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A study of women in transition: becoming a nurse

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A STUDY OF WOMEN IN TRANSITION: BECOMING A NURSE

A thesis submitted in fulfilment of the requirements for the award of the degree

Doctor of Philosophy

from

The University of Wollongong

by

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Department of Psychology

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Finally, to the many friends who have offered me support and encouragement during the process of this research - my heartfelt thanks; your understanding and patience will always be remembered.
A model for exploring the process of transition during life event changes has been proposed, using personal construct theory (Kelly, 1955) as a theoretical base and conceptual framework. The study involved an exploration of the lives of women during their transition to becoming a nurse. One hundred and forty-four women participated in the study. In developmental terms, seventy-two were at the stage of late adolescence (17 to 20 years) and seventy-two were adults (22 to 48 years). Due to differences in the nature of the two nursing courses from which the participants were drawn, they had different professional roles; seventy-two were hospital employees and the remaining seventy-two were university students. Intra and interpersonal accounts of the women's experience during the transition event were obtained by five interviews spread over the three year course. Content analysis of their verbalisations was performed and scored for both positive and negative affect, indicative of construct change during a transition experience. Higher than normal levels of construct invalidation, in the form of anxiety and depression, were noted for all participants. Significant differences according to developmental stage and professional role were also noted thus supporting the predicted hypotheses. Older women and nurse trainees who were hospital employees experienced significantly higher levels of construct invalidation than younger women and university
students. Support for the revised model of transition was provided, also validation for both a personal construct theory approach and the methodology adopted. The implications of the results for an understanding of the process of transition in life event change have been discussed, also opportunities for necessary interventions. The attention of nursing academics, and others associated with vocational courses which are potentially stressful in nature, is directed to the influence of developmental stage, professional role and gender on the process of transition together with the implications for further research.
# Table of Contents

Acknowledgements ........................................... i  
Abstract .................................................. ii  
Table of Contents ......................................... iv  
List of Tables ............................................. x  
List of Figures ........................................... xii  
List of Appendices ....................................... xiv

## Chapter One

TRANSITIONS AND LIFE CHANGES .......................... 1
INTRODUCTION TO CHANGE .................................. 1
AN OVERVIEW OF LIFE EVENT RESEARCH .................. 3
THEORETICAL FOUNDATIONS AND EXPLANATIONS .......... 7
CONSTRUCTIVISM: A CONCEPTUAL FRAMEWORK .......... 11

## Chapter Two

A CONSTRUCTIVIST VIEW OF LIFE EXPERIENCES ........ 14
THE ANTICIPATORY POSTURE .............................. 16
THEMES AND PATTERNS .................................. 20
INDIVIDUAL DIFFERENCES ................................ 21
LIFE’S CHOICES .......................................... 24
COMMONALITIES AND SOCIAL INTERACTIONS .......... 26
CONSTRUCTS: AN ALTERNATIVE VIEW OF LIFE .......... 29

## Chapter Three

CONSTRUCT CHANGE DURING TRANSITION ............... 32
THEORIES OF EMOTION .................................. 33
NEGATIVE EMOTIONS ..................................... 36
CHAPTER EIGHT

DEVELOPMENTAL INFLUENCES
ON THE PROCESS OF TRANSITION ......................... 139

QUALITATIVE RESULTS .................................... 139

DEVELOPMENTAL STAGE INFLUENCES ...................... 140

EXPERIENCES OF OLDER WOMEN ............................ 140
  Anxiety ............................................... 140
  Depression .......................................... 145
  Hostility and Anger ................................. 148

EXPERIENCES OF YOUNGER WOMEN ...................... 152
  Fear of Death and Mutilation ....................... 152
  Satisfying Social Interactions and Friendship ..... 154
  Personal Satisfaction and Happiness ............... 156

CHANGES DURING THE TRANSITIONAL PROCESS .......... 157

SUMMARY OF DEVELOPMENTAL DIFFERENCES OVER TIME ........ 161

CHAPTER NINE

PROFESSIONAL ROLE INFLUENCES ON TRANSITION ........ 163

DIFFERENCES ACCORDING TO PROFESSIONAL ROLE .......... 163

EXPERIENCES OF HOSPITAL EMPLOYEES ................... 164
  Anger and Anxiety ................................... 164
  Guilt and Shame .................................... 167
  Uncertainty ........................................ 168
  Loneliness and Isolation ............................ 169
  Helplessness ....................................... 171

CHANGES DURING THE TRANSITIONAL PROCESS ............. 174

EXPERIENCES OF UNIVERSITY STUDENTS ................. 177

SUMMARY OF THE EFFECT OF PROFESSIONAL ROLE ....... 179

CHAPTER TEN

THE INFLUENCE OF TIME ON TRANSITION ................. 181

EXPERIENCES AND NEGATIVE EMOTIONS OVER TIME ........ 181
CHAPTER TEN (Continued)

Uncertainty ................................................. 182
Anger and Depression .................................... 184
Helplessness ................................................. 186
Fear of Death .............................................. 189

EXPERIENCES OF POSITIVE EMOTIONS .................. 192
Satisfaction, Friendship and Achievement ............. 192

SUMMARY OF IMPORTANT CHANGES OVER TIME .......... 194

CHAPTER ELEVEN

PERSONAL CONSTRUING OF TRANSITION ................. 197

GUILT AND UNCERTAINTY IN A YOUNG WOMAN: CAROL ...... 198

RELATIONSHIP LOSS IN THE PURSUIT OF A CAREER: YVONNE .... 200

INVALIDATION OF SELF-CONSTRUCTS: ELAINE ............... 203

FRIENDSHIP AND SATISFACTION IN NURSING: JULIE ........ 205

INDIVIDUALS AND CHANGE .................................. 209

CHAPTER TWELVE

ISSUES AND IMPLICATIONS ARISING FROM A CONSTRUCTIVIST APPROACH TO TRANSITION .............. 211

THE RESEARCH PARTICIPANTS ................................ 212

RESEARCH INTERACTION DYNAMICS .......................... 214

USEFULNESS OF THE CONTENT ANALYSIS SCALES .......... 215

SUPPORT FOR RESEARCH PREDICTIONS ...................... 216

The Influence of Developmental Stage .................... 217
The Influence of Professional Role ....................... 219

CONCEPTUAL FRAMEWORK AND MODEL OF TRANSITION .. 223

IMPLICATIONS FOR THE FUTURE ............................ 228

Psychological Research Issues ............................. 229
Implications for Nursing .................................... 231
Implications for Constructivism ............................ 234
LIST OF TABLES

Table 7.1 Means and standard deviations for Total and Cognitive Anxiety, Hostility Inward and Hostility Outward for all women over five interviews ..............................120

Table 7.2 Multivariate analysis of variance of content analysis scale scores for interviews one and five ..............................124

Table 7.3 Univariate repeated measures analysis of variance of content analysis scale scores ..........126

Table 7.4 Means and standard deviations for content analysis scale scores showing significant developmental stage differences over five interviews .........................127

Table 7.5 Means and standard deviations for content analysis scale scores showing significant professional role differences over five interviews .........................129
Table 7.6  Univariate repeated measures analysis of variance of anxiety sub-scale scores ......................... 130

Table 7.7  Means and standard deviations for anxiety sub-scale scores showing significant professional role differences over five interviews ................................. 131

Table 7.8  Means and standard deviations for anxiety sub-scale scores showing significant developmental stage differences over five interviews ................................. 133

Table 7.9  Means and standard deviations for content analysis scale scores which showed a significant effect for time for all women over five interviews ................. 135

Table 7.10 Means and standard deviations for the Death Anxiety Sub-scale scores for all women over five interviews ................................. 136
LIST OF FIGURES

Figure 5.1  A revised model of transition .............83

Figure 10.1  Mean Cognitive Anxiety Scale
   scores for all women over
   five interviews .........................183

Figure 10.2  Mean Hostility Outward Scale
   scores for all women over
   five interviews .........................183

Figure 10.3  Mean Hostility Inward Scale
   scores for all women over
   five interviews .........................187

Figure 10.4  Mean Pawn Scale scores for
   all women over five interviews ..........187

Figure 10.5  Mean Death Anxiety Sub-scale
   scores for all women over
   five interviews .........................190

Figure 10.6  Mean Positive Affect Scale
   scores for all women over
   five interviews .........................190
Figure 10.7  Mean Sociality Scale scores
for all women over five
interviews  ................................191

Figure 10.8  Mean Origin Scale scores
for all women over five
interviews  ................................191
LIST OF APPENDICES

Appendix One: Model of transition..............274

Appendix Two: Table 1: Reported inter-
judge reliability
estimates for eight
ccontent analysis scales .........275

Table 2: Reports on the
internal consistency of
ten content analysis
scales ......................277

Table 3: Reported stability
estimates for ten content
analysis scales ..............278

Appendix Three: Table 1: Reported
evidence of validity
for eight content
analysis scales ..............279

Appendix Four: Table 1: Scoring
schedule and examples
for the Cognitive
Anxiety Scale ..............285
Appendix Five: Figure 1: Interview schedule of hospital employees .......................... 289

Figure 2: Interview schedule of university students .............................. 290

Appendix Six: Table 1: Means and standard deviations for content analysis scale scores for younger women over five interviews ............. 291

Table 2: Means and standard deviations for content analysis scale scores for older women over five interviews ...................... 292

Table 3: Means and standard deviations for anxiety sub-scale scores for younger women over five interviews ................. 293
Appendix Six: Table 4: Means and standard deviations for anxiety sub-scale scores for older women over five interviews ......................294

Appendix Seven: Figure 1: Mean Total Anxiety Scale scores by developmental stage over five interviews ............295

Figure 2: Mean Hostility Inward Scale scores by developmental stage over five interviews ............295

Appendix Seven: Figure 3: Mean Guilt Anxiety Sub-scale scores by developmental stage over five interviews ......................296

Figure 4: Mean Shame Anxiety Sub-scale scores by developmental stage over five interviews ......................296
Appendix Seven: Figure 5: Mean Diffuse Anxiety Sub-scale scores by developmental stage over five interviews .................297

Appendix Seven: Figure 6: Mean Hostility Outward Scale scores by developmental stage over five interviews ............297

Figure 7: Mean Positive Affect Scale scores by developmental stage over five interviews ...............298

Figure 8: Mean Sociality Scale scores by developmental stage over five interviews ...............298

Figure 9: Mean Death Anxiety Sub-scale scores by developmental stage over five interviews ...............299
Appendix Seven: Figure 10: Mean Mutilation Anxiety Sub-scale scores by developmental stage over five interviews ..........299

Appendix Eight: Figure 1: Mean Separation Anxiety Sub-scale scores by professional role over five interviews ...............300

Figure 2: Mean Total Anxiety Scale scores by professional role over five interviews ..........300

Figure 3: Mean Diffuse Anxiety Sub-scale scores by professional role over five interviews ..........301

Figure 4: Mean Hostility Outward Scale scores by professional role over five interviews .................301
Appendix Eight:

Figure 5: Mean Cognitive Anxiety Scale scores by professional role over five interviews ...............302

Figure 6: Mean Pawn Scale scores by professional role over five interviews ...............302

Figure 7: Mean Shame Anxiety Sub-scale scores by professional role over five interviews ........303

Figure 8: Mean Guilt Anxiety Sub-scale scores by professional role over five interviews ........303

Appendix Nine:

Table 1: Univariate repeated measures analysis of variance for content analysis scale scores showing interaction effects ............304
Appendix Nine: Table 2: Univariate repeated measures analysis of variance for anxiety sub-scale scores showing interaction effects ...........305
CHAPTER 1

TRANSITIONS AND LIFE CHANGES
TRANSITIONS AND LIFE CHANGES

INTRODUCTION TO CHANGE

An almost inescapable aspect of modern life is the need to deal with change. Change is a normal part of the human condition. In addition to changes that occur as a result of natural developmental processes, individuals are confronted daily with change in contemporary society.

It has been suggested that as life speeds up and becomes more complex, more people will be confronted more often with unfamiliar new situations (Adams, 1976). Concern has been expressed regarding the rate and effect of change in our society. Toffler (1972) contends that people experience overwhelming shock as a result of too much change, too soon. Changes in job and occupational status occur with increasing regularity as a result of advances in technology. In turn, rising rates of occupational turnover and enforced geographical relocation affect the formation of relationships. Change is not confined only to the adult world, it affects all ages. Children may suffer from the impact of social mobility, as schools increasingly suffer high turnover rates in both student body and members of the teaching staff. Families may also be dislocated, psychologically and environmentally, as a result of change due to marriage breakdowns, divorce or separation, to name but a few examples (Toffler, 1972). In a study of contemporary
family life cycles, Norton (1983) states that recent trends in marriage, divorce and childbearing indicate that individuals and families are undergoing more transitions as they pass through the life course than in the past. What were once considered to be exceptional circumstances are now quite common.

As our appreciation of the importance of life events, which precipitate change in the lives of individuals has grown, so too has the recognition that these events may play an important role in the etiology of many disorders affecting human beings.

It has been stated that the rapidly shifting psychological environment of contemporary society forms part of a situational context to which individuals must adapt if they are to survive psychologically (Felner, Farber and Primavera, 1983). Arguments have been advanced by these and other authors emphasizing the importance of the need to target preventative efforts of life events. The assumption underlying these arguments is that change in people's lives may be associated with increased levels of psychosocial stress. Before preventative efforts can be targeted, many questions need answers, and require an understanding of the dynamics of the change process in life events. Why does one person respond differently to another and what factors influence the appraisal of an event (Moos, 1986)? An overview of life event research is required in order to determine the variations encountered
AN OVERVIEW OF LIFE EVENT RESEARCH

For the purpose of this discussion, and in agreement with previous research (Thoits, 1983), life events or life changes are defined as objective experiences that disrupt, or threaten to disrupt, an individual's usual activities; causing a substantial readjustment in the individual's behaviour. Examples of life events include marriage, divorce, graduation and loss of job, changes that most people experience in the natural life cycle.

Life events research originated with Cannon in 1929 (cited by Thoits, 1983), who, in a study of people who had experienced severe emotional traumas, proposed that traumatic events might produce psychological reactions that would, if not discharged or eliminated, generate illness. This argument was later adopted by Adolf Meyer in the 1930's who suggested that life events might be important factors in the etiology of disease. Meyer stated that life events need not be major traumas to be pathological but could be simply ordinary normative changes in people's lives (Thoits, 1983). Later research by Selye (1956) substantiated this hypothesis and provided the impetus for studies of psychosocial stressors. Further focus was provided by the seminal work of Holmes and Rahe (1967) in an examination of the psychological effects of multiple events in peoples
lives. This work was based on the notion that life change per se, required readjustment and that this process of adjustment, whether positive or negative, was stressful. More recently however it has been shown that negative life events may be associated with dysfunction, and positive life events with more positive adjustment (Rowlison and Felner, 1988; Zautra and Reich, 1983).

The interest in the study of life events has tended to emphasise adaptive coping responses to specific stressful life events such as widowhood (Clayton, 1972; Clayton and Darvish, 1979; Parkes, 1971) and loss of job (Kasl, Gore and Cobb, 1975; Viney, 1983). Mindful of individual differences in the complex area of life transitions, stress researchers working in natural life settings have also studied the effects of positive, but potentially stressful, events such as getting married (Rausch, Goodrich and Campbell, 1963), experiencing pregnancy (Leifer, 1980) and the transition to parenthood (Belsky, Ward and Rovine, 1986; Eakins, 1983) with its effect on the marital relationship (Belsky, 1985; Ruble, Fleming, Hackle and Stangor, 1988).

Stress related transactions between the person and the environment (Dubos, 1985; Lazarus and Folkman, 1984; Suedfeld, 1985) have received close attention. Occupational events combined with environmental factors have also been examined, particularly among health workers (Bell, 1984; Eden, 1982; Hay and Oken, 1985;

Research has been directed to age-specific areas, including stressful life events among children and adolescents (Cowen, 1985; Rowlison and Felner, 1988). Longitudinal studies of psychological disturbance occurring as a result of the transition to university have been evaluated (Compas, Wagner, Slavin and Vannetta, 1986; Fisher and Hood, 1987, 1988). The coping efforts of children experiencing school transitions have been investigated at kindergarten and primary school levels (Bogat, Jones and Jason, 1980; Ladd and Price, 1987) and the transition to high school (Felner, Ginter and Primavera, 1982). Developmental life events occurring during the passage of adult life have also been discussed by such authors as Sheehy (1977), and Hoff (1984).

Other studies have emphasised the degree of perceived predictability and the role of locus of control in determining the stressfulness of events (Dohrenwend and Martin, 1979; Johnson and Sarason 1978; Sandler and Lakey, 1982).

These studies, which focus on the individual rather than the precipitating events themselves, seek to understand the process by which the individuals adapt to critical life events. This approach arose in part, from crisis theory (Caplan, 1964) and also from studies of the impact of environmental stressors (Felner, et al; 1982,
These authors argue against the conceptualisation of discrete life changes, stating that some events are limited, both temporally and in their repercussions on individuals' lives.

A preventative focus would be better served by a view that focuses on the entire transitional period, during which individuals are being called upon to engage in adaptive efforts by the change process they are experiencing. Knowledge of the change process would facilitate the use of appropriate therapeutic interventions. Interventions implemented during the period of actual crisis have been shown to be beneficial in assisting recovery outcomes (Viney, Clarke, Bunn and Benjamin, 1985). An important element is the shifting of the focus from stress and its pathogenic effects as the predominant concern, to the nature of the changes which characterise such transitions and the process of adapting to them (Felner, et al., 1983). It has also been noted that, in trying to understand the impact of major events, it is important to focus not only on the precipitating events but also on the actual changes, daily hassles and disruptions in the day to day life of the individual that they engender (Lazarus and Folkman, 1984; Rowlison and Felner, 1988).
THEORETICAL FOUNDATIONS AND EXPLANATIONS

The focus on the process of change has been described in a phenomenological account of psychosocial transitions (Parkes, 1971). The term transition, as it relates to life change and mental health, was initially employed by Tyhurst (1957) in a discussion of the role of transition states in mental illness. Tyhurst's account of transitional states focuses on the pathological responses of individuals experiencing change rather than the change process itself (Tyhurst, 1957).

By contrast, Parkes prefers to regard transition as a process rather than a state. He defines transitions as:

major changes in life space which are lasting in their effects, which take place over a relatively short period of time and which affect large areas of the assumptive world.

(Parkes, 1971, p. 103)

The assumptive world is created from the total set of assumptions built up by the individual on the basis of past experience. Parkes' focus on transition is directed to the process; and he notes the effort required by individuals to restructure their world in that "old patterns of thought must be discarded and fresh ones developed" (Parkes, 1971, p. 102).

This phenomenological perspective is supported by Adams, Hayes and Hopson (1976) who offer a framework for
the understanding of the process of transition. These authors define transition as a discontinuity in the experienced life space. This discontinuity is as perceived by the experiencing individual, rather than dependent upon other people's perceptions. Perhaps the most detailed account of transitions from the individual's attribution is offered by Viney (1980). Her view of the individual in transition is an active experiencing being whose expectations are of prime importance. Viney is concerned with the mediating experiences which effect the transitional process and the development of a comprehensive phasic model of transition (Appendix 1). Each transitional event is considered in terms of that which it elicits from those experiencing it, rather than simply an account of reactions to events. This model, which has implications for the present research, will be examined further in later chapters.

Support for this view of transitional and life event changes is addressed by Waterhouse (1984). In a plea for consideration of the meaning of a particular event for any individual, he condemns the absence of "psychic" events, and states that a process orientation is required for this area of research. The need for studying coping over time and the use of multivariate studies that can take into account interactions between variables is also documented (Waterhouse, 1984). Adams et al. (1976) support the need for studies of transition over time. They state that distortion of the individual's
perceptions occur in retrospective studies, therefore longitudinal studies are required.

Although researchers have shown great interest in reactions to stressful events, it has been noted that there have been few systematic attempts to discuss the experience of transition or place it within a theoretical framework. Parkes (1971), in his study of psychosocial transitions, states the importance of understanding the process of change that takes place in people in response to major changes in life space. He notes that major transitions affect not only the individual but also family members and significant others, extending to the work group and wider social setting.

In an attempt to develop a framework for the identification of elements involved in the transition dynamics, Adams, et al. (1976) noted, at that time, transitional studies have no sound theoretical base. Similar to Kubler-Ross' (1969) exposition of the transition from life to death, Adams, et al. (1976) offer a linear model of the transitional process and identify phases of reactions and feelings experienced by people undergoing change. No theoretical conceptualisation, however, has been offered by these authors.

Viney (1980), as previously discussed, offers one of the more comprehensive accounts of transitions in her
study of women's experiences of change. Her work is based on the belief that women are active participants who are capable of solving and learning from the problems encountered during the transitionary process and she supports the need for a theoretical base to be developed which will reflect this view of women, as well as of people in general (Viney, 1980).

Rowlison and Felner (1988), in a summary of the life event literature, make an appeal for a more comprehensive understanding of the life change process. After two decades of research they note the nature of the relation between life events and human adaption continues to be a focus of debate. Felner, et al. (1983), in similar vein, argue it is of no purpose to be only concerned with discrete events or the individual's affective response to the change (that is, the experienced level of stress). There is a need for an understanding of what people do, cognitively or behaviourally, during adaption to the new circumstances in their lives resulting from events and the transitional tasks they precipitate. These authors support Parkes' (1971) statement that transitions or changes affect people's assumptive world, that view of the world which encompasses interpersonal relationships, familiar environments, possessions, physical and mental capacities, and roles and status. From this perspective, individuals facing major life changes are required to modify their existing set of expectations and assumptions about their world and develop others which more
accurately reflect their new situation (Felner, et al., 1983). The person thus has an active role in the change process.

CONSTRUCTIVISM: A CONCEPTUAL FRAMEWORK

This view of people as active participants has implications for an understanding of the change process. In the past, people's appraisal of events has been viewed as essentially static; that is, it does not seem to change during the coping or adaptive process. The role of cognitive appraisal as simply a mediator in the adaptive process is too simplistic. Lazarus and Folkman (1984) assert that cognitive appraisal is not information processing per se but rather an evaluative process that takes place continuously. In a discussion in which the almost atheoretical life events approach is noted, these authors give an account of changed appraisals based on new information from the environment and/or the person experiencing change.

Acceptance of these views suggests that people's appraisal of the changing situation is an indicator of adaptive success in its own right. Their appraisals are changed in such a way that their views come to reflect their changed circumstances and allow them to function effectively. Thus while people's cognitive appraisals may indirectly act simply as mediators (by determining the amount of stress the event generates), they are also
active indicators of the adaption process (Felner et al, 1983). This argument contributes a view of people as active experiencing beings who are capable of restructuring their world - a view that is expressed in the work of George Kelly (1955), whose theory of personality is based upon the philosophical position of constructive alternativism.

The focus of constructive alternativism is on a personal internal reality, as opposed to an external reality (Fransella, 1985). Although there is a real world of events, it is people’s own personal constructions of it that count. These differ according to the individual, whose interpretations are neither right nor wrong. There are always alternative ways of construing any event. A constructive alternative approach implies that people are active participating beings:

We take the stand that there are always alternative constructions available to choose among in dealing with the world. No one needs to paint himself into a corner; no one needs to be completely hemmed in by circumstances; no one needs to be the victim of his biography

(Kelly, 1955, p.15)

Constructive alternativism is stating that people have the ability to control their own lives, that whatever exists in their personal world can be reconstrued by them. The underlying premise of personal construct psychology emphasises people’s abilities and strengths and offers a distinctive view of humankind.
The need for a deeper understanding of the transitional process is evident. So also is the need for a sound theoretical framework through which to explore this process. One which offers an insight into how people perceive their world, how they anticipate change and how they play an active role in restructuring their assumptive world. The next chapter I will devote to an examination of the psychology of personal constructs (Kelly, 1955) through which, it is predicted, the process of transition may be explored more comprehensively. It is my proposal that personal construct psychology may provide a conceptual framework for building a theoretical model - one incorporating the elements nominated in Viney's (1980) model - which can be used to gain a better understanding of the process of transition.
CHAPTER 2

A CONSTRUCTIVIST VIEW OF LIFE EXPERIENCES
A CONSTRUCTIVIST VIEW OF LIFE EXPERIENCES

If we are to pursue an explanation of transition then it is necessary to understand how people might adapt to life experiences; how they participate in the reconstruction of their worlds.

As discussed previously, research relating to the impact of life event changes and transitions reveals that adaption is necessary if people are to negotiate change successfully (Felner, et al., 1983; Fisher and Hood, 1987; Rowlison and Felner, 1988). It has been suggested that individuals experiencing change must restructure their way of looking at the world for successful adaption. Tyhurst (1957), writing of retirement transitions, points to the necessity for people to adopt a new orientation, and Lazarus and Folkman (1984) give examples of successful adaptation outcomes related to coping and functioning in stressful conditions.

There is an abundance of evidence to suggest that people can, and do, adapt successfully. Social learning theory proposes that people actively engage their environment to increase the chances of obtaining positive re-enforcement (Bandura, 1977). Hobfall (1989) argues that people in stressful situations strive to retain, protect and build their resources. A basic resource of people is their developmental history, that is, what they have learned through experience to be valuable to them.
Parkes (1971) states that people experiencing changes in their assumptive world are experiencing beings, engaged in actively reaching out and sampling their environment. The abandonment of previously held expectations and assumptions, stated by Parkes (1971) to be necessary for change, implies that people experiencing transition are active participators who are capable of adaptation to life's events.

Personal construct theory makes the same assumptions about the active nature of human beings. Kelly (1955) emphasises the way in which people interact with their world and actively process rather than passively store their experiences (Diamond, 1985). One of construct theorists' fundamental assumptions about the nature of human beings is that they are essentially interpretative, always in the process of attributing meaning to their ongoing experience (Neimeyer, 1987). Like scientists (Tschudi, 1983), people attempt to understand, predict and control the course of their lives. This acknowledgement of the active nature of individuals contrasts directly with theories which view human beings as hapless victims of learned associations and reinforcement contingencies, or unconscious forces and early childhood experiences (Costigan, 1985).
THE ANTICIPATORY POSTURE

The cornerstone of personal construct theory is the claim made by Kelly (1955) that human nature is basically anticipatory rather than just reactive. People actively develop constructs or representations of the world which are intended to aid their predictive efforts. The fundamental assumption of personal construct theory is that:

a person's processes are psychologically channelised by the way in which he anticipates events.

(Kelly, 1955, p.46)

In other words, people live their lives by reaching out into the future and they do this by using their personal construction of events (Kelly, 1979a). It may be said that people's personal experiences of the world consist of their anticipatory constructions. Using the analogy of people as scientists (Kelly, 1955), these anticipatory constructions can be seen as hypotheses, and behaviour as the experiments by means of which the hypotheses are tested (Tschudi, 1983).

The predictive nature of individuals negotiating change and the role of experience in transitional events is documented by Parkes (1971). It is hypothesised that the assumptive world is built on the basis of past experience and allows recognition of events and predictions for the future:
The assumptive world is the only world we know and it includes everything we know or think we know. It includes our interpretations of the past and our expectations of the future, our plans and our prejudices.

(Parkes, 1971, p.103)

When people have time to anticipate and prepare for the restructuring of their world, the chances that this will follow a satisfactory course are greater than if the change is sudden or unexpected (Parkes, 1971). In a study focusing on the impact of sudden severe demands on people, Tyhurst (1957) suggests that victims of sudden change should be encouraged to construct new futures, based on the old past and the new present. Anticipation assists people to bring their assumptions into greater continuity and to reverse old conceptions and integrate new elements (Tyhurst, 1957). People adjust more readily to change when they are encouraged to formulate new views of the world.

It has been said that the process of living continually invites us to reconsider our assumptions (Button, 1985). A personal construct system is not static but changes according to the accuracy of the person's predictions. As stated, constructs are basically hypotheses and therefore capable of revision; this revision occurs as a result of people's experience.

Kelly's theory is essentially a dynamic theory. Life does not stand still but is constantly changing and:
the successive revelation of events invites people to place new constructions upon them whenever something unexpected happens. Otherwise one's anticipations would become less and less realistic.

(Kelly, 1955, p.72)

Kelly emphasises that it is not what happens around people that makes them experienced; it is the successive construing and reconstruing of what happens, when it happens, that enriches the experience of life (1955, p.73). He describes experience as a cycle that contains the elements of anticipation, involvement, commitment and reconstruction (Kelly, 1977).

Kelly is postulating that, as people's anticipations or assumptions are revised due to changing events, their construction systems must also undergo change, if adaption is to be successful. The more successfully people can fit their constructions to events both within and without, the more control they have over their own lives (Fransella, 1981).

In support of Kelly and personal construct psychology, Mancuso and Adams-Webber (1982) propose that individuals slowly approximate reality by the process of interpretation and reinterpretation of events. This approximation takes place gradually and develops with experience. Thus the person's construction system gradually evolves and construct formation is a result of experience, rather than simply a result of environmental
Life transitions require construct change. It has already been stated that one of the tasks individuals confront, when coping with life changes, is modifying their views of their life situations. This is necessary for successful adaption in the transitionary process:

The life space is constantly changing...

... Some of these changes fulfill expectations and require little or no change in the assumptive world, others necessitate a major restructuring of that world, the abandonment of one set of assumptions and the development of a fresh set to enable the individual to cope with the new, altered life space.

(Parkes, 1971, p.103)

People adjust to changes in the assumptive world by constant interpretation. The succession of events in the transitionary process continually subjects people’s construction systems to a validation process. Validation, in personal construct language, represents the compatibility between people’s predictions and their observed outcomes (Tschudi, 1983). An improvement in the predictive ability of events allows the experience of the event to become more manageable and therefore less stressful. Predictability and control of events have been found to be key factors in determining their potential stressfulness (Dohrenwend and Martin, 1979; Schaffer, 1982). It has been noted in studies that stressful life events seem to be most pathogenic when they are perceived as uncontrollable (Dohrenwend and Martin, 1979).
THEMES AND PATTERNS

Predictability implies a sense of order, an ability to impose meaning on events. It is the process of construction which ensures management of the complex environment of our world. By the process of construction we control our world. Construct theory's emphasis on people's anticipatory nature presupposes that the human organism possesses certain basic tendencies. Chief among these is the set to perceive certain regularly recurring patterns in the complex environment (Neimeyer, 1987). Kelly (1955) acknowledged this feature of construing activity with the proposition that a person anticipates events by construing their replications. Confronted with the complexity of the universe, people attempt to attribute properties to events and "the person notes features in a series of elements which characterize some of the elements and are particularly uncharacteristic of others" (Kelly, 1955, p.50). As recurrent themes are identified by people, then their world begins to make sense. Once events have been given their beginnings and endings, their similarities and contrasts, it becomes possible to predict them and to act on those predictions.

People in transition employ this active structured approach. In the model of transition developed by Viney (1980), certain mediating experiences, occurring in the interaction of people with their environment, are identified. These experiences occur during the process of
change as they cope with significant life events. The assumptions made by people, as a result of the change, represent recurring themes which enable them to give meaning to their experiences. Recurring patterns of reactions occurring during transitions have also been identified by Kubler-Ross (1969), Hopson and Adams (1976), and Tyhurst (1957). People in transition do not only respond to their environment. They actively make sense of it; they construe it.

INDIVIDUAL DIFFERENCES

Although certain common themes may emerge in transitional experiences, however, it is also evident that people place different interpretations on their experiences. It has been found that people ascribe different emphasis to stressful life events (Holmes and Rahe, 1967). Transitions or discontinuities in the person's life space, state Hopson and Adams (1976), should be viewed from the person's own unique perspective rather than by general consensus. It is necessary for a distinction to be made between the actual nature of an event and people's different appraisals of that event. Some may appraise transitional demands as threatening, while others, seeing the potential in engaging them, appraise them as challenging.

