I'm not a robot

Evaluate learning theories that are appropriate for nursing programs. Behavioral Theory Cognitive Theory Constructive Theory Humanism Caring Interpretive pedagogies Learning theories explain the different ways people process information and then retrieve it when needed (Sink, 2008). Learning theories provide ways people respond to and interpret information into cognition (Aliakbari, Parvin, Heidari, & Haghani, 2015). Nurse educators may structure and design courses based on a learning theory or theories (Sink, 2008). Common theories found in nursing programs are as follows: Behavioral theory is learning that can be observed when a persons behavior has changed, usually responding from a stimulus (Aliakbari, Parvin, Heidari, & Haghani, 2015). Behavioral theory is useful when you want a person to receive information, practice it, and then have it reinforced (Sink, 2008). Learning psychomotor nursing skills, such as starting an IV, is an example of using a behavioral theory. Cognitive theory is learning that occurs within the mind through the process of understanding, storing and retrieving information (Sink, 2008). Cognitive theory is useful when you want someone to learn how to organize his or her thinking in a way that allows him or her to perform a task (Sink, 2008). For instance, when learning a new concept, the brain finds a way to understand the concept and then retrieve it when needed. Once example would be assimilation, which is associating a new concept to old knowledge then combining into reorganized knowledge (Sink, 2008). Constructive theory is when a learner constructs or makes sense of an experience (Sink, 2008). The learner discovers and begins to understand something. Nursing educators can use constructive theory by creating an experience that assists the student to come to a conclusion about what they have gathered, observed, or experienced. Otherwise known as an aha moment where the light bulb in the mind goes on. Humanism theory takes learning from a humanistic approach where a person is valued and provided with dignity (Billings & Halstead, 2016). Educators provide learning experiences so that students develop a sense of responsibility, cooperation, and mutual respect(Billings & Halstead, 2016, p. 219). The hope is that students learn to be engaged, assume responsibility for their learning, reflect and develop caring behaviors. Caring theory is learning to care for people and self through the foundations of morals, ethics, love and valuing (Billings & Halstead, 2016). Learning experiences are geared toward assisting the student to develop into a professional nurse that adheres to nursing philosophies associated with caring. Interpretive pedagogies are when learning is discovered and broken down to be understood such as understanding human behavior and experiences (Billings & Halstead, 2016). Students learn to take an experience or story and find meaning within it. This type of theory becomes helpful for students when they are given a mass of information and have to understand it and act on it. Differentiate between learning theories used for online, classroom, and clinical modalities and settings. Several of the same learning theories can be used across different teaching modalities such as online, classroom, learning resource centers, and clinical settings. Behaviorist principles are often seen when faculty structures a situation where steps can be observed, objectives are met, and feedback given (Billings & Halstead, 2016). Constructivist allows the student to take an active role to make sense of something complex, practice it, and organize it into memory. Constructivists allows for new knowledge to build on old knowledge as the faculty member acts as coach and facilitator (Billings & Halstead, 2016). Students can learn by themselves or through interactions with others. In practice learning centers and virtual clinical experiences, simulation-based learning allows for students to apply knowledge, practice skills, critically think, evaluate knowledge and work with others (Billings & Halstead, 2016). In acute and transitional care environments, students practice caring, psychomotor, cognitive and communication while working in a complex environment (Billings & Halstead, 2016). In clinical practicum, faculty needs to create a comfortable environment for students to learn in. Focused clinical learning allows for faculty to design experiences where students can practice their skills (Billings & Halstead, 2016). For distance learning, faculty needs to create a sense of community and be available to students via electronic means. Evaluate the analysis, design, development, implementation, and evaluation(ADDIE) instructional design model versus one other instructional design model. ADDIE Model: Analysis Design Development Implementation Evaluation Kirkpatrick Model: Reaction Learning Behavior Results ADDIE Model: The ADDIE Model is a best practice instructional systems design model that helps educators strategize to choose learning experiences that are not only based on theories but meet individual and program needs (Sink, 2008). The ADDIE Model phases are analysis, design, development, implementation, and evaluation (Sink, 2008). The outcomes of each step are used for the next step. During the analysis phase, the gap in knowledge between a desired outcome and what students already know is recognized and acknowledged. During the design phase, the designer develops learning objectives, assessment instruments, exercises, and content (Kruse, n.d.). In the development phase, learning materials are created from the design phase. Students receive materials during the implementation phase that are then evaluated in the evaluation phase for effectiveness (Kruse, n.d.). Kirkpatrick Model: Another instructional design is the Kirkpatrick model that consists of four phases known as reaction, learning, behavior, and results (Billings & Halstead, 2016). The Kirkpatrick model uses any type of training and can be used prior to, during, and after training (Kurt, 2016). Reaction phase determines how a person reacted to instruction (Kurt, 2016). Learning phase looks at whether or not instruction was understood, which can be through increased knowledge, skills or experience (Kurt, 2016). Behavior phase determines if a person is able to transfer what is learned through application in their work (Kurt, 2016). Results phase evaluates if what a person learned and applied to work benefited an organization or business (Kurt, 2016). The Kirkpatrick model works best for evaluating and analyzing results (Kurt, 2016). Each phase occurs in subsequent order and measures the effectiveness of the instruction. Each phase takes a relatively long time to obtain and evaluate. Evaluate effective instructional methods you plan to incorporate in the program. Teaching strategies: Factual knowledge Lectures Group discussion Conceptual knowledge Procedural knowledge Metacognitive knowledge Effective instructional methods that could be used for a program should engage students and involve active learning. According to Billings & Halstead (2016), active and engaged learning increases academic learning, personal development, and improves likelihood of meeting learning outcomes. Faculty should facilitate learning and provide prompt feedback. Blooms knowledge dimensions were used as a means for choosing appropriate teaching strategies. Within Blooms teaching strategies are factual, conceptual, procedural, and