Teaching the Theory Component

Understanding the conceptual considerations of chronic illness assists in developing an appreciation for the unique role nurses assume in providing care to persons living a life with chronic illness. This chapter discusses classroom implementation and thus focuses on teaching the theory and academic content of chronic illness.

LETTING GO OF CONTENT

Our theory course (NRS 340) is a four-credit course with classes that meet for 2 hours twice a week over 16 weeks. The course is designed to meet five objectives that derive from and are intertwined with the six curricular strands: caring, health, client/person, professional nursing, environment, and critical thinking.

Course Objectives

1. Examine the concept of chronicity and characteristics of specific chronic illnesses.
2. Examine the interplay between the client with a chronic illness and the environment in which they exist.
3. Identify resources that have been developed to aid individuals and families who have chronic illnesses.
4. Discuss management of chronic health problems within the framework of caring.
5. Integrate nursing science with an understanding of the lived experience of individuals and families living with chronic illness.

The course objectives serve as a compass, continually directing us to the place the course has in the overall curriculum, so as not to overlap.
with the content addressed in earlier or subsequent courses. In other words, the objectives guide what gets covered in the course.

Somewhere around the time we were revising the undergraduate program, the Edgewood nursing faculty attended a weekend conference presented by world-renowned educator Richard Paul. Excited and rejuvenated by his work, we left vowing to completely overhaul our theory courses and revitalize classroom teaching. Though our always too-busy academic schedules intervened in ways that precluded total transformation, we did learn a very important lesson from Dr. Paul that has had a profound effect on how we think about our curriculum and teaching. When we are feeling particularly overwhelmed by the ever increasing amount of material our profession and accreditation agencies expect us to disseminate to students, we comfort ourselves with Dr. Paul’s wise challenge to “let go of content.” This was such a refreshing idea, though initially quite frightening.

Clearly, a history professor can eliminate a battle here or a treaty there or a literature professor might omit a novel or short story, but how could nursing instructors possibly omit anything? We felt compelled to cover everything! After all, our students would be taking care of real patients, sometimes in life or death situations. Paul’s “let go” sparked many heated debates among faculty about what it means to cover a topic. We heard faculty say they threw out certain exam questions because they “didn’t cover it in class.” Was a topic covered because the instructor mentioned it in class? There is something incongruous with this line of reasoning, and it prevented us from letting go of content. It is easy to translate the ever expanding body of nursing knowledge to mean, “we have more material to ‘cover’ in class.” Paul’s legacy for our course has been our commitment to continually question and revise as needed what we teach and how we do it. Several other caveats that have given us permission beyond Paul’s to let go of content follow.

**LIMITED LANGUAGE AND PARADOXICAL PEDAGOGY**

As teachers our job is not merely to feed our students digestible bites of knowledge and evaluate their ability to regurgitate them but, rather, to engage them in a process of discovery that clarifies, edifies, and creates meaning that ultimately enhances their practice. This is contingent not only on their readiness to learn but also on our own. One thing we learn over and over again is that there are limits to language.
Our philosophy of *whole person care* and a *storied approach* to teaching are intended to foster in our students an ability to think in a variety of modes simultaneously. Trying to sum ourselves and actions as teachers in a book or a chapter, much less in singular phrases, is indeed challenging. Once represented by particular names, phenomena become inextricably snarled in the nuances that accompany them. Various meanings of the words used, images peculiar to them at any particular time, theories that have incorporated them, and their emotional or political context can spin out further webs of terminology that can catch us in a terminal snare (Miller & Dzurec, 1993). The language we use both allows us to and prevents us from adequately expressing what it is we teach and how we do it. Sometimes words confound us with their multiple meanings.

**Pamela’s Humbling Experience**

About my fourth year into teaching, I found myself especially overextended in my work commitments. A propensity toward perfectionism was beginning to do me in. The hours I was spending trying to come up with a faultless lesson in every class every week was leading me down the path toward what is often called burnout. One of my students, a “mature learner” in her 30s who had returned for a second degree, astutely noted, “You look awful. I think you need some time off.” I confessed to being stressed and that my husband was getting sick of taking a second place to The Academy.