Personal construct theory acknowledges the primacy of the individual, stating that persons differ from one
another in their construction of events (Kelly, 1955). Kelly explains that the crucial differences between people have less to do with the different events they have encountered than with the unique constructions they place on these events (Neimeyer, 1987). Kelly, in effect, proposed that we might better understand people if we accept that each of us differs in how we perceive and interpret a situation.

A willingness to accept that there are workable alternative ways for people to construe their worlds and that people's experiments are valid for them, has been argued before in psychological research (Preston, 1987; Richardson, 1984; Viney, 1980). It has been noted that studies of change or reactions to life events have in the past, made assumptions that individual appraisal of the nature of events is not relevant (Lazarus, Cohen, Folkman, Kanner and Schaefer, 1980). Freed of the influence of stimulus-response theories, which ignored the personal interpretations people place on their experience, the pendulum appears to be swinging back (Button, 1985). Evidence of this change appears in more recent life event studies, where, not surprisingly, sophisticated current research has highlighted the fact that individual differences account for a much higher proportion of the variance than the events per se (Andrews, 1981).
In a discussion on the importance of the recognition of individual variations, Lazarus and Folkman (1984) suggest that although a shared social reality resulting from social and cultural influences exists, all individuals have their own private identity which arises from:

our own private thoughts, feelings, wishes and goals and, for that matter, our own consciousness and unconscious. What each of us knows is not exactly what anyone else knows and therefore the way social reality is constructed differs from individual to individual.

(Lazarus and Folkman, 1984, p.232)

In personal construct terms, these individual differences based on divergent life histories, may be said to be a result of the variation in construct systems occurring as a result of life experiences.

The very essence of personal construct theory is its emphasis on personal meanings and any account of its conceptual basis must take into consideration an account of the person's interpretation of events. Because of the variety of situations which can be conceived as transitions or events and because of the scope of the interpretation of these events there is a danger that research in this area can be criticized for the imprecision of its meaning (Parkes, 1971). It is of paramount importance, however, that we accept the validity of the individual's personal experience or we will fail in understanding this or any account of the
transitional process.

LIFE'S CHOICES

Individual differences in people's account of transitionary experiences might also be better understood in the light of the choice corollary:

a person chooses for himself that alternative...through which he anticipates the greater possibility for extension and definition of his system.

(Kelly, 1955, p.64)

Because human nature is essentially interpretive, people tend to move in directions which seem to them to make more sense, that is, directions which seem to elaborate their systems. Elaboration can take the form of definition (confirming in increasing detail aspects of experience which have already been actively construed) or extension (reaching out to increase the range of the construct system by exploring new ideas that are only partially understood). Bannister and Fransella (1987) stress that elaboration is sought in terms of the system as it exists at the time and that the corollary does not imply that people always elaborate successfully. Kelly suggests that the overriding issue is the continuing need to anticipate events (Kelly, 1955).

This may account for the different choices made by people undergoing the apparently same transitional event. It may be preferable to make a "wrong" choice rather than
risk the uncertainty of living without it (Button, 1985). It is not the event per se that requires understanding so much as the individual differences interacting within the transitional process. Individuals may choose to define their systems by making them very explicit and clear cut. Others may choose to extend their systems facing uncertainty in their quest for greater comprehension. It has been stated that when people choose to extend their systems they opt for adventure, rather than security, by "living on the frontiers of experience rather than within cosily settled conventions" (Mair, 1977, p.268).

People must inevitably make choices in life event transitions. An example given by Neimeyer and Neimeyer (1987) focuses on the conflict often observed in individuals struggling with career decisions. Should they pursue further training in their current line of work (definition of their existing system) or face the uncertainty of pursuing a new path altogether (extension). Ultimately, individuals make what they regard as an elaborative choice, which optimizes the anticipatory potential of their systems. Two people experiencing the same life event can have a very different experience due to differences in choice of constructs.
COMMONALITIES AND SOCIAL INTERACTIONS

It should not be thought, however, that personal construct theory endorses the position that each individual is encapsulated in a private world that makes no contact with other people. Such a theory would be of no use in accounting for life event transitions and would offer no hope for preventative interventions. It should be remembered that Kelly’s formal theory originally commenced as psychotherapeutic guidelines rather than a theoretical statement. His focus was the development of a useful clinical tool and with this in mind, he specifically stated that the focus of convenience of construct theory was in the area of human adjustment to stress (Kelly, 1955).

The usefulness of personal construct theory for life event transitions may be seen in the statement:

to the extent that one person employs a construction of experience which is similar to that employed by another, their processes are psychologically similar.

(Kelly, 1955, p.90)

Having emphasised the fact that people may be dissimilar in their interpretation of similar events, Kelly implies that they may also be similar, with respect to events which have the same meaning for them. In other words, people can share similar interpretations. Certainly, because our personal constructs often have a
social origin, substantial overlap in our construing with others is ensured by our common membership in a cultural or subcultural group (Neimeyer, 1987). The emphasis here though is on the similarity in construing rather than the experience itself. Commonality with others in a similar situation offers a way in which an understanding of transitions may be discussed and offers the hope that therapeutic interventions may be generalised to a wider population.

A further approach to the understanding of transitional processes may be found in Kelly’s notion of role. Kelly lays considerable stress on this aspect of interpersonal relationships and it is regarded as the key corollary in terms of therapeutic processes (Bannister and Fransella, 1986; Neimeyer, 1987). His definition of role is encompassed in the sociality corollary (Kelly, 1955). According to this statement, social roles can be played with other people only insofar as one is able to construe their constructions. The ability to have constructive social experience depends on whether we can see things from the other persons point of view.

This does not imply that accuracy is mandatory. In everyday life many role relations are of necessity based on very fragmentary and limited readings of other’s constructs. For interpersonal interaction to take place, however, a meaningful picture of the person’s construct system is required, one that is based on one’s
understanding of the other person. Kelly's notion of role is thus different to traditional definition. Rather than seeing role as a socially prescribed set of expectations he suggests that role behaviour is not just something to be acted out, it may also be a means of understanding events (Button, 1985).

Since relationships with others are usually generally involved in life changes, the concept of role and sociality may be useful in illustrating the individual's understanding of encounters with other players involved in the transitional event. Social interaction involves the need to understand other people's personal construct systems.

Lazarus and Folkman (1984) support this notion, in their study of adaptational outcomes to changing and stressful situations. They state that in order to achieve good overall functioning, the way a person appraises events should be reality based and match the flow of events:

Many relationships can withstand occasional errors of appraisal, but any relationship will be put to a severe test if inappropriate appraisals are frequent.

(Lazarus and Folkman, 1984, p.190)

The need for an understanding of encounters with others is emphasised by Parkes (1971) who suggests that:
people who have successfully come through major transactions in their own lives are often best able to help other individuals who are still caught up in the process of realisation.

(Parkes, 1971, p.112)

This implies that a social role involves empathy and an understanding of how a person might construe change as a result of experiencing a similar situation. The need for social support and understanding, in crisis situations which result from major change in people’s lives, is documented by others including Aneshensel (1986), Fisher (1985) and Porritt (1979). It has been noted that women experiencing the adjustment to college life are assisted by the support of others (Hobfall, 1986; Ostrow, Paul, Dark and Behrman, 1986). People can interact meaningfully only if they understand each other's way of making sense of the world. Meaningful social support can thus facilitate the transitional process.

CONSTRUCTS: AN ALTERNATIVE VIEW OF LIFE

Kelly’s view of the essential active and enquiring nature of humankind ensures that personal construct theory is an appropriate basis for an understanding of life event changes. Based on constructivism, it asserts that people are co-creators of the realities to which they respond (Mahoney, 1988). It is only through their behaviour that people make their way into the real world of human events, states Kelly (1979b). In order to study
behaviour, however, it is necessary to have some understanding of the dimensions within which people operate.

Personal construct theory envisions that these dimensions are constructs, personal constructs, that may be redrawn and revalidated by the users, to structure anew their thoughts and behaviour (Kelly, 1979c). To elaborate further on this statement, the basic nature of constructs must be defined. Constructs are ways "in which some things are construed as being alike and yet different from others" (Kelly, 1955, p.105). They can be seen as a personal invention or way of viewing the world, by means of which, elements can be differentiated and interpreted or construed (Viney, 1984).

Because constructs are discriminations, that is, they simultaneously abstract similarities and differences, they allow people to make sense out of confusion. They are also limited, that is they have a finite range of convenience. There are few, if any, personal constructs which are relevant to everything. Kelly acknowledges this, stating:

A construct is convenient for the anticipation of a finite range of events only.

(Kelly, 1955, p.68)

Kelly also emphasises that constructs should not be confused with cognition or concepts; they are
psychologically construed units for understanding human processes (Kelly, 1979d). They are building blocks with which we construct our reality. People organise constructs into personal systems which allow them to deal with the meaning of events. As such, they provide the key to the understanding of transition; by understanding how constructs themselves change, it is possible to examine how people adapt to life's changes.

Personal construct theory offers a unique opportunity for the study of life event change. It allows the constructivist researcher to differentiate not only between individuals but between their past experience and their future predictions. For an understanding of the process of change, however, it is necessary for me to examine the process by which construct systems themselves undergo transition. An understanding of the mediating experiences of construct change will form the framework for the proposed model of transition.
CHAPTER 3

CONSTRUCT CHANGE DURING TRANSITION
CONSTRUCT CHANGE DURING TRANSITION

The concept of transition is specifically referred to by Kelly (1955) in an explanation of the changes which occur in people's construct systems. Kelly addresses two facets of change: under what conditions can change occur and what, in fact, changes in the person's construction of reality (Hayden, 1982). An explanation is given by Kelly (1955) in the modulation corollary which, in effect, is a definition of the parameters for change:

The variation in a person's construction system is limited by the permeability of the constructs within whose range of convenience the variants lie.

(Kelly, 1955, p.77)

This implies that in order for people to enhance change, their constructs must be permeable; that is, be capable of admitting new elements. The permeability of a construct refers to the extent which it can make sense of new events, the degree to which it can assimilate new elements within its range of convenience and generate new implications. Both permeable and impermeable constructs are useful in given contexts. It has been stated that a person with too permeable a system would be in danger of being disturbed by every occurrence (Button, 1985). If too many constructs are impermeable, however, there is a danger of failure to make sense of changing events or a tendency to avoid new situations. There may possibly be an attempt to force new experiences into the existing construct system, however, bad the fit.
It is therefore argued that the ability to make sense of events during a period of life event change is essential. Transitions involve periods of change that cause disruption of a prior structure, or order, in people's lives (Compas, et al., 1986). The need for successful adaptation during these periods has been well documented in a previous chapter (Rowlison and Felner, 1988; Compas, et al., 1986; Lazarus and Folkman, 1984; Felner, et al., 1983; Parkes, 1971).

THEORIES OF EMOTION

A criticism often directed at personal construct theory is that it is purely a cognitive theory and is therefore limited by its failure to recognise much of human nature (Rogers, 1956). It has been said by some (Bruner, 1956; Rogers, 1956) that Kelly's approach is "over intellectual" and has failed to recognise the importance of human emotions. Supporters of Kelly state that critics have failed to understand his attempt to dispense with the classical thinking-feeling dichotomy (Bannister, 1977) or the trichotomy of intellect, will and emotion traditionally offered by psychology (McCoy, 1977).

Kelly wished to create a theory with which to encompass all of human behaviour and thus avoid the reductionist 'man-is-a-sum-of-his-parts' mentality. The approach used by Kelly (1955) in dealing with this
problem was to focus on the construing process, thereby presenting a unique perspective of emotional phenomena. In personal construct terms, emotions are defined as diagnostic of certain transitional states of construction (Katz, 1984). Emotion is our experience of, or resistance to, change. In seeking to understand this we are reminded by Bannister and Fransella (1987) that Kelly, when dealing with these problems, remains firmly within the general framework of personal construct theory. It is not the intention of this research to compare differing theories of emotion, however it is perhaps useful to be aware of the difference in perspective on emotion between Kelly and other theorists.

A long tradition holds that emotion is separated from cognition and although the place of emotion has been elevated in cognitive theories of emotion, the impression nevertheless remains that they still are separate and distinct entities that affect each other. Similar to Kelly (1955), Lazarus, Coyne and Folkman (1982) argue that the person described in this way is fragmented and incomplete. Lazarus and Folkman (1984) propose that theories of emotion should reflect the natural integrity of the whole person and offer evidence that the integration of emotion and cognition is becoming more widely accepted in theoretical studies of emotion.

A constructivist view of emotion is offered by Averill (1980), who argues that emotions are social constructions
and also improvisations, based on the individual's interpretation of situations. Like Kelly (1955) and Lazarus et al. (1982), Averill is concerned with the notion of the importance of a person's appraisal or discrimination of a situation. The appraised object is not something that exists "in limbo"; it is a meaning imposed on the environment, a cognitive construction (Averill, 1980).

Although there are some points of similarity, Kelly's (1955) definition of emotion generally is more comprehensive than the traditional theorists, as it encompasses the notion of the construct system undergoing change. In contrast to other theorists, and despite his choice of traditional terms such as guilt, hostility, aggression and anxiety, he defines emotions from the phenomenological perspective. These definitions will follow shortly, essentially, however, Kelly was focusing on the meaning of the situation for the person experiencing change, rather than the meaning of the situation for external observers.

It should be noted that definitions of emotions other than those previously mentioned by Kelly (1955) are also discussed. These others are permutations developed by McCoy (1977) who offers an expansion of Kelly's original conceptualisation. McCoy (1977), eloquently arguing a need for a more comprehensive list than those previously defined within the personal construct frame of reference,
provides definitions which include the fundamental emotions identified in current research. This expansion provides the therapist with additional professional constructs and may assist interventions in the therapeutic situation.

McCoy (1977) reminds us that it is not essential that people experiencing change consciously define the emotions they are experiencing. Consciousness is not an essential feature of construing. Being in a state of awareness of some change or fate of the construct system is, however, essential for distinguishing emotional from non-emotional behaviour (McCoy, 1977). Emotional behaviour is a sign that people construe their construct systems as being in the process of being used (McCoy, 1977, p.99).

NEGATIVE EMOTIONS

Anxiety

The emotion of anxiety is related to stress in two respects, one being that they appear to be the dominant themes of twentieth century living. The two concepts of anxiety and stress are widely recognised as having a large overlap, although the word stress did not appear in the psychological literature until relatively recently (Lazarus & Folkman, 1984). In contrast, the development of the concept of anxiety is said to have occurred as long ago as the Hellenistic era at the time of Alexander
the Great (McReynolds, 1985). Although contemporary anxiety phenomena appears to have their historical roots in the work of Kierkegaard (1944), an existentialist philosopher, it is Freud who is credited with attempting to define the meaning of anxiety within the context of psychological theory (McReynolds, 1985). Freud proposed that "The psyche develops the affect of anxiety when it feels itself incapable of dealing with a task approaching it externally" (Freud, 1959, p.101-102) and defined anxiety as something felt, an unpleasant emotional state.

Kelly (1955) proposes that people do not always have the necessary resources to deal with life’s situations and, in a departure from traditional perspectives, defines anxiety in terms of the reorganisation required in developing new constructs. In personal construct terms, anxiety is "the recognition that the events with which one is confronted lie outside the range of convenience of one’s construct system" (Kelly, 1955, p.495). Kelly argues that the failure of the construct system to embrace events may accompany the use of incompatible subsystems. He also contends that people:

may successfully employ a variety of construction subsystems which are inferentially incompatible with each other.

(Kelly, 1955, p.83)

In other words, some incompatibility or inconsistency may be tolerated. People’s constructions, however, are
limited by the permeability of superordinating constructs. If these are incompatible enough not to allow new constructs into the existing construction system's range of convenience, then people undergoing transitional changes in their construct systems will experience anxiety. This may only be momentary, the result of some puzzling aspect of everyday life, or may extend to the pervasive "free floating" anxiety which betrays a breakdown in superordinate structures. When construction systems fail, people can no longer accurately predict the changing world. They have no guide to carry them through transition (Kelly, 1955). Anxiety therefore, is not seen by Kelly as an inherent part of personality; it is a transient condition.

Anxiety is common in transitional events. The majority of studies dealing with these phenomena comment on some distress or anxiety. This anxiety is associated with the person's perception of events as stressful (Adams, Hayes, Hopson, 1976; Fisher, Frazer and Murray, 1984; Lazarus et al., 1980; Lazarus and Folkman, 1984). Anxiety in transitional states occurs during the "period of recoil", identified by Tyhurst (1957, p.152) as the time when trauma survivors achieve their first awareness of their experience. It is during this period that people demonstrate subjective feelings (emotions) including anxiety. Other examples (Tyhurst, 1957) include studies of migrants, who, faced with incongruity between their frame of reference and the new society, experience increasing anxiety and depression. These examples are
analogous with Kelly's statement that anxiety is a result of the recognition that events taking place lie mostly outside the range of convenience of one's construct system.

Hopson and Adams (1976), discussing the effect of transitional change in people, state that all transitions involve some stress, regardless of whether they are positive or negative changes. They theorize that a common element of transition is the necessity to adjust to the new situation. This requires decisions to be made about the appropriateness of new and old behaviour patterns. It is stated that when there is a lowering of adaptive responses, the perceptual field narrows and cognitive processes become more rigid; when people experience high levels of anxiety, they tend to become more inflexible in problem solving activities (Hopson and Adams, 1976).

Both of these examples relate to Kelly's experience of anxiety. In events of a transitional nature, there is an awareness that changes have occurred. People become anxious when they can only partly construe the events encountered, and many of the implications of these events are unclear to them. They may be aware of change but the implications may be unknown. This recognition creates the emotion of anxiety.

It has been argued that a common objection to this constructivist view of anxiety arises from the fact that
people often claim to be very familiar with the things that make them anxious (Bannister, 1977). The explanation, states Bannister (1977), lies in the meaning of the phrase "lie mostly outside the range of convenience of one's construct system". Some things are very familiar and well within the range of convenience of people's construct system; others are not so clear or familiar.

The assumptive world contains many familiar aspects: people, environments and possessions to name a few (Parkes, 1971). People, facing life changes, may find that some particular aspect has changed, that some modification of their expectations and assumptions is required. New ones need to be interpreted which more accurately reflect the situation, in order to reduce anxiety.

Kelly offers constructions about construing that relate specifically to adaptive changes during transition (Kelly, 1955, p.487). One is the construct of dilation versus constriction. This dimension sees persons as either broadening their view of a situation in order to reorganise it more comprehensively, or constricting their view to minimize apparent incompatibilities. Dilatation may result in people not accounting for the precise aspects of situations as the constructions which are used are too broad. Constriction results in people ignoring some aspects of experience. Both processes prevent people from creating alternative constructions of situations.
The other construct of this type, offered by Kelly (1955), is tight versus loose. The tightness and permeability of a construct will determine its flexibility. Kelly defines a tight construct as one which produces unvarying predictions. Loose constructs lead to variations in predictions, but still can be identified as continuing interpretations (Bannister and Fransella, 1987). They may not, however, be very useful for dealing with the practicalities of a situation.

Hostility

The construct of hostility, as used by many investigators, is a global one, embracing many conceptually different factors (Gottschalk and Gleser, 1969). It is generally viewed as a complex pattern of emotions and drives, with anger being its most prominent manifestation (Goldstein and Segal, 1979). It has also been stated to be a purely cognitive process, not containing any behavioural activity (Izard and Buechler, 1980).

Kelly’s definition of hostility differs from the customary definition of the disposition to harm someone. He seeks instead to understand it from the perspective of the participants and what it is they are trying to accomplish. Hostility, it is stated, is the continued effort to extort validational evidence in favour of a type of social construction which has already proved
Kelly is arguing that people do not always construe accurately or wisely; rather than change constructs that have been invalidated, they may try to make the existing evidence fit. This is preferable to changing constructions which are central to one’s belief system. It has been stated that, when constructs are abandoned, chaos may occur if there are no alternative ways of viewing the situation (Bannister and Fransella, 1987). Rather than experience the disequilibrium of chaos, people may choose anger to express themselves.

McCoy (1977) in a reconstruction of Kelly’s account of emotions, defines anger as an emotion, but not hostility. Hostility, she states, does not meet the necessary criteria for an emotion; it does not necessarily involve a state of awareness of the fate of the construct system. In contrast to Izard and Buechler (1980), McCoy perceives hostility to be a behaviour arising from the emotion of anger. Anger is defined as an awareness of the invalidation of constructs, which leads to hostile behaviour. It is an attempt to force events into conformity, so that predictions do not become failures, and constructs will not be invalidated (McCoy, 1977, p.118).

People in transition are said to experience anger and hostility (Parkes, 1971). A study of businessmen,
experiencing change as a result of a disaster, revealed that hostility was a common response (Pefley, 1987). Children experiencing grief from bereavement, often express bitter anger towards the lost parent (Parkes, 1971). It has been found that people undergoing transition, experience an active stage in which, it is said, they test out new situations and new behaviours. As they begin to deal with the new reality, they may experience feelings of anger and irritability (Hopson and Adams, 1977). These expressions of anger, from people experiencing change, could be an awareness of the invalidation of old constructs in the new situation. Hostility may arise as a result of the awareness of the fate of construct system undergoing change.

Depression

Hostility and anger may also be experienced as depression. Depression can be defined as hostility turned inwards on self or internalized anger (Gottschalk and Gleser, 1969; Viney, 1980). People who are depressed constrict their world, states Rowe (1978). They place restrictions on themselves. This self constriction can eventually lead to pessimism, lack of flexibility and ruling out of choices (Viney, 1981). Depression has been noted in field studies of people experiencing transition (Aneshensel, 1986; Tyhurst, 1957; Viney, 1980). It could be hypothesised that they constrict their view in order to minimise the incompatibilities brought about by
Low self-esteem has also been linked with depression (Beck, 1967). Self-devaluation is expressed in terms of inadequacy and embarrassment. Feelings of inadequacy and depression associated with transition have been reported by Tyhurst (1957). Shame and guilt are also closely associated with depression and have been noted in transitional studies (Viney, 1980).

Guilt

Similarly to anxiety and hostility, guilt is defined as a condition of people's construction systems (Kelly, 1955). The conventional notion of guilt relates to man's awareness of the evil within him, an awareness of which, developmental psychologists state, appears early in childhood (Erikson, 1963).

Kelly defines the experience of guilt as the perception of one's apparent dislodgement from one's core role structure (Kelly, 1955, p.502). The term, core role structure, refers to the system of constructs which deal specifically with the self, by which people maintain their identity and existence. Core role constructs are the means by which people evaluate the central aspects of their behaviour as social beings. They lead people to act "as if" certain personal attitudes, judgements, and evaluations were reflections of some factual and
permanent core. As such, core constructs involve dimensions along which people chose to see themselves and others most significantly (Woodfield and Viney, 1984).

Within one's core structure there are those frames which enable one to predict and control the essential interactions of himself with other persons and with societal groups of persons. Altogether these constitute his conceptualization of his core role.

(Kelly, 1955, p.502)

Kelly is suggesting that people will experience guilt when they realise that they are acting in ways discrepant from their understandings of themselves. People in transition may experience this discrepancy. Viney (1984), in a study of people experiencing change as a result of illness, noted that they experienced guilt when their image of themselves was threatened. Similarly Parkes (1971), notes denial is practised by those who refuse to accept that they no longer have an occupational role. This denial is related to guilt and the awareness that their actions are no longer consistent with their understanding of themselves as providers.

People in transition thus may be aware that, due to changing circumstances, their previous perception of themselves no longer fits, or is true, of their new self. They may also be aware of feelings of shame, that is, other people's perceptions of them have changed.
Shame differs from guilt in that its locus is more external than internal. It is like guilt, however, in that it involves a phenomenological assessment of the self in a role.

The unpleasant feelings called shame are elicited by an expectation that other people will be disappointed in the fact that a standard has been violated. The unpleasant feelings called guilt are caused by expectations that the self will disapprove.

(Kagen, 1969, cited in McCoy, 1977, p.113)

Shame then, is awareness of the dislodgement of the self from others construing of your role. It is vital, states McCoy (1977) states, to understand the concept of role as defined by Kelly:

.....a role is an ongoing pattern of behaviour that follows from a persons understanding of how the others who are associated with him in his task think.

(Kelly, 1955, p.97)

Shame involves an awareness of another’s construing of role and the fact that behaviour has not been as the other anticipated (McCoy, 1977). It is predictable that people undergoing change may experience shame. Transitions do not take place in isolation; social interaction of some form is usually involved. Feelings of inadequacy and embarrassment may occur when people recognise that they are interacting with others in ways which do not fit with other’s expectations (McCoy, 1977).
This may particularly occur in the adaption to a new role. It has been noted by Aneshensel (1986) that women undertaking employment, often experience depression, which is related to feelings of shame. They perceive that they are not living up to the expectations of others, in their rejection of the marital role.

Change is a threat to people; they become aware that some change of constructs are needed. This may even entail a change in their most important constructs, their perception of self or actual identity. People undergoing personal transition due to altered body image, experience shame, notes Viney (1984). Situations calling for a major reassessment of self are also likely to cause feelings of insecurity and despair, notes Hobfall (1989).

Helplessness

Feelings of inadequacy, and associated shame and guilt, have been linked with expectations and coping. In the search for knowledge, our expectations about personal control over life are invariably formed. A number of theories have been constructed to explain this aspect of experience, dealing with such constructs as learned helplessness (Seligman, 1973); self efficacy (Bandura, 1977); attribution theory and locus of control (Rotter, 1966).
The concept of locus of control is defined by Rotter (1966) as the extent to which individuals perceive themselves as having control over environmental reinforcers. Adler (1930) has described the need to control one's personal environment as an intrinsic necessity of life. Similarly, De Charms (1968) has stated that a primary motivational factor for people, is to be effective in producing changes in the environment. De Charms argues that an important aspect of people's experience is their perception of control; whether they perceive their behaviour as determined by their own choice or as determined by forces beyond their control. Feelings of helplessness are associated with anxiety; when people perceive the probability of an outcome to be uncertain they experience discomfort (Garber, Miller and Abramson, 1980).

The anticipatory nature of people is noted in a study of locus of control interactions conducted by Ganellan and Blaney (1984). These authors argue that locus of control does not only refer to perceived responsibility for past events but also to perceptions of control over future events. The attributional dimension of locus of control could thus be seen as an anticipatory construct for negotiating change. Locus of control has also been linked to life change and transition. Johnson and Sarason speculate that:
life change may have its most adverse effects on individuals who perceive themselves as having little or no control over such events.

(Johnson and Sarason, 1978, p.206)

People experiencing the transition from adulthood to old age have experienced adverse consequences as a result of decreased control (Langer and Rodin, 1976). Other adverse consequences, which have been noted in relation to locus of control, include manifestations of anxiety and depression (Krause and Stryker, 1984; Moore and Paolillo, 1984). A sense of lack of control, exacerbated by feelings of helplessness and personal inadequacies, has been noted in the transition of school leavers to the workplace. Pawn-like feelings, due to a sense of manipulation by others in the new environment, have also been found in these circumstances (Viney, 1980).

POSITIVE EMOTIONS

Happiness and Satisfaction

The discussion so far has, of necessity, focused on the so called "negative" emotions, those emotions which are involved in the invalidation of constructs. People undergoing change may also experience "positive" emotions. Positive emotions are currently receiving more interest in the literature, particularly with reference to their role in adaption to psychological stress (Lazarus, et al., 1980; Averill, 1980). The need for a
measurement of the distinction that people make between good and bad experience has been discussed with reference to the notion that even in crisis, people may experience positive experiences (Westbrook, 1976).

The experience of positive events encompasses not only happiness and the emotional states of elation and joy but also the dimension of general well-being. This has been defined as a thoughtful appraisal of the quality of life as a whole, the satisfaction dimension (Argyle, 1987). The main sources of satisfaction or positive affect concern other people, work and leisure. Relationships are major sources of satisfaction especially those encountered in happy marriages. Aspiration and achievement are also sources of positive feelings and are closely linked to job satisfaction. Pleasant events are also said to increase positive moods (Argyle, 1987).

Happiness is defined in personal construct terms as an awareness of validation of a portion of one's core structure (McCoy, 1977). Unlike love, it does not require total validation of the person, only some. Satisfaction is more external and encompasses a sense of the predictability of events as well as one's own ability to predict correctly (McCoy, 1977).
Satisfying Social Interaction

It has been said that we live in a social world and rely on others for support to bolster our own resources, particularly when our own resources are depleted (Ostrow et al., 1986). The positive role of support in crisis has been well documented (Fiore, Coppel, Becker and Cox, 1986; Kaufmann and Beehr, 1986). It has been argued that good support from people who have experienced a similar situation can assist those in crisis (Porritt, 1979). Social support and interaction also assist in facilitating adjustment to the new work situation (Adams et al., 1976; Fisher, 1985). It has been stated that people who experience good social support are less depressed and more healthy (House, 1981) and social interaction and social networks are also said to be a source of satisfaction and happiness (Argyle, 1987).

Similarly, personal satisfaction in interpersonal relationships has been noted to be a positive experience (Viney, 1981; Viney and Westbrook, 1979). Friendship is more important than work or leisure, particularly for young people, and social skills and interpersonal competencies are important sources of happiness. It is suggested that people who are effective in these spheres are likely to be less depressed and isolated. The importance of satisfying social interaction in personal construct theory has been discussed elsewhere in this study. Suffice to say, it is a key factor in
understanding how people negotiate the transitionary process.

**Competency and Control**

It has been noted earlier in this chapter that an important aspect of people's experiences is their perception of the personal control they exert in their lives. It has been stated that the notion of competence is central to much of human behaviour (Langer and Rodin, 1976). Although there is no single comprehensive formulation of critical competencies in the literature, certain specific skills which consistently receive attention include problem solving skills and interpersonal competencies (Ostrow et al., 1986). Feelings of competency and control resulting from qualifications and job skills have also been noted as increasing feelings of job satisfaction (Argyle, 1987). Viney (1980) notes that increasing knowledge facilitates development of a sense of competence and contributes to a positive experience in the workplace.

Competency is closely linked with feelings of self-confidence which is defined in personal construct terms as a sense of "the goodness of fit of the self in one's core role structure" (McCoy, 1977, p.112) Self-confidence may be described as the opposite of guilt.
The emotions presented for discussion in this chapter go beyond those stated by Kelly, as being implicated, or having particular relevance, to transition. As discussed previously, this expanded list, created by McCoy (1977, 1980), stems mainly from variations in the dimension categories used by Kelly (1955) when defining the original terms of threat, fear, anxiety and guilt. The new, more comprehensive, list includes notions of positive affect in addition to the common negative emotions.

McCoy (1980) presents a sound argument for the inclusion of positive emotions, based on Kelly's fundamental view of motivation, stating:

Since man seeks to make his world predictable and for this purpose develops a construct system, positive emotions are those which follow validation of construing; negative emotions follow unsuccessful construing.

(McCoy, 1980, p.97)

The seemingly arbitrary practice of classifying and discriminating between positive and negative emotions thus reflects the theoretical viewpoint of personal construct psychology. Like many of the emotions discussed, positive emotions were not included in Kelly's original discussion. McCoy (1980) justifies their inclusion by the necessity to provide more extensive
therapeutic direction in addition to opening up a fresh approach to the assessment of construing.

Indirectly, Kelly endorses the use of positive emotions in relation to construct formation, by stating that flexibility in construing will determine whether the events of tomorrow will bring happiness or misery (Kelly, 1963, p.22). From a personal construct perspective, it would appear logical to examine both poles of a construct, that is, the positive as well as the negative aspect, for as stated previously constructs are bipolar by nature. It has also been argued that if psychologists are to fully understand people's experience of events, some measure of positive as well as negative feelings are needed (Westbrook, 1976).