metacognitive knowledge (Billings & Halstead, 2016). Within factual knowledge is lecturing and group discussions where basic components of knowledge are obtained (Billings & Halstead, 2016). Lecturing would involve the educator providing information and content in an oral presentation. Oral presentations can incorporate videos, pictures, case studies, and handouts to make them interactive. Discussions among small or large groups of students can revolve around a concept or topic, and can occur in a classroom or online. Discussions lead to student interaction to solve problems and learn from each other. Find Out How NursingAnswers.net Can Help You! Our academic experts are ready and waiting to assist with any writing project you may have. From simple essay plans, through to full dissertations, you can guarantee we have a service perfectly matched to your needs. View our academic writing services Within conceptual knowledge are debates and simulation where the relationship between concepts come together and are understood (Billings & Halstead, 2016). Debates allow students to inquire about a topic or problem and form a judgment. Debates teach students to work together, analyze, and recognize complex situations in healthcare (Billings & Halstead, 2016). Simulations allow students to practice skills, critically think, solve problems, and use clinical reasoning in a non-threatening environment (Billings & Halstead, 2016). Simulations vary in realism from individuals practicing on a model to acting out a scenario in groups. Procedural knowledge is learning how to do something through various techniques, methods, skills, or algorithms (Billings & Halstead, 2016). Demonstrations and games fall within procedural knowledge (Billings & Halstead, 2016). Demonstrations allow students to showcase what they have learned, how they perceived meeting an objective, and portray a process to aid in retention. Demonstrations are interactive and can be evaluated through projects and presentations online or in a classroom. Games are used to reinforce learned knowledge, are interactive and fun, and can be used online or within the classroom. At the end of the game the student can receive immediate feedback. Metacognitive knowledge is when a student is aware of their knowledge or of cognition (Billings & Halstead, 2016). Case studies and reflection are two strategies found within metacognitive knowledge (Billings & Halstead, 2016). Case studies are given scenarios that depict real life situations that can be analyzed to assess ones learned knowledge. Case studies can be used in groups, online, and in class. Case studies help students transfer knowledge of theory into practice and allow for active participation. Reflection allows students to review what they have learned and how it relates to given objectives. Reflection can be written in a journal, discussed in a group, online, or in the classroom. Evaluate how accrediting standards influence the development of curriculum. Accreditation Agencies Accreditation Commission for education on Nursing (ACEN) Commission on Collegiate Nursing Education (CCNE) Accreditation standards are put in place to ensure institutions provide high quality education that is above or meets national standards. Curriculum must adhere to accrediting standards so that programs can continue to run, receive accreditation, and receive funds. Curriculum needs to keep up with changes that are occurring in healthcare and technology to compete with other institutions and meet student needs. Accreditation standards guide institutions as they continue to make improvements to their curriculum. Two known accreditation agencies that influence nursing program curriculum are the Accreditation Commission for education on Nursing (ACEN) and the Commission on Collegiate Nursing Education (CCNE) (Billings & Halstead, 2016). Accreditation Commission for education on Nursing (ACEN) Mission Administrative capacity Faculty and staff Students Curriculum Resources Outcomes When ACEN visitors are on site, nursing programs are expected to provide a report of program strengths, processes in development and how they are meeting ACEN standards (Billings & Halstead, 2016). The program should provide evidence that they are meeting standards through course materials, curriculum, resources, faculty information, and student outcomes to name a few. Specifically for curriculum, ACEN requires curriculum that meets professional nursing standards, has well-defined student learning outcomes, and offers various evaluation methods and learning environments (The National Council of State Boards of Nursing, 2017). The ACEN has the authority to deliver accreditation that can lead to funding of programs. Commission on Collegiate Nursing Education (CCNE) Mission and governance Institutional commitment and resources Curriculum Teaching-learning practices The CCNE is associated with the American Association of College of Nursing (AACN) and provides a voice for public health (Billings & Halstead, 2016). The CCNE is another accrediting agency that ensures the public that nursing programs are providing quality education and that produces successful nurses. The CCNE encourages programs to continually make improvements, be innovative and creative. Programs may exhibit innovation and creativity by imparting several evidence-based learning and teaching strategies into their curriculum. New technology such as simulations and online modules can enhance a program, provide interactive learning, and attract nursing students. Standards and AACN Essential guidelines list outcomes and competencies that nursing program curriculum should achieve (Billings & Halstead, 2016). For example, a baccalaureate-prepared nursing program should adopt AACN outline of content, teaching strategies, values, and competencies (The American Association of Colleges of Nursing, 2019). According to the Commission on Collegiate Nursing Education (2018), curriculum should state learning outcomes that correlate with program mission and goals, provide diverse experiences, allow for practice of new knowledge, incorporate interprofessional collaboration, and be evaluated continuously to improve student outcomes. References Aliakbari, F., Parvin, N., Heidari, M., & Haghani, F. (2015). Learning theories application in nursing education. Journal of Education and Health Promotion, 4, 2. Doi: 10.4103/227-9531.151867 American Association of Colleges of Nursing. (2019). AACN Essentials: The essentials of baccalaureate education for professional nursing Practice (2008). Retrieved from Billings, D. M. & Halstead, J. A. (2016). Teaching in nursing: A guide for faculty (5th ed.). 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It is the lifelong, dynamic process by which individuals acquire new knowledge or skills and alter their thoughts, feelings, attitudes, and actions.Learning enables individuals to adapt to demands and changing circumstances and is crucial in health carewhether for patients and families grappling with ways to improve their health and adjust to their medical conditions, for students acquiring the information and skills necessary to become a nurse, or for staff nurses devising more effective approaches to educating and treating patients and one another in partnership. Despite the significance of learning to each individuals development, functioning, health, and well-being, debate continues about how learning occurs, which kinds of experiences facilitate or hinder the learning process, and what ensures that learning becomes relatively permanent.Until the late 19th century, most of the discussions and debates about learning were grounded in philosophy, school administration, and conventional wisdom (Hilgard, 1996). Around the dawn of the 20th century, the new field of educational psychology emerged and became a defining force for the scientific study of learning, teaching, and assessment (Woolfolk, 2001). As a science, educational psychology rests on the systematic gathering of evidence or data to test theories and hypotheses about learning.A learning theory is a coherent framework of integrated constructs and principles that describe, explain, or predict how people learn. Psychological learning theories and motor learning are discussed in this chapter, each of which has direct applicability to nursing practice. Rather than offering a single theory of learning, psychology provides alternative theories and perspectives on how learning occurs and what motivates people to learn and change (Hilgard & Bower, 1966; Ormrod, 2004; Snowman & Biehler, 2012). Motor learning evolved as a branch of experimental psychology and can be differentiated from verbal learning (Newell, 1991). By the middle of the 20th century, motor learning was established as a specialized area of study, and it has been influenced by behavioral theory, cybernetics, and information processing (VanSant, 2003). Psychological learning theories are useful in acquiring information and in situations involving human thought, emotions, and social interaction. Motor learning is of particular interest to nurses as they try to help their patients and students learn or relearn skills.The construction and testing of learning theories over the past century contributed much to the understanding of how individuals acquire knowledge and change their ways of thinking, feeling, and behaving. Reflecting an evidence-based approach to learning, the accumulated body of research information can be used to guide the educational process and has challenged a number of popular notions and myths about learning (e.g., Spare the rod and spoil the child, Males are more intelligent than females, You cant teach an old dog new tricks, The more feedback, the better). In addition, the major learning theories have wide applicability and form the foundation of not only the field of education, but also psychological counseling, workplace organization and human resources management, and marketing and advertising.Whether used singly or in combination, learning theories have much to offer the practice of health care. Increasingly, health professionalsincluding nursesmust demonstrate that they regularly employ sound methods and a clear rationale in their education efforts, patient and client interactions, staff management and training, and continuing education and health promotion programs (Ferguson & Day, 2005).Given the current structure of health care in the United States, nurses, in particular, are often responsible for designing and implementing plans and procedures for improving health education and encouraging wellness. Beyond ones profession, however, knowledge of the learning process relates to nearly every aspect of daily life. Nurses can apply learning theories at the individual, group, and community levels not only to comprehend and teach new material and tasks, but also to solve problems, change unhealthy habits, build constructive relationships, manage emotions, and develop effective behavior.This chapter reviews the principal psychological and motor learning theories that are useful to health education and clinical practice. Behaviorist, cognitive, and social learning theories are most often applied to patient education as an aspect of professional nursing practice. This chapter argues that emotions and feelings also need explicit focus in relation to learning in general (Goleman, 1995) and to health care in particular (Halpern, 2001). Why? Emotional reactions are often learned as a result of experience, they play a significant role in the learning process, and they are a vital consideration when dealing with health, disease, prevention, wellness, medical treatment, recovery, healing, and relapse prevention. To address this concern, this chapter treats psychodynamic and humanistic perspectives as learning theories because they encourage a patient-centered approach to care and add much to our understanding of human motivation and emotions in the learning process. The review provided here includes motor learning because it offers a framework for nurses teaching motor tasks to patients and students.The chapter is organized as follows. First, the basic psychological principles of learning advocated by behaviorist, cognitive, social learning, psychodynamic, and humanistic theories are summarized and illustrated with examples from psychology and healthcare research. With the current upsurge and interest in neuroscience research, brief mention is made of the contributions of neuropsychology to understanding the dynamics of learning and sorting out the claims of learning theories.Then, the psychological learning theories are compared with regard to the following aspects:Their fundamental procedures for changing behaviorThe assumptions made about the learnerThe role of the educator in encouraging learningThe sources of motivation for learningThe ways in which learning is transferred to new situations and problemsNext, motor learning theories and variables, including their application for teaching skills to patients and students, are addressed. Finally, the theories are compared and then synthesized by identifying their common features and addressing three questions: (1) How does learning occur? (2) Which kinds of experiences facilitate or hinder the learning process? (3) What helps ensure that learning becomes relatively permanent? While surveying this chapter, readers are encouraged to think of ways to apply the learning theories to both their professional and personal lives.The goals of this chapter are to provide a conceptual framework for subsequent chapters in this text and to offer a toolbox of approaches that nurses can use to enhance learning and change in patients, students, staff, and themselves. Although there is a trend toward integrating learning theories in education, knowledge of each theorys basic principles, advantages, and shortcomings will enable nurses to select, combine, and apply the most useful components of learning theories to specific patients and situations in health care. After completing the chapter, readers should be able to identify the essential principles of learning, describe various ways in which the learning process can be approached, and develop alternative strategies to change attitudes, behaviors, and skills of learners in different settings.PSYCHOLOGICAL LEARNING THEORIESThis section summarizes the basic principles and related concepts of the behaviorist, cognitive, social learning, psychodynamic, and humanistic learning theories. While reviewing each theory, readers are asked to consider the following questions:How do the environment and the internal dynamics of the individual influence learning?Is the learner viewed as relatively passive or more active?What is the educators task in the learning process?What motivates individuals to learn?What encourages the transfer of learning to new situations?What are the contributions and criticisms of each learning theory?Behaviorist Learning TheoryFocusing mainly on what is directly observable, behaviorists view learning as the product of the stimulus conditions (S) and the responses (R) that followsometimes termed the S-R model of learning. Whether dealing with animals or people, the learning process is relatively simple. Generally ignoring what goes on inside the individualwhich, of course, is always difficult to ascertainbehaviorists closely observe responses and then manipulate the environment to bring about the intended change. Currently in educational and clinical psychology, behaviorist theories are more likely to be used in combination with other learning theories, especially cognitive theory (Bush, 2006; Dai & Sternberg, 2004). Behaviorist theory continues to be considered useful in nursing practice for the delivery of health care.To modify peoples attitudes and responses, behaviorists either alter the stimulus conditions in the environment or change what happens after a response occurs. Motivation is explained as the desire to reduce some drive (drive reduction); hence, satisfied, complacent, or satiated individuals have little motivation to learn and change. Getting behavior to transfer from the initial learning situation to other settings is largely a matter of practice (strengthening habits). Transfer is aided by a similarity in the stimuli and responses in the learning situation and those encountered in future situations where the response is to be performed. Much of behaviorist learning is based on respondent conditioning and operant conditioning procedures.Respondent conditioning (also termed classical or Pavlovian conditioning) emphasizes the importance of stimulus conditions and the associations formed in the learning process (Ormrod, 2004). In this basic model of learning, a neutral stimulus (NS)a stimulus that has no particular value or meaning to the learneris paired with a naturally occurring unconditioned or unlearned stimulus (UCS) and unconditioned response (UCR) (Figure 3-1). After a few such pairings, the neutral stimulus alone (i.e., without the unconditioned stimulus) elicits the same unconditioned response. Thus learning takes place when the newly conditioned stimulus (CS) becomes associated with the conditioned response (CR)a process that may well occur without conscious thought or awareness.Consider an example from health care. Someone without much experience with hospitals (NS) may visit a relative who is ill. While in the relatives room, the visitor may smell offensive odors (UCS) and feel queasy and light-headed (UCR). After this initial visit and later repeated visits, hospitals (now the CS) may become associated with feeling anxious and nauseated (CR), especially if the visitor smells odors similar to those encountered during the first experience (see Figure 3-1).In health care, respondent conditioning highlights the importance of the healthcare facilitys atmosphere and its effects on staff morale. Often without thinking or reflection, patients and visitors formulate these associations as a result of their hospital experiences, providing the basis for long-lasting attitudes toward medicine, healthcare facilities, and health professionals.In addition to influencing the acquisition of new responses to environmental stimuli, principles of respondent conditioning may be used to extinguish a previously learned response. Responses decrease if the presentation of the conditioned stimulus is not accompanied by the unconditioned stimulus over time. Thus, if the visitor who became dizzy in one hospital subsequently goes to other hospitals to see relatives or friends without smelling offensive odors, then her discomfort and anxiety about hospitals may lessen after several such experiences.FIGURE 3-1 Respondent conditioning model of learning.Systematic desensitization is a technique based on respondent conditioning that is used by psychologists to reduce fear and anxiety in their clients (Wolpe, 1982). The assumption is that fear of a particular stimulus or situation is learned; thus it can also be unlearned or extinguished. With this approach, fearful individuals are first taught relaxation techniques. While they are in a state of relaxation, the fear-producing stimulus is gradually introduced at a nonthreatening level so that anxiety and emotions are not aroused. After repeated pairings of the stimulus under relaxed, nonfrightening conditions, the individual learns that no harm will come to him from the once fear-inducing stimulus. Finally, the client is able to confront the stimulus without being anxious and afraid.In healthcare research, respondent conditioning has been used to extinguish chemotherapy patients anticipatory nausea and vomiting (Lotfi-Jam et al., 2008; Stockhurst, Steingrueber, Enck, & Kloster-halfen, 2006), while systematic desensitization has been used to treat drug addiction (Piane, 2000), phobias (McCullough & Andrews, 2001), and tension headaches (Deyl & Kaliappan, 1997), and to teach children with attention-deficit/hyperactivity disorder (ADHD) or autism to swallow pills (Beck, Cataldo, Slifer, Pulbrook, & Guhman, 2005). As another illustration, prescription drug advertisers regularly employ conditioning principles to encourage consumers to associate a brand-name medication with happy and improved lifestyles; once conditioned, consumers will likely favor the advertised drug over competitors medications and the much less expensive generic form. As a third example, taking the time to help patients relax and reduce their stress when applying some medical interventioneven a painful procedurelessens the likelihood that patients will build up negative and anxious associations about medicine and health care.Certain respondent conditioning concepts are especially useful in the healthcare setting. Stimulus generalization is the tendency of initial learning experiences to be easily applied to other similar stimuli. For example, when listening to friends and relatives describe a hospital experience, it becomes apparent that a highly positive or negative personal encounter may color patients evaluations of their hospital stays as well as their subsequent feelings about having to be hospitalized again. With more and varied experiences, individuals learn to differentiate among similar stimuli, at which point discrimination learning is said to have occurred. As an illustration, patients who have been hospitalized a number of times often have learned a lot about hospitalization. As a result of their experiences, they make sophisticated distinctions and can discriminate among stimuli (e.g., what the various noises mean and what the various health professionals do) that novice patients cannot. Much of professional education and clinical practice involves moving from being able to make generalizations to discrimination learning.Spontaneous recovery is a useful respondent conditioning concept that needs to be given careful consideration in relapse prevention programs. The underlying principle operates as follows: Although a response may appear to be extinguished, it may recover and reappear at any time (even years later), especially when stimulus conditions are similar to those in the initial learning experience. Spontaneous recovery helps us understand why it is so difficult to completely eliminate unhealthy habits and addictive behaviors such as smoking, alcoholism, and drug abuse.Another widely recognized approach to learning is operant conditioning, which was developed largely by B. F. Skinner (1974, 1989). Operant conditioning focuses on the behavior of the organism and the reinforcement that occurs after the response. A reinforcer is a stimulus or event applied after a response that strengthens the probability that the response will be performed again. When specific responses are reinforced on the proper schedule, behaviors can be either increased or decreased.Table 3-1 summarizes the principal ways to increase and decrease responses by applying the contingencies of operant conditioning. Understanding the dynamics of learning presented in this table can prove useful to nurses in assessing and identifying ways to change individuals behaviors in the healthcare setting. The key is to carefully observe individuals responses to specific stimuli and then select the best reinforcement procedures to change a behavior.Two methods to increase the probability of a response are to apply positive or negative reinforcement after a response occurs. According to Skinner (1974), giving positive reinforcement (i.e., reward) greatly enhances the likelihood that a response will be repeated in similar circumstances. As an illustration, although a patient moans and groans as he attempts to get up and walk for the first time after an operation, praise and encouragement (reward) for his efforts at walking (response) will improve the chances that he will continue struggling toward independence.A second way to increase a behavior is by applying negative reinforcement after a response is made. This form of reinforcement involves the removal of an unpleasant stimulus through either escape conditioning or avoidance conditioning. The difference between the two types of negative reinforcement relates to timing.TABLE 3-1 Operant Conditioning Model: Contingencies to Increase and Decrease the Probability of an Organisms ResponseTo increase the probability of a response:Positive reinforcement: application of a pleasant stimulusReward conditioning: a pleasant stimulus is applied following an organisms responseNegative reinforcement: removal of an aversive or unpleasant stimulusEscape conditioning: as an aversive stimulus is applied, the organism makes a response that causes the unpleasant stimulus to ceaseAvoidance conditioning: an aversive stimulus is anticipated by the organism, which makes a response to avoid the unpleasant eventTo decrease or extinguish the probability of a response:Nonreinforcement: an organisms conditioned response is not followed by any kind of reinforcement (positive, negative, or punishment)Punishment: following a response, an aversive stimulus that the organism cannot escape or avoid is appliedIn escape conditioning, as an unpleasant stimulus is being applied, the individual responds in some way that causes the uncomfortable stimulation to cease. Suppose, for example, that when a member of the healthcare team is being chastised in front of the group for being late and missing meetings, she says something humorous. The head of the team stops criticizing her and laughs. Because the use of humor has allowed the team member to escape an unpleasant situation, chances are that she will employ humor again to alleviate a stressful encounter and thereby deflect attention from her problem behavior.In avoidance conditioning, the unpleasant stimulus is anticipated rather than being applied directly. Avoidance conditioning has been used to explain some peoples tendency to become ill so as to avoid doing something they do not want to do. For example, a child fearing a teacher or test may tell his mother that he has a stomachache. If allowed to stay home from school, the child increasingly may complain of sickness to avoid unpleasant situations. Thus, when fearful events are anticipated, sickness, in this case, is the behavior that has been increased through negative reinforcement.According to operant conditioning principles, behaviors also may be decreased through either nonreinforcement or punishment. Skinner (1974) maintained that the simplest way to extinguish a response is not to provide any kind of reinforcement for some action. For example, offensive jokes in the workplace may be handled by showing no reaction; after several such experiences, the joke teller, who more than likely wants attentionand negative attention is preferable to no attentionmay curtail his or her use of offensive humor. Keep in mind, too, that desirable behavior that is ignored may lessen as well if its reinforcement is withheld.If nonreinforcement proves ineffective, then punishment may be employed as a way to decrease responses, although this approach carries many risks. Under punishment conditions, the individual cannot escape or avoid an unpleasant stimulus. Suppose, for example, a nursing student is continually late for class and noisily disrupts the class when she finally arrives, annoying both other students and the instructor. The instructor discovers there is no valid reason for the students latenessthe student says she overslept and did not allow sufficient time to find a parking place, and cites other factors she should have more control over. The instructor tries praising the student the few times she comes to class on time (positive reinforcement) and tries not paying attention to her when she arrives late (nonreinforcement), but the student continues to be late to class more often than she is on time. The student appears to enjoy the attention she receives. As a last resort, the instructor may try punishment, which involves applying a negative reinforcer and removing a positive reinforcer. The positive reinforcers to be removed are the attention the student receives and the fact that she really does not need to change her behavior to conform to classroom expectations. The instructor might tell the student that if she is late, she must come in the back door and sit in back of the class, making sure not to disturb anyone (removal of the positive reinforcer of attention). Each time the student is late, the instructor will make note in her grade book (negative reinforcer of not doing well in the course).The problem with using punishment as a technique for teaching is that the learner may become highly emotional and may well divert attention away from the behavior that needs to be changed. Some people who are being punished become so emotional (sad or angry) that they do not remember the behavior for which they are being punished. One of the cardinal rules of operant conditioning is to punish the behavior, not the person. In the preceding example, the instructor must make it clear that she is punishing the student for being late and disrupting class rather than convey that she does not like the student.If punishment is employed, it should be administered immediately after the response with no distractions or means of escape. Punishment must also be consistent and at the highest reasonable level (e.g., nurses who apologize and smile as they admonish the behavior of a staff member or client are sending mixed messages and are not likely to be taken seriously or to decrease the behavior they intend). Moreover, punishment should not be prolonged (bringing up old grievances or complaining about a misbehavior at every opportunity), but there should be a time-out following punishment to eliminate the opportunity for positive reinforcement. The purpose of punishment is not to do harm or to serve as a release for anger; rather, the goal is to decrease a specific behavior and to instill