Image: Journal of Nursing Scholarship, 13, 2.

Fawcett, J. (1989). Analysis and evaluation of conceptual models of nursing (2nd ed.). Philadelphia: F.A. Davis.

Field, P. (1983). An ethnography: Four public health nurses' perspectives of nursing. Journal of Advanced Nursing, 8, 3-12.

Friere, P. (1970). Cultural action for freedom. Cambridge, Massachusetts: Harvard Educational review.

Ferguson, M. (1980). The aquarian conspiracy: Personal and social transformation in the 1980's. Los Angeles: J.P. Tarcher, Inc.

Gernand, H. And Reedy, W.J. (1986). Planck, Kuhn and scientific revolutions, Journal of the History of Ideas, 47, July-September, 469-489.

Gould, R. (1978). Transformations: Growth and change in adult life. New York: Simon and Schuster, Inc.

Griffin, W. (1983). Teaching-learning models. Toronto: Ontario Ministry of Education and Ministry of Colleges and Universities.

Harman, W. (1988). Global mind change: The promise of the last years of the twentieth century. Indianapolis, Indiana: Knowledge Systems Inc.

Heidegger, M. (1959). An introduction to metaphysics. New Haven: Yale University Press.

Kelly, G. (1955). A theory of personality: The psychology of personal constructs. New York: W.W. Norton.

Knowles, M. (1975). Self-directed learning: A guide for learnes and teachers. New York: Cambridge Books.

Kuhn, T. (1970). The structure of scientific revolutions (2nd ed.). Chicago: University of Chicago Press.

Lefkoe, M. (1985). Shfiting context: A better approach to training? Training, 22, (2), 43-47.

Loder, J. (1981). The transforming moment: Understanding convictional experiences. San Francisco: Harper and Row.

Marriner-Tomey, A. (1980). Nursing theorists and their work (2nd ed.). St. Louis: C.V. Mosby.

McWaters, B. (1981). Conscious evolution: Personal and planetary transformation. San Francisco: Institute for the Study of Conscious Evolution.

Meleis, A. (1985). Theoretical nursing: Development and progress. Philadelphia: J.B. Lippincott Cot.

Mezirow, J. (1978). Perspective transformation. Adult Education, 28, (2), 100-110.

Mezirow, J. (1985). A critical theory of self-directed learning. In S. Brookfield (ed.), Self directed learning; From theory to Practice. San Francisco: Jossey-Bass.

Mezirow, J. (1990). Fostering critical reflection in adulthood. San Francisco: Jossey-Bass.

Monette, M. (1977). The concept of educational need: An analysis of selected literature. Adult Education (USA), 27, (2), 116-127.

Monette, M. (1979). Needs assessment: A critique of philosophical assumptions. Adult Education (USA), 29, (2), 83-95.

Nightingale, F. (1969). Notes on nursing: What nursing is and is ot. New York: Dover.

Perry, J. (1985). Has the discipline of nursing developed to the stage where nurses do 'think nursing'? Journal of Advanced Nursing, 10, 31-37.

Polanyi, M. (1962). Personal knowledge; Towards a post-critical philosophy. Chicago: University of Chicago Press.

Roberts, S. (1983). Oppressed group behavior: Implications for nursing. Advances in Nursing Science, 5, (4), 21-29.

Rogers, M. (1989). Creating a climate for the implementation of a nursing conceptual framework. Journal of Continuing Education in nursing, 20, (3), 112-117.

Rogers, M. (1989). Perspective transformation: Understanding the experience of nurses as they learn a nursing conceptual framework. Unpublished research. Toronto, Ontario.

Rosenthal, N. (1984). Consciousness-raising: From revolution to re-evaluation. Psychology of Women Quarterly, 8, (4), 309-325.

Staples, C. And Mauss, A. (1987). Conversion or commitment: A reassessment of the Snow and Machalel approach to the study of conversion. Journal for the study of Religion, 26, (2), 133-147.

Taylor, M. (1979). Adult learning in an emergent learning group: Towards a theory of learning from a learner's perspective. Unpublished doctoral dissertation, University of Toronto, Toronto, Ontario.

Tyler, R. (1949). Basic principles of curriculum and instruction. Chicago: University of Chicago Press.

Wardle, M. And Mandle, C. (1989). Conceptual models used in clinical practice. Western Journal of Nursing Research, 11, (1), 108-114.

Watson, J. (1990). The moral failure of the patriarchy. Nursing Outlook, 38, (2), 62-66.

Wolfe, P., O'Conner, D. And Crary, M. (1990). Transformations in life structure and personal paradigms during the midlife transition. Human Relations, 43, (10) 957-973.