In conclusion, although Kelly assigns a restricted meaning to the more common definition of emotions, it is also clear that he does, despite his denials, address the concept of emotions both theoretically and in his use of emotive terminology in his writings. He has, however, dispensed with the traditional notions attached to the concept and thus freed researchers from the restricted meaning of other's interpretations. The new meanings, are accompanied by a disclaimer (Kelly, 1955; McCoy, 1980) stating that there is no intention that these definitions are the only way certain emotions may, or should be, construed. They are intended as indicators of the state of one's construct system, following awareness of a need
to construe. Emotions are a signal, in personal construct terms, of the otherwise difficult to observe construing process (McCoy, 1980).

My research, however, is not confined simply to a theoretical account of transition and construct change. It is specifically directed to the study of how women of different ages experience change as a result of undertaking a career. If we are to extrapolate purposeful information from this study, then it is necessary to have an understanding of the psycho-social development of women and the different professional roles they are about to undertake in the transitionary event. The focus of the following chapter will be devoted to an examination of the variables that I predict will influence the transitional event.
CHAPTER 4

PERSONAL AND SITUATIONAL ASPECTS OF TRANSITION
PERSONAL AND SITUATIONAL ASPECTS OF TRANSITION

The model of transition proposed by Viney (1980, p.21) delineates essential elements of the process of transition and offers a suitable method of measurement. It identifies initial reactions and the thoughts, feelings and beliefs of people involved in various transitionary events. Because of the range of the events and the different stages of transition assessed in women, Viney (1980) warns of limitations regarding its application but suggests that certain useful themes and patterns of experience emerge.

The present research is a response to questions which arise from an examination of Viney's (1980) model. Kelly (1979e) states that the constructivist researcher raises new questions, not because old answers are incorrect, but because human nature can be regarded as open to an infinite variety of alternative constructions (Kelly, 1979e).

The questions of this research ask how the developmental stages of life and professional role, representing the personal and situational aspects of transition, relate to transitional processes. How might these two variables effect the transitionary process, as experienced by women undertaking a course in nursing? These aspects of the change process are explored in the present chapter together with discussion of the influence
of sex role socialization. The last-named, although not included as a variable for testing in the present study, nevertheless forms a rich back-drop against which the transitions of nursing may be perceived more readily.

The stages of interest relevent to this particular study are late adolescence (17 to 21 years) and young to middle adulthood (22 to 45 years). These are the stages of development of the women undergoing the transitional experience under study.

GENDER AND DEVELOPMENTAL CHANGE

It is commonly recognised that the lives of women follow patterns and involve themes that are different from those of men (Gilligan, 1982; Mohney and Anderson, 1988; Reinke, Holmes and Harris, 1985). According to Gilligan (1982), developmental theorists ignore gender differences and implicitly adopt the male life as the norm. Gender influence on development has been noted by Salmon (1985) who argues that the shape of living can be very different for females. In our society the goals of men and women are likely to be differently located within the life span. For men, career achievement is an ongoing process throughout life. Women's traditional goals are those of marriage and family, and career achievement is often secondary to these objectives.
In contrast to the relatively linear time progression experienced by males, women are more likely to experience discontinuity in their career pattern and, instead of a progression, a long plateau in which time may be marked rather than lived. Educational and career goals may not be achieved until later in life when further development becomes a lonely venture, likely to demand a great deal of courage (Salmon, 1985).

Developmental theorists traditionally offer an overview of human development which describes a developmental task for each stage of life. In these accounts, the normal sequence of events is well defined, with one stage following another in logical succession (Moos and Schaefer, 1986). The expectations regarding age appropriate behaviour have varied over time, however, particularly over the past two decades (Evans, 1985; Norton, 1983). The rapidly shifting psycho-social environment of contemporary society means that the rhythm of the life cycle is much more fluid. Couples divorce and it is more common for middle-aged people to return to college or start new careers. The increasing flexibility of adulthood highlights the range of transitional events adopted out of sequence, or outside of normal life patterns, and people's subsequent coping abilities.

Personal construct theory does not subscribe to a theory of development, that is, development in the traditional psychological sense. Development implies
linear movement towards some end product and there is no such concept within the psychology of personal constructs (Bannister and Fransella, 1987). Personal construct theory is a theory of perpetual change, of continuing development for all people, regardless of gender. The variation in people's construct systems, as they successively construe the replication of events, is a point where construct theory makes contact with developmental theory. From infancy onwards a person's construction system undergoes the vast variation that reflects the successive construing of a huge diversity of event-associated information (Morrison and Cometa, 1982).

Development In Late Adolescence

A sense of personal identity is necessary for the transition from the experiences of childhood to the formation of goals, values and attitudes which characterise adulthood (Berger, 1983). Identity cannot emerge until adolescents can envision themselves within the vision of an unfolding future. In marked contrast to earlier stages of development, adolescents are not concerned only with the present. It is important for them to anticipate the future, assessing what it holds for them. It is a period of transition, from lives centered psychologically and economically around parents, to lives of independence. One of the tasks adolescents face in establishing their sense of self is to outgrow dependency on their parents. It has been said that it is a time of
exploration: jobs, college courses and careers are all tried for personal fit (Sales, 1978).

Young people, who are moving onward into adult life, are constantly faced with the need to make choices. Young women's choices, however, may sometimes be limited by societal influences and conditioning. For many women, traditional sex-role expectations are still salient, especially in adolescence and early adulthood. Their socialisation still emphasises marriage as the central role and goal; work choices are often viewed as temporary jobs rather than permanent careers (Dennis and Hassol, 1983). Adolescence is about change; the transformation of the child into an adult identity, brought about by the complex blending of the person's past, present and future. The rapid changes they undergo in the transition from childhood to adult life does not leave adolescents untouched. The ambiguity of the new experience, within existing structures, causes changes in the developing construct system (Adams-Webber, 1982). Feelings of anxiety and uncertainty may be anticipated. In personal construct terms, it is a time of variation in the developing person's construct system: a time of transition (Kelly, 1979f).

More so than at any other time in the life cycle, it has been noted that anticipation is central to ambition, purpose and identity for adolescents (Mitchell, 1986). People's need to predict and control their worlds is a
fundamental belief of personal construct theory. It is
the means by which people can attribute meaning to their
ongoing experience (Neimeyer, 1987) and control over
their lives (Fransella, 1981) and appears to be
particularly relevant to adolescents.

Despite changes in many life spheres, however, it has
been found that many adolescents see themselves as
competent people who can manage the problems that come
their way without much difficulty. They are optimistic
and happy and face life's challenges with confidence
(Offer, Ostrov and Howard, 1981). Friendship and social
interactions are important and are related to feelings of
happiness (Peterson, 1987).

Adult Development

The focus in young adulthood is the breaking away from
parents, that begins in adolescence, and the taking up of
tasks that occupy the remainder of the life span (Berger,
1983). Young adults may choose to continue their formal
education or they may begin to climb the career ladder;
they also choose partners and may begin families. It is
said that by their late twenties most people have made
their commitment and move from a period of exploration to
one of stabilization (Berger, 1983). A task that is not
addressed by stage psychologists, however, is the
conflict experienced by women and engendered by having to
choose between parenthood or a career.
Many women are satisfied to remain within the traditional feminine role imposed by societal expectations. They find the responsibilities important and the work, at least sometimes, creative and pleasurable (Evans, 1985) and may experience high levels of satisfaction in the interpersonal aspects of motherhood (Viney, 1980). Many, however, experience conflict in trying to fulfill themselves as people, while attempting to play the traditional feminine role. Some may experience depression due to a sacrifice of identity (Beck and Greenberg, 1974; Schur, 1984). Feelings of helplessness and powerlessness, leading to depression and a sense of low self-esteem arising from the traditional feminine role, have been well documented (Evans, 1985; Mathews, 1984; Schur, 1984).

In entering into marriage women seek to extend their construct systems. A feature of personal relationships is the search by individuals for the ways in which their partner can help develop and elaborate their systems (Neimeyer and Neimeyer, 1985). If this has not occurred it is predictable that in later years, at a suitable time, women will again seek further elaboration. As marriage and mothering roles diminish later in adulthood, it is not uncommon for them to seek out new sources of satisfaction to maintain and repair their weakened sense of self (Bueche 1986). The time between the ages of thirty-five and forty, is gaining increased attention in the literature as a critical period for women. It is said
to be a time of renewed identity crisis and a second important period for career exploration (Brandenberg, 1974) rather than the stage of generativity suggested by age-related theories of development.

Studies of mature-age female college students reveal support for the notion of a developmental time lag for women (Kaplan, 1982; Suchinsky, 1982). These women express the need to achieve independence and a sense of identity. From a constructivist view, identity may be conceptualised as a self-generated theory about the self, which individuals formulate as they cope and adapt in their day-to-day lives (Berzonsky, 1989).

The priority that women place on considering relationships in making their decisions, may help explain their developmental time lag and the "partial education - marriage - job - children - more education - career" sequence, which is common in women (Mohney and Anderson, 1988). Women tend to put their decision to embark on a career or enrol in college in the context of what they perceive as other people's needs (Mohney and Anderson, 1988). Gilligan (1982) maintains that unlike men, women are never disconnected from the importance of others. They inevitably define themselves in terms of relationships and tend to retain this commitment as a basis for their actions.
Adulthood, then, like adolescence, is a time of transition. The transitions for adult women may not necessarily take place at some culturally appointed time but they do occur. Women anticipate their future, and make individual choices based on societal pressures, which affect the normal male-oriented developmental sequences. They actively plan a role in creating the reality to which they respond. Ultimately, in their desire for a clear sense of identity they seek elaboration and make further choices. When these are made they may involve role change and, in the case of the choice of a career in nursing, the adoption of a professional role.

PROFESSIONAL ROLE

Professional role is the second variable for consideration in this quest to construct a model of transition. In the present study it involves two transitional aspects, the role of a university or college student and the role of a professional employee - a hospital nurse. Both aspects will be discussed in this next section.

Women and Tertiary Education

The transition to university, although generally regarded as positive, nevertheless involves change. There is the need to adjust to the demands of a new environment
and to adapt to the new challenges which present themselves. A new set of assumptions has to be formulated; new constructs developed to encompass the magnitude of changes which occur in the transition to the college experience. While the college population, generally, has been portrayed as a high risk group for the development of psychological difficulties (Ostrow et al., 1986) it has been noted that female students constitute a higher risk group. Success in an academic environment requires achievement striving, competition and aggressiveness, behaviours that are associated with a masculine rather than a feminine sex role (Ostrow et al., 1986).

Younger students

It has been stated that entry into university immediately following high school years may not be considered a transitional event for the participants, because it is a continuation of the student role. Viney (1980) argues that the roles are very different and states that young women undertaking this transition are faced with many demands. Developmental theorists also state that the college years constitute a psychologically significant time in the lives of young people. For many, this period coincides with the transition from child to adult roles. University students face demands of independent living, new relationships with parents and peers, academic challenges, financial pressures and the
need for career decisions (Compas et al., 1986; Ostrow, et al., 1986). For many students it is their first experience of living away from home and friendships and social interaction become increasingly important (Hobfoll, 1986).

Students' transition to university can be considered a role transition (Rapoport, 1964; Viney, 1977) involving personal and environmental change. Viney (1977) has recorded trends in the anxiety levels of students, as they commence and finally resolve, their transition to university. Transition to university involves separation from friends and family and adjustment to a new set of social and academic demands. Separation anxiety has been noted in university students (Fisher and Hood, 1987) and also sex differences in psychological responses to the transition to university (Fisher and Hood, 1988). University is a stressful experience for women and the importance of informal networks of social support for women on campus has been supported by Ostrow et al. (1986). Compas et al. (1986) suggest social support may be a critical factor in understanding the relationship between disorder and life events during this normative transition in young people's lives. We live in a social world and often rely on others for support to bolster our own resources. It has been noted that the individual's stage of life may create differences in the type of role transitions undertaken during the change process (Viney, 1987a). As the transition tasks generally differ between
the different developmental stages, it could be anticipated that some aspects of the transition to university may differ.

Older students

It has been stated that the adult learner is a highly motivated, self-directed person with unique and individual goals (Knowles, 1970). The passage of years and the gaining of maturity is said to alter students' learning experiences. It is generally accurate to say that mature-age students have more life experiences to draw on than younger students and they bring their richer life histories with them into the learning environment (Sullivan, 1984; Webb, 1986).

Many mature women decide on a career and education later in life because of a sense of unfinished business, resulting from missed career opportunities earlier in their development. This attitude affects not only the time of their enrolment but also achievement levels. Older women often have to contend with external barriers such as continuing marital and parental responsibilities, which may preclude their undertaking the additional role of student successfully.

For many older women the transition from dependence to independence may proceed smoothly; a sense of renewed freedom and pleasurable excitement in new possibilities
to be explored may prevail (Donelson and Gullahorn, 1977). The experience of a late return to the classroom, however, can be both stressful as well as fulfilling. Jarvis and Gibson (1980), found that mature students embarking on a study programme tend to be highly anxious and Hirsch (1980) noted that many older students are likely to be unprepared for the academic and interpersonal demands of the college environment.

Older students are also more likely to feel threatened by the learning environment. Memories of childhood may no longer be congruent with the adult-self image and the "school" environment can evoke feelings that may create resistance in the learner (Jarvis and Gibson, 1980).

Anger has been noted in adult nursing students who return to the classroom at a later stage, seeking upward educational mobility (Ipock, 1982). Anger is an indication of awareness of the invalidation of old constructs in the new situation. It is probable that older students experience many invalidations of established constructs in their entry into the complex world of campus life. They also may be aware they do not have the structure to deal with the new situation; a feeling which is compatible with their high anxiety levels, an indication of the inadequacy of their construct systems. Fear of failure also generates anxiety; adult students become anxious about their ability to cope with the course, particularly when they
have additional domestic and family commitments. In many cases they find it difficult to make the emotional detachment necessary for concentration on studies and course attendance (Jarvis and Gibson, 1980).

Many of the mature participants in this study are only in early adulthood. Their reasons for enrolment in a university course vary but generally, they are seeking to establish their future career. Young people experiment with many different roles before making a final decision. Some may choose to enter paid employment immediately upon leaving school for financial reasons; others may wish to experience a break following the years of intense study necessary for matriculation; and so there is a temporary postponement of role identity. Regardless of the age of these women, however, the reason given for enrolment was that they wished to undertake a vocation - the profession of nursing.

Nursing As A Choice Of Career

Selection of an appropriate occupation is an important step in people's lives. In personal construct terms it is the beginning to a major experiment in living. In approaching career decisions, people bring a set of beliefs based upon their interpretations of the world, the self and particular occupations. These beliefs form a personal theory from which predictions and expectations are made (Cochran, 1987). The choice of career can be
deemed a life experiment with the consequent validation or invalidation of one's beliefs (Cochran, 1983).

It is argued by many feminist writers that the traditional socialisation of women to be passive, dependent and nurturing limits their aspirations and career options (Eisenstein, 1982; Muff, 1982). Many chose occupations that reflect the nurturing aspect of the traditional feminine role. Nursing with its stereotypic image of caring, nurturing and subservience has traditionally been, and continues to be, primarily a woman's profession. Similar to other women's professions, societal norms allow the incumbents to fulfill their feminine role responsibilities. Interruption of career for marriage, child-rearing and other family needs is tolerated but nurses are not expected to display the masculine characteristics of assertiveness, competitiveness and independence. The development of nursing as a profession, which dates from the mid-nineteenth century, reflects the Victorian ideology of what was befitting for a woman.

Nursing is distinctly woman's work ... women are peculiarly fitted for the onerous task of patiently and skillfully caring for the patient in faithful obedience to the physicians orders. Ability to care for the helpless is women's distinctive nature. Nursing is mothering.

(Gamarnikow, 1978, p.131)

Women chose nursing as a career because it reflects their beliefs about their role in society; it also
reflects their need for interpersonal relationships. The most stated reason for choosing nursing as a career is the altruistic need to help others (Flanagan, 1982).

Formerly the domain of the lower classes, the profession of nursing is an excellent example of the wider social process of the sexual division of labour. In order to open a semi-professional career path to middle-class women, the entrepreneurial Florence Nightingale accepted a trade-off that acknowledged the control of medical practice by doctors (Connell, 1987; Muff, 1982). Nursing became a continuance of the wife-mother role, based on the patriarchal family system of Western society. Nurses learned to evaluate themselves in relation to powerful others in the environment and, as a consequence, see themselves as powerless to influence others.

Stress In Nursing

Although nursing is concerned with caring, nurses themselves are required to work in highly stressful environments. The profession is bluntly outspoken on the demands faced by members.

If you want to study the effects of air pollution you go to a large industrial city. If you want to evaluate the effects of radiation, Hiroshima is a major stop. And if you want to observe the mechanics of on-the-job stress, the logical place to look is a hospital-based nursing service.

(Levenstein, 1982, p.47)
Contemporary nurses are required to work with highly technical equipment and, simultaneously they must interact effectively with a diverse patient population and other members of the health care team. Nursing has a high level of personal interaction and calls for the adoption of many roles in day to day activities (Kelly, 1982). Some of the stresses of nursing result from the intensely emotional aspects of hospital life and the strong cultural codes of behaviour. People who are hospitalised are in crisis (Viney, Clarke, Bunn and Teoh, 1983). The normal cultural mores that ordinarily make human interactions enjoyable are stripped away by sickness and pain. Nurses are required to interact daily with persons who are undergoing revision of their construct systems; people who, as a result, are anxious and depressed, helpless and hostile.

It has been said that nurses work in an environment in which they are constantly bombarded with an unending array of stimuli (Smythe, 1982). Some of these are novel situations, especially to student employees working without supervision. The new nurse frequently experiences uncertainty in the stressful environment of a hospital ward with its many emergencies; extra constructs are needed but are often not available. Incongruity may be experienced especially in relation to role. Because the client’s welfare is not necessarily equivalent to the welfare of the organisation, professional and bureaucratic principles provide competing sources of
loyalty. Professional standards are sometimes compromised for efficiency and the prestige of the organisation (Corwin, 1961). Frequently nurses find themselves rewarded, in terms of recognition and promotion, for values and skills which do not require patient contact. Yet patient contact and the need to help and care for people is the reason they have chosen nursing as a career.

Particular areas of clinical specialisation are more anxiety provoking than others. The stresses of the operating room frequently generates high staff anxiety (Cross and Kelly, 1983; Preston, Ivancevich and Matteson, 1981). Anxiety, depression and other psychological symptoms, have been reported in nurses working in intensive care units (McHenry, 1981; Norbeck, 1985). Certain aspects of clinical practice are also anxiety provoking, especially to beginning nurses (Eden, 1982). Psychiatric nursing may be stressful to student nurses (Stacklum, 1981); also the stress of examinations and other forms of assessment procedures may cause considerable anxiety (Davis, 1986).

In a study of student nurses, Selleck (1982) and Parkes (1980) reported that many incidents relating to patient care and initial clinical experiences were anxiety provoking. Interpersonal difficulties with other staff members were noted and homesickness was also a problem (Porritt and Taylor, 1981). Role conflict and
ambiguity have been found to be associated with anxiety in registered nurses (Baj, 1983). It has been noted that shift work is associated with anxiety and depression (Milne and Watkins, 1986; Vaslamatzis, Bazas, Lyketsos and Katsouyanni, 1985). Understaffing issues relating to the clinical situation and insufficient time for patient care have been noted as a cause of tension and anxiety (Dewe, 1986). The nature of nursing concerned as it is with disability, disfigurement and dying, may result in nurses experiencing mutilation and death anxiety, particularly in students (Combs, 1981; Schrock and Swanson, 1981).

The stress response in nursing is also associated with feelings of aggression, either directed outwards or inwards toward the self, as depression. Scapegoating of junior personnel by senior staff is one form of displacement of anger noted in the clinical situation by Hobbs (1985). Nursing personnel, who see themselves as victims in a high stress environment, respond with hopeless despair or rage against what they perceive as an unjust system (Smythe, 1982). Nurses are required to exercise professional responsibility and even as novices are held accountable for their actions. Yet although they are given great responsibilities, at the same time they are deprived of the opportunity to be more responsible in the traditional definition of the term. Resentment is common; but the resulting bitterness and anger may not be openly revealed in interaction with the hospital
heirarchy (Menzies, 1988). A sense of hopelessness develops from nurses' perceptions that they are unable to influence their environment and are powerless to alter events. This may give rise to burn-out (Smythe, 1982) or anxiety (Dewe, 1986). The psychological cost of nursing is high.

The hierarchical nature of nursing that accounts for many of these feelings of hopelessness also serves to devalue nursing. In the hospital context, health care tasks are often assigned a hierarchical value: those who carry out high level tasks are considered important and those who carry out low level tasks are de-valued. Nursing, which has as its focus of concern the ongoing care and daily activities of the patient, is seen as a lower level task than medicine which focuses on the disease process. The failure of other health care professions to recognise the value of the unique nature of the nursing role evokes anger and hostility. Nurses seldom, however, express their anger openly and directly. Women and therefore, by definition, nurses have been taught that to express anger is to risk alienating those seen as powerful and important. They therefore tend to express anger in passive-aggressive ways, experience depression, or guilt and feelings of worthlessness (Muff, 1982).
Transitions In Nursing

Changes in nursing are occurring, albeit slowly. There is a new found militancy amongst nurses, energised no doubt by the women’s movement and the feminist ideals of assertiveness, self-esteem and independence (Campbell, 1985). It is predictable that recent changes which have occurred in nursing may affect the transition process experienced by women in this study.

Nursing in Australia is currently fighting to improve its position. Professional organisations and nurse educators are pursuing a professionalisation strategy based on the establishment of tertiary-based nursing education and development of the academic discipline of nursing (Short and Sharman, 1987). Nurses, tired of the inequities arising from their lack of professional status, became more vigorous in their demands and the need for change from the old apprenticeship system of nursing became the subject of numerous professional and Government (both Federal and State Government) enquiries. Nursing education was condemned as being narrow and restricted and the assertion of nurse educators that the system was stressful and anxiety provoking, was supported by a Government appointed Committee of Inquiry (Sax, 1978). The inadequacies of the system were noted, particularly the low ratio of trained staff to student nurses and the resulting lack of supervision and teaching. The report concluded "Student nurses are not
properly prepared to cope with the strange and often traumatic situations they have to face in the wards" (Sax, 1978, p.42).

**Professional Role Differences**

In an attempt to meet the demands for tertiary education of nurses, and to overcome organisational difficulties encountered in the local region, an interim measure was implemented by the N.S.W. State Government. In this new venture, nurses received the academic component of their course at a local college of advanced education but still continued to work, as paid employees, in the regional hospitals. Now the recipients of a more comprehensive education, they were still subject to the stresses engendered by being responsible for patient care as in the apprenticeship type training in hospital-based schools of nursing.

A major change to pre-registration nursing education in NSW was implemented in 1985. Basic nursing education was transferred totally from the hospitals to tertiary education institutions. Student nurses were no longer employees but gained their clinical experience as supernumerary students, thus relieving them of the onerous task of being responsible and accountable for patient care. The evidence suggests that stress levels and therefore anxiety is reduced when students are not used as apprentices. A pilot study by Booker and
Rouhiainen (1981), comparing stress levels in nursing students undertaking traditional and tertiary college programmes, revealed significant differences between the two groups in the areas related to clinical practice and the support received in direct patient-care situations. Nurses undertaking traditional apprenticeship programmes experienced higher levels of stress than the tertiary students. These findings correlated with those of a study conducted by Birch (1979) who found that the old pattern of general nurse education produced anxiety in student nurses because of its failure to adequately prepare them for their role in relation to patients' psychological needs.

It could be expected then that the group of women undertaking nursing as hospital employees, would experience higher levels of construct reorganisation than women in the tertiary programme. The demanding environment of the health care system is highly stressful. Students in the old system were required to perform tasks involving clinical judgement for which they had often been poorly, if at all, prepared. Many situations contained new events which were outside the range of convenience of the students' construct systems. The heirarchical structure of a hospital does not create an ideal learning or caring environment. Inevitably, with continued lack of support, nurses feel a sense of guilt and failure and feelings of inadequacy arise from the unrealistic expectations of others (Scott, 1982).
Although new situations are encountered by the tertiary students when undertaking clinical placements, it is a different experience. As supernumerary students, with minimum responsibilities and supervised at all times by registered nurses, it is a less stressful situation. Additionally, their clinical placements are preceded by the relevant academic input and there has been opportunity to rehearse the clinical task in the well equipped nursing laboratories.

THE NATURE OF WOMEN

This chapter cannot be concluded without a statement of my beliefs regarding the nature of women. A survey of the literature reveals a somewhat pessimistic picture. Feminists argue that women are more likely than men to underestimate their competence, to be less confident and to underestimate their own success. In Western society it is men, not women, who are socialised to adopt the personality characteristics related to success. The list of negative aspects resulting from the socialisation process of women is depressing.

An alternative view of women suggests that most women are motivated to achieve. The socialisation literature assumes that women internalise the feminine role completely. Muff (1982) argues against this view and asserts, that while the messages are ambivalent in Western society, it is incorrect to assume that all women
are socialised into a position of subservience. Women are not naturally passive or dependent. Rather, they are active experiencing beings, able to predict and anticipate their future. Although cultural emphasis has been placed on the traditional roles, historically, women have played a great variety of significant political, economic and productive roles in addition to their reproductive ones (Keller, 1974). Mulvey and Dohrenwend (1983) note that life event research has been more concerned with the generic experiences of women rather than their life experiences as individuals. They argue that gender is experienced in relation to other people, situations and events and in relationship to individual characteristics. A survey of contemporary society supports this notion and reveals that many women occupy positions of power.

I believe that women have special strengths arising from the socialisation process. As discussed earlier in this chapter, although they are less concerned with autonomy, women focus more on responsibilities within relationships and social skills. They have been encouraged to be in touch with their own emotions and are able to recognise negative and positive aspects in themselves and respond to these feelings in others. Women are capable of constructing their own life story; they are capable of dealing with change in their assumptive worlds. The women participants in this research may be able to tell us much about the experience of transition.
The two variables hypothesised to influence the transitional process, developmental stage and professional role, are not experienced exclusively by women. Evidence has been presented in this chapter, however, that these variables may have a special significance for the transitional event under study. A special emphasis has been given to the subject of gender since for most people it is a central core role construct and its bearing on what we come to know might well be more than incidental (Salmon, 1977).

Evidence has been given regarding the suitability of a personal construct approach to an understanding of the process of transition and an explanation of the relevant aspects of the psycho-social development of women and the career option of nursing have been presented. These variables I predict to be important factors in the transitional process under scrutiny and will be included in a model of transition based on constructivist theoretical underpinnings. The next chapter will deal with the construction and elaboration of the model of transition and the aims of the present research.
CHAPTER 5

PROPOSITIONS AND PREDICTIONS
The aim of this research is to develop and test a model of women's experience of transition, based on concepts drawn from personal construct theory and the literature reviewed in preceding chapters. The model (Figure 5.1) is based on a set of assumptions. These include the belief that human nature is basically anticipatory and, as a consequence, women actively seek to understand, predict and control these changes in their lives. The concepts from which this model is drawn are presented in the next section.

The transition that is the focus of this research, is the undertaking of a career, a course in nursing. For younger women it is a time of exploration, when further education and careers are all tried in order to arrive at a fit between options, abilities and interests and the creation of a personal identity (Sales, 1978). For older women it is the realisation of an ambition, the opportunity to gain simultaneously an education, a career and a new identity. Both age groups are experiencing common events, but their way of experiencing those events could be expected to differ. They are at different stages of life, so that the events should have very different meanings for them. An examination of age-related developmental stages reveals that differing constructs
Figure 5.1  A revised model of transition adapted from Viney, (1980).
are associated with age-related tasks (Viney, 1987a). It is also noted that the interrelationships between constructs increase in complexity with age (Salmon, 1977).

Differences that have been documented in the professional role undertaken by these women, as a result of changes in nursing education, may also be expected to affect the transitional experience. It has been observed that there are differences in the professional experiences of hospital student nurses as opposed to university students of nursing (Booker & Rouhiainen, 1981). Both groups, however, will bring a similar life experience to the situation: their experience as women and how this affects the way they relate to the world and their interactions with others.

It has been noted, in this account of the transitional process, that constructs develop from people's experience of the world. Personal construct theory explains how the construing and integration of events, which are encountered in changing experiences, take place through a construing cycle of validation and invalidation of constructs (Bannister & Fransella, 1987). It is thus anticipated that the experience of undertaking a course in nursing will cause some invalidation of constructs and the women's manner of viewing the world will change.
These changes or transitions may occur as a result of the women's realisation that their existing construct systems are no longer appropriate for future predictions. They may attempt to extort validational evidence in support of their old beliefs. As their view of the world undergoes transition, as differing themes and patterns emerge over time, changes will occur in their construct systems that will manifest themselves in varying amounts of different emotions and types of emotional behaviour. The psychological cost of the transition will thus vary, although research has shown that certain negative emotions such as uncertainty, anxiety and frustration are initial reactions to transitional events (Viney, 1980). Positive feelings may also emerge as the opportunities for psychological growth, which transition offers, present themselves and are taken up by the women.

The model of transition developed by Viney (1980) (Appendix 1) presents a detailed analysis of the change process; one that focuses initially on the onset of transition, then certain mediating experiences (thoughts, feelings and beliefs) and finally its outcome. This model, however, while providing a comprehensive and analytic account of the transitional process, is incomplete in certain respects and would be strengthened by a theoretical explanation.

It is proposed that people undergoing a life event transition experience construct change. Confronted with
the new experience, they attempt to restructure their world in a manner that will make sense of the changing events confronting them. As they attempt to anticipate the new events, and consistent with Viney's (1980) model (Appendix 1), they will initially experience certain responses (Figure 5.1). These responses are a result of the women's realisation that their construct systems are no longer appropriate for the future prediction of events and thus anxiety, which may take many forms, and uncertainty, occurs. When people cannot act freely on their predictions, they may experience frustration which may later lead to feelings of anger.

In an elaboration of Viney's model it is predicted that personal and situational aspects will act as mediators of the transitional process (Figure 5.1). These include the developmental stages of the research participants. Situational aspects of the transition will also affect the mediating experience, in this instance, the differences in professional roles imposed by the differing settings of the university and hospital environments. These factors should influence the anticipations of women as they negotiate the transitionary experience.

Viney (1980) also identifies certain mediating experiences of transition, that vary according to the type of transitional event experienced. These are responses to change, emanating from varying sources,
which correspond with the emotional states predicted in the present study, as arising as a result of construct change. These experiences collectively contribute to the outcome of transition.

Some of the changes experienced by the women may be described as negative emotional states and include different types of emotion. Anxiety is one type and this can take many forms. It has been stated that women may blame themselves for their lack of effective coping (guilt) and feel inadequate and embarrassed (shame) (Viney, 1980). These feelings may be linked to the changes in core constructs relating to role, experienced by the women as they become nurses, some as university students and others as employees. Feelings of loneliness and home-sickness may arise from constructs relating to separation anxiety.

Women undertaking nursing will inevitably be confronted with death and mutilation. Through the use of various teaching strategies they will be shown how to deal with the anxieties they generate and it is predictable that their ways of viewing these basic fears will change. It is also predictable that not all construct changes will be directly attributable to a specific source but instead, may be experienced as diffuse anxiety. This occurs as a result of failure to produce constructions which are wholly applicable to the new events.
In the same way, anxiety may also arise as a result of uncertainty which can occur when the women are faced with unexpected or unknown situations. It is postulated in the present model that this anxiety, defined as an initial response to change by Viney (1980) and called uncertainty, may also be present as a mediating experience. Uncertainty is identified here as cognitive anxiety. Similar to Viney's model (Viney, 1980), anger, resulting from attempts to secure validational evidence in support of old beliefs, will be evident during this stage of the transitionary experience. This will be evidenced either as anger directed outward or experienced inwardly as depression.