self-discipline.Operant conditioning and discussions of punishment were more popular during the mid-20th century than they are currently. However, it is important for nurses to be aware of the many cautions about punishment because punishment continues to be used more than it should in the healthcare setting, and all too often in damaging ways.The use of reinforcement is central to the success of operant conditioning procedures. For operant conditioning to be effective, it is necessary to assess which kinds of reinforcement are likely to increase or decrease behaviors for each individual. Not every client, for example, finds health practitioners terms of endearment rewarding. Comments such as Very nice job, dear, may be presumptuous or offensive to some clients. A second issue involves the timing of reinforcement. Through experimentation with animals and humans, researchers have demonstrated that the success of operant conditioning procedures partially depends on the schedule of reinforcement. Initial learning requires a continuous schedule, reinforcing the behavior quickly every time it occurs. If the desired behavior does not occur, then responses that approximate or resemble it can be reinforced, gradually shaping behavior in the direction of the goal for learning. As an illustration, for geriatric patients who appear lethargic and unresponsive, nurses might begin by rewarding small gestures such as eye contact or a hand that reaches out, and then build on these friendly behaviors toward greater human contact and connection with reality. Once a response is well established, however, it becomes ineffective and inefficient to continually reinforce the behavior; reinforcement then can be administered on a fixed (predictable) or variable (unpredictable) schedule after a given number of responses have been emitted or after the passage of time.Operant conditioning techniques provide relatively quick and effective ways to change behavior. Carefully planned programs using behavior modification procedures can readily be applied to health care. For example, computerized instruction and tutorials for patients and staff rely heavily on operant conditioning principles in structuring learning programs. In the clinical setting, the families of patients with chronic back pain have been taught to minimize their attention to the patients whenever they complain and behave in dependent, helpless ways, but to pay a lot of attention when the patients attempt to function independently, express a positive attitude, and try to live as normal a life as possible. Some patients respond so well to operant conditioning that they report experiencing less pain as they become more active and involved. A systematic review of physiotherapist-provided operant conditioning (POC) found moderate-level evidence showing that POC is more effective than a placebo intervention in reducing short-term pain in patients with subacute low back pain (Bunzli, Gillham, & Esterman, 2011). Operant conditioning and behavior modification techniques also have been found to work well with some nursing home and long-term care residents, especially those who are losing their cognitive skills (Proctor, Burns, Powell, & Tarrier, 1999).The behaviorist theory is simple and easy to use, and it encourages clear, objective analysis of observable environmental stimulus conditions, learner responses, and the effects of reinforcements on peoples actions. There are, however, some criticisms and cautions to consider when relying on this theory. First, behaviorist theory is a teacher-centered model in which learners are assumed to be relatively passive and easily manipulated, which raises a crucial ethical question: Who is to decide what the desirable behavior should be? Too often the desired response is conformity and cooperation to make someones job easier or more profitable. Second, the theorys emphasis on extrinsic rewards and external incentives reinforces and promotes materialism rather than self-initiative, a love of learning, and intrinsic satisfaction. Third, research evidence supporting behaviorist theory is often based on animal studies, the results of which may not be applicable to human behavior. A fourth shortcoming of behavior modification programs is that clients changed behavior may deteriorate over time, especially once they return to their former environmentan environment with a system of rewards and punishments that may have fostered their problems in the first place.The next section moves from focusing on responses and behavior to considering the role of mental processes in learning.Cognitive Learning TheoryWhereas behaviorists generally ignore the internal dynamics of learning, cognitive learning theorists stress the importance of what goes on inside the learner. Cognitive theory is assumed to comprise a number of subtheories and is widely used in education and counseling. According to this perspective, the key to learning and changing is the individuals cognition (perception, thought, memory, and ways of processing and structuring information). Cognitive learninga highly active process largely directed by the individualinvolves perceiving the information, interpreting it based on what is already known, and then reorganizing the information into new insights or understanding (Bandura, 2001; Hunt, Ellis, & Ellis, 2004).Cognitive theorists, unlike behaviorists, maintain that reward is not necessary for learning to take place. More important are learners goals and expectations, which create disequilibrium, imbalance, and tension that motivate learners to act. Educators trying to influence the learning process must recognize the variety of past experiences, perceptions, ways of incorporating and thinking about information, and diverse aspirations, expectations, and social influences that affect any learning situation. A learners metacognition, or understanding of her way of learning, influences the process as well. To promote transfer of learning, the learner must mediate or act on the information in some way. Similar patterns in the initial learning situation and subsequent situations facilitate this transfer.Cognitive learning theory includes several wellknown perspectives, such as gestalt, information processing, human development, social constructivism, and social cognition theory. More recently, attempts have been made to incorporate considerations related to emotions within cognitive theory. Each of these perspectives emphasizes a particular feature of cognition; collectively, when pieced together, they indicate much about what goes on inside the learner. As the various cognitive perspectives are briefly summarized here, readers are encouraged to think of their potential applications in the healthcare setting. In keeping with cognitive principles of learning, being mentally active when processing the information encourages its retention in longer-term memory.One of the oldest psychological theories is the gestalt perspective, which emphasizes the importance of perception in learning and lays the groundwork for the various other cognitive perspectives that followed (Kohler, 1947, 1969; Murray, 1995). Rather than focusing on discrete stimuli, gestalt refers to the configuration or patterned organization of cognitive elements, reflecting the maxim that the whole is greater than the sum of its parts. A principal assumption is that each person perceives, interprets, and responds to any situation in his or her own way. While many gestalt