As her advisor and teacher for three of the courses she had taken, I had come to know Heather fairly well. To support herself through her studies, she worked as a nanny, and she was also a substitute teacher in the preschool where my daughter was enrolled. Thus, she knew not only me, but also my family. In what was clearly her fondness for us, she insisted that I allow her to baby sit so my husband and I could have an evening of respite. After agonizing over whether that would constitute a transgression of the student-teacher relationship, I finally relented by insisting that I would take her up on her offer as long as she would allow me to pay her.

My husband and I indulged in a rather extravagant evening and had a lovely time. When we returned home I told Heather about the expensive restaurant where we had dined. I teasingly tried to play on her sympathies. “I’m feeling much more relaxed, but I hope you won’t add to my stress by charging us too much. You know I’m just a poor teacher.”

“Yes,” Heather replied. “I know, I’ve had you for three classes!”

Another recurrent lesson for us is that humility is an essential ingredient for survival in academia. We take our teaching seriously, but we take ourselves lightly. We do not and cannot know everything our
students need to know. Ellsworth (1997, p. 9) notes the essentially paradoxical nature of pedagogy and challenges us to consider what we might learn from ways of teaching that are predicated on the ironic impossibility of teaching. No matter how well intentioned or planned, our curriculum always misses its mark to some degree. We each have our own teaching styles, as do the guest lecturers who grace our classroom, but the transcendence of our pedagogical framework—that is, the whole-person care frame and its three lenses—gives some constancy and cohesion to what otherwise might be a chaotic classroom.

On a regular basis, we also have to relearn that all understanding is incomplete and/or fleeting. We recognize that reduction of thinking into two camps is simplistic. Within the logico-scientific and the narrative modes, or the technical knowledge and ontological knowing dichotomy, one could find the four fundamental patterns of knowing in nursing conceptualized by Carter years ago (cited in Chinn & Kramer, 1999). Empirical knowing with its devotion to sensory experience springs from the logico-scientific mode and is consistent with technical knowledge. Aesthetic, ethical, and personal knowing flow more readily with the narrative mode and ontological knowing. At the most basic level, we are trying to teach our students to think like a nurse. This means appreciating that some things are inexplicable or unknowable (Silva, Sorrell, & Sorrell, 1995), and that unknowing can be a pattern of knowing (Munhall, 1993). Knowing what to call our teaching principles is simply a guide to using them intentionally (Vella, 2002, p. 227).

**A WEB OF WHAT AND HOW**

As the primary faculty we are to a large extent accountable for what happens in the theory course. Like Vella, we understand accountability to be a mutual process that means, “the teacher is responsible to teach what he has promised learners will learn” and “the learners are responsible to do the work of learning” (2002, p. 213). In our case the teachers’ promise is encapsulated in the course objectives, and at every turn, we must consider how to determine whether our students are fulfilling their end of the academic bargain.

**Student Assessment**

In order to pass the theory course, each student must demonstrate mastery of the scientific knowledge necessary to provide competent
Teaching the Theory Component 47
care to individuals with chronic illness. It is undeniable that nursing practice relies to a large extent on hard data. The purpose of the NCLEX-RN (National Council Licensure Exam) is to determine whether a given applicant is minimally safe to practice nursing. We appraise this primarily through four NCLEX-like multiple-choice exams. In order to familiarize the students with our testing format, the first exam is a take home. The next two exams are completed in class, with the third including questions about material introduced subsequent to the second exam and topics addressed in all previous classes. In other words, the third exam is comprehensive. Three fourths of a student’s final grade derives from his or her score on these three exams. The standardized, commercially prepared, and Web-based fourth exam is not graded, but it is required for completion of the course. It helps students to gauge their strengths and weaknesses related to the NCLEX and provides aggregated data for the purpose of program evaluation.