It can be seen that, to some extent, the different phases of the model overlap. The emotional states discussed, and presented as an initial reaction to transition, also form part of the response of mediating experiences. A further element proposed by Viney (1980) as acting as a mediator of the transitional event, at least indirectly, as indicated by the broken lines in Figure 5.1, is the experience of lack of personal control. In earlier chapters in this study, evidence has been presented showing that perceptions of control (De Charms, 1968) and its role in determining the stressfulness of events (Sandler and Lakey, 1982) are important aspects of the anticipatory nature of people (Ganellan and Blaney, 1984). Constructs relating to perceived helplessness, or lack of control, may be seen
as a negative dimension of locus of control and accordingly, this has been included with other negative states in the present model.

A positive dimension of locus of control, a sense of personal competence, may also indirectly influence the outcome of the transitional event. Other possible positive mediating experiences are women's constructs relating to perception of the social support they receive (Adams, et al., 1976; Fisher, 1985) also feelings of personal happiness and satisfaction. The indirect contribution of these positive dimensions is indicated in the model by broken lines (Figure 5.1). Like the negative aspects of transition, these experiences vary, according to the unique nature of the women's individual constructs.

The final stage of this and Viney's (1980) model deals with the outcomes of transition; the psychological cost of forming new constructs necessary for the negotiation of the transitional event. No attempt has been made to provide a proposed ratio of outcomes in the determination of psychological cost, as the main thrust of the model concerns the mediating experiences of transition. It is suggested, however, that both negative and positive emotions should be experienced by people in transition if they are to make a successful adaption. It would therefore seem to be a reasonable conclusion that the ratio should reflect a healthy flexibility in construct
change. Psychological cost, it is suggested, will vary but it is at this stage of the model that intervention may be useful. People experiencing "high cost outcomes" may benefit from counselling. As for the other aspects, there is overlap between this stage of the model and the others. Psychological cost is accumulative and may occur at any stage of the model.

GENERAL PROPOSITIONS OF THE MODEL

From the application of this model of transition, based on personal construct theory and, in some part, from other conceptual approaches to life event changes, it is possible to make the following propositions and predictions.

(1) Women experiencing change are active people who try to make sense of their world by anticipating events. They do this by developing interpretations of their present experience on the basis of previous experience.

(2) The process of transition implies a need for individuals experiencing change to restructure their world. Previous assumptions or constructs may have to be abandoned and fresh ones formulated. Women experiencing changes in the societal definition of their role (as a set of expectations held by others within which they find themselves encompassed) may find that these changes require changes in their core role constructs. People
experiencing transition may hang on to their old ways of viewing the world but will find their anticipations are not effective when their constructs are no longer applicable.

(3) Emotions are an integral component of a changing construct system. They signify an awareness of construct revision. Women experiencing change need not necessarily consciously define the emotions they are experiencing; but it is necessary that they are aware of changes in their construct systems.

(4) Women's constructs are modified by developmental processes; so that the transitional experience will vary according to the stage of life span development they have reached. Women's developmental tasks differ at different chronological ages and it could be anticipated that older women will have a different experience of the transitory event when compared with the younger women. Generally, it is expected they will experience higher levels of invalidation of constructs and experience more construct change from different sources, to that of younger women. The developmental time-lag experienced by women should be taken into consideration as the differences may not hold true across all variables.
(5) External factors, which include environmental factors, may modify the transitional process. The experience and responsibility of being an employee is expected to require higher levels of invalidation of constructs and also more construct change than that experienced by university students. New constructs may be required to incorporate the changes resulting from these influences. Women differ in the permeability of their construct systems, some are open to experience, others may resist change. It is the permeability of the construct system which ultimately allows for growth.

(6) Women who are experiencing transition differ in how they construe the new experience. Women are individuals who differ in their construction of similar events. Some may find nursing interesting; others may perceive it as stressful.

(7) When women’s construct systems enable them to interpret and anticipate what is happening to them effectively, they experience positive emotions; when their systems are ineffective they experience negative emotions.

(8) Women in transition become anxious when the events they experience are beyond the range of their construct systems. They become anxious when they cannot meaningfully interpret new information or when they are required to act in the absence of information.
(9) Women in transition experience anxiety from different sources according to the personal and situational aspects of the transitionary event.

(10) Women in transition become angry when they are trying repeatedly to secure validation for a construct that has failed them in their attempts at anticipation. They may exhibit this anger directly as hostile behaviour. Anger may also be turned inwards and experienced as depression.

(11) Women in transition may feel helpless when confronted with evidence of invalidation of their constructs relating to their control of new situations.

(12) When women feel that they are in control of a new situation, they feel competent.

(13) Women in transition feel happy when they experience validation of their central constructs. They also experience satisfaction when aware of the validation of more peripheral constructs.

(14) Changes that occur in women's construct systems will vary over time.
SPECIFIC PREDICTIONS FOR TESTING

From these general propositions it is possible to formulate specific predictions about the outcome of the transitional process when applied to the women undertaking the courses in nursing described in these chapters. The following hypotheses will be tested.

(1) Women undertaking a nursing course will experience higher levels of construct change evidenced as anxiety, than the normal population.

(2) Women undertaking a nursing course, in attempting to secure validation for failed constructs, will experience higher levels of depression than the normal population.

(3) Older women will experience higher levels of construct change, or anxiety, than younger women.

(4) Older women, more than younger women, will attempt to secure validation of failed constructs and thus experience anger and depression.
(5) Older women will experience higher levels of anxiety resulting from constructs relating to shame and guilt than younger women.

(6) Older women will experience more unspecified or diffuse anxiety than younger women.

(7) Younger women will experience higher levels of separation anxiety from constructs relating to feelings of isolation.

(8) Younger women will also experience higher levels of death and mutilation anxiety than older women.

(9) Social interaction will be more marked in younger than older women.

(10) Nurse trainees who are hospital employees will experience higher levels of anxiety than university students.

(11) Nurse trainees who are hospital employees will experience greater amounts of anger than university students.
(12) Nurse trainees who are hospital employees will experience higher levels of helplessness than university students.

(13) Nurse trainees who are hospital employees will experience higher levels of shame, guilt and diffuse anxiety than university students.

(14) Nurse trainees who are hospital employees will experience higher levels of separation anxiety than university students.

(15) The amounts of anxiety experienced by the women will change over time.

(16) The amounts of anger and depression and also helplessness will change over time.

(17) The amount of positive feelings which include happiness, feelings of competence and social interaction will change over time.

(18) The amount of anxiety resulting from constructs relating to death will
decrease over time.

The model of transition presented in this research represents personal change and continuing development in the lives of women. Utilisation of the personal construct approach conveys the message that life event changes or transitions are not one-off isolated incidents with certain, usually negative repercussions. Rather, they reflect the developing and expanding world of individuals who have many shifting preoccupations and interests; who are faced with new circumstances, opportunities and constraints. Personal construct theory also suggests a method which is suitable for measuring construct change, one that is non-intrusive and allows for the measurement of subjective data. The following chapter contains a rationale for, and outline of this methodology, as well as a description of the measurement process.
CHAPTER 6

MEASUREMENT OF TRANSITION
MEASUREMENT OF TRANSITION

MEASURING CHANGE

The personal construct approach maintains that people's thinking and behaviours are influenced by their efforts to anticipate and predict their lives. They are, in effect, researchers seeking to achieve a better understanding of their own personal world, gathering information and deciding what to do with it. Parkes (1971) refers to these personal worlds as assumptive worlds which, based on our perceptions of past experience, allow us to make predictions. Perception is not simply that which we associate with cognition. It is the interpretation, based on emotion as well as cognition, of personal construct psychology (McCoy, 1977; Viney, 1987b). If people construe their perceived worlds so that they take on specific meanings (Viney, 1987b) the changing worlds of the research participants in this study should provide valuable information about change. Their personal research findings can provide us with information about the transition process. We are, in effect, exploring the predictive system of researchers experiencing a transitional event - undertaking a course in nursing.

It has been noted that investigators also use their own personal predictive systems to organise and predict aspects of the anticipatory processes of the participants.
(Preston, 1987). Personal construct psychology is a reflexive psychology. What is appropriate for the psychologist's research participant is also appropriate for the psychologist; experimenters then, as well as subjects, should be seen as construers (Viney, 1987b). The constructs I have formed as a result of my personal and professional background, as a nurse, enable me to form predictions which reflect past and present experiences in the lives of women undergoing the transition of a nursing course. These influences, depicted in Figure 5.1, include the psychosocial developmental stage of the participants, the different roles of the hospital nurse and the university nursing student and finally, the experience of being a woman. My central anticipations, however, have to do with the construing of women experiencing transition and the changes occurring in that construing.

The focus of this chapter on the assessment of the emotional states expressed in verbal communications by the use of content analysis scales. The measures of the emotional states noted by Kelly (1955) and McCoy (1977) to be indicative of construct change will be examined, and issues of reliability and validity discussed. The methods of data collection and analysis and the research design are also included.
Various methods for eliciting and measuring personal constructs are used; the most popular being Kelly’s (1955) Role Construct Repertory Technique. Although used for the majority of investigations in personal construct research, repertory grids are directed primarily to assessing the structure of construct systems and the relationships between the constructs and their relevant elements (Preston, 1987). There has also been criticism from within the ranks of personal construct psychologists, directed at the too frequent use of the repertory grid. Becker (1980) calls for methodology which will widen the scope of personal construct research techniques, stating that explanatory methods are also required. A more useful tool for the present research, and one which has been found to be of particular use in accessing the difficult to observe construing process, is the research technique of content analysis of speech.

Content analysis scales are based on the assumption that the language in which people choose to express themselves contains information about the nature of their psychological states (Viney, 1986). It is a non-obtrusive way of listening to and interpreting people’s verbal accounts of events. Content analysis is a technique which enables the researcher to tap into the experiences of people and allows for reflection of the current construing of the people involved. It provides minimal
restraint on the verbalizations of the people studied and thus increases the possibility that the samples of speech analysed will be closely related to actual constructions of experience. In its scaled form content analysis is a useful alternative to other methods of data collection as it recognises and values subjective data and is amenable to soundly based statistical analysis (Viney, 1983a). Content analysis scales also enable comparisons to be made over time during a transition process without the problems associated with retesting using the same instrument (Viney, 1986). Most importantly it meets the constructivist criteria that research should focus on the experience and interpretations of the people being investigated (Viney, 1987b).

Content analysis scales have been effective in tapping research participants' interpretations of a range of life changes (Viney, 1980), their reactions to the crisis of illness (Viney, 1989a) and unemployment (Viney, 1983b). Intensive study of specific aspects of life changes relating to child bearing have also been examined, using content analysis scales (Westbrook, 1978, and 1979). Hampton (1989) and Viney (1981) report their usefulness for studies in community psychology and it has been found to be of value in psychotherapy research (Brunink and Schroeder, 1979) including in the evaluation of treatment outcomes (Bunn and Clarke, 1979). A more comprehensive account of the diversity of topics to which this methodology has been applied may be found in a review by
McCoy (1980) recommends content analysis scales as being consistent with the personal construct psychology view of emotions and agrees with Viney (1983) that they provide access to the construing processes. They have been found to meet a high proportion of the criteria for data collection tools recommended for a science of construing people (Viney, 1987b), as it allows the reflecting person to be the primary source of data. They appear appropriate for a model of human experience which accounts for, and expects changes over time in people's construct systems.

The focus of this next discussion is directed to the content analysis scales that have been developed to measure the psychological states applicable to this study. Specific scales have been created that allow for an analysis of changes in the construing process and which cover both positive and negative feeling states. These include scales which measure the disruptive and distressing psychological states of anxiety and hostility (Gottschalk, Winget and Gleser, 1969), feelings of uncertainty (Viney and Westbrook, 1976) and helplessness (Westbrook and Viney, 1980). Pleasant or positive emotional states including general positive affect (Westbrook, 1976), feelings of control (Westbrook and Viney, 1980) and scales which tap people's perceptions of satisfying interpersonal interactions have also been
developed (Viney and Westbrook, 1979) and included. Validational evidence is available for the scales. It is important, however, that some general issues concerning reliability and validity in the social sciences first be addressed.

CONTENT ANALYSIS SCALE RELIABILITY AND VALIDITY

Important considerations, when designing research and choosing measurement tools, are issues such as the stability of test scores over time and the extent to which the tool measures what it purports to measure.

Personal construct theory contends that people’s experiences of ongoing events invariably undergoes change. Thus, although some stability in the organisation of constructs would be expected, (Hinkle, 1965) some evidence of progressive modifications to construing should also be present. Reliability of measures of construing would therefore be expected to differ for different aspects of construing. Personal construct psychology views traditional reliability over time as an index of the extent to which a test is insensitive to change (Bannister and Fransella, 1987).

Although it has been argued that stability over time is not necessary for measures of psychological states, interjudge reliability is necessary, for an assessment technique is reliable only to the extent that it is
consistent in measurement. The means and ranges of the interjudge reliability coefficients of the eight content analysis scales used in the present research are reported in Appendix 2 (Table 1). Reported average co-efficients for inter-rater reliability are acceptably high for content analysis scales ranging from 0.71 to 0.96 also the size of the co-efficients is generally consistent (Gottschalk, Lolas and Viney, 1986). The internal consistency of content analysis measures is reported in Table 2 (Appendix 2). In an analysis of these, Viney (1986) comments about the lack of information particularly in regard to relationships between content categories.

Reports on split-half reliability studies on the negatively toned Gottschalk and Gleser scales are also discussed by this researcher. Information regarding test-retest reliability is reported in the form of generalizability coefficients in Table 3 (Appendix 2). Reports suggest that the scales vary in their stability over time as a function of the population of research participants or events under consideration. More information regarding consistency over time as well as internal consistency is needed, however, (Viney, 1986). The reader is referred to this author's comprehensive account of the assessment of psychological states through the use of the content analysis scales. This includes a complete summary of available information about the reliability and validity of the major content analysis
scales in current use.

Construct validity best reflects whether a content analysis scale is achieving its aims (Gottschalk et al., 1986). As noted, the data come directly from the research participants and therefore can be said to have inherent content validity. Evidence of construct validity is revealed by the relationship of the scales with other indices. Any biases according to the sex, age, educational level and occupational status of the research participants should be known for every scale. This information is provided in Appendix 3 (Table 1) for the content analysis scales under consideration. Correlations with other measures of the same construct such as self-reports and observations of behaviour that provide further confirmation of validation (Vinay, 1986) are also included in this table.

Estimates of criterion based validity are available for certain types of content analysis scales, for example the Pawn and Origin scales (Vinay, 1986). Evidence of discriminant validity for certain scales is also available (Westbrook and Vinay, 1980). Assessment of construct validity in experimental manipulations is also addressed by Vinay (1986). Table 1 (Appendix 3) reveals that more information regarding validity is available for some content analysis scales than others. To date, the negatively toned scales, due no doubt to the interest in distressed psychological states, have received more
attention than the positively toned scales. Time since construction is also a factor accounting for the scarcity of validational scales. It may be anticipated that more evidence will be available in the future for the more recently developed scales.

MEASUREMENT OF NEGATIVE EMOTIONS
BY CONTENT ANALYSIS SCALES

Anxiety and Uncertainty

The Total Anxiety scale (Gottschalk, 1979; Gottschalk and Gleser, 1969; Gottschalk et al., 1969) was used to provide a measure of awareness that events were outside the range of the participants' construct systems. This scale measures state or free floating anxiety, the type of anxiety said by Kelly (1955) to indicate a breakdown in superordinate structures experienced by people undergoing transitional changes in their construct systems. Although based on a psychoanalytic model (Gottschalk and Gleser, 1969), its components have a conceptual parallel with the constructivist concept of core anxiety (Viney and Westbrook, 1981). It taps anxiety from six different sources: death, mutilation, separation, guilt, shame and diffuse or non-specific anxiety.

An assumption made by Gottschalk et al., (1969) is that the more anxiety people experience, the greater is the probability of verbalisation of anxiety relating to self. People realise that their construct systems are
failing during periods of change; events seem to call for new constructs which they do not have. During periods when the anxiety diminishes, Gottschalk et al. (1969) predict that people are more likely to speak in terms of others or, even more remotely, in terms of anxiety related to inanimate objects. Unsolicited denial of anxiety is also construed as being indicative of low levels of anxiety. A scoring schedule is provided by Gottschalk et al. (1969) indicating progressive weighting schedules for these categories.

The Cognitive Anxiety Scale developed by Viney and Westbrook (1976) is designed to measure aspects of anxiety that may best be described as uncertainty, and which are not taken into account by the Gottschalk - Gleser Anxiety Scale. Cognitive anxiety is defined as people's inability to anticipate and integrate experience meaningfully, using their available constructs (Preston, 1987). This scale, which appears a very suitable measure of construct ineffectiveness, indicates people's reaction to unexpected or unknown situations which provoke feelings of uncertainty. Similar to the Total Anxiety Scales, it is assumed that the more cognitive anxiety a person is experiencing, the greater is the possibility of self-reference. Reference to others and denials of anxiety are scored but with decreased weighting. A scoring schedule and examples of verbalisations for the Cognitive Anxiety Scale are included in Table 1, Appendix Four, for a more
comprehensive understanding of content analysis scoring criteria.

Anger, Depression and Helplessness

Depression and anger is measured by the Hostility Directed Inward and the Hostility Directed Outward Scales (Gottschalk, 1979; Gottschalk and Gleser, 1969; Gottschalk et al., 1969;). The construct of hostility covers many interrelated factors including the emotion of anger (McCoy, 1977). The Hostility Directed Outward Scale (Gottschalk and Gleser, 1969) assesses people's expressions of blame, anger and depreciation toward other people or things, which may be interpreted as efforts to resist invalidation of constructs or to extort validational evidence for failed predictions. Anger turned inward on self and manifested as depression, is measured by the Hostility Directed Inward Scale which focuses on self-destructive and self-critical comments, indicating anger directed at self.

Similar to the Gottschalk-Gleser Anxiety Scales, the Hostility Scales make possible the assessment of the relative contributions of different sources of hostility for any person at any point in time. That is, they permit differentiation between different ways of expressing anger; whether it is expressed directly or whether it is experienced as depression. Normative data supplied by Gottschalk and Gleser (1969) reveal that scores above
1.00 for the Hostility Directed Inward Scales and 1.70 for the Hostility Directed Outward Scales are rare.

Feelings of helplessness and lack of control are measured by the Pawn Scale (Westbrook and Viney, 1980). These authors note that an important aspect of people's experiences is their perception of control.

MEASUREMENT OF POSITIVE EMOTIONS BY CONTENT ANALYSIS SCALES

A measure of positive affect, developed by Westbrook (1976) is used to explore positive emotional reactions in a variety of situations. According to McCoy (1977) some indications of people's experience of validation and affirmation of constructs should be given by the extent to which they express satisfaction and happiness.

Feelings of competence are measured by the Origin Scale developed by Westbrook and Viney (1980). Origin statements are those which refer to the research participant's own intention, ability or influence and have their roots in attribution theory (Viney and Westbrook, 1984).

The extent to which participants perceive they are experiencing satisfying social relationships are measured by the Sociality Scale (Viney and Westbrook, 1979). The concept of sociability, in this context, refers to experiencing oneself as participating in interpersonal
interactions. It has been proposed that the relationships which are important to people influence their construing process (Leitner, 1985b).

Content analysis scales are relevant for the exploration of the personal constructs of women undertaking a transitional event. They provide a measure of the emotional states experienced by people in transition plus the rigour of established reliability and validity (Viney, 1987b). A description of the people, whose subjective experiences form the data for this study, follows.

THE RESEARCH PARTICIPANTS

The research was undertaken in two Schools of Nursing, one in an urban, industrial city and the other within the metropolitan region of a capital city. The former was a variation of the hospital apprenticeship system; the nurses receiving their education during blocks of academic study at a Regional School of Nursing situated at a local college of advanced education. The remainder of the three year course was spent in employment in the regional hospitals which offered a variety of clinical experiences. These student nurses were, actually, full-time employees and the concept of nurses attending college part-time for their education, rather than the hospital school, was a departure from tradition. This interim stage of nurse education was thus a new venture
and students recruited to this programme were subject to close scrutiny by the local hospital nurses.

From this context two groups of students were invited to participate in the research. One group were 36 mature age applicants (age 22 to 48 years) and the other 36 younger students (age 18 to 20 years) accepted as having obtained the required aggregate mark in the N. S. W. Higher School Certificate necessary for entry into the course. Two entire groups were selected, as student intake numbers were limited and a reasonable sample size was needed for a comparative longitudinal study.

The other source of participants was a School of Nursing within a metropolitan university. These students, unlike the others, were tertiary students, not hospital employees and as such, were exposed to a variety of clinical placements as supernummary students rather than being part of the work force. The transition of nursing into the tertiary sector was, at that time, a hotly debated issue and the students were the subject of much discussion when exposed to the clinical practice area. Hospital staff were divided as to the wisdom of the new venture and this was readily apparent to the students during clinical experience placements.

The random sample of 72 university students were taken from a larger group of students of mixed entry background, that is, students who were selected according
to the prevailing admission criteria of matriculation or equivalent standard and special entry categories. Equal numbers of mature age (age 22 to 35 years) and younger students, (age 18 to 20 years) volunteered to participate in the research programme in response to my request for subjects. The selection of participants from the volunteers was random. A small number of male volunteers were interviewed to divert attention from the fact that the sample under scrutiny was female.

The total sample of participants, consisting of 72 mature age and 72 younger women from both schools, were invited to take part in a research project that required their involvement in five interviews spread over the duration of the respective courses. Details of the specific nature of the research were not disclosed although a general explanation was given stating that a survey requiring interviews with nursing students was being conducted. The majority of the students were from middle-class, socio-economic backgrounds although some variations did exist. Those in the younger age group were, without exception, unmarried with no dependents, whereas many of the older students had long-term relationships and children at varying stages of dependency.

The ethnic background of both groups was varied but all students were fluent in English. The educational background of the younger students was a progression from
primary level to secondary levels, finishing with the attainment of a minimum aggregate of 250 in the N. S. W. Higher School Certificate. The educational background of the mature age students varied considerably, only four having attained the N.S.W. Higher School Certificate or its equivalent and one, a tertiary qualification. Work experience varied greatly between the groups as could be expected. Fifty-six of the mature age students had previous full-time work experience, compared with the younger students, the majority of whom had only worked in part-time positions during school vacations. The majority of the university students combined part-time work with their studies during the length of the course whereas all the hospital students, as employees of the Department of Health, were required to work in the regional hospitals when not in study block.

THE RESEARCH PROCEDURE

Collection of Interviews

The Regional School interviews were conducted during five of the six academic study sessions interspersed over the course. As the employing hospitals were widely dispersed across an Area Health Region, their verbalisations were collected during these sessions when the women were regrouped for teaching purposes, prior to the following clinical placement (Figure 1, Appendix Five). Data samples were not collected during the sixth
session when, due to the high levels of stress generated by daily examinations, atypical results could have been obtained.

The university students were also interviewed on five separate occasions, each interview being conducted as close as possible to a clinical placement, in order to approximate the conditions under which the Regional School interviews were conducted (Figure 2, Appendix Five). These students were not employed but undertook clinical placements supervised by academic staff, as supernumerary students, at a variety of health care agencies in the Sydney metropolitan area.

The Interviews

The purpose of the interviews was to collect samples of speech for content analysis for positive and negative emotions. Each interview was conducted privately and participants were assured of confidentiality. Permission was obtained, on an individual basis, to record the interviews. The participants were then asked to talk freely about their lives as they were currently experiencing them. The instructions given by the researcher were:

I would like you to tell me how you are at this stage in life - what it is like to be (subject's name). You are free to discuss any aspects of your life but I am mainly concerned with how you feel. I would like you to talk for about five minutes and please try not to ask me any questions until the interview is
complete as I must not participate in the recording. Are there any questions you would like to ask me before we begin?

Content Analysis Scale Scoring of Interviews

The resulting total of 626 interviews were transcribed and clauded, according to the methodology prescribed by Gottschalk et al., (1969). Verbalisations from the women on each of the five interview occasions were scored, using the appropriate content analysis scales to obtain individual scores. A total of 14 scales and sub-scales were used in the scoring of the five interviews over the three year time period of each of the nursing courses. Eight types of anxiety were scored, measured by the Cognitive Anxiety Scale and the Total Anxiety Scale; the latter being a summation of the anxieties resulting from six different sources: death, mutilation, separation, guilt, shame, and diffuse anxiety. Other negative emotional states were measured by the content analysis scales including helplessness (Pawn Scale), depression (Hostility Directed Inwards Scale) and anger (Hostility Directed Outwards Scale). Positive emotional states which were measured included competence (Origin Scale), happiness/satisfaction (Positive Affect Scale) and social interaction (Sociality Scale).

To overcome the problems involved in scoring communications of different lengths, the correction
factor recommended by Gottschalk et al. (1969) was then applied to the raw scores. The correction factor (C.F.) is the total number of words divided into 100. The raw score was multiplied by the correction factor and 0.5 of the correction factor was then added to the score in order to account for verbalizations where there was no scorable content i.e. Final score = [(Total score x C.F.) + (C.F. x 0.5)]. This provides a uniform transformation over all samples. Square root transformations were applied in order to minimise skew, in accordance with the instructions for each scale.

Scoring was undertaken by the researcher, apart from the Pawn and Hostility Scales which were scored by two independent researchers. Interrater reliability of scoring was established by the random selection of twenty-five of the transcripts, which were analysed by a person experienced in the use of the scales. Correlation co-efficient scores for the Total Anxiety Scale including the sub-categories of Mutilation, Guilt, Shame and Diffuse Anxiety fell within the normal range of 0.84 to 0.94. Exceptions were the scores of 0.77 for Death and Separation Anxiety. Correlations for Cognitive Anxiety were 0.92; Hostility 0.83; Pawn 0.87; Origin 0.92 and Sociality 0.95. No significant differences were found between scorers, when t-tests between matching samples of scores were performed.
The Research Design and Analysis of Data

The study used a two by two by five repeated measures factorial design. The between-subjects factors were developmental stage (older/younger) and professional role (hospital employees/university students). The within-subjects factor was time (Interviews One to Five).

Data resulting from the scoring of verbal samples were submitted to procedures from a software programme "Statistical Programme for the Social Sciences (SPSSX) (Nei, Hull, Jenkins, Steinbrenner and Bent, 1975). Means and standard deviations for the 14 dependent variables were calculated from the raw scores to determine whether scores for Total Anxiety and Hostility Inward were within the normal range described by Gottschalk and Gleser (1969) (Hypotheses 1 and 2).

Four multivariate analyses of variance (MANOVA) were initially undertaken to assess the significance of the effects of the two between-subjects independent variables, developmental stage and professional role on the two groupings of the dependent variables, the total scales and the anxiety sub-scales for Interviews One and Five. Multivariate analysis is recommended for the analysis of data containing more than two dependent variables (Tabachnick and Fidell, 1989).
Significant multivariate effects were found for developmental stage and professional role, providing a justification for the use of univariate repeated-measures analysis of variance for all dependent variables over the five interview occasions. In each of these analyses, developmental stage and professional role were entered as between-subjects variables and time as the within-subjects independent variable. This allowed the assessment of the value of these independent variables in predicting construct change through the scoring of the participants emotional states. (Hypotheses 3-18).

The results of these analyses are contained in the next chapter.
CHAPTER 7

RESULTS OF THE ANALYSES OF MEASURES OF EMOTIONAL STATES EXPERIENCED BY WOMEN IN TRANSITION
RESULTS OF THE ANALYSES OF MEASURES OF EMOTIONAL STATES EXPERIENCED BY WOMEN IN TRANSITION

The results from the quantitative analyses of data obtained from women undergoing a transitional event are presented in this chapter. The difference between the degrees of freedom (1,99) and the number of participants interviewed will be noted. Only complete sets of five interviews were included in the analyses; sets of interviews which were incomplete, for whatever reason, were excluded. A qualitative analysis can be found in the following chapters.

EMOTIONAL STATES AND THE NATURE OF THE TRANSITION

The first results to be examined concern the hypotheses relating to the nature of the transitional process: the experience of participating in a course in nursing. It was predicted that women undertaking a course in nursing will experience higher than normal levels of anxiety (1) and will suffer higher than normal levels of depression (2).

Table 7.1 show the means and standard deviations for the content analysis scale scores for both the older and younger women, over Interviews One to Five, irrespective of professional role. The mean Total Anxiety Scale score was 1.59, which may be compared with the normative data given by Gottschalk and Gleser (1969). These authors obtained normative anxiety data on 282 non-psychiatric
TABLE 7.1: Means and standard deviations for Total Anxiety, Cognitive Anxiety, Hostility Inward & Hostility Outward for all women over five interviews.

<table>
<thead>
<tr>
<th>SCALES</th>
<th>1</th>
<th>2</th>
<th>INTERVIEW</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>1.59</td>
<td>0.97</td>
<td>1.74</td>
<td>1.16</td>
<td>1.64</td>
<td>1.02</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>1.42</td>
<td>0.74</td>
<td>1.46</td>
<td>0.92</td>
<td>1.20</td>
<td>0.71</td>
</tr>
<tr>
<td>Hostility Inward</td>
<td>1.31</td>
<td>0.78</td>
<td>1.62</td>
<td>0.83</td>
<td>1.51</td>
<td>0.71</td>
</tr>
<tr>
<td>Hostility Outward</td>
<td>1.01</td>
<td>0.48</td>
<td>1.10</td>
<td>0.53</td>
<td>1.25</td>
<td>0.63</td>
</tr>
</tbody>
</table>
employees, students and medical patients (x = 1.46 and SD = 0.71). They also assessed anxiety scores in psychiatric out patients (N = 107) and obtained a mean of 1.92 (SD = 0.82). From their percentile data, Gottschalk and Gleser (1969) concluded that a mean of 2.2 was indicative of moderate anxiety; and a mean of 3.0, severe anxiety.

For the purpose of the present study, Gottschalk and Gleser's (1969) normative data could be of interest for a comparison with the data obtained from these analyses. The mean Total Anxiety Scale score, for women in the present study, at Interview One was 1.59 (SD = 0.97). This varied only slightly over the next four interviews, ranging from 1.56 (Interview Four) to 1.74 (Interview Two). The mean Total Anxiety Scale score from these five assessments was 1.65, SD = 1.02 thus Hypothesis 1 could be said to be partially supported. Because access to the raw data of Gottschalk and Gleser's (1969) sample was not available, however, inferential comparisons could not be made. A comparison of the means of the different samples could also be open to criticism due to differences in the time period between the two studies and the confounds arising from disparate populations.

Table 7.1 shows the means and standard deviations for the Hostility Inward Scale (experienced as depression). The mean Hostility Inward score at Interview One was 1.31 (SD = 0.78). This varied only slightly over the remaining four interviews, ranging from 1.26 (Interview Five) to
1.62 (Interview Two). The mean Hostility Inward Scale score from these five interviews was 1.4, SD = 0.73. Gottschalk and Gleser (1969), using a non-psychiatric sample, state that scores above 1.00 (< 10%) for hostility inward are rare. The mean for the present population lay well above this figure and thus Hypothesis 2 could be said to be supported. The same caution concerning confounds arising from population differences and time discussed with reference to Hypothesis 1 must per force be observed. Means and standard deviations for each of the content analysis scales for both younger women (Table 1) and older women (Table 2) are contained in Appendix Six and the reader is advised to refer to these for comparisons of significant trends across the five interviews.

EMOTIONAL STATES, AGE AND PROFESSIONAL ROLE

Further results relate to the predictions concerning the developmental stage of the participants and differences in the professional role imposed by the different settings in which the changes occurred.

Multivariate analysis of variance (MANOVA) was used to test for the significance of the effects of both developmental stage and professional role on the two sets of scores obtained from Interviews One and Five as shown in Table 7.2. Significant multivariate F values were found for both these effects, justifying further
examination of the data. Univariate repeated measures analysis of variance was next performed for all sets of scores.

The specific hypotheses relating to the effects of developmental stage and professional role are: older women will show higher scores on the Total Anxiety Scale, than younger women (3); older women more than younger women will show anger, as measured by the Hostility Directed Outward Scale and more depression, as measured by the Hostility Directed Inward Scale (4); differences in the sources of anxiety, as measured by the anxiety sub-scales, will be noted according to developmental stage; older women will show higher anxiety scores as a result of shame and guilt (5) and show higher scores for unspecified or diffuse anxiety (6); younger women will show higher levels of separation anxiety (7) also higher levels of death and mutilation anxiety (8); and higher scores for satisfying social interaction, as measured by the Sociality Scale, will be shown in younger women (9).

It is also predicted that professional role expectations will influence the transitional event. Where there are higher performance expectations (hospital employees) it is hypothesised that the women experiencing them will score higher levels of anxiety as measured by the Total Anxiety and Cognitive Anxiety Scales than when there are relatively few expectations (university students) (10). This difference is also expected to
TABLE 7.2: Multivariate analysis of variance for content analysis scale scores for interviews one and five

<table>
<thead>
<tr>
<th></th>
<th>Content Analysis Scales</th>
<th>Anxiety Sub-Scales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interview 1</td>
<td>Interview 5</td>
</tr>
<tr>
<td>Professional Role</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.69**</td>
<td>11.86**</td>
</tr>
<tr>
<td>Developmental Stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.78**</td>
<td>-</td>
</tr>
<tr>
<td>Professional Role by Developmental Stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.23**</td>
<td>3.66*</td>
</tr>
</tbody>
</table>

\[ p < 0.05 \]
\[ * p < 0.005 \]
\[ ** p < 0.001 \]
extend to the expression of higher scores on the content analysis scales measuring anger (Hostility Directed Outward Scale) (11) and helplessness (Pawn Scale) (12).

Sources of anxiety may also vary according to the professional role. Specifically, it is hypothesised that hospital employees will experience higher anxiety scores as measured by the anxiety sub-scales for shame and guilt and diffuse anxiety (13); also higher levels of separation anxiety (14).

The results of the univariate analyses of the content analysis scale scores are depicted in Table 7.3. A significant univariate main effect was found for developmental stage for scores on the Total Anxiety, $F(1,99) = 37.83$, $p < .01$, Hostility Directed Inward, $F(1,99) = 4.78$, $p < .05$, Hostility Directed Outward, $F(1,99) = 3.95$, $p < .05$, Positive Affect, $F(1,99) = 21.95$, $p < .01$, and Sociality Scales, $F(1,99) = 13.87$, $p < .01$ (Table 7.3). Inspection of the means (Table 7.4) indicated that older women scored higher on the Total Anxiety, Hostility Directed Inward and Hostility Directed Outward Scales, giving support to Hypotheses 3 and 4. Younger women scored higher on the Sociality Scale thus giving support to Hypothesis 9, also for the Positive Affect Scale.

A significant univariate main effect was found for professional role for the Total Anxiety, $F(1,99) =
### TABLE 7.3: Univariate repeated measures analysis of variance for content scale scores showing interaction effects

<table>
<thead>
<tr>
<th>Variable</th>
<th>Between Subject Effects</th>
<th>Within Subject Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Professional Role</td>
<td>Developmental Stage</td>
</tr>
<tr>
<td></td>
<td>d.f. 1,99</td>
<td>1,99</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>207.82*</td>
<td>37.83*</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>64.59*</td>
<td>--</td>
</tr>
<tr>
<td>Hostility In</td>
<td>--</td>
<td>4.78</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>6.46</td>
<td>3.95</td>
</tr>
<tr>
<td>Pawn</td>
<td>9.21*</td>
<td>--</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>--</td>
<td>21.95*</td>
</tr>
<tr>
<td>Origin</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Sociality</td>
<td>--</td>
<td>13.87*</td>
</tr>
</tbody>
</table>

\[ p < 0.05 \]

\[ * p < 0.01 \]
TABLE 7.4: Means and standard deviations for content analysis scale scores showing significant developmental stage differences over five interviews

<table>
<thead>
<tr>
<th>Groups</th>
<th>Younger</th>
<th>Older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>1.45</td>
<td>0.58</td>
</tr>
<tr>
<td>Hostility In</td>
<td>1.31</td>
<td>0.43</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>1.07</td>
<td>0.34</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>1.22</td>
<td>0.31</td>
</tr>
<tr>
<td>Sociality</td>
<td>0.27</td>
<td>0.10</td>
</tr>
</tbody>
</table>
207.82, \( p < .01 \), Cognitive Anxiety, \( F(1,99) = 64.59, p < .01 \), Hostility Directed Outward \( F(1,99) = 6.46, p < .05 \), and Pawn Scales \( F(1,99) = 9.21, p < .01 \). Inspection of the means revealed that for all four scales, women who were hospital employees scored higher than university students (Table 7.5). Support was thus given to Hypotheses 10, 11 and 12.

**SOURCES OF ANXIETY, AGE AND PROFESSIONAL ROLE**

Following the finding of significant multivariate \( F \) values for the anxiety sub-scales (Table 7.2) univariate repeated measures analysis of variance were performed for the scores obtained from the six anxiety sub-scales (Table 7.6) A significant main effect for professional role was found in the sub-scales of Separation Anxiety \( F(1,99) = 14.35, p < .01 \), Guilt Anxiety \( F(1,99) = 13.76, p < .01 \), Shame Anxiety \( F(1,99) = 218.43, p < .01 \), and Diffuse Anxiety \( F(1,99) = 54.00, p < .01 \). Table 7.7 reveals that hospital employees scored higher on all four scales. The higher scores for the Guilt, Shame and Diffuse and Separation Anxiety sub-scales for hospital employees gave support to Hypothesis 13 and 14.
TABLE 7.5: Means and standard deviations for content analysis scale scores found showing significant professional role differences over five interviews

<table>
<thead>
<tr>
<th>Groups</th>
<th>University Students</th>
<th>Hospital Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>1.15</td>
<td>0.36</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>1.03</td>
<td>0.35</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>1.06</td>
<td>0.34</td>
</tr>
<tr>
<td>Pawn</td>
<td>0.59</td>
<td>0.10</td>
</tr>
</tbody>
</table>
TABLE 7.6: Univariate repeated measures analysis of variance for anxiety sub-scale scores

<table>
<thead>
<tr>
<th>Scale</th>
<th>Between Subject Effects</th>
<th>Within Subject Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Professional Role d.f. 1,99</td>
<td>Developmental Stage d.f. 1,99</td>
</tr>
<tr>
<td>Death</td>
<td>--</td>
<td>9.02</td>
</tr>
<tr>
<td>Mutilation</td>
<td>--</td>
<td>5.42</td>
</tr>
<tr>
<td>Separation</td>
<td>14.35*</td>
<td>--</td>
</tr>
<tr>
<td>Guilt</td>
<td>13.76*</td>
<td>6.35</td>
</tr>
<tr>
<td>Shame</td>
<td>218.43*</td>
<td>39.45*</td>
</tr>
<tr>
<td>Diffuse</td>
<td>54.00*</td>
<td>18.00*</td>
</tr>
</tbody>
</table>

p < 0.05

* p < 0.01
TABLE 7.7: Means and standard deviations for anxiety sub-scale scores showing significant professional role differences over five interviews

<table>
<thead>
<tr>
<th>Groups</th>
<th>University Students</th>
<th>Hospital Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>0.63</td>
<td>0.13</td>
</tr>
<tr>
<td>Guilt</td>
<td>0.57</td>
<td>0.10</td>
</tr>
<tr>
<td>Shame</td>
<td>0.65</td>
<td>0.16</td>
</tr>
<tr>
<td>Diffuse Anxiety</td>
<td>0.92</td>
<td>0.30</td>
</tr>
</tbody>
</table>
A significant main effect was found for developmental stage for the sub-scales Death Anxiety $F(1,99) = 9.02, p < .01$, Mutilation Anxiety $F(1,99) = 5.42, p < .05$, Guilt Anxiety $F(1,99) = 6.35, p < .05$, Shame Anxiety $F(1,99) = 39.45, p < .01$, and Diffuse Anxiety $F(1,99) = 18.00, p < .01$ (Table 7.6). Younger women scored higher for Death and Mutilation Anxiety (Table 7.8) thus giving support to Hypothesis 8. No support was found for Hypothesis 7. Older women scored higher on the sub-scales for Guilt, Shame and Diffuse Anxiety thus supporting Hypotheses 5 and 6 (Table 7.8). Means and standard deviations for both age groups are contained in Tables 3 and 4 in Appendix Five and the reader is advised to refer to these for comparisons of significant trends across the five interviews.

EMOTIONAL STATES OVER TIME

It is hypothesised that the women will experience changes in anxiety levels as measured by the Total and Cognitive Anxiety Scales over Interviews One to Five (15). The women will also show changes in scores relating to anger and depression as measured by the Hostility Directed Inward and Hostility Directed Outward Scales and helplessness as measured by the Pawn Scale (16).

It is predicted that positive feelings as measured by the Positive Affect, Origin and Sociality Scales will also change over time (17). It is also predicted that all
TABLE 7.8: Means and standard deviations for anxiety sub-scale scores showing significant developmental stage differences over five interviews

<table>
<thead>
<tr>
<th>Groups</th>
<th>Younger</th>
<th>Older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Death Anxiety</td>
<td>0.55</td>
<td>0.11</td>
</tr>
<tr>
<td>Mutilation Anxiety</td>
<td>0.54</td>
<td>0.09</td>
</tr>
<tr>
<td>Guilt</td>
<td>0.58</td>
<td>0.10</td>
</tr>
<tr>
<td>Shame</td>
<td>0.87</td>
<td>0.37</td>
</tr>
<tr>
<td>Diffuse Anxiety</td>
<td>1.00</td>
<td>0.36</td>
</tr>
</tbody>
</table>
the women will experience decreases in death anxiety by
the completion of the course (18).

Significant univariate differences across time were
found for the Cognitive Anxiety $F(4,396) = 4.56, \ p < \ .01$, Hostility Directed Inwards $F(4,396) = 6.12, \ p < \ .01$, Hostility Directed Outward $F(4,396) = 3.06, \ p < \ .05$, and Pawn Scales $F(4,396) = 3.71, \ p < .01$, but not for the Total Anxiety Scale, $p > .05$ (Table 7.3). Mean values for these scores over Interviews One to Five are depicted with standard deviations in Table 7.9. Hypothesis 15 was thus supported for Cognitive Anxiety but not for Total Anxiety Hypothesis 16 was fully supported.

Significant differences across time were also found for the positive emotions, as measured by the Positive Affect Scale, $F(4,396) = 7.84, \ p < .01$, Origin Scale, $F(4,396) = 4.2, \ p < .01$, and Sociality Scale, $F(4,396) = 5.65, \ p < .01$, as shown in Table 7.3. Mean values for these variables over Interviews One to Five are depicted in Table 7.9. Hypothesis 17 was thus supported.

A significant difference for time was found for the Death Anxiety sub-scale, $F(4,396) = 3.82, \ p < .01$ (Table 7.6). Mean values for scores for this scale over Interviews One to Five are shown in Table 7.10. Hypothesis 18 was thus supported.
TABLE 7.9: Means and standard deviations for content analysis scale scores which showed a significant effect for time for all women over five interviews

<table>
<thead>
<tr>
<th>SCALES</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Anxiety</td>
<td>1.42</td>
<td>0.74</td>
<td>1.46</td>
<td>0.92</td>
<td>1.20</td>
<td>0.71</td>
<td>1.25</td>
<td>0.78</td>
<td>1.25</td>
<td>0.76</td>
</tr>
<tr>
<td>Hostility In</td>
<td>1.27</td>
<td>0.70</td>
<td>1.62</td>
<td>0.84</td>
<td>1.50</td>
<td>0.71</td>
<td>1.28</td>
<td>0.63</td>
<td>1.26</td>
<td>0.73</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>1.01</td>
<td>0.59</td>
<td>1.10</td>
<td>0.53</td>
<td>1.26</td>
<td>0.63</td>
<td>1.21</td>
<td>0.74</td>
<td>1.06</td>
<td>0.59</td>
</tr>
<tr>
<td>Pawn</td>
<td>0.57</td>
<td>0.15</td>
<td>0.60</td>
<td>0.20</td>
<td>0.63</td>
<td>0.27</td>
<td>0.65</td>
<td>0.26</td>
<td>0.64</td>
<td>0.24</td>
</tr>
<tr>
<td>Origin</td>
<td>0.19</td>
<td>0.40</td>
<td>0.94</td>
<td>0.43</td>
<td>0.87</td>
<td>0.39</td>
<td>0.98</td>
<td>0.47</td>
<td>1.08</td>
<td>0.41</td>
</tr>
<tr>
<td>Sociality</td>
<td>0.30</td>
<td>0.18</td>
<td>0.26</td>
<td>0.17</td>
<td>0.21</td>
<td>0.14</td>
<td>0.21</td>
<td>0.14</td>
<td>0.21</td>
<td>0.14</td>
</tr>
</tbody>
</table>
TABLE 7.10: Means and standard deviations for the death anxiety sub-scale scores for all women over five interviews

<table>
<thead>
<tr>
<th>SCALES</th>
<th>INTERVIEW</th>
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SUMMARY: EMOTIONAL STATES IN WOMEN IN TRANSITION

The results reveal that women experiencing the transitional event of a course in nursing, had higher mean scores for anxiety and depression than normal when compared with a general population sample.

A significant main effect was found for developmental stage in this study. Differences were found between the scores of younger and older women. Older women obtained significantly higher scores for anxiety, anger and depression while younger women obtained significantly higher scores for social interaction and positive affect. Significant differences in the sources of anxiety between older and younger women were also noted.

A significant main effect was also found for professional role. Differences were found between the scores of hospital employees and university students. Hospital employees experienced significantly higher scores for anxiety, anger and helplessness. Significant differences in the sources of anxiety between hospital employees and university students were also noted.

Significant differences over time were evident for all women for all emotional states with the exception of Total Anxiety.
The results reveal considerable support for both the general and specific predictions concerning change in the constructs of women who are experiencing a transitional event, a course in nursing. Support is thus indirectly given to the more general propositions of the model of transition presented in this study. The results of the predictions will be examined in the following chapters in order to provide an account of construct change during this transitional process.
CHAPTER 8

DEVELOPMENTAL INFLUENCES ON

THE PROCESS OF TRANSITION
DEVELOPMENTAL INFLUENCES ON
THE PROCESS OF TRANSITION

QUALITATIVE RESULTS

The results of analyses presented in the previous chapter focus on the emotional states experienced by women undertaking a course in nursing. These statistical analyses provide interesting data for consideration in the construction of a theoretical model of the transitionary process. Although precise statistical measurements do provide an account of psychological processes, it would be inconsistent in a constructivist thesis to ignore qualitative data. It is necessary to provide accounts of the meaningful constructions of individual research participants, to supplement the normative measurement analyses reported to-date. Kelly (1979b) states that the humanistic experimenter designs research in a way that will make the research experience an optimal one, and is continually seeking fresh perspectives. It is my belief that a discussion focusing more closely on the statements of the participants in this research design, will confirm and enrich the precise and objective statements reported in the previous chapter. The focus of discussion in this chapter is directed to differences in the transition process attributable to the developmental stage of the participants.
DEVELOPMENTAL STAGE INFLUENCES

Some homogeneity but also some interesting differences are revealed in the cohorts of women experiencing transition. An important effect was found for developmental stage in this study, differences being found between the scores of older and younger women. As predicted, the findings revealed that older women obtained significantly higher scores for anxiety, anger and depression, while younger women scored higher for positive affect and sociality. Older women then, experienced more negative emotional states during the transitionary process and younger women, more positive emotional states. As predicted, sources of anxiety differed according to developmental stage; older women experienced higher levels of anxiety as a result of guilt, shame and diffuse anxiety while younger women suffered higher levels of death and mutilation anxiety.

EXPERIENCES OF OLDER WOMEN

Anxiety

The high levels of anxiety experienced by older women, reveal that many were aware of the inadequacy of their construct systems in the new situation they were experiencing. Much that occurred initially during the course in nursing was outside the range of their existing constructs, so that they were no longer able to anticipate or predict the events at hand. The sources of
anxiety which were important for older women included shame, guilt, and diffuse anxiety. Older women then, were more inclined to be self-blaming than younger women. They felt guilt when their interactions with others did not meet their own expectations, and shame when they did not measure up to others' expectations.

The act of returning to school is, for many older women, a first experience in assuming a non-traditional role and it is predictable that their reactions may include an increased sense of guilt and other sources of anxiety (Bueche, 1986). For many of the married women in this study, the feelings they experienced were due to the difficulties they encountered in managing the role of student, additional to their responsibilities as wives and mothers. It has been established that even in the eighties women still continue to carry the major responsibility for nurturing and homemaking, along with career-job demands (Hewlett, 1988; Mohney and Anderson, 1988). Resumption of studies inevitably creates conflict within mature age women, who are torn between their desires for personal growth and achievement and their belief that they should also consider the needs of the family (Malarkey, 1979). Guilt feelings and a general, diffuse anxiety were prevalent in most of these women, many commenting in interviews that the time spent in study put a strain on their relationships with husbands and children.
Role is structured in relationship to the significant people in our lives; and, when we fail to live up to ourselves as social beings, we experience guilt. By assuming the role of career women these older women were departing from what Kelly (1955) identified as core role structures; in this case, from their perceptions of themselves as homemakers and principal care givers. Brandenburg notes that as older students become more involved in their work and study, some aspect of their lives change; there is usually "a sacrifice of housekeeping responsibilities and less time for family and friends" (Brandenburg 1974, p. 13). The resulting guilt feelings are then exacerbated by the reactions of these significant others, who may initially be supportive but frequently become anxious and then hostile. Many of the women commented on the negative attitude of their marriage partners and the lack of family support for their venture.

The guilt, shame and general anxiety experienced by the women were, in part, a result of the complexity and difficulty level of the study required in the nursing course. Frequent self-references were made concerning their inadequacies in the academic area, particularly with regard to poor concentration and memory; and many expressed regret at not completing their education at a younger, more suitable, age. Some had high self-expectations and were disappointed when they failed to meet these self-imposed standards, while others exhibited
a lack of self-confidence in their own capabilities.

It was evident that the majority of the women had not anticipated the challenge they were confronting in undertaking a course in nursing. Many had underestimated the complexity of the course and there was a need for a revision of their constructs concerning the nature of nursing. Initially, there was a general failure to understand the relevance of support subjects such as the physical and behavioural sciences; studies in nursing had been anticipated, but many of the women had failed to anticipate the sciences would be a foundation for nursing knowledge. An examination of their interview transcripts revealed that this failure to anticipate the broad scope of contemporary nursing contributed to the sense of general anxiety experienced by the older women, many of whom had not studied these subjects during an often limited school education.

Admitting their difficulty in coping with the academic studies only exacerbated the women's feelings of a sense of departure from their self-perceptions. Although the older women were dissatisfied with their previous roles, hence the motivation to become a nurse, never-the-less they perceived themselves as competent in the tasks they had formerly performed. Faced with the demands of academic study, however, their conceptualization of themselves was rapidly undergoing change. Nursing is traditionally undertaken by young women, newly graduated
from high school and thus more oriented to study and familiar with study techniques. The effect of home responsibilities and age differences upon their academic performance did not go unnoticed by the mature students and was a cause of much anxiety. They were no longer competent home-makers; they were now students struggling to get pass grades. At times, they appeared resentful of the classroom atmosphere which appeared to arouse childhood memories which were incongruent with their adult self-image, again causing general feelings of anxiety.

Another factor which was the cause of anxiety was the fear of failure, a common feature of adult learners (Jarvis and Gibson, 1980). Many of the women were keenly aware that their acceptance as mature age entrants in the nursing course was, in effect, a second chance in life. It is not unusual for mature women to experience these feelings; they frequently need to find understanding and support with respect to the importance and difficulty of their decision to continue their education (Brandenburg, 1974). An extract from an initial interview with one of the students is typical of many of the comments:

"This is my big chance, this really is my chance, to make something of myself. You may never take a group of mature students again. It really is important to me to pass. I want to show them I can do it."

Shame was experienced not only in the classroom situation but also in the clinical areas. The older women were
keenly aware of their inadequacies and one commented that she felt embarrassed that, after a lifetime of domesticity, she was now having to be shown the "correct way" to make a bed. This was a task she had anticipated she would perform competently but her predictions proved to be incorrect. Others stated they felt useless, particularly in their initial clinical placement. Some did not know how to communicate with sick people, others were embarrassed when being assessed for their clinical competence on nursing procedures by clinical supervisors. One woman spoke on behalf of many when she stated:

You think you are a reasonably intelligent human being and then you walk into a hospital and find out all the things you can’t do and you feel so stupid and useless, you wonder where you’re really at.

Depression

Feelings of inadequacy are often associated with depression, a state of anger which is directed inwards upon the self. The older women in this study experienced significantly higher levels of depression than the younger cohort and also, like the young women, higher levels than those experienced by the general population.

People who feel depressed have self-destructive and self-critical thoughts (Gottschalk and Gleser, 1969; Viney and Westbrook, 1982). From a personal construct perspective it would be predicted that depressed people,
in contrast to non-depressed individuals, assimilate negative self-evaluations into their core role structures. While non-depressed individuals tend to apply the positive poles of their self-referent constructs, depressed people apply the negative aspects (Neimeyer, 1985).

The transcripts of interviews reveal that the older women in the study were highly self-critical, often referring to their lack of education, and expressing strong feelings of inadequacy and worthlessness. Others, discouraged by the difficulty of the course, made frequent and despairing statements indicating their feelings of hopelessness. The shame and embarrassment they experienced, together with their low self-esteem, did not encourage predictions of success.

Others, however, were depressed because of the perceived lack of support from their marriage partners. Frequent comments indicated that often husbands regarded their attempts at a career as only a temporary venture, failing to understand the significance and importance of their wives' attempt at gaining independence and a new self-identity. Others experienced despair regarding the difficulties of performing a dual role and worried about coping with family crises such as children's illness and other similar problems. Many of the women experienced feelings of loneliness during the course and some felt deprived with respect to the amount of free time in their
lives, due to the demands of family and course requirements. Many expressed feeling driven to meet some self-imposed standard and were angry with themselves when they failed to meet their own expectations. Frequent comments were made regarding their endeavours, how hard they were working and what they hoped to achieve.

Depression has been noted in studies of people experiencing transition (Aneshensel, 1986; Tyhurst, 1957; Viney, 1980) along with shame and guilt. Depression is also associated with a low self-esteem, particularly in women (Evans, 1985; Schur, 1984). The difficulties that mature age women experience during transition as result of role strain have been noted by Barr (1984). It is understandable that women undertaking a career may experience feelings of depression. Their low self-esteem and the feelings of worthlessnesss they suffer as a result of their perceived inadequacies result in anger which is focused inwards.

The depression they experience is a response to an awareness of the invalidation of many of their core role constructs. As they persist in trying to validate old patterns of thought, which no longer hold true in their new roles, they begin to acknowledge that there has been a change and, although they may have voluntarily created this change themselves, they experience depression and frustration. This occurs because of the difficulty they have in knowing how best to cope with the new
requirements, the ways of being, the new relationships that have been established (Hopson and Adams, 1976).

Kelly (1955) asserts that angry (and therefore depressed) people take active steps to make the data fit their predictions. In their continuing need to predict events people constrict their world to the known and familiar. Many statements contained in the women's interviews confirm this theme of constriction, stated by Rowe (1978) as being characteristic of the experience of depression. Frequent references were made to their inability to have normal social or family lives; their reliance on others and their sadness and despair regarding their academic inadequacies. The worlds of many of the women appeared to be restricted to work; whether within the home, studying or working in hospitals and other associated health-care agencies. It was evident, in many cases, that they were trying to validate their beliefs about themselves, "I'm a grown woman and I should be able to cope" was an often repeated comment, even when it was apparent they were not coping. Also many, in their despair, continued to believe that their willingness to study would compensate for any lack of the cognitive ability necessary to obtain the high grades they were so anxiously seeking.

Hostility and Anger

Many were hostile and angry in their need to extort
validational evidence that their existing ways of viewing
the world were still applicable. As people deal with the
reality of change they tend to stereotype, to have
categories and classifications of the ways things, and
people, should or should not be in the new situation
(Adams and Hopson, 1976). Although faced by mounting
piles of contradictory evidence, they persisted in their
endeavours at prediction, to make the evidence fit
(Bannister, 1977).

Examples of these attempts to prevent failure of their
predictions may be found in statements by these older
women undergoing the transitionary experience. Many who
were in relationships expressed hostility and anger
toward their partners for the lack of support they
experienced. It was apparent that they had anticipated
more assistance with housework and family
responsibilities. They saw themselves as students and
health professionals, people who had the right to follow
their chosen career. Their partners however still
maintained the old traditional images of them as house­
wives. Neimeyer and Hudson (1985) suggest that, in
seeking elaboration, important relationships may fail if
people fail to subsume their partners constructs and
limit their understanding of each other. This ultimately
leads to dissatisfaction and unhappiness in the
relationship. Other relationships, particularly parents,
also caused anger and irritation was expressed when
people failed to recognise their need for independence.
Duck (1983) argues that a crucial element in relationships is the ability to construe other individuals in the same way as they construe themselves.

Others displayed an intolerance to the younger women who complained of difficulties with their study during the course. They criticised them for their lack of application, saying they didn't realise how lucky they were to be young and single and not to have to worry. It was apparent that their constructs concerning academic success were associated with not having family responsibilities. Some displayed anger toward the academic component of the course, some toward individual lecturers but frequently it was directed at subjects they thought a waste of time, such as the behavioural sciences. These were a matter of common sense they argued; it appeared that their image of nursing was one of performance of skills rather than an understanding of people.

Ironically, their strongest anger was directed at other health professionals who, it seemed, failed to understand the human condition and were only interested in performance and routine. It was apparent that they had anticipated that health-care personnel particularly other nurses, would be sympathetic, friendly people, helpful and caring. Their anger, when they experienced the reality of hospital life, was indicative of their struggle to validate constructs which were failing them.
One gave a graphic account of a seriously ill and highly anxious patient who had received less than optimum treatment; others spoke of the apparent disinterest and lack of caring by nurses. Their expectations and anticipations concerning care givers were high and they failed to recognise the effects of "burnout", the syndrome afflicting health-care professionals who are emotionally exhausted, and, which results in detached and impersonal behaviour (Maslach, 1982).

Grief was interlaced with anger when they spoke of the lack of caring they had personally suffered at the hands of other nurses. One spoke of getting in her car at the end of a day's work and crying as she drove home. Others talked of the rudeness they encountered as unpleasant and frustrating. The hospital group of older women, particularly, were angry and resentful at the attitude to them. Many complained of the hostility they received from the registered nurses and were resentful of what they perceived to be victimisation and intolerance because of their mature age. Part of the problem appeared to result from the fact that the older hospital cohort was a readily identifiable group. It has been noted that when "special" courses are mounted for mature students, they may feel isolated and different from the mainstream student body (Jarvis and Gibson, 1980).

Anger was sometimes directed to specific clinical units, particularly areas of high technology. It appeared
that the depersonalisation of both staff and patients in critical and intensive care areas again did not fit with their image of nursing. It has been noted that many women have unrealistic perceptions of nursing (Muff, 1982).

The older women, then, had more negative experiences during the transitional process. It has been noted that returning registered nurse-learners in baccalaureate programmes overseas, easily become defensive, anxious and hostile (Green, 1987). This is attributed in part to the multiple roles these women have to deal with and the socialization they have received as women. As a result, older behavioural repertoires become at odds with behaviour now considered appropriate. In personal construct terms it may be seen that the women’s construct systems were undergoing change. Their old ways of viewing their assumptive worlds were no longer appropriate. They were aware that new ways of perceiving the world were required. New themes and patterns were emerging which needed interpretation and construal.

EXPERIENCES OF YOUNGER WOMEN

Fear of Death and mutilation

Although younger women experienced less anxiety than their older colleagues, they experienced higher levels than would normally be expected. Significant sources of anxiety experienced by the younger women related to death and mutilation fears. Because people are always
attempting to anticipate events, personal construct psychology would predict that people, ill or well, search for meaning in death (Viney, 1983). Kelly (1955), however, states that because most people lack the necessary constructs to enable them to make sense of death, it can be very anxiety-arousing. It was accurately predicted that fear of death would be significantly higher in the younger women in this study, as it was felt that they would have fewer death-related experiences than older women.

Although it may be anticipated that older people would show more death-related concerns, it has been reported that it is younger people who fear death more (Weisman and Kastenbaum, 1968). The most frequent comments made by the younger women were in reference to deaths within their immediate or close family circle. Only a few spoke of patients' deaths and their reactions to these events. Fear of death as a child was discussed and the traumas it invoked; some used humour as a method of dealing with their fears. The reality and possibility of death is difficult to admit even with people who are prepared to discuss it at an intellectual level (Combs, 1981).

Fears of body damage or mutilation also contribute to general feelings of anxiety (Viney, 1983). It was predicted that younger women would experience significantly higher levels of mutilation anxiety than older women. Several of the younger women made references
to family members experiencing severe illness or surgery. Some spoke about friends who had been involved in accidents and sustained various trauma. Occasionally, reference was made to motor vehicle accidents they themselves had been involved in, and great detail was supplied regarding the damage to the vehicles involved. As for death anxiety, the reality of possible injury to themselves was not expressed directly.

The young women, then, experienced anxiety during the transitional period of learning to become a nurse, but from different sources to that of older women. As for those experienced by older women, they were indications of the changing view of their new world.

Satisfying Social Interactions and Friendship

Satisfying social interaction is a highly important factor in life event change (Lazarus and Folkman, 1984); and it was confirmed in this study that younger women undertaking a course in nursing experience significantly higher levels of this than older women. Friendship is most important for young people, from adolescence to marriage, when it is the main relationship (Argyle, 1987). The younger women’s positive experiences were reflected in statements referring to the personal satisfaction they enjoyed in their interpersonal relationships. Frequent references were made to their friends and families, and it was evident that these
aspects were perceived as very important by them.

Friends and family also acted as strong support agents and, consistent with the literature (Ostrow et al., 1986), it appeared that these natural support systems were utilised in preference to professional help during times of crisis. Statements indicating support from the hospital staff contrasted with the experience of older women from the hospital cohort. It appeared that younger women more easily fitted the staff’s image of student nurses and so they displayed a more positive attitude to them. It is said that social support must be earned by the display of appropriate role behaviour and attitudes (Fisher, 1985). Adult women are generally accustomed to being self-directing and tend to resist and resent situations in which they feel they are treated like children (Knowles, 1970). It could be expected that they would perhaps not always conform to the hierachical hospital system.

Many shared experiences with friends and family were related by the young women and it was evident that they had many options for validation of their constructs. When communication is effective between people, validation can occur more effectively (Viney, 1985). As people come to understand each other’s way of viewing the world then they can interact more meaningfully. Good interpersonal relationships facilitate the transitional process, as they enable people to construe each others constructions.
Personal satisfaction and happiness

Other positive emotions that were experienced at significant levels by younger women included states that are considered pleasureable, agreeable and desirable. Satisfaction and happiness were included, both of these feelings presumably being at the positive pole of most people's constructs. The younger women were very enthusiastic about campus life and were happy to have been selected for the course. New friendships, particularly social interactions with male students, gave them much pleasure. It has been noted that relationships and work form the main sources of happiness (Argyle, 1987; Reich and Zautra, 1980). In the changing worlds of the young women, in the present study, these sources offered validation of their expectations and predictions. The clinical area was also a great source of satisfaction, they enjoyed interaction with the patients particularly, and got on well with staff. Success in their assessments were a source of satisfaction, particularly their mastery of specific skills in the clinical arena. Their constructs of nursing as satisfying were validated and many stated how pleased they were to be doing the course. They were happy with their choice of a career and made plans for the future based on their new identities as registered nurses.
The discussion in this section deals with developmental stage differences, as they occurred sequentially over the five interviews. An examination of these events allows a closer perspective of the aspects of the transitional process relating to the development of women.

The anxiety and depression experienced by the older women rose sharply on the occasion of the second interview (Figures 1 and 2, Appendix Seven) as did feelings of guilt, shame and diffuse anxiety (Figures 3, 4 and 5, Appendix Seven). These feelings appeared to be associated with the academic demands of the nursing course. Generally, the initial period of study in nursing programmes consists of introductory level subjects and the focus is directed to normal events, rather than the complex pathophysiology encountered at later stages of the programme. The mature women, happy and excited because of their recent acceptance into the course, coped with the first session quite easily. The situation was novel enough for their families, and partners, to be supportive.

By the second interview, however, they had completed a demanding academic block containing many complex subjects, which required increased application on their part. Anxiety and depression were high as they realised
the extent of the new venture they were undertaking and feelings of guilt and shame increased. It was apparent that they had failed to anticipate the academic rigour of the course. Some of the older women had previous experience as nursing assistants or aides, courses in which few intellectual demands are made. They had gained a certain standard of clinical expertise which, based on their previous experience, they mistakenly construed as the essential requirement and had therefore underestimated the difficulty of the academic component. These women experienced feelings of guilt and shame, and were embarrassed when their anticipation of themselves coping easily with the course proved incorrect. One woman said:

I love the practical work, but then I've done that before, so it's no worry. But I've been upset because of the project we are having to do .... I found it very hard and I've never had to do anything like that before.

Insufficient time was the main problem for many of the older women, as they were finding it increasingly difficult to deal with the many roles in their lives. Family and other relationships require time and energy, additionally, homemaking demands do not decrease when a woman becomes a student. An increase in guilt occurred again at the fourth interview. The women were feeling the strain of coping with study, demanding physical work and family commitments. One complained:

I think that two (study) blocks so close together is heavy. I find that at night time it is a bit hard until all the kids
go to bed and by then I'm getting tired .... I try to give them some more time but I have so much to do .... I usually survive somehow but my husband gets annoyed.

As they become more organised and skilled in study techniques, they experienced less anxiety and depression. Despite their difficulties, they were coping with the course and experiencing success in the examinations. Feelings of shame and guilt subsided to below the levels of their initial interview but a general, diffuse anxiety persisted.

Their anger also remained, peaking on the same occasion of the fourth interview (Figure 6, Appendix Seven). The focus of the hospital employees hostility was directed simultaneously at the school and the hospital environment. Their academic work load was high and most had had a short but demanding clinical placement in areas such as operating theatres and accident and emergency.

University-based students also had recently experienced their first psychiatric placement, traditionally a stressful area (Stacklum, 1981). They were confronted with the reality of the psychiatric institutions and the evidence that the ideals and dedication of nursing envisaged by them, were not necessarily practised. One student commented:
It was a real disappointment. It sounds so good in theory - all the discussion with the patients and their treatment programmes and all that. Then when you talk to the staff they just laugh. If they were busy you could understand but half the time they just sit in the tearoom and drink coffee. They look at their watches and tell the patients "sorry Joe I’m too busy now" and then they go and play snooker. It’s really depressing.

By the final interview, however, this placement was finalised and they were within completion of the course. Their anger subsided to the level of the first interview.

The younger women’s feelings of happiness and satisfaction also decreased, as did their reports of social interactions (Figures 7 and 8, Appendix Seven). The majority of the younger university-based students found it necessary to undertake part-time employment and found little time for social outings and other interactions. They complained frequently of the effect on their social lives, as did the hospital-based younger women. Their initial satisfaction, stemming from acceptance into the respective courses, was diminishing - they had now entered the adult world and were experiencing the realities of life. During school days, they had, to a certain extent, been sheltered and protected by parents but this was rapidly changing. Additionally, many of the young college students were anticipating their future employment in the hospital sector and the responsibilities this would bring. They were concerned about their lack of expertise in the
clinical area and needed reassurance that they would quickly consolidate their clinical skills. As previously discussed, death and mutilation fears decreased with exposure to these situations over time (Figures 9 and 10, Appendix Seven).

**SUMMARY OF DEVELOPMENTAL DIFFERENCES OVER TIME**

Different emotional states were experienced by the two groups of women, who differed in age, in this study. These differences were related to the different developmental stages of life the women were experiencing as well as other factors to be discussed later. Both groups were experiencing the same event, the commencement of a career in nursing; both groups therefore were experiencing an awareness of alterations to their construct systems. Because of developmental differences, however, the variations that occurred were of different intensities and character. Older women proved to be confronted with more unconstruable events than younger women and from different sources. They also were more likely to continue with maintaining their old ways of construing their world, trying to anticipate matters in psychologically unsuitable ways. Older women thus experienced more anxiety from feelings of shame and guilt, as well as depression and hostility.

Younger women also experienced considerable anxiety but from different sources; the fear of death and
mutilation. Their experience of the transitionary event was generally more positive. They received frequent validation of their constructs and derived much satisfaction from friendship groups and other forms of social interaction.

My anticipations that women's developmental stage of life affects the transitional process were validated. Other factors, including professional role, were also predicted to affect psychological processes during transition and these will be discussed in the next chapters.
CHAPTER 9

PROFESSIONAL ROLE INFLUENCES ON TRANSITION
PROFESSIONAL ROLE INFLUENCES ON TRANSITION

DIFFERENCES ACCORDING TO PROFESSIONAL ROLE

It is proposed in the model of transition that the role undertaken by people experiencing change will act as a mediating factor of the transitionary event. It is the purpose of this chapter to examine the implications of professional role upon the women involved in this study and its effect upon the way they deal with the change occurring in their lives.

Professional role, as discussed here, is the traditional sense of role as a socially prescribed course of action, rather than the personal construct definition of role. In this study, professional role may indicate the role of hospital employees or may refer to university students.

Professional role was found to be an important and significant aspect in undertaking a course in nursing and the predictions were supported that hospital employees would experience higher levels of anxiety, anger and feelings of helplessness than supernumerary university students. Predictions concerning the sources of anxiety were also upheld; the hospital cohort experienced higher levels of shame, guilt, diffuse and separation anxiety. Professional role was thus related to the invalidation of constructs and was a significant
factor in the transitional process.

Role, in the personal construct sense as defined earlier in this study, may be said to be interpersonal relating based upon the understanding of other people (Leitner, 1985b). Although the social interaction encountered in nursing does not imply a similarity in constructs it could be expected that registered nurses, who have experienced a similar transitionary process during the course of their own training, may have at least a meaningful picture of these women's construct systems. Like all relationships, professional relationships have the potential to vary, from little to a high level of understanding of the other persons' constructs.

EXPERIENCES OF HOSPITAL EMPLOYEES

Anger and Anxiety

An examination of the transcripts of interview reveal that much of the anger experienced by the hospital cohort was a response to the perceived absence of understanding from the registered nurses. Many of the women commented, "No one helps you, they just don't care" and "No one says anything to you when you do your best but, even if little things go wrong, they give you a bad report". Others spoke of the lack of personal warmth and support from senior nursing personnel, stating, "You don't feel as if you belong. You are the outsider and don't belong
Menzies (1988) writing of the hospital apprenticeship training in the United Kingdom, contends that it is not so much a matter that senior nursing staff do not care. She suggests they understand only too well and indeed have vivid memories of the personal agonies of their own training. They lack confidence, however, in their ability to handle emotional stress in any way other than by repressive techniques.

Although these senior staff could function within operational relationships, traditional nursing roles and relationships which require discipline and reprimand from senior to junior nurse, had not prepared them to handle closer more supportive relationships in the work environment. Menzies (1988) states, "They tended to fall back on the only behaviour they knew - the discipline and severity they experienced in their own training" (p. 113).

Supporting evidence for a lack of team spirit and caring may be found in an Australian study conducted by Booker and Rouhainen (1981). These researchers found that a lack of support from other nursing staff contributed to the anxiety and stress levels of hospital trainee nurses. In my observation, lack of care for junior staff is accepted behaviour in hospitals where nurses tend to pursue their own tasks with scant regard for colleagues.
Caring is reserved for patients. The nursing service organisation generally does not facilitate care, or collegiality, between staff in the ward unit.

It has been noted that many nurses enter the profession with the perception that hospitals are kind and supportive organisations (Menzies, 1988). The hope that this might be the case was expressed by one of the younger hospital employees who stated, "You don't need anything too grand, just someone to smile at you, a friendly face that's all". Another young woman, however, was more critical and said angily:

They don't explain - they wait until you do it and then tell you that you are wrong and say "we don't do it that way here". They seem to have forgotten what it was like for them when they started. They seem to be waiting for you to do something wrong so they can have a go at you for making a mistake. I mean they are supposed to be caring for the patients aren't they? and it seems to me, it would be better to tell you first.

Their anger and hostility was an indication that they had not accepted the harsh reality of the professional nursing world; that others could understand their situation but fail to assist them. They had failed to confirm their predictions about the nature of nurses but continued to seek validation of their beliefs.
Guilt and Shame

It has been stated that nursing is the only profession which expects its new practitioners to be as skilled as its experienced ones (Dean, 1982). The high expectations of senior staff exacerbates feelings of guilt in junior nurses, who fail to see themselves as learners in their desire to function at the level of experienced practitioners. It has also been noted that senior nurses' expectations promote feelings of inadequacy and increase stress and anxiety in junior nurses (Selleck, 1982). Anxiety, resulting from feelings of shame, was experienced by the women in the present study when they failed to live up to the registered nurse's unrealistic standards. Common statements from the women included "You think of the things you should have done and the things you may have done wrong" and "I'm so slow with any work. I know they won't be happy but I'm scared". Trainee nurses, particularly in the early learning phase of tasks, frequently suffer embarrassment and high levels of anxiety resulting from lowered levels of self-esteem (Kushnir, 1986). This is exacerbated by the presence of patients and more senior colleagues observing them as they perform their tasks.

Other sources of anxiety were also present. As I have shown in an earlier chapter, the sources of stress in a hospital are numerous. Nurses face heavy demands, not only in task performance but from patients requiring
compassion and sympathy. It also has been stated that they are frequently expected to do the impossible in the way of providing comfort or cure (Menzies, 1988).

Patients are sometimes difficult and nurses often find themselves getting angry and resentful - feelings which, in turn, increase further feelings of shame and guilt as they fail to live up to expectations.

Uncertainty

Uncertainty in the clinical area was caused by the unexpected and new situations they encountered in their rotation between the region's four hospitals. The largest hospital in the group was used as a referral centre for patients requiring more specialised care and its staff had a reputation for unfriendliness towards the students. The women repeatedly expressed their uncertainty about their ability to function adequately at that particular clinical placement. "I am a bit worried, "X" hospital is a busy place and I think they will expect much more of me" was a typical comment. Others were concerned that they would be unable to deal with the amount of work. One woman stated, "You're so busy in the hospital - you are apprehensive at first just getting to know the place and finding out where things are" and another said, "I don't know what they expect of me".

Uncertainty was also experienced with regard to academic work, particularly by the younger women. Unlike
their older counterparts, they did not experience shame or guilt feelings to any significant degree but frequently expressed their anxiety with respect to the amount and extent of the work. The uncertainty indicated an awareness by both the younger and older women that their construct systems generally were ineffective. They had difficulty in predicting events in the new and changing environment they found themselves in.

Loneliness and Isolation

A further significant source of anxiety was separation anxiety or feelings of loneliness and isolation. These generally occurred because of the rotation of students to the varied clinical placements, which could last for lengthy periods of up to six months. Although every effort was made by administrators not to send women with commitments away from their families on lengthy placements, this was often unavoidable as clinical experience had greater priority. The nurses' home, which provided accommodation for these women, was stated by many to be a lonely place, particularly by women from country areas who were missing their families and their close knit communities. The younger women also experienced feelings of homesickness and isolation as a result of separation from their family and friends.

Feelings of isolation also occurred as a result of demands imposed by the academic workload. Younger women
found it necessary to curtail social activities and married women had less time for interaction with their families. Married women often spoke of the feelings of isolation they experienced as a result of antagonistic or simply disinterested husbands. One stated, "My husband doesn't really like me doing it and, if I come home in tears, he just tells me to leave. He doesn't want to know or discuss my problems." Others spoke of their husbands fears, "My husband isn't very helpful. I think he's afraid that I will be "above him" so he doesn't want to know. He is afraid that I will change."

It was evident that not all husbands shared or supported their wives ambitions to pursue their chosen career. When marital partners do not share common constructs for interpreting experience there is a possibility that the relationship will be weakened (Neimeyer & Neimeyer, 1985). The lack of ability to accommodate change can cause invalidation of constructs and therefore increase feelings of anger and distress.

Others expressed feelings of isolation which they had experienced as a result of the lack of professional support when they were in need. One woman told the following poignant story:

You need someone to talk to, someone who will listen and understand. When I was in theatre, a little boy died and I was so upset I rang him at work but he didn't understand. But that little boy could have been my son, he had blond, curly hair and blue eyes and he was so
lovely. It was terrible, really terrible. We did everything we could, we fought for his life and then he died, just died. And there was nothing to see, just a tiny scar and he was dead.... And there's no one to talk to, no one. I can talk to you now and it helps just to get it out of your system. But, at the time, there was no one, no one at all. Well there 's other staff but you don't talk about it at work because you can't. You have just got to get on with the job and do the best you can. But its bad, really bad....You really need someone there, a counsellor or someone, just to talk about things.

This interview exemplifies the feelings of anxiety, loneliness and despair experienced by people practising as nurses. They are confronted with the reality of death as few people are and yet rarely receive any support. The helplessness and despair, recorded by the subject of this interview, was an indication of her inability to meaningfully interpret and predict events, particularly the death of a child.

Helplessness

Significant feelings of helplessness were experienced by the hospital group. Helplessness is a common feeling in nurses. By virtue of their female gender and the nursing sub-culture, they have been socialised into being dependent, rather than independent, practitioners (Muff, 1982). The majority of these feelings were a result of the women's perceptions of powerlessness regarding their choice of ward placements. Although they could, within reason, request their choice of hospital, the
registration authority requires the fulfillment of certain clinical criteria so, in reality, choice was limited. All student nurses, regardless of their status, were required to gain this specified clinical experience. As employees, the hospital group were allocated to work for lengthy periods in comparison to the college group, who were only required to fulfill specific, but brief, learning experiences. Younger women were particularly resentful. Typical comments which experienced their concern included:

You are thrown into so many different areas. You finally get to know an area and then you're moved on and you lose your confidence and you have to re-learn everything again when you're moved, you have to start all over again.

Shiftwork was another source of helplessness, especially night duty which was very unpopular with younger women, especially for lengthy periods. Although a range of coping strategies may be tried, nurses usually find shiftwork stressful (Vaslamatzis et al., 1985) and night duty is generally disliked (Milne and Watkins, 1986).

Rotation to specific specialised clinical areas was a further source of concern; some actively disliked maternity nursing, a few were overwhelmed by the hopelessness of the sick, elderly and others disliked operating theatre or intensive care unit. Some doubted their coping abilities and others gave accounts of succumbing to illness or accidents as coping mechanisms; while still others put their faith in an all-powerful God.
The anxiety and helplessness suffered by work-stressed nurses has been well documented (Gillespie and Gillespie, 1986). Similarly the effects of new or novel clinical experiences (Hover, 1974). Much of this anxiety is a result of dealing with patients and relatives, in understaffed areas, leaving little time for emotional support for the patient (Dewe, 1986). One of the young women agitatedly stated that she felt helpless at times when confronted with critically ill patients "I held her hand" she said, referring to an incident when she was the only (and very junior) nurse on duty during the night sisters' supper-break "I didn't know what else to do, she was in such pain and I thought she might die. I was scared, I felt I should have done something but I just didn't know what to do."

The hospital-based employees had no choice but to accept the conditions imposed by the hospital administrative system. Choice is a crucial factor in enhancing feelings of control (Langer & Rodin, 1976) and many nurses feel trapped and vulnerable due to their sense of powerlessness (McCurdy, 1982). The feelings of helplessness, uncertainty and anxiety experienced by the group was a result of the invalidation of their belief concerning their ability to control their lives. As one woman stated succinctly, "It's a strange place. Instead of me being in control, it [the hospital] had me in control. I found it pretty hard to handle at times."
CHANGES DURING THE TRANSITIONAL PROCESS

Professional role differences, as they occurred sequentially over the five interviews, give an interesting insight into the change process as it was experienced by the women, from the perspective of their different roles.

Separation from friends (Figure 1, Appendix Eight), which occurred as a result of the rotating clinical placements, was a concern for the hospital cohort. During the initial introductory academic block and the first clinical placement, strong, friendship ties were formed. The women were very conscious of their role as the "new nurses" and, they were very supportive to each other, both on and off duty. Commencing at the second interview anxiety about separation from friends became a feature of the hospital cohort, although no explanation is available for the decrease at interview four.

A complicating factor was that a small group of the young women, due to assessment regulations, were ineligible for entry into the same academic study bloc with the remainder of the cohort. The enforced separation from friends had caused high anxiety and feelings of a lack of control. One of the "culprits" said sadly:

I miss the others - we all miss the others. Its bad if you can understand. It had to happen but you miss them. The others are a nice group and they all feel embarassed and they try to help.
Its just that they are strangers and its not the same.

Overall and general diffuse anxiety levels, which had slowly subsided as the hospital cohort gained mastery of events, increased at the last interview as did feelings of anger (Figures 2, 3 and 4, Appendix Eight). An examination of these reveals that many of the younger hospital employees felt anxious about their ability to function as registered nurses. Feelings of uncertainty, however, did not increase (Figure 5, Appendix Eight). The women were feeling the stress of the last academic block, which contained a comprehensive range of subjects. Relationships suffered and tempers were strained, as a result. Many reported difficulties in their personal life and were resentful of the demands of the course. One woman complained:

Its very hard. I think if I knew what I know now, I would have thought twice about starting. I have found it really hard the last six months to cope with every thing. It is not anything in particular. It is the whole lot clumped together. I think it affected the family through my doing nursing. I have not got time for them and now that the time is coming up I am losing them. Two of my kids have left home and the guy I was going out with for three and a half years well he has gone because he was fed up with my studying.

Feelings of helplessness (Figure 6, Appendix Eight) which had arisen as a consequence of the transition did not entirely subside. This was predictable, as the final
registration examinations were drawing closer. Happily the feelings of shame experienced by the hospital group subsided by the occasion of the final interview (Figure 7, Appendix Eight) and the transcripts revealed that, as senior nurses, their perceptions of their status were more positive. Feelings of guilt were still evident, however, (Figure 8, Appendix Eight) as the women continued to set high standards for themselves. Many of the younger, hospital nurses particularly, felt anxious about their ability to function as registered nurses.

At the final interview, the majority of the hospital group expressed sadness about the anticipated loss of friendships which would occur at the completion of the course. Although most had chosen to remain in the hospital environment, they were allocated to different areas of work experience. Many had been offered employment out of the local area and some of the younger women had made plans to travel. Others were to be married after graduation and, inevitably, old ties would be broken. Their construing of themselves as members of a tight cohesive group was changing. They became aware of the new concerns that completion of the course would bring. One young woman stated:

I’m going to miss everyone, I really am. I can’t believe it’s nearly over and we’ll soon be going our separate ways. I wonder what everyone will be doing – we’ll have to have a reunion. We were all talking about it the other day – we’ll have a reunion every two years just to keep in touch.
By comparison, the amount of construct invalidation experienced by the university students was not as high. Total anxiety and some uncertainty were experienced but at lower levels (Figures 2 and 5, Appendix Eight). Similarly to the hospital employees, they experienced anger when confronted with evidence that their constructs were no longer applicable (Figure 4, Appendix Eight). Feelings of helplessness were also evident (Figure 6, Appendix Eight). University students were often overwhelmed by the academic component of the course, in particular the frequently occurring assessment requirements. Anger was frequently expressed in response to what they perceived as excessive academic workloads. This was the first intake of nursing students into the tertiary sector and, in their anxiety to gain academic credibility, many teaching faculty imposed onerous evaluation schedules on the initial participants.

The clinical area, however, was much less stressful. Hospital-based nursing students are subject to service demands when caring for their patients, whereas university students are not part of the workforce. They thus do not experience the amount of anxiety-creating incidents discussed previously by both Dewe (1986) and Selleck (1982), as characteristic of the hospital learning environment. University nursing students gain their clinical experience during hospital placements but
with the benefit of full-time student status, which has been said to remove much of the stress experienced by those with employee status (Owen, 1988). They are thus spared the trial and error learning characteristic of hospital employees (Owen, 1988) and the role overload and lack of support identified by Booker and Rouhiainen (1981) as a major source of stress amongst hospital personnel.

The characteristics of an ideal learning environment include a minimum of stressful encounters, learning experiences sequenced to allow the student to progress from the known to the unknown, and the opportunity for supervised student participation (Selleck, 1982). The clinical component of the university nursing programme included these features and every effort was made to provide a supportive environment by experienced clinical teaching staff. Time for discussion, rather than a task oriented approach, and praise and encouragement, rather than criticism and unrealistic expectations were key features of the university clinical programme. The slower introduction of students to stressful ward situations provided a greater opportunity for the students to develop appropriate constructs.

Full-time student status has many advantages for individuals participating in nursing programmes. Students within a higher education setting have greater opportunity to mix with people their own age, and share
ideas and experiences rather than being oriented to sick people from the start. Tertiary nursing education allows career progression and an opportunity to broaden horizons (Owen, 1988); factors which are reflected in lower attrition rates for the graduates (Bell, 1989; Owen, 1988). The university setting, without the responsibility and accountability of total patient care but with graded exposure to new situations, provided a safer learning environment for these neophyte nurses. Their lower levels of negative emotions are an indication of the decrease in construct invalidation experienced by the university cohort.

SUMMARY OF THE EFFECT OF PROFESSIONAL ROLE

The changes in emotional states, which occurred during the transitional event as a result of professional role influences, are indications of the restructuring of the women's constructs over the length of the course. As predicted, professional role differences accounted for many of the changes which occurred during the nursing course. The experience of being employees, resulted in these women placing different constructions on events than the university students. They had been unable to anticipate effectively and had clung to constructs which were no longer realistic in the new situation. As accountable employees, the women, working within the framework of their own personal world-view, were required to make sense of the myriad of new events inherent in an
established and firmly entrenched system. New elements had to be admitted to their construct systems; changes made which would enable them to make sense of the patterns of human behaviour with which they were confronted. The amount of construct change in university students was insignificant by comparison. Construct invalidation was at lower levels and consequently the transitionary process was less stressful.

The psychological cost of transition was especially high for hospital employees, confirming previous research revealing the stressful nature of "apprenticeship" type training (Booker and Rouhiainen, 1981). It has been noted that nursing involves a strong sense of personal responsibility and nurses discharge their duties at considerable cost (Menzies, 1988). Some of the events the hospital employees experienced, however, were common to all the participants. These events occurred over the length of the nursing course and required many revisions of the women's personal worlds. Changes over time, and certain individual experiences of transition, will form the basis of the final chapters in this exploration of change.
CHAPTER 10

THE INFLUENCE OF TIME ON TRANSITION
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EXPERIENCES AND NEGATIVE EMOTIONS OVER TIME

The dimensions of transition must perforce include the concept of time. The essence of time is that it brings change; it alters things and ushers in what is new and unpredictable (Salmon, 1985). The length of time during which an event takes place is therefore important; parameters are set for the participant’s experience and changes occur which are significant. Changes over time which were significant in the present study were the effects of cognitive anxiety, anger, depression and helplessness (Figures 10.1 to 10.4) positive affect, origin and sociality (Figures 10.6 to 10.8). A further significant aspect of this transitional event resulted from anxiety about death (Figure 10.5).

The experience of the combined groups, regardless of developmental stage or professional role, was a result of a common experience and certain themes and patterns emerged which merit examination. As stated in earlier discussion, the importance of the transitionary experience is in the meaning it contains for the participating individuals. This does not preclude, however, the teasing out of commonalities for further discussion and future application.
Uncertainty

Cognitive anxiety or uncertainty reached its highest levels in the initial interviews (Figure 10.1) and was indicative of the novel situations the women experienced. They were aware of the ineffectiveness of their previous constructs but were unable to impose structure and meaning on the new situation. For many of the hospital cohort, the clinical area was a changing source of uncertainty and apprehension. During the first placement there were low performance expectations. Senior hospital staff had indicated, however, that following their return from the second study block, they could be expected to assume greater responsibilities. Many lacked the confidence at this stage to deal with the increased accountability expected of them. Feelings of doubt arose and many experienced guilt and shame. One woman said "They expect a lot and I'm not sure that I'm ready" while another commented "its a problem - the responsibility I mean. Its something you have to be conscious of all the time." Many comments were made regarding the uncertainty of their next clinical placement, how they would cope and their anxiety was exacerbated by the rotation between the hospitals. One woman stated:

I'm getting a bit nervous about starting at "X" hospital. I'll be the only one from my group.... its all so new and you don't know what's expected of you.

Predictably, these feelings, together with the uncertainty engendered by the introduction of new
Figure 10.1: Mean Cognitive Anxiety Scale Scores for all women over five interviews.

Figure 10.2: Mean Hostility Outward Scale Scores for all women over five interviews.
subjects into each successive study block, subsided to base levels by the completion of the course.

Uncertainty was also experienced by the university students, though for different reasons. Some of their anxiety arose from the novel situations they experienced in the initial stages of the course: the complexity of study and the adjustment to university life. A further, and major, cause of uncertainty arose from the transfer of nursing education courses into the tertiary sector. The sample, drawn from students in the initial intakes, were caught between the crossfire of divided professional and public opinion regarding the wisdom of the transfer. They experienced doubt with respect to the credibility of university nursing courses and were critical of the amount of clinical experience in the programme. This anxiety decreased as the students expectations regarding the course began to change. In time, with increased knowledge and experience, they were able to modify outmoded constructs regarding nurse education and accept the format of the new curriculum.

Anger and Depression

Varying levels of anger and depression were an important aspect of the transitionary process. Some initial anger was experienced by university students, who expressed a preference for the more traditional hospital-based nursing training. An examination of the transcripts
revealed that this subsided by interviews two and three, as students accepted the inevitability of the transfer of nurse education to the tertiary sector. Other sources of anger, whether expressed openly or as depression, increased significantly after the first and second interviews but subsided by interview five. Hostility and depression were initially manifested by students who found the experience of the transition from school to university overwhelming. Many commented on the differences between high school and university. One student stated, "It's a good place but no one cares if you are there or not" while another said:

I’m a bit confused. I guess that coming from High School, well, you’re a big person in sixth form - the tops if you know what I mean. Now you’re at university and you’re at the bottom so to speak and it's a bit hard to deal with. That’s one of the biggest things I’m having trouble with at the moment.

Anger was also experienced by the hospital employees, together with feelings of anxiety. The sources of the anger were twofold; the academic component and the clinical area. A change in assessment techniques had been introduced in the regional school programme, focusing on progressive evaluation rather than examinations. The workload was high and the older women, particularly, struggled with the seemingly excessive amount of written assignments which were very time consuming. Many expressed their anger, particularly in the younger cohort. One young woman stated indignantly:
Every hour is booked, every second of time accounted for. It's unreal the amount of work they cram into this course - the amount is incredible. You have to neglect people for things - well I don't like having to do that - neglecting my friends I mean. You have an obligation to keep up friendships and I don't think a course should interfere with that.

It was apparent that the women's constructs regarding their ability to successfully combine nursing and a normal family or social life were not validated. The introductory block had been comparatively easy; they now realised that if they wished to succeed, hard work was inevitable. Failure resulted in exclusion from the course and, as one person stated angrily "You have to do all that study and then, if you don't pass, you get kicked out. It's not fair!"

Helplessness

Feelings of helplessness, unpredictably, continued to rise over the length of the course (Figure 10.4). High scores for helplessness are usually associated with the negative affects of anxiety and depression (Westbrook & Viney, 1980). In the present study (Figures 10.1 and 10.3) these decreased after interview two, but it must be remembered that levels of total anxiety and depression still remained above the norm, even at the final interview. An examination of the interviews reveal that the majority of high scores arising from feelings of helplessness, originated from the effects of professional
Figure 10.3: Mean Hostility Inward Scale Scores for all women over five interviews.

Figure 10.4: Mean Pawn Scale Scores for all women over five interviews.
role. It had been anticipated that changes over time would occur for feelings of helplessness but my expectation was that there would be a decrease by interview five. The higher than normal anxiety and depression levels offer a partial answer. An examination of the transcripts reveals that the explanation is complex, involving many different factors. Some of the women experienced personal problems which exacerbated their feelings of not being in control of events. A few had health problems, often of a quite serious nature, while others confided of family situations which were causing them concern. It has been noted that the multiplicity of problems confronted by working women, in their busy lives, are at times simply overwhelming (Green, 1987).

An examination of the interviews suggests that the area of greatest concern and the reason for the continued feelings of helplessness, related to the hospital employee and the clinical component of the course. The many complexities of this particular facet of the transitional event have been discussed at length in previous chapters. A further problem, relating to the hospital cohort and concerning the approaching registration examinations, is also documented.

University students also experienced a feeling of a lack of control over events which generally were related to personal situations. Parental conflict was a frequent
and reoccurring problem, which appeared to arise as a consequence of the full-time student status and therefore, financial dependency, of these women. Due to the high accommodation costs of independent living, many of the students found it necessary to return to live in the parental home and conflict arose when parental control was reimposed. Mother-daughter clashes, were common, as evidenced in the following example:

Mum still carries on and it's no use me arguing with her - I haven't got the money to move out. I can't please her whatever I do so I just switch off.... I really can't do anything else at the moment - that sounds like I'm taking advantage of them, I know but it will be worse if I try and move out.

Other incidents which were construed as not being within their control were relationship problems and illness. Many reported accidents and injuries, particularly, during periods of stress. Their inability to exert control over their lives was an important aspect of the transitionary event.

Fear of Death

Important changes occurred in anxiety relating to fear of death and, as predicted, this anxiety diminished over the length of the nursing course (Figure 10.5). Anxiety about death is common in nurses and is a source of much anxiety and stress (Menzies, 1988). Contemporary nursing programmes are more cognisant of the needs of nurses and generally include opportunities for enabling them to talk
Figure 10.5: Mean Death Anxiety Sub-scale Scores for all women over five interviews.

Figure 10.6: Mean Positive Affect Scale Scores for all women over five interviews.
Figure 10.7: Mean Sociality Scale Scores for all women over five interviews.

Figure 10.8: Mean Origin Scale Scores for all women over five interviews.
about death-related matters. In this way constructs regarding death may be examined, the objective being that fear may be resolved and seen as an inappropriate response to thoughts of death (Combs, 1981). Both nursing educational facilities offered experiential workshops of this nature and student evaluations revealed the success of this teaching strategy, which is documented in the literature, as reducing fear of one’s own death (Campo, 1980). This supportive environment enabled the women to explore their feelings about death and discuss methods of coping. A slight rise in death anxiety occurred on the occasion of the fourth interview, when the hospital cohort were assigned to intensive-care units or accident and emergency wards; all acute-care clinical areas, where many deaths occurred.

EXPERIENCES OF POSITIVE EMOTIONS

Satisfaction, Friendship and Achievement

Other significant changes involved the feelings of positive affect and sociality. The decrease in these positive emotions over time, occurred after the first interview (Figures 10.6 and 10.7) and in the case of sociality, reached a plateau by the occasion of the third. There was a significant increase, however, in the women’s feelings of achievement and control (Figure 10.8).
As discussed earlier, opportunities for continuing friendships rapidly diminished with increased course and employment demands. There was little opportunity for sustaining old friendships or for initiating new ones. Lack of leisure time has been noted as a contributing factor to stress related problems in other students (Vitaliano, Russo, Carr, and Heerwagen, 1984). The decline in satisfactory social relationships contributed to the decrease in feelings of personal satisfaction noted in Figure 10.6. Interaction with others in joint leisure activities is a contributing factor to positive affect (Argyle, 1987), and it has been noted that increases in social contacts lead to increases in happiness (Reich and Zautra, 1981).