principles worth knowing have been identified (Hilgard & Bower, 1966), the discussion here focuses on those that relate to health care.A basic gestalt principle is that psychological organization is directed toward simplicity, equilibrium, and regularity. For example, study the bewildered faces of some patients listening to a complex, detailed explanation about their disease; what they actually desire most is a simple, clear explanation that settles their uncertainty and relates directly to them and their familiar experiences.Another central gestalt principle that has several ramifications is the notion that perception is selective. First, because no one can attend to all possible surrounding stimuli at any given time, individuals orient themselves to certain features of an experience while screening out or ignoring other features. Patients who are in severe pain or who are worried about their hospital bills, for example, may not attend to well-intentioned patient education information. Second, what individuals pay attention to and what they ignore are influenced by a host of factors: past experiences, needs, personal motives and attitudes, reference groups, and the particular structure of the stimulus or situation (Sherif & Sherif, 1969). Assessing these internal and external dynamics has a direct bearing on how a health educator approaches any learning situation with an individual or group. Moreover, because individuals vary widely with regard to these and other characteristics, they will perceive, interpret, and respond to the same event in different ways, perhaps distorting reality to fit their goals and expectations. This tendency helps explain why an approach that is effective with one client may not work with another client. People with chronic illnesseseven different people with the same illnessare not alike, and helping any patient with disease or disability includes recognizing each persons unique perceptions and subjective experiences (Imes, Clance, Gailis, & Atkeson, 2002).Information processing is a cognitive perspective that emphasizes thinking processes: thought, reasoning, the way information is encountered and stored, and memory functioning (Gagn, 1985; Sternberg, 2006). How information is incorporated and retrieved is useful for nurses to know, especially in relation to older peoples learning (Hooyman & Kiyak, 2005; Kessels, 2003).Figure 3-2 illustrates an information-processing model of memory functioning. Tracking learning through the various stages of this model is helpful in assessing what happens to information as each learner perceives, interprets, and remembers it, which in turn may suggest ways to improve the structure of the learning situation as well as ways to correct misconceptions, distortions, and errors in learning.FIGURE 3-2 Information-processing model of memory.The first stage in the memory process involves paying attention to environmental stimuli; attention, then, is the key to learning. Thus, if a client is not attending to what a nurse educator is saying, perhaps because the client is weary or distracted, it would be prudent for the educator to try the explanation at another time when the client is more receptive and attentive.In the second stage, the information is processed by the senses. Here it becomes important to consider the clients preferred mode of sensory processing (visual, auditory, or motor manipulation) and to ascertain whether he or she has any sensory deficits.In the third stage of the memory process, the information is transformed and incorporated (encoded) briefly into short-term memory, after which it suffers one of two fates: The information is disregarded and forgotten, or it is stored in longterm memory. Long-term memory involves the organization of information by using a preferred strategy for storage (e.g., imagery, association, rehearsal, or breaking the information into units). Although long-term memories are enduring, a central problem is retrieving the stored information at a later time.The last stage in the memory-processing model involves the action or response that the individual undertakes on the basis of how information was processed and stored. Education requires assessing how a learner attends to, processes, and stores the information that is presented as well as finding ways to encourage the retention and retrieval processes. Errors are corrected by helping learners reprocess what needs to be learned (Kessels, 2003).In general, cognitive psychologists note that memory processing and the retrieval of information are enhanced by organizing that information and making it meaningful. A widely used descriptive model has been provided by Robert Gagn (1985). Subsequently, Gagn and his colleagues outlined nine events and their corresponding cognitive processes that activate effective learning (Gagn, Briggs, & Wagner, 1992):Gain the learners attention (reception)Inform the learner of the objectives and expectations (expectancy)Stimulate the learners recall of prior learning (retrieval)Present information (selective perception)Provide guidance to facilitate the learners understanding (semantic encoding)Have the learner demonstrate the information or skill (responding)Give feedback to the learner (reinforcement)Assess the learners performance (retrieval)Work to enhance retention and transfer through application and varied practice (generalization)In employing this model, instructors must carefully analyze the requirements of the activity, design and sequence the instructional events, and select appropriate media to achieve the outcomes.Within the information-processing perspective, Sternberg (1996) reminds educators to consider styles of thinking, which he defines as a preference for using abilities in certain ways (p. 347). Thinking styles concern differences, he notes, rather than judgments of better versus worse. In education, the instructors task is to get in touch with the learners way of processing information and thinking. Some implications for health care are the need to carefully match jobs with styles of thinking, to recognize that people may shift from preferring one style of thinking to another, and, most important, to appreciate and respect the different styles of thinking reflected among the many players in the healthcare setting. Yet striving for a match in styles is not always necessary or desirable. Tennant (2006) notes that adult learners may actually benefit from grappling with views and styles of learning unlike their own, which may promote maturity, creativity, and a greater tolerance for differences. Because nurses are expected to instruct a variety of people with diverse styles of learning, Tennants suggestion has interesting implications for nursing education programs.The information-processing perspective is particularly helpful for assessing problems in acquiring, remembering, and recalling information. Some strategies include the following:1. Have learners indicate how they believe they learn (metacognition)2. Ask them to describe