Though we are adamant that we will not “teach to the NCLEX,” and our test questions theoretically require not only memorization of facts but clinical judgment, we admit that they in no way assess the depth or breadth of our students’ ontological knowing. Fortunately, the close contact we have with them during clinical experiences, as discussed in chapter 5, allows us greater opportunity for that. We take great pains to let our students know the limits of our assessment methods and how such tests can inadvertently undermine they ability to practice nursing in the grey zone. While an answer of “it depends” followed by sound options and rational is often applauded in the clinical arena, it is never a plausible response on the NCLEX or our exams. We tell our students up front that there will always be one right answer for every NCLEX or class exam question. We discuss strategies for discerning the best response, even when they know that in the real world “it depends” is the superior answer.

To preclude student grades from hinging solely on test performance, we also give credit toward the final grade for work done in advance of each class. Colleen uses the student study guide that accompanies the medical-surgical nursing text toward this end, along with a selection of clinical simulations available on CD-ROM. Pamela has created a series of worksheets corresponding in part to the psychiatric nursing text and other materials, which are discussed later in this chapter. Students are awarded a set number of points for each assignment handed in prior to the class period in which the relevant topic is being addressed. Partial points may be granted in the event that the work is incomplete or
inaccurate. We have found this method particular useful in motivating our students to complete assigned readings in a timely fashion. Though optional, the weekly assignments give students an opportunity to earn the equivalence of on exam’s worth of points toward their final grade.

What we actually teach—the content—and how we go about doing it—the process—constantly evolves. Below, we identify some of the basics of each, recognizing that, though we address them separately here, in the classroom they are intimately intertwined.

Content—The *What* of Our Teaching

As noted earlier, the theory course situates what customarily might be regarded as medical/surgical and psychiatric/mental health content in one chronic illness course founded on the notion of whole-person care. Because we are still “old school” enough to worry about our students’ passing their board exams, that content derives to a substantial degree from the topics outlined in the NCLEX blueprint. Table 4.1 delineates what we teach in the class. That listing of topics might falsely simplify what are really very complex issues, but it helps us organize the semester. In general, there is one class period dedicated to each topic listed. In the course syllabus and schedule, each topic is prefaced with “Nursing Care of the Client With… ” We do this to remind the students that they are learning to care for people, not medical conditions.

At first glance, the topics presented in Table 4.1 probably make this class look like other, more conventional nursing courses. Even were the reader to scrutinize the syllabus our students receive each semester, what is unique about the course might not be readily apparent. While we maintain that teaching nursing care of people living with chronic illness is very different than teaching acute care, we use the very same medical-surgical nursing, psychiatric nursing, pharmacology, and nutrition textbooks that are required for students in their previous adult health classes (NRS 310/311). The decision to do so was not made simply to prevent further student disinterest in chronic illness management by having them spend another $100–$200 on additional textbooks.

Each year, the nursing faculty as a whole decides collaboratively on which primary texts to use in each course. Though these change from year to year to keep up with continual shifts in information and practice, they are selected from the usual menu of conventional reference books that nursing faculty are inundated with annually. We have found them
### TABLE 4.1 NRS 340 Content