Happiness and satisfaction increased on the occasion of the last interview. This was associated with feelings of achievement (Figure 10.5), thus supporting the claim by Westbrook and Viney (1980) that people's perception of themselves as determinants of their own behaviour is generally associated with other positive feeling states. The statements made by the women indicated their pleasure in overcoming the difficulties they experienced in the course. They expressed new found confidence in their abilities and reflected an optimism for the future. One young woman said proudly "I've coped well, I've become organised. I know now that I can do anything I want - within reason that is." Although final examinations were still to be faced, the majority of the students,
particularly the older women, expressed a new found confidence in their abilities to cope with academic pressures. One woman said "I’m not too worried about the exams. I think to myself, well I’ve got this far and I’ll make sure I get there now!"

Events were no longer outside the range of their constructs; they had learned how to surmount the obstacles facing them. Each progressive academic success lead them to place new constructions on events - they now perceived they could successfully complete the course.

One woman stated:

I’m confident now. Like I said - I never was brilliant but I’m getting through and that is the main thing. When I was at school we did not do assignments and things. I left school early but I’m learning now. I’m getting to know more of what you want and I understand what I’m doing and talking about.

These feelings of being in control spilled over to the clinical area. The hospital cohort were now senior nurses and conscious of their status in the hospital hierarchy. They made comments such as "I feel confident at work now" and "I feel I can handle it now".

SUMMARY OF IMPORTANT CHANGES OVER TIME

Although uncertainty was a feature in the initial stages of the course, this diminished over time to below
commencement levels. High levels of anger, directed inwards and expressed as depression, was evidenced over the length of the course but this also decreased to below the level evidenced at the first interview. Overt anger or hostility, however, increased and remained at a higher level than when the transitionary event was commenced. Feelings of helplessness increased to higher than commencement levels but some evidence of a decrease was apparent at the final interview.

Because of the high demands of the course over the three years, the opportunities for social interaction diminished and associated feelings of satisfaction also declined.

These results were not unexpected and reflect the changes which occurred in the participant’s construct systems over the length of the course. In addition to the invalidation of constructs, validation was also experienced over time. Emotional states associated with feelings of achievement were evident and reached higher levels than at the first interview. Associated feelings of happiness and satisfaction were evident at the final interview.

These effects will have future consequences for the women in this study. It has been stated that transitions are periods of vulnerability but that they also offer increased potential for growth (Viney, 1987a). Continuing
development is ensured by people's changing constructions of events. Bannister and Fransella (1987) state that construct systems are guides to future living, so that the changes experienced by these women will influence their future. Despite their stress and general turmoil it was evident, from their increase in confidence, that this process had commenced. As they looked back over their success and the achievements over the duration of the course they perceived they had overcome many difficulties. One woman spoke on behalf of many when she stated:

I have achieved something and I'll never feel so proud again. I've worked so hard and learned so much and at last - I've made it.
CHAPTER 11

PERSONAL CONSTRUING OF TRANSITION
The discussion so far has focused on the identification of common themes and patterns of construing of women in transition. Personal construct psychology, however, is a psychology of personal meanings and constructivist research attempts to differentiate between people, to make the individual stand out in clearer perspective (Kelly, 1979b). The women in this study differ from one another, not because there are differences in the transitional event they seek to predict but because there are different ways to view similar events.

Salmon (1985) states that, "each of us lives a story that is ours alone" (p. 138). The participants in the present study were responsible for constructing their own interpretation and meaning of events. Their understanding of the process they experienced has implications for their future predictions and may assist other women who choose nursing as a career. It is necessary, therefore, to examine the private worlds of the participants so that we may understand the unique construction people place on events. Their thoughts, feelings and beliefs as they experienced their chosen career of nursing should facilitate our understanding of individual construct patterns and processes.
GUILT AND UNCERTAINTY IN A YOUNG WOMAN: CAROL

The first example of an individual's experience indicates the psychological cost of change, the discomfort of trying to make sense of a changing world. Carol's story illustrates the lack of confidence experienced by some women when facing change in their lives, their low self-esteem and feelings of guilt when they do not live up to their self expectations.

Carol was 29 years old and had enrolled in the nursing course approximately six months after her return from a working holiday overseas. Before her overseas trip, she had been employed in secretarial duties but had been unable to find suitable employment upon her return. Seeing the invitation for mature-age applicants for the hospital course in nursing she remembered a long-ago unrealised ambition to become a nurse.

She was extremely anxious, uncertain and found it difficult at times to construe the new events she was experiencing. Much of her anxiety was related to feelings of guilt and it was also apparent that she had difficulty in processing the wide range of subject matter in the course. Viney and Westbrook (1976) refer to this as cognitive anxiety or uncertainty. She confided that she thought, if she worked hard, she was capable of passing but was very aware of her disorganisation and tendency to procrastinate. She frequently expressed her uncertainty
Quite frankly I am scared because it's years since I left school and I am panicking about these exams looming ahead. I may just scrape through but I haven't got a study routine. And I haven't got determination, or strength of character to get into the books.

Carol was also very aware of the importance of her relationships with others and experienced guilt and anxiety when she found these difficult to maintain. At a later interview she stated:

I've become a fair-weather friend these days. I never see my friends because I am always having to study. The course is very concentrated.... There is so much to get through and I think I've lost a few friends.

She continued with her fears and doubts until the occasion of the last interview.

I need to go home and sort out things in my mind. I feel I am running out of time to do that. The exams are everything at the moment. I've been stuck at home with my books and I was cramming. I do it every time. I cram. It would be so much easier to sort out a study plan.

The guilt she expressed with regard to her inability to set a study plan and the continued use of cramming as a study technique occurred because her actions were in conflict with her constructs about herself. When we find ourselves doing those things we would not have expected to do if we were the kind of person we always thought we were, then we suffer from guilt (Bannister & Fransella,
Carol perceived herself as an "orderly" person who is capable of doing the "right thing" such as organising study plans and who is therefore prepared for examinations, hence her guilt. Her sense of shame was evident when she spoke about her feelings of insecurity. She was conscious that some lecturers construed her as attention seeking and overly anxious but was unwilling or unable to stop her behaviour.

Since her successful completion of the course and subsequent employment as a registered nurse Carol, although inclined to make the occasional self-disparaging remark, gained confidence. She stated that the process of becoming a nurse was the most difficult experience she had ever encountered.

RELATIONSHIP LOSS IN THE PURSUIT OF A CAREER: YVONNE

Many of the older women were coping with the dual role of wife and mother in addition to that of student. Yvonne was in her late thirties, married and with two children. Her story illustrates the struggle women face when trying to establish an identity and career later in life, when coping with marriage and parenting responsibilities. It was important for Yvonne to construct an identity other than that of the domestic role she had performed since marriage. When she spoke about her life, she expressed the difficulties she was experiencing in this respect.
You try to sit down and study and the kids come along and you can't neglect them, after all you are their mother and they didn't ask me to go nursing. My husband - well we have a few problems over the amount of study I have to do at home. He says: "It seems to me you're never here and, when you are here, you've got your nose in a book." I'm worried in case I don't get through and I'm frightened, in case it causes too much friction at home.

She then went to explain the importance of completing the course and becoming a registered nurse.

I married young and I never had a chance to do what I wanted to do. I mean with the kids and that, well, you just can't have a career. But I thought, now the kids are older well I could have my chance to do what I'd always wanted, make something of myself, do something for me. But its not just that easy. It's the usual story, being a wife or doing what you'd really like to do, but you have to think of the kids.

It was evident that Yvonne was ashamed of her lack of achievement in life and was determined to succeed in becoming a professional woman. This determination to forge a new identity eventually resulted in a high personal cost. On the occasion of her final interview she stated:

Well things are not really good but I'm coping. Its over, finished! He couldn't accept that I had to finish my training. He didn't understand how important it was to me. He didn't even try to understand. It was just a case of "well if you were at home everything would be different". Well its not different, I have a right to finish this, I've worked hard. I don't do marvellous but I hang on in. I've sweated, worried and I'm not
throwing it in. I know I should be at home more and I know I haven't done everything for them but I don't think they've come to any harm.

She was struggling with her guilt for not behaving as the ideal mother, devoting her time unselfishly to her children, but she was resolute in her desperate determination to continue her career. Her final comments were:

I’ll manage. I’m determined to make a career. I will do that and I won’t have to bother about men again. I cried and cried but that’s all behind me now. I’m on my own and I’ll manage. It’s me and the boys now. I just hope I get through and get a job.

Yvonne’s vision of herself as the competent career women was, unfortunately, not shared by her husband. It has been stated that an indispensable element in the construing of other people’s psychological processes involves construing them in a way in which they do themselves (Duck, 1983). Yvonne’s husband failed to support her in her new endeavour or understand that, in undertaking nursing, she was making the choice to extend her existing construct system regarding herself. Relationships develop from the sharing of common constructs (Duck, 1973), however, assistance in the elaboration of one’s construct system is also needed in healthy partnerships (Neimeyer & Neimeyer, 1985).
Invalidation of constructs in women undertaking the transition was also manifested as depression and overt anger. Many of the older women experienced these emotions in their roles as hospital employees. This story is an account of one woman who experienced these feelings but who was determined not to succumb to invalidating evidence which threatened her perception of her performance in the course. Elaine, a married woman in her early forties, was allocated to the operating theatres to work with a group of more experienced students. The operating unit nurses failed to take her inexperience into consideration and did not even give her the customary orientation to the unit. In an account of this episode during an interview she made these comments:

Theatre was bad, really, really bad. I used to get in the car going home and I'd just cry and cry. I didn't think I'd ever get through it. The experience was degrading, the way the staff speak to you. People shouldn't speak to another person in that manner. Its wrong. Why do they do it? Thank goodness for my husband he really helped me and cheered me up.

In Elaine's case the support she received from her husband helped to overcome her feelings of depression and facilitated the extension of her construct system. Elaine's feelings of shame and depression later turned to anger, which was directed at the operating unit staff, when she discovered she had been allocated to a second
I hate Operating Theatre. Its an understatement to say I don’t like it. Do you know why I cannot stand it? Because I cannot stand the people and their attitudes. The work is interesting and I don’t balk at the procedures. Its the attitude of the staff. Its degrading and I can’t stand it.

She became agitated and distressed in the telling of her story but continued:

I’ve got my own ideas about how you should be treated and I’m not going to take any more nonsense. I’ve told my husband that if I get the sack he will have to understand that its because I will have answered back. I won’t be rude or swear or shout or scream but I certainly will tell them I’m a human being the same as them. I’ve never had to act this way before. I’ve always been treated and respected as a decent human being. If others want to put up with it they can but I won’t. I know I’m a good nurse, I know it, without people having to tell me.

Elaine’s self-esteem was obviously intact. She had a high self-value and would not accept others’ constructions of her as incompetent. It has been noted by Berzonsky (1989) that some individuals manage to conserve and maintain self-beliefs in the face of what appears to be disconfirming evidence. Elaine never revised this self-construct and continued to resist any attempts to make her abandon it. It could appear that her anticipation of how she should be treated was too rigid; perhaps as a consequence of constructs which were not permeable enough to allow flexibility. An examination of
Elaine's ward assessments, however, revealed that she was generally regarded, by hospital staff, as having good interpersonal skills and adapting well to most situations. It was only in this one highly specialised clinical area that she encountered difficulty.

Her hostile outbursts were indicative of the way she chose to make sense of the confusing experience of the operating theatre placement. Because Elaine had such a strong belief in her competency as a nurse, the invalidating evidence assumed overwhelming proportions. Kelly (1979g) states that by expressing hostility, people adopt the role of active participants, rather than victims, of change. In an effort to impose structure on her world, Elaine chose to make the evidence conform to her prediction regarding her ability to function as an operating unit nurse.

FRIENDSHIP AND SATISFACTION IN NURSING: JULIE

In contrast to some of the negative experiences recounted, many women experienced great satisfaction in undertaking the course. Julie, aged 18 years at the commencement of the course, single and living with her parents, was one such person. Her story is an account of a person who liked meeting people and enjoyed the experience of university life. She was a happy and vivacious young woman who stated:
I am enjoying my career and I'm meeting heaps of new people. I'm looking forward to going to the hospitals in the next couple of weeks. I am having a good social time. I should do more work but I'm having fun. It's a good time in my life. I am going to as many functions as I can so I can get involved with different people. I'm looking forward to my work experience and I'm a bit worried about that but when I get there and meet the people it should be good. My family life is fine.

Her feelings of satisfaction and happiness with university life were obvious. As with many of the younger women, social interaction was an important and high priority. Although she had no previous nursing experience it was apparent that the clinical area held no great terrors for her and she stated later in the course:

I am happy being a nurse. I like the practical side. I like it a lot better than I thought. I expected to be worried but the people are good and they really are helpful. There is a lot of work and I have to organise myself a lot. The social life is good and I like meeting people. I have made a lot of friends. I think going to college is good though its harder than people realise.

Julie's comments indicated that she felt in control of events and was capable of organising herself both socially and professionally. It is noted that when people define a situation as subject to their control, then presumably they gain confidence that they can deal with situations in such a way as to minimise any negative impact (Krause & Stryker, 1984). Julie's success with initiating and maintaining friendships during the course served as a validation of her constructs about herself.
She enjoyed social interactions and continued to place a high priority on friendship but, as the course progressed, she developed a special interest in nursing cancer patients. Because of their prognosis and frequent admission to hospital, many of the rigid protocols are relaxed for these patients, facilitating a more natural environment. Julie said:

I like the wards but I really like Oncology the best. I'd rather do my clinical there than anywhere else. I really enjoy oncology nursing. You feel really good like you can really nurse - it's not all technical and I like that. I'll be glad when the exams are over then we are all going away on holidays together. I am looking forward to that.

Julie continued to experience the satisfaction of bedside nursing while managing to retain her social activities. In the final interview she expressed her boredom with college life and her interest in becoming the practical nurse.

I'm sick of college and all the lectures. I just can't wait to finish. I feel I have really achieved something. The whole future has opened up and I'm looking forward to it all. ....my family are excited and they keep calling me Sister....they're all so proud of me. Its a very good feeling. I've had my job interview and I start in January.

Julie had been assisted to overcome her initial fears about the clinical area by the social interaction she experienced. Friendship is important in women's lives (Hirsch & Renders, 1986) and is also considered an important factor in career development in nursing.
(Rosenow, 1982). Good interpersonal relationships are the basis for identity formulation in adolescents (Viney, 1987a). Although the self is often pictured in isolation in developmental studies, construct theory in contrast, emphasises the importance of interpersonal relationships. Kelly (1955) argues at length that people define and elaborate themselves through interplay with others, through their perception of others perceptions and through the choices that their lives represent (Bannister, 1985). University life and a career in nursing facilitated Julie in her achievement of an identity and she completed the course happily anticipating her future career.

In personal construct terms, it could be said that the social process facilitated a shared social reality for Julie. Her friends and family were important for her understanding and making sense of her world. As well, hospital staff related to the young student; her ability to relate meaningfully to patients was obvious, and although young in years, she had the capacity to understand the construct systems of the very sick. Her story illustrates the continuing development of youth and the ability of people to adapt to change. By her success in interpreting the events of the course in nursing, she had become a competent nurse and was quickly developing a credible professional identity.
INDIVIDUALS AND CHANGE

The story told by these individuals is both promising and satisfying. The results indicate the conflict many of the women experienced in commencing a career in nursing: their anxiety and uncertainty when they were confronted with events that they were unable to predict or control.

The women clearly demonstrated their capacity to deal with the new situation; the feelings of guilt and shame experienced by them were an indication of the changes taking place in their construct systems. The individual women cited in this chapter, were resolute in their determination to shape their own lives and decide their future direction and identity. Their stories are inspiring, as well as offering an insight into individual's perceptions of transition. They reveal that women are active construing people, capable of fashioning their own lives.

Individuals draw inspiration and learn from the stories of others. Although these are the women's own personal insights, I have endeavoured to make sense of them in order to increase my understanding of the transitionary process. Only through careful consideration to the details of the individual's account of transition does it become possible to construct its wider ramifications. Salmon (1985) asserts, that by tracing in detail the progress of women's life stories, other women will be able to anticipate further and future
developments. In the next, and final, chapter I will endeavour to state my anticipations and their implications for future research in the lives of women.
CHAPTER 12

ISSUES AND IMPLICATIONS ARISING
FROM A CONSTRUCTIVIST APPROACH TO TRANSITIONS
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FROM A CONSTRUCTIVIST APPROACH TO TRANSITIONS

The focus of this research has been an exploration of people's experience of transition; specifically women's experience of a course in nursing. The questions asked were, in part, a response to previous research and the predictions made were a result of my own constructs concerning women and nursing. The process of the research project has assisted me to gain fresh insights into the profession of nursing which, in my role as a nursing academic, may be useful for future discussions concerning nursing education. Equally important, it may be anticipated that the information gained from the results of this research will add to psychology's knowledge of the transitionary process and add a further dimension to the study of life events. Before proceeding with the outcomes of the research, it is appropriate to evaluate its validity as a research venture. A critical approach regarding the methodology and theoretical foundation will be taken in the first sections of this chapter. The usefulness of the proposed model and the implications of personal construct theory for the study of life transitions will next be considered. The influence of developmental stage and professional role upon the transition experience will be evaluated and the implications for constructivism and future research discussed. The contribution of this research to the development of the profession of nursing is also
Some criticism may be made of the fact that the university cohort were recruited as volunteers, rather than by the process of random selection. In this respect, the sample may represent a group of students who were motivated enough to volunteer. It is acknowledged that some bias may be evident in the findings due to this factor, although no consistent bias effect was to be found in the data.

A further criticism of the study is, that with hindsight, it can be seen that a portion of the sample was, in certain respects, atypical. The older hospital employees, with an average age of 35 years, were recruited as an entire intake of special admission (mature-age) students, rather than the usual mixed age group. This was done by the Regional Council of Nurse Education for recruitment purposes, in an area of traditional high female unemployment. As discussed previously, nursing courses normally recruit school-leavers and this older group were therefore highly visible in the conservative hospital establishment. Because of this, they were the focus of some initial suspicion in the region’s hospitals, which was exacerbated by the fact that they were "regional school" as opposed to "hospital nurses". This attitude may, in
part, have affected the content analysis scale scores at the second interview, which were conducted after the students initial exposure to the clinical area; it is also possible that some negative attitudes prevailed, to emerge on later occasions. Not all hospital staff were unhelpful, but many of the older hospital employees still perceived that they were treated differently from younger students. A constructivist approach to research must take into account that people express their own individual perception of events. The dynamics resulting from the atypicality of these participants could mean that the findings of this research may not be readily generalized to all mature age, hospital-trained nurses.

A further note of caution, for consideration, is that the university sample was the first intake in the transfer of nurse education to the tertiary sector. As such, it is probable that the students may have experienced additional uncertainty and this should be taken into any account of further comparative estimations. It is also quite predictable that their perception of events would be different to those of later students. The transition had been relatively smooth due to careful planning; but nursing courses on campus were a novelty for the Australian tertiary sector, and as such, attracted some initial teething problems.
Other factors also need to be taken into consideration. The research could, perhaps, have been strengthened by the use of an independent research assistant to conduct the interviews. The knowledge of my administrative role, as course co-ordinator, no doubt influenced disclosures made by some of the research participants. Younger students initially were hesitant to discuss matters of a more personal nature, other students, however, freely used the interviews as an opportunity to communicate their dissatisfaction with the course. Having identified this issue during initial interviews, the problem was partially overcome by instructing participants that, if they wished, I would be available to listen to any discussion relating to course matters immediately following their interview. The problem of students feeling constrained in their verbalizations may have reduced the opportunity to analyse certain elements of their experience. More detail, from the participants, regarding personal aspects such as family or social interactions, may have facilitated this study. The tendency of the participants to talk specifically about the nursing course and related factors could, however, be seen as facilitating the research as it served to focus on the specific aspect of the transition under scrutiny rather than extraneous matters. It has been suggested (Viney, 1987b) that both the experimenter and the subject contribute to the data
collection. They are influenced by their anticipation of
the research situation and the interplay of interactions
which take place.

USEFULNESS OF THE CONTENT ANALYSIS SCALES

The application of content analysis scales to the
participant's verbalizations of their lives, provided an
important understanding of the process of transition. The
use of the scales enabled a qualitative and quantitative
analysis of construct validation and invalidation which
occurred throughout the course, thus providing an insight
into the process of construct change. This has provided a
strong case for the inclusion of content analysis
methodology in future explorations of life event
research. It is noted that content analysis scales are a
very flexible tool and, because they are not situation
specific, they have the potential for use in many
different circumstances (Viney, 1981).

The value of using this method for constructivist
exploration of life events and transitions would,
however, be increased by the development of more scales
based on the concepts of a personal construct theory. The
anxiety sub-scales, like other Gottschalk-Gleser content
analysis scales are based on psychoanalytic theory and
involve the use of defence mechanisms and other
associated psychodynamics. Guilt anxiety is stated to
invoke "the unconscious need for punishment" (Gottschalk
et al., 1969, p.45) and mutilation anxiety is said to be synonymous with castration anxiety (Gottschalk et al., 1969, p38). As a constructive psychologist, I do not reject Freudian concepts as incorrect; it is, however, only one of the many alternative perspectives available to the clinician. It would seem that a methodology used in constructivist research would be better served with constructivist theoretical foundations rather than based on a psychoanalytic model. Personal construct psychology does not perceive guilt, for example, as an unconscious need for punishment. It is a property of construing, namely, the perceptions of people's dislodgement from core role structures. A content analysis scale based on this definition could only facilitate constructivist research.

SUPPORT FOR RESEARCH PREDICTIONS

The majority of the predictions made in this research were supported. It was anticipated that anxiety from many different sources would be present in people experiencing the new event of a course in nursing. Some degree of uncertainty and inadequacy was also found and, like the other sources of anxiety, was a result of the women's inability to construe events. Each component of the nursing course brought new problems and fresh changes. It was only in the latter stages, that the women were able to detect patterns which enabled them to make more accurate predictions. Success was, in part, the result of
a developmental process, the approximation of changing constructs toward the reality of the everyday world of nursing.

The Influence of Developmental Stage

Anxiety arose from many different sources, as discussed in recent chapters, but primarily, from the feelings of shame and guilt experienced by the older group. These feelings were common to older women in both the university and hospital cohorts. Thus it would appear that people's stage of psychosocial development has an influence on the constructions of new life events. It was apparent that, in the initial period, the process of transition affected the women's perception of themselves as capable people. The process of becoming students or very junior hospital employees affected their core-role constructs, their actions were now not consistent with their self-image. Even stronger than feelings of guilt, however, was their sense of shame; they were disappointed that they could not live up to others expectations, however illogical those expectations may have been. The persistent invalidation of key constructs meant they were unable to predict events; and in the hospital setting, particularly, they were no longer in control of their lives. Accompanying feelings of diffuse, generalized anxiety were also evident in these initial stages.
Developmental stage also influenced feelings of anger. Older women were more aware of construct invalidation and were inclined, initially, to persist in perservering with existing constructs, rather than forming new ones. They realised their construct systems were failing them, but at this stage, they had not arrived at new ways of coping with their new and frequently bewildering world. With the passage of time and each new experience, new perspectives were formed and their construct systems slowly underwent change, enabling them to cope with the role of the beginning nurse practitioner.

Younger women had a different experience. The invalidation of their constructs was evident in their higher than normal levels of anxiety and depression but, in comparison with older women, these were not as important. They were at a different stage of development and had different tasks to accomplish. Friendships were important, although the requirements of course work and the demands of full or part-time work, mitigated against the levels of social interaction they desired. They experienced many instances of validation of constructs, contributing to their feelings of satisfaction and happiness. As young people they fitted the expectations of their professional colleagues; they were optimistic and did not experience the same feelings of guilt and shame felt by older women. Because they did not have the multiple role responsibilities which accompany established relationships, they generally had more time
to enjoy social interactions and the other positive aspects of the course.

They were in the process of becoming adults and, by undertaking nursing, were taking a positive first step toward identity formation and the creation of self-constructs. Some significant invalidation of constructs during the transitionary process did occur: the developmental stage of life was found to affect people's concerns about death and injury. Younger women initially lacked the necessary constructs enabling them to make sense of these, and so death-related anxiety was a feature, early in the transition period, for this group. This disappeared gradually with the process of time but a higher overall level of anxiety and depression was maintained throughout all the interview occasions. Learning to become a nurse is a stressful transition, irrespective of developmental stage.

The Influence of Professional Role

Professional role influenced the process of transition, causing women who participated in the hospital apprenticeship scheme to experience anger, uncertainty and feelings of helplessness. The stressful world of the hospital environment consisted of many situations which were anxiety provoking to the new employees. Much uncertainty was experienced due to novel situations and new experiences. Their interactions with
senior colleagues were not as they had anticipated; they found the reality of the hospital world to be harsh and unsympathetic.

The high levels of emotions, signalling the invalidation of constructs, were not unexpected in the hospital cohort. According to Kelly's (1955) definition of role, people play roles when the role enactment reflects the constructions used by other people in that role. The enactment of the "student" nurse role (as hospital trainee nurses were identified) involved the organization of input from other health professionals, particularly their more senior colleagues. In the same way that people learn parenting roles (McDonald and Mancuso, 1987), women who understood the constructions of the reference group, and used these in their transition into the role of nurse, experienced validation of constructs. They were successful in their prediction about their senior colleagues reactions to their enactment of the role. But if, as happened, they failed in this and built a role construction at odds with the senior staff, then they were unable to anticipate accurately and the senior staff's responses invalidated their enactment. The hospital cohort thus experienced feelings of shame and guilt. They not only failed to act according to their own self-image but failed to meet others expectations.
The separation from friends, as they moved from one clinical environment to another, contributed to their feelings of loneliness and general despair. The requirement of the academic programme also contributed to their sense of isolation, they had no time to enjoy friends and families. In their desire to forge a professional identity, and in their striving for elaboration of their construct systems, they were required to abandon previously held preconceptions and beliefs. The bureaucratic world of the public hospital system was unsympathetic to their requirements. As a consequence personal constructs regarding the so-called "caring" profession were invalidated; they were required to adjust to a very different reality than that which they had anticipated.

It is tempting to state that some of these beliefs were central to their understanding of nursing. The superordinacy of their constructs was not assessed but the evidence suggests that for many, this was the case. There was a shared anticipation among the women concerning the phenomena of caring - a commonality of construing which was rejected by their senior colleagues. It has been suggested (Cochrane, 1987) that people form well organised beliefs about careers, based in part upon their interpretations of particular occupations. From the personal theory formed, anticipations are made; these may be either validated or invalidated. Initially the women actively resisted the evidence that confronted them and
tried hard to force events to conform to their expectations; later when faced with high workloads and what they perceived as further evidence of a lack of understanding of their needs, they again tried to restructure events to their way of understanding. Eventually, however, they incorporated the new elements required for a successful transition; the adaptation to new concepts is essential when faced with change. Their sense of helplessness remained also feelings of anxiety which, while not specifically attributable to any source, nevertheless persisted.

Overall, the women adapted well to the transition event. Depression and anger decreased, also uncertainty, but their sense of a lack of control remained. This is not surprising in view of the fact that their anxiety and depression levels, with the exception of the fear of death, remained above normal levels. The demands of the course continued to limit their social interactions and feelings of satisfaction. There were some indications that they were beginning to experience a validation of constructs, as feelings of happiness started to increase again toward the end of the course. The university students generally experienced validation of their constructs and, although construct change occurred, it did not evoke the high level of negative emotion states experienced by their counterparts in the hospital system of nurse training.
From the evidence presented in this study, I would argue that the psychology of personal constructs provides a suitable framework for the explanation of life transition processes. Personal construct psychology is a theory of people: how they interpret their experience and seek to anticipate what lies ahead, through the use of what Kelly (1955) conceptualises as personal construct systems. Kelly defines constructs as the discriminations people make in life, rather than concepts or units of logic which exist independently of psychological processes. By refraining from separating thoughts and feelings into discrete categories, he presents an integrated view of people, defining emotions as evidence of constructs undergoing transition rather than independent entities. This conceptualization allows us to observe, and measure, changes in people's construing during a period of life event transition or change.

Thus freed of traditional meanings, emotions become indicators of the ways in which people adapt to change during a particular life event transition. High or low levels of emotions signal the amount of construct change and the type of emotion, whether positive or negative, is indicative of whether validation or invalidation of constructs is experienced. Using this framework, a model of transition may be constructed which reveals the sequencing of events and the mediating influences and
experiences of transition. An existing model was available (Viney, 1980) but lacked an identifiable conceptual framework. It was my perception that certain revisions were required, such as the inclusion of important influences on the mediating experiences of people during transition. I therefore developed a revised model, based on Viney's (1980) original proposal but containing additional elements, specific to the transition under scrutiny. This proved a useful tool in the exploration of a transition process. It enabled a coherent account of the necessary restructuring of people's worlds and yet delineated the component parts of a transition event.

The women in transition, confronted with the course events, experienced certain emotional states, identified by Kelly (1955), McCoy (1977; 1980) and Viney (1980) as being evidence of construct change. The presence of statistically significant levels of anxiety and uncertainty indicated an initial reaction to change. Characteristics of the women experiencing the change and the change situation itself were identified as influential elements in the revised model of transition. These were the changes that occur throughout the life span of women and the professional roles imposed by the different modes of nurse education. Significant differences found between the two age groups under scrutiny, late adolescence and adulthood, and between the two professional groups, students and hospital employees,
supported this prediction. These elements were important influences upon the mediating experiences of the transition, the women's personal constructs. The model, which delineated the different aspects of transition, served to facilitate the measurement of each of its major features.

It may be argued that the concept of developmental stages has no place in constructivist research. Kelly (1955) is not concerned with chronological stage or task oriented development. Salmon (1977) contends that developmental stage theories do not allow for the active and anticipatory nature of people. They are stated to be static and concerned only with intrinsic factors rather than the unique nature of the individual. The usefulness of psycho-social developmental themes as an influence on the mediating experiences of women in transition is, I feel, vindicated by the fact that this allows the constructivist researcher to overcome certain problems associated with social science research.

It has been stated that our usefulness as researchers is restricted by the low generalizeability of our research findings, which are often valid only for specific cohorts (Viney, 1989b). The use of a socio-dynamic developmental approach to transition, which utilises the concept of age related tasks, serves to provide identifying themes or patterns. Personal construct theory argues that, when people have a variety
of life experiences, they develop a variety of constructs and development is related to these rather than age. A socio-phenomenological approach to life span development has found support for Erikson's (1963) approach and, although some differences are noted, states that many similarities in the heirarchical arrangement of experience-based constructs and age-related tasks have been found (Viney, 1987a). The problems associated with a developmental stage task approach may be thus minimized and the more specific predictions they provide allow a wider generalisation to other research populations.

The influence of gender socialisation on development was also taken into account. Gender theory is a contentious issue. The literary tools of constructionism and deconstructivism have alerted researchers to the sources of potential bias in this area. It has been noted that these may result in an overemphasis or underemphasis of gender differences, also many culturally based assumptions exist which are not supported by the research data (Hare-Mustin and Maracek, 1988). Gender has been recognised as an influence in the present study, based on my observation of the women and the supporting evidence of their statements. The examples given were from their perception of events, as they construed the reality of their social worlds. I was not concerned, however, with gender differences.
The concept of role may also be justified for reasons similar to those of developmental stage. Role, in my sense, is a set of socially prescribed actions and therefore differs from Kelly’s (1955) definition of role. By its inclusion it allows a more meaningful structure and so more precise predictions, especially for research into life events. In this instance, role is specifically designated as professional role, but it may equally apply to any role undertaken by the individual during a period of transition. The behaviour required of the person in a particular role and other's reactions to the role, has been found significantly to influence peoples perception of their world and ultimately, their construct system.

The content analysis scales discussed in previous chapters were effective in measuring the impact of construct change and facilitated a rigorous examination of the mediating experiences occurring in women in transition. These included the so-called negative emotions of anxiety from many different sources, uncertainty, anger, depression and indirectly, feelings of a lack of personal control. Positive emotional states of satisfaction and happiness were also invoked, and, indirectly, a sense of personal competence and feelings of achievement. Social interactions, which formed a social support system for the women were also indirectly involved. These experiences revealed important changes over the length of the three year course. These aspects of transition were present in varying amounts, depending
upon the developmental stage of the participants and their professional role.

The outcome of the cost of transition reflects the total amount of construct change occurring during the course. This may consist of high levels of negative emotions reflecting frequent invalidation of constructs or conversely, high levels of positive emotions, that is, evidence of validation of constructs. The cost of the transition was highest for older women and those who, irrespective of age, were required to undertake the additional role of hospital employees in their apprenticeship based system of training. Both these groups experienced significantly higher levels of negative emotional states: those which are equated with consistent construct invalidation. A lower or less stressful level psychological cost was experienced by younger women and university students. The younger women experienced significantly higher levels of the positive emotional states relating to happiness, satisfaction and social interactions.

IMPLICATIONS FOR THE FUTURE

Understanding the process of transition and the meaning of change for participants involved in a transition process is important for psychologists. It is also important for those who are responsible for specific transition events: the planners and coordinators of
vocational courses which are necessary requirements of our society but which are stressful in nature. Discussion focusing on these aspects serves as a conclusion to this study.

Psychological Research Issues

Methodological issues have been identified as problematic in research focusing on change (Lazarus and Folkman, 1984), mainly because of their inability to deal with process. The adoption of personal construct theory as the basis for a study focusing on a transition process has provided an insight into how people construe and deal with change. This approach shifts the focus from a concern with pathogenic effects, to the nature of the changes which occur during a transition event. It has been suggested that it is only by an emphasis on identification of the types of change which confront people during transitions, that a preoccupation with "coping with some vaguely defined levels of stress" will be avoided (Felner et al., 1983, p.209). Personal construct theory provides a coherent account of the changes which occur in personal construct systems as a result of the validation or invalidation of constructs. The use of this theory meets the need for an adequate theoretical explanation of transitions, requested by Adams et al. (1976) and Viney (1980), also the process orientation suggested by Felner et al. (1983).
Personal construct theory is an account of the active and experiential nature of people. It construes life as a process in which people constantly adapt to changing circumstances and environments. Lazarus and Folkman (1984) contend that research in the behavioural sciences is too often based on a structure based approach which is static in outlook. These authors note studies which overcome this problem, notably those which incorporate a series of assessments over time. The use of multivariate analysis of individual changes over time during the transition process in the present study provide an intraindividual perspective which takes into account the content in which the observations are made. A study of interindividual factors, those which compare a person with others, is also incorporated into this design but within the same social context. Lazarus and Folkman (1984) state that an ideal of life event research are studies which incorporate both of these factors and argues that research of this nature is essential for the study of process. Waterhouse (1984) also calls for accounts of coping processes over time, which take into account interactive effects, making a plea for an explanation which takes into account the perspective of the individual.

Personal construct psychology stresses the importance of the individual's construal of events whilst acknowledging that people who share similar constructs may have a similar experience of events (Kelly, 1955).
Research based on this theoretical model may thus be generalised if it is acknowledged that certain populations may share similar constructs, based on culturally shaped socialisation factors. A further benefit to life event research was the interview technique used in obtaining the verbalisations of the research participants. The open ended question asking the women what is was like to be them, elicited a good account not only of major events but also the relatively minor stressors or hassles of daily living. These are said to be influential in life event change as they reflect the more dynamic transition process (Rowlison and Felner, 1988). Daily uplifts or positive experiences were also elicited. These have been stated to be as important as daily hassles in their capacity as indicators of adaptation to life event changes (Kanner, Coyne, Schaefer and Lazarus, 1981). Content analysis methodology also contributes to the study of individual perspectives over time, overcoming many of the problems associated with more traditional methods (Viney, 1983c).

Implications for Nursing

The recent transfer of nursing education into the tertiary sector in Australia requires nurses to conduct evaluative research which will assist the future development of the nursing profession. The transfer, long sought by nursing leaders and educators, is vulnerable to political influences and documented comparative evidence
is required which is supportive of the benefits of tertiary studies for nurses. The present research, based on rigorous empirical methodology, strengthens the case for the continuation of the transfer of nursing education from the hospital-based apprenticeship schemes.

Nursing is a stressful occupation and nurses are subject to high attrition rates during the educational process (Bell, 1989). Studies which assist in revealing specific areas of stress are useful, inasmuch as they may motivate or mobilise preventative efforts which have as their goal the reduction of stressful aspects of transitional changes. Arguments have been advanced emphasising the need to target preventative efforts to specific areas of vulnerability in nursing, especially older students with multiple roles (Green, 1987). The impact of gender should also not be overlooked as it influences the wellbeing of professional women; many of whom, particularly those with multiple role responsibilities, do not wish to admit they are overworked, for fear of being thought inadequate (Yoge, 1982). Research, evaluating the interactions between the developmental stage of the adult learner and role expectations may contribute to the knowledge of potential stress areas in the female dominated profession of nursing. A logical extension of the present study would be an examination of the significant interactive effects between these variables, which are documented in Tables 1 and 2, Appendix Nine. This would necessitate multiple
comparisons, requiring specialised testing of the contrasts to be performed. It is anticipated that this will be the focus of a future research project.

Many areas of vulnerability for women undertaking nursing have been revealed. Professional development requires that all nurses, regardless of status, recognise the difficulties confronting both men and women who undertake the study of nursing. Nursing academics must be alert to the issues facing their students and provide study programmes which have achievable workload expectations. Students should be informed of the advantages of seeking assistance from student counselling services and encouraged to attend at identifiable, potentially stressful periods. A realistic approach to the real world of the practising health professional is required and consensus building with service personal on the development of common performance expectations should be a priority. Clinical nurses in health care settings should learn to recognise the needs of beginning nurses. Students, irrespective of their age or status, need the help which would result from a strong professional social support system (Bond, 1982). Social supports mitigate and mediate the stress of transition by offering assistance, encouraging positive feelings of social integration and access to a broader range of resources, as well as promoting a sense of self-esteem.
Implications for Constructivism

It is my anticipation that this study will widen the range of convenience, and thus the focus, of personal construct research. Adams-Webber (1981) reports that personal construct theory has been employed in evaluating the effects of certain types of professional training. Nursing, however, has not previously been a focus of empirically based constructivist research. Surprisingly, with the exception of the study undertaken by Viney (1980) neither has life event research or the study of transitional processes. There are many ways in which a constructivist model of transition may be useful in stimulating research. New content analysis scales may be created or other relevant methodology attempted. The study of people in different age groups may be undertaken and attention directed to different occupational groups. These findings may have implications for professional nurses also for coordinators of other vocationally oriented courses. Anxiety and stress has been noted in other students in health related disciplines (Bjorksten, Sutherland, Miller, and Stewart, 1983; Vitaliano et. al., 1984). Student nurses and other students may benefit from interventions designed to assist people coping with construct change. By the identification of people’s perception of events, patterns may be established and areas of vulnerability targeted for the focus of preventative interventions. People experiencing transition may be assisted with counselling directed to
loosening tight constructs. Counselling sessions enabling them to deal with disruptive emotions would also assist. Short-term psychotherapy, noted by Viney (1989b) as being useful in similar situations, could be directed to improving coping skills, enhancing self-construing, the development of new constructs and the modification of old ones.

Finally, I hope these findings have implications for those who seek to understand and predict their world. The collective experience of women seeking an identity allows us an insight into the nature of human beings and provides us with a sense of hopefulness for the future. In our desire to understand our world, to understand ourselves and others, the scope of further elaboration in our construct systems appears limitless. Personal construct theory offers each of us the possibility of change and personal growth, also the capacity to transcend situations, by acknowledging the unique ability of humans to form their own individual constructions of life.
REFERENCES
REFERENCES


Brodinsky (Eds.), *Thinking about the family*. New Jersey: Erlbaum.


APPENDIX ONE
ONSET  
(triggered by environmental change)

MEDIATING EXPERIENCES  
(thoughts, feelings & beliefs)

OUTCOME  
(cost to the individual)

CONSTRUCTS

- perceived social support
- sense of personal competence
- lack of personal control

uncertainty

anxiety

frustration

guilt
- shame & inadequacy
- loneliness & loss
- mutilation anxiety
- death anxiety
- or diffuse anxiety

anger out

anger in

positive affect

psychological cost

Figure 1 A Model of Transition
Table 1: Reported interjudge reliability for eight content analysis scales

<table>
<thead>
<tr>
<th>Average coefficient (1)</th>
<th>Range of coefficients</th>
<th>Literature source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positively toned scales</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Origin</td>
<td>0.92</td>
<td>0.91-0.94</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>0.93</td>
<td>-</td>
</tr>
<tr>
<td>Sociality</td>
<td>0.96</td>
<td>0.95-0.97</td>
</tr>
<tr>
<td><strong>Negatively toned scales</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>0.96</td>
<td>0.71-0.99</td>
</tr>
<tr>
<td>Hostility In</td>
<td>0.94</td>
<td>0.76-0.98</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>0.79</td>
<td>0.58-0.87</td>
</tr>
<tr>
<td>Pawn</td>
<td>0.90</td>
<td>0.87-0.93</td>
</tr>
<tr>
<td></td>
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Table 1 Continued:

<table>
<thead>
<tr>
<th>Average coefficient (1)</th>
<th>Range of coefficients</th>
<th>Literature source</th>
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<tbody>
<tr>
<td>Total Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.90</td>
<td>0.76-0.94</td>
<td>Gottschalk and Gleser (1969)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Viney and Manton (1973)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Schofer et al. (1979)</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>0.79</td>
<td>0.58-0.87</td>
</tr>
</tbody>
</table>

(1) Arithmetic mean of several coefficients when more than one has been obtained in one or more studies.

Table 2. Reports on the internal consistency of ten content analysis scales.

<table>
<thead>
<tr>
<th>Evidence concerning internal consistency</th>
<th>Literature source</th>
</tr>
</thead>
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<tr>
<td><strong>Positively toned scales</strong></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
</tr>
<tr>
<td>Origin</td>
<td></td>
</tr>
<tr>
<td>Positive Affect</td>
<td></td>
</tr>
<tr>
<td>Sociality</td>
<td>Subscales not significantly intercorrelated and making separate contributions to the total score</td>
</tr>
<tr>
<td><strong>Negatively toned scales</strong></td>
<td></td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td></td>
</tr>
<tr>
<td>In</td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td>Subscales significantly intercorrelated</td>
</tr>
<tr>
<td>Out</td>
<td></td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td></td>
</tr>
<tr>
<td>Pawn</td>
<td></td>
</tr>
<tr>
<td><strong>Total Anxiety</strong></td>
<td>Subscales intercorrelated differently for different samples and making separate contributions to the total score</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Generalizability coefficient</th>
<th>Literature source</th>
</tr>
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<tbody>
<tr>
<td><strong>Positively toned scales</strong></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
</tr>
<tr>
<td>Origin</td>
<td>Over 5 occasions:</td>
</tr>
<tr>
<td></td>
<td>0.22a</td>
</tr>
<tr>
<td>Positive Affect</td>
<td></td>
</tr>
<tr>
<td>Sociality</td>
<td>Over 5 occasions:</td>
</tr>
<tr>
<td></td>
<td>0.67</td>
</tr>
<tr>
<td><strong>Negatively toned scales</strong></td>
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<tr>
<td>Cognitive Anxiety</td>
<td>Over 5 occasions:</td>
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<tr>
<td></td>
<td>0.63</td>
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<tr>
<td>Hostility In</td>
<td>Over 2 occasions:</td>
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<tr>
<td></td>
<td>0.00a, 0.00a, 0.52</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>Over 2 occasions:</td>
</tr>
<tr>
<td></td>
<td>0.15, 0.28a, 0.39</td>
</tr>
<tr>
<td></td>
<td>Over 3 occasions:</td>
</tr>
<tr>
<td></td>
<td>0.30, 0.38, 0.59</td>
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<tr>
<td>Ambivalent Hostility</td>
<td>Over 2 occasions:</td>
</tr>
<tr>
<td></td>
<td>0.27a, 0.37, 0.40</td>
</tr>
<tr>
<td></td>
<td>Over 3 occasions:</td>
</tr>
<tr>
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<td>0.27a, 0.46, 0.61</td>
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<tr>
<td>Pawn</td>
<td>Over 5 occasions:</td>
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<tr>
<td></td>
<td>0.51</td>
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<tr>
<td>Total Anxiety</td>
<td>Over 2 occasions:</td>
</tr>
<tr>
<td></td>
<td>0.19a, 0.32, 0.38, 0.43</td>
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<tr>
<td></td>
<td>Over 3 occasions:</td>
</tr>
<tr>
<td></td>
<td>Over 5 occasions:</td>
</tr>
</tbody>
</table>

*For the associated F value for the occasion factor, *P*<0.01*

**Note:** From Content analysis of verbal behaviour (p.63) by L.A. Gottschalk, F. Lolas and L.L. Viney, 1986, Heidelberg: Springer-Verlag. Copyright 1986 by Springer-Verlag Berlin Heidelberg. Adapted by permission.
Table 1

Reported evidence of validity for eight content analysis scales

<table>
<thead>
<tr>
<th>Scale and literature source</th>
<th>Evidence of validity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative Toned Scales</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Cognitive Anxiety</strong></td>
<td></td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1976)</td>
<td>Independent of sex, age, but correlated with occupational status</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1976)</td>
<td>Significantly correlated with measures of other negatively toned states</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1976)</td>
<td>Significantly correlated with measures of state anxiety, not trait anxiety</td>
</tr>
<tr>
<td>Viney (1980)</td>
<td>Discriminated people in situations which were new to them from those who were not in new situations</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1976)</td>
<td>Discriminated people’s accounts of situations which were unpredictable from those which were not</td>
</tr>
<tr>
<td>Bunn &amp; Clarke (1979)</td>
<td>Discriminated relatives’ accounts when waiting for emergency medical patients from those who were not</td>
</tr>
<tr>
<td><strong>Hostility In</strong></td>
<td></td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Independent of sex, age, educational level</td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Significantly correlated with self reports of depression and fatigue</td>
</tr>
<tr>
<td>Scale and literature source</td>
<td>Evidence of validity</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Negative Toned Scales</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Hostility In Continued</strong></td>
<td></td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Significantly correlated with ratings of depression-related behaviours by observers</td>
</tr>
<tr>
<td>Gottschalk (1979b)</td>
<td>Significantly correlated with psychiatrists' ratings of depression</td>
</tr>
<tr>
<td>Viney &amp; Manton (1973)</td>
<td>Discriminated psychiatric admissions from others</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1982)</td>
<td>Discriminated chronically ill from others</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1982)</td>
<td>Predicted good rehabilitation of medical patients</td>
</tr>
<tr>
<td><strong>Hostility Out</strong></td>
<td></td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Independent of sex, age, educational level</td>
</tr>
<tr>
<td>Gottschalk (1979b)</td>
<td>Significantly correlated with self reports of anger</td>
</tr>
<tr>
<td>Gottschalk (1979b)</td>
<td>Significantly correlated with ratings of angry behaviours by observers</td>
</tr>
<tr>
<td>Viney (1980)</td>
<td>Discriminated &quot;empty nest&quot; mothers from other women</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1982)</td>
<td>Predicted good rehabilitation for medical patients</td>
</tr>
</tbody>
</table>
Table 1 Continued

<table>
<thead>
<tr>
<th>Scale and literature source</th>
<th>Evidence of validity</th>
</tr>
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<tr>
<td><strong>Negative Toned Scales</strong></td>
<td></td>
</tr>
<tr>
<td>Hostility Out Continued</td>
<td></td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Responded as predicted to experimental (psychological and drug) manipulation</td>
</tr>
<tr>
<td>Pawn</td>
<td></td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Independent of sex, age, but correlated with occupational status</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Significantly correlated with measures of other negatively toned states</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Significantly correlated with other measures of this state</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Significantly correlated with appropriate use of coping strategies</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1982)</td>
<td>Discriminated chronically ill from others</td>
</tr>
<tr>
<td>Viney (1983)</td>
<td>Discriminated unemployed youth from others</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1982)</td>
<td>Predicted poor rehabilitation of medical patients</td>
</tr>
</tbody>
</table>

**Total Anxiety**

<p>| Viney &amp; Westbrook (1982) | Independent of sex, age, educational level |</p>
<table>
<thead>
<tr>
<th>Scale and literature source</th>
<th>Evidence of</th>
</tr>
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</tr>
<tr>
<td><strong>Total Anxiety Continued</strong></td>
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<tr>
<td>Gottschalk (1979)</td>
<td>Significantly correlated with self reports of anxiety</td>
</tr>
<tr>
<td>Gottschalk (1979)</td>
<td>Significantly correlated with ratings of anxiety-related behaviours by observers</td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Significantly correlated with psychiatrists' ratings of anxiety</td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Significantly correlated with physiological measures of anxiety</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1982)</td>
<td>Discriminated chronically ill from others</td>
</tr>
<tr>
<td>Bunn &amp; Clarke (1979)</td>
<td>Discriminated relatives' accounts when waiting for emergency medical patients from those who were not</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1982)</td>
<td>Predicted good rehabilitation for medical patients</td>
</tr>
<tr>
<td>Gottschalk &amp; Gleser (1969)</td>
<td>Responded as predicted to experimental (psychological and drug) manipulations</td>
</tr>
<tr>
<td><strong>Positive Toned Scales</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Origin</strong></td>
<td></td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Independent of sex, age, but correlated with occupational status</td>
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Table 1 Continued

<table>
<thead>
<tr>
<th>Scale and literature source</th>
<th>Evidence of validity</th>
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<tbody>
<tr>
<td><strong>Positive Toned Scales</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Origin</strong></td>
<td></td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1981)</td>
<td>Significantly correlated with measures of other positively toned states</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Significantly correlated with other measures of this state</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Significantly correlated with reported use of appropriate coping strategies</td>
</tr>
<tr>
<td>Westbrook &amp; Viney (1980)</td>
<td>Discriminated those who were experiencing controllable events from those who were not</td>
</tr>
<tr>
<td>Viney (1981)</td>
<td>Discriminated youth workers from the clients they worked with</td>
</tr>
<tr>
<td><strong>Positive Affect</strong></td>
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</tr>
<tr>
<td>Westbrook (1976)</td>
<td>Independent of sex, age, education and occupational status</td>
</tr>
<tr>
<td>Westbrook (1976)</td>
<td>Independent of measures of negatively toned states</td>
</tr>
<tr>
<td>Viney &amp; Bazeley (1977)</td>
<td>Discriminated women who were moving to a new home from those who were not</td>
</tr>
<tr>
<td>Viney (1980)</td>
<td>Discriminated mothers reporting on childbearing events from women reporting on other events</td>
</tr>
<tr>
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<td>Evidence of validity</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td><strong>Positive Toned Scales</strong></td>
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<tr>
<td><strong>Sociality</strong></td>
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<td>Viney &amp; Westbrook (1979)</td>
<td>Independent of sex, age, occupational status</td>
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<td>Significantly negatively correlated with negatively toned states</td>
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<td>Viney &amp; Westbrook (1979)</td>
<td>Discriminated informants who were maintaining good relationships from those who were not</td>
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<tr>
<td>Viney (1981a)</td>
<td>Discriminated youth workers from the clients they worked with</td>
</tr>
<tr>
<td>Viney &amp; Westbrook (1982)</td>
<td>Discriminated youth workers from the clients they worked with</td>
</tr>
<tr>
<td>Viney (1981b)</td>
<td>Responded as predicted to experimental manipulation</td>
</tr>
</tbody>
</table>

**NOTE:** From *Content analysis of verbal behaviour* (pp 65-67) by L.A. Gottschalk, F. Lolas and L.L. Viney, 1986, Heidelberg: Springer-Verlag Berlin Heidelberg. Adapted by permission.
APPENDIX FOUR
Table 1: Scoring schedule and examples for the Cognitive Anxiety Scale

<table>
<thead>
<tr>
<th>SCORE</th>
<th>EXAMPLES</th>
</tr>
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<tbody>
<tr>
<td>Ca3</td>
<td>Cognitive anxiety, experienced by self, as a result of:</td>
</tr>
<tr>
<td></td>
<td><strong>NOVEL STIMULI</strong></td>
</tr>
<tr>
<td></td>
<td>I've never had to write essays before.</td>
</tr>
<tr>
<td></td>
<td>(I'm just a bit unsure about ward work)</td>
</tr>
<tr>
<td></td>
<td>it's all so new.</td>
</tr>
<tr>
<td></td>
<td>It was very different to what I expected.</td>
</tr>
<tr>
<td></td>
<td><strong>EXTRA CONSTRUCTS NEEDED</strong></td>
</tr>
<tr>
<td></td>
<td>I'm not so sure about nursing/ I don't know what I want to do.</td>
</tr>
<tr>
<td></td>
<td>I'm not sure what I'm doing.</td>
</tr>
<tr>
<td></td>
<td>(Time is a big factor in this course) I'm not sure how to organise it.</td>
</tr>
<tr>
<td></td>
<td><strong>INCONGRUOUS STIMULI</strong></td>
</tr>
<tr>
<td></td>
<td>&quot;X&quot; hospital was an incredible place.</td>
</tr>
<tr>
<td></td>
<td>It was a strange sensation.</td>
</tr>
<tr>
<td></td>
<td>It was like a giant jig-saw (you had to put it all together).</td>
</tr>
<tr>
<td></td>
<td><strong>HIGH RATE OF STIMULUS PRESENTATION</strong></td>
</tr>
<tr>
<td></td>
<td>There's been too many changes in my life lately.</td>
</tr>
<tr>
<td></td>
<td>(We have to adapt to all the work) there's so much to do.</td>
</tr>
<tr>
<td></td>
<td>(It's ridiculous) the amount of work we are expected to do.</td>
</tr>
</tbody>
</table>
Cb2  Cognitive anxiety experienced by other(s), as a result of:

NOVEL STIMULI

(She was scared) she'd never had to do that before.

It was difficult for them to study (in the Nurses Home).

She said she felt strange.

EXTRA CONSTRUCTS NEEDED

They don't know what they are doing half the time.

She didn't seem very sure.

They didn't know what was wrong (they tried everything).

INCONGRUOUS STIMULI

They were amazed when they found out.

It was strange for everyone (including me).

She just couldn't believe some of the things (I had to do).

UNAVAILABLE RESPONSES

My mother doesn't seem to understand (what I'm doing).

It really confused them (they'd seen nothing like it before).

They didn't know how it would turn out.
HIGH RATE OF STIMULUS PRESENTATION

They didn't have time to finish.
Life was pretty hectic for them (and for me).
Everyone had too much to do.

Cd1 Cognitive anxiety expressed but denied, occurring as a result of:

NOVEL STIMULI
I don't think the course will be too difficult for me.
I don't have any problems (its new but I can cope).

EXTRA CONSTRUCTS NEEDED
I wasn't too worried - (because I know what it is all about).
(It was all so confusing) but I didn't worry.

INCONGRUOUS STIMULI
It wasn't as ridiculous as they thought.
I just take it as it comes (even if it does seem crazy).

UNAVAILABLE RESPONSES
(I didn't know what to do) but I didn't panic.
(I could get very upset about not being told)/but I don't.
Table 1: Continued

HIGH RATE OF STIMULUS PRESENTATION

(I can cope with this)/ I'm not put off by all that work.

(It's very rushed) but I'm not unhappy.
APPENDIX FIVE
Figure 1: Interview schedule of hospital employees
Figure 2: Interview schedule of university students
TABLE 1: Means and standard deviations for content analysis scale scores for younger women over five interviews

<table>
<thead>
<tr>
<th>SCALES</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>1.65</td>
<td>0.98</td>
<td>1.51</td>
<td>0.87</td>
<td>1.38</td>
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<tr>
<td>Cognitive Anxiety</td>
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<td>0.70</td>
<td>1.40</td>
<td>0.90</td>
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<tr>
<td>Hostility In</td>
<td>1.24</td>
<td>0.77</td>
<td>1.62</td>
<td>0.85</td>
<td>1.42</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>0.92</td>
<td>0.49</td>
<td>1.15</td>
<td>0.52</td>
<td>1.17</td>
</tr>
<tr>
<td>Pawn</td>
<td>0.57</td>
<td>0.15</td>
<td>0.62</td>
<td>0.22</td>
<td>0.66</td>
</tr>
<tr>
<td>Origin</td>
<td>0.87</td>
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<td>0.86</td>
<td>0.40</td>
<td>0.91</td>
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<td>Positive Affect</td>
<td>1.43</td>
<td>0.63</td>
<td>1.17</td>
<td>0.58</td>
<td>1.19</td>
</tr>
<tr>
<td>Sociality</td>
<td>0.33</td>
<td>0.18</td>
<td>0.29</td>
<td>0.17</td>
<td>0.25</td>
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<tr>
<td>TABLE 2: Means and standard deviations for content analysis scale scores for older women over five interviews</td>
<td></td>
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<td>Mean</td>
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<td>Cognitive Anxiety</td>
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<td>0.95</td>
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<tr>
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<td></td>
<td>1.58</td>
<td>0.83</td>
</tr>
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<td>Hostility Out</td>
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<tr>
<td>Positive Affect</td>
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<tr>
<td>Sociality</td>
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TABLE 3: Means and standard deviations for anxiety sub-scale scores for younger women over five interviews

<table>
<thead>
<tr>
<th>SUB-SCALES</th>
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<th>5</th>
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<tbody>
<tr>
<td>Death</td>
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<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td></td>
<td>0.61</td>
<td>0.26</td>
<td>0.54</td>
<td>0.16</td>
<td>0.54</td>
</tr>
<tr>
<td>Mutilation</td>
<td>0.59</td>
<td>0.21</td>
<td>0.53</td>
<td>0.11</td>
<td>0.55</td>
</tr>
<tr>
<td>Separation</td>
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<td>0.32</td>
<td>0.64</td>
<td>0.31</td>
<td>0.75</td>
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<tr>
<td>Guilt</td>
<td>0.59</td>
<td>0.17</td>
<td>0.56</td>
<td>0.19</td>
<td>0.55</td>
</tr>
<tr>
<td>Shame</td>
<td>1.00</td>
<td>0.76</td>
<td>0.91</td>
<td>0.70</td>
<td>0.83</td>
</tr>
<tr>
<td>Diffuse</td>
<td>0.99</td>
<td>0.60</td>
<td>1.01</td>
<td>0.65</td>
<td>0.94</td>
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TABLE 4: Means and standard deviations for anxiety sub-scale scores for older women over five interviews

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<th>SUB-SCALES</th>
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<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean S.D.</td>
<td>Mean S.D.</td>
<td>Mean S.D.</td>
<td>Mean S.D.</td>
<td>Mean S.D.</td>
<td>Mean S.D.</td>
</tr>
<tr>
<td>Death</td>
<td>0.36 0.21</td>
<td>0.52 0.09</td>
<td>0.45 0.16</td>
<td>0.50 0.14</td>
<td>0.48 0.12</td>
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<tr>
<td>Mutilation</td>
<td>0.55 0.18</td>
<td>0.52 0.10</td>
<td>0.49 0.24</td>
<td>0.50 0.13</td>
<td>0.49 0.12</td>
<td></td>
</tr>
<tr>
<td>Separation</td>
<td>0.65 0.37</td>
<td>0.65 0.35</td>
<td>0.72 0.48</td>
<td>0.63 0.35</td>
<td>0.82 0.61</td>
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</tr>
<tr>
<td>Guilt</td>
<td>0.39 0.21</td>
<td>0.69 0.47</td>
<td>0.59 0.31</td>
<td>0.63 0.31</td>
<td>0.56 0.29</td>
<td></td>
</tr>
<tr>
<td>Shame</td>
<td>1.20 0.78</td>
<td>1.34 1.00</td>
<td>1.10 0.78</td>
<td>1.11 0.74</td>
<td>0.99 0.74</td>
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</tr>
<tr>
<td>Diffuse</td>
<td>1.11 0.60</td>
<td>1.39 0.80</td>
<td>1.28 0.71</td>
<td>1.20 0.70</td>
<td>1.17 0.66</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX SEVEN
Figure 1: Mean Total Anxiety Scale Scores by developmental stage over five interviews.

Figure 2: Mean Hostility Inward Scale Scores by developmental stage over five interviews.
Figure 3: Mean Guilt Anxiety Sub-scale Scores by developmental stage over five interviews.

Figure 4: Mean Shame Anxiety Sub-scale Scores by developmental stage over five interviews.
Figure 5: Mean Diffuse Anxiety Sub-scale Scores by developmental stage over five interviews.

Figure 6: Mean Hostility Outward Scale Scores by developmental stage over five interviews.
Figure 7: Mean Positive Affect Scale Scores by developmental stage over five interviews.

Figure 8: Mean Sociality Scale Scores by developmental stage over five interviews.
Figure 9: Mean Death Anxiety Sub-scale Scores by developmental stage over five interviews.

Figure 10: Mean Mutilation Anxiety Sub-scale Scores by developmental stage over five interviews.
Figure 1: Mean Separation Anxiety Sub-scale Scores by professional role over five interviews.

Figure 2: Mean Total Anxiety Scale Scores by professional role over five interviews.
Figure 3: Mean Diffuse Anxiety Sub-scale Scores by professional role over five interviews.

Figure 4: Mean Hostility Outward Sub-scale Scores by professional role over five interviews.
Figure 5: Mean Cognitive Anxiety Scale Scores by professional role over five interviews.

Figure 6: Mean Pawn Scale Scores by professional role over five interviews.
Figure 7: Mean Shame Anxiety Sub-scale Scores by professional role over five interviews.

Figure 8: Mean Guilt Anxiety Sub-scale Scores by professional role over five interviews.
APPENDIX NINE
TABLE 1: Univariate repeated measures analysis of variance for content analysis scale scores showing interaction effects

<table>
<thead>
<tr>
<th>Scale</th>
<th>Between Subject Interactions</th>
<th>Between/Within Subject Interaction Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prof. Role/ Developmental Stage</td>
<td>Develop. Stage/ Time</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>38.73*</td>
<td>3.81*</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hostility In</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Pawn</td>
<td>21.10*</td>
<td>--</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>7.62*</td>
<td>--</td>
</tr>
<tr>
<td>Origin</td>
<td>4.75</td>
<td>--</td>
</tr>
<tr>
<td>Sociality</td>
<td>18.75*</td>
<td>--</td>
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</tbody>
</table>

p < 0.05

* p < 0.01
### TABLE 2: Univariate repeated measures analysis of variance for anxiety sub-scale scores showing interaction effects

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Between Subject Interactions</th>
<th>Between/Within Subject Interaction Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prof. Role/Developmental Stage</td>
<td>Prof. Role/Time</td>
</tr>
<tr>
<td>Death</td>
<td>6.07</td>
<td>--</td>
</tr>
<tr>
<td>Mutilation</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Separation</td>
<td>7.02*</td>
<td>--</td>
</tr>
<tr>
<td>Guilt</td>
<td>8.98*</td>
<td>2.82</td>
</tr>
<tr>
<td>Shame</td>
<td>54.00*</td>
<td>3.47</td>
</tr>
<tr>
<td>Diffuse</td>
<td>--</td>
<td>2.74</td>
</tr>
</tbody>
</table>

* p < 0.01

\[ p < 0.05 \]