Nystrom, Darley, & Cohen, 2001).Emotional intelligence (EI) entails an individual managing his emotions, motivating himself, reading the emotions of others, and working effectively in interpersonal relationships, which some argue is more important to leadership, social judgment, and moral behavior than cognitive intelligence is (Goleman, 1995).Self-regulation includes monitoring cognitive processes, emotions, and the individuals surroundings to achieve goals, which is considered a key factor to successful living and effective social behavior (Eccles & Wigfield, 2002).The implications are that nursing and other health professional education programs would do well to exhibit and encourage empathy and emotional intelligence in working with patients, family, and staff and to attend to the dynamics of self-regulation as a way to promote positive personal growth and effective leadership. Research indicates that the development of these attributes in self and patients is associated with a greater likelihood of healthy behavior, psychological well-being, optimism, and meaningful social interactions (Brackett, Lopes, Ivcevic, Mayer, & Salovey, 2004).A significant benefit of the cognitive theory to health care is its encouragement of recognizing and appreciating individuality and diversity in how people learn and process experiences. When applied to health care, cognitive theory has proved useful in formulating exercise programs for breast cancer patients (Rogers et al., 2004), understanding individual differences in bereavement (Stroebe, Folkman, Hansson, & Schut, 2006), and dealing with adolescent depression in girls (Papadakis, Prince, Jones, & Strauman, 2006). This theory highlights the wide variation in how learners actively structure their perceptions; confront a learning situation; encode, process, store, and retrieve information; and manage their emotionsall of which are affected by social and cultural influences. The challenge for educators is to identify each learners level of cognitive development and the social influences that affect learning, and then to find ways to foster insight, creativity, and problem solving. Difficulties may arise in ascertaining exactly what is transpiring inside the mind of each individual and in designing learning activities that encourage people to restructure their perceptions, reorganize their thinking, regulate their emotions, change their attributions and behavior, and create solutions.The next learning theory combines principles from both the behaviorist and cognitive theories.Social learning theory is largely based on the work of Albert Bandura (1977, 2001), who mapped out a perspective on learning that includes consideration of the personal characteristics of the learner, behavior patterns, and the environment. Since its original inception, this theory has gone through several paradigm shifts (Bandura, 2001, p. 2). In early formulations, Bandura emphasized behaviorist features and the imitation of role models; later, the focus shifted to cognitive considerations, such as the attributes of the self and the internal processing of the learner. More recently, Banduras attention has turned to the impact of social factors and the social context within which learning and behavior occur. As the model has evolved, the learner has become viewed as central (what Bandura calls a human agency), which suggests the need to identify what learners are perceiving and how they are interpreting and responding to social situations. As such, careful consideration needs to be given to the healthcare environment as a social situation.One of Banduras early observations was that individuals need not have direct experiences to learn; considerable learning occurs by taking note of other peoples behavior and what happens to them. Thus learning is often a social process, and other individuals, especially significant others, provide compelling examples or role models for how to think, feel, and act. Role modeling, then, is a central concept of social learning theory. As an example, a more experienced nurse who demonstrates desirable professional attitudes and behaviors sometimes serves as a mentor for a less experienced colleague. Armstrong (2008) emphasizes that to facilitate learning, role models need to be enthusiastic, professionally organized, caring, and self-confident, as well as knowledgeable, skilled, and good communicators. Research indicates that nurse managers attitudes and actionsensuring safety, integrating knowledge with practice, sharing feelings, challenging staff nurses and students, and demonstrating competence and willingness to provide guidance to othersinfluence the outcomes of the clinical supervision process (Berggren & Severinsson, 2006). How nurse mentors perceive their role is an important consideration in the leadership selection process (Neary, 2000).Vicarious reinforcement, another concept from social learning theory, involves determining whether role models are perceived as rewarded or punished for their behavior. Reward is not always necessary, however, and a learner may imitate the behavior of a role model even when no reward is available to either the role model or the learner. Nevertheless, in many cases, whether the model is viewed by the observer as rewarded or punished may have a direct influence on learning. This relationship may be one reason why it is difficult to attract health professionals to geriatric care. Although some highly impressive role models work in this field, geriatric health care is often accorded lower status with less pay in comparison to other specialty areas.Although social learning theory is based partially on behaviorist principles, the self-regulation and control that the individual exerts in the process of acquiring knowledge and changing behavior are considered more critical and are more reflective of cognitive principles. Bandura (1977) outlines a four-step, largely internal process that directs social learning (Figure 3-3). Although some of this models components are similar to the information-processing model described previously, a principal difference is the inclusion of a motivational component in the social learning theory model.The first step in Banduras model is the attentional phase, a necessary condition for any learning to occur. Research indicates that role models with high status and competence are more likely to be observed, although the learners own characteristics (e.g., needs, self-esteem, competence) may be the more significant determiner of attention. The second step comprises the retention phase, which involves the storage and retrieval of what was observed. Third is the reproduction phase, during which the learner copies the observed behavior. Mental rehearsal, immediate enactment, and corrective feedback strengthen the reproduction of behavior. The fourth step is the motivational phase, which focuses on whether the learner is motivated to perform a certain type of behavior. Reinforcement or punishment for a role models behavior, the learning situation, and the appropriateness of subsequent situations where the behavior is to be displayed all combine to affect a learners performance (Bandura, 1977; Gage & Berliner, 1998). Well suited to conducting health education and staff development training, this organized approach to learning requires paying attention to the social environment, the behavior to be performed, and the individual learner (Bahn, 2001).Only gold members can continue reading. Log In or Register to continue Share copy and redistribute the material in any medium or format for any purpose, even commercially. Adapt remix, transform, and build upon the material for any purpose, even commercially. The licensor cannot revoke these freedoms as long as you follow the license terms. Attribution You must give appropriate credit , provide a link to the license, and indicate if changes were made . 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