<table>
<thead>
<tr>
<th>Medical-Surgical Nursing</th>
<th>Psychiatric Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Care of the Client With Chronic Illness</strong></td>
<td><strong>Introduction to the Self-regulation, Stigma, and Caregiver Lenses</strong></td>
</tr>
<tr>
<td><strong>Metabolic problems and self-regulation</strong></td>
<td>Chronic mental illness</td>
</tr>
<tr>
<td>Case model: Diabetes mellitus and self</td>
<td>Case model: Social construction of stigma</td>
</tr>
<tr>
<td><strong>Sensory/perceptual disorders</strong></td>
<td>Psychotic disorders</td>
</tr>
<tr>
<td>Case model: CVA/Parkinson’s</td>
<td>Case model: Schizophrenia</td>
</tr>
<tr>
<td><strong>Changes in mobility and self-image</strong></td>
<td>Mood disorders</td>
</tr>
<tr>
<td>Case models: MS, ALS, and MG</td>
<td>Case models: Depression &amp; mania</td>
</tr>
<tr>
<td><strong>Brain insult</strong></td>
<td>Safety concerns</td>
</tr>
<tr>
<td>Case models: Dementia &amp; TBI</td>
<td>Case model: Restraints and seclusion</td>
</tr>
<tr>
<td><strong>GI disorders</strong></td>
<td>Iatrogenic disease</td>
</tr>
<tr>
<td>Case model: Crohn’s disease</td>
<td>Case model: Psychopharmacology</td>
</tr>
<tr>
<td><strong>Changes in cardiac function</strong></td>
<td>Substance-related disorders</td>
</tr>
<tr>
<td>Case models: CHF and hypertension</td>
<td>Case model: Multiple substance abuse</td>
</tr>
<tr>
<td><strong>Changes in oxygenation</strong></td>
<td>Anxiety disorders</td>
</tr>
<tr>
<td>Case model: COPD</td>
<td>Case model: ODC</td>
</tr>
<tr>
<td><strong>Changes in mobility and self-image</strong></td>
<td>Personality disorders</td>
</tr>
<tr>
<td>Case models: Arthritis and osteoporosis</td>
<td>Case models: Obsessive-compulsive, narcissistic, borderline, antisocial personalities</td>
</tr>
<tr>
<td><strong>Changes in immunocompetence</strong></td>
<td>Dissociative disorders</td>
</tr>
<tr>
<td>Case model: AIDS</td>
<td>Case models: PTSD and DID</td>
</tr>
<tr>
<td><strong>Changes in energy levels &amp; quality of life</strong></td>
<td>Eating disorders</td>
</tr>
<tr>
<td>Case model: Chronic renal failure</td>
<td>Case models: Anorexia, bulimia, obesity</td>
</tr>
<tr>
<td><strong>Changes in energy levels &amp; quality of life</strong></td>
<td>Mental disorders of childhood or adolescence</td>
</tr>
<tr>
<td>Case model: Chronic liver failure</td>
<td>Case models: ADHD and autism</td>
</tr>
<tr>
<td><strong>Facing the end of life</strong></td>
<td>Facing the end of life</td>
</tr>
<tr>
<td>Case model: Family caregiver concerns</td>
<td>Case model: Professional caregiver concerns</td>
</tr>
</tbody>
</table>
quite adequate in terms of addressing the logico-scientific, technical knowledge our students need to care for clients with chronic illness. Each topic area delineated in Table 4.1 has corresponding readings in these texts that help ready students for classroom discussion.

Where the course syllabus hints at what is unique about NRS 340 is that the concept of tertiary prevention directs the selection and presentation of content. Tertiary prevention emphasizes nursing management outside the acute care setting and provides students with valuable information regarding the nurse’s role. The venue of preparatory materials listed in the syllabus comes not only from the required texts but is balanced with selections from Charmez’s *Good Days, Bad Days*, articles culled from the current literature, the books *Tuesdays With Morrie* and *Gracefully Insane*, and both educational and popular videos. These all help put students in the narrative frame of mind necessary for ontological reflection on what it means to live a life with chronic illness.

**Process—The How of Our Teaching**

A primary challenge for any faculty member teaching chronic illness management and whole-person care lies in shifting the content emphasis from acute care interventions to living a life. For example, when we discuss nursing care of clients with changes in cardiac function, very little time is spent discussing inpatient management for an acute episode of heart failure, which is likely to be 2 or 3 days in length. Rather, the emphasis is shifted to discuss caring for these clients on a daily basis—the other 362 days of the year when they aren’t hospitalized.

**Joe’s Story**

For several years before we revised our curriculum, Colleen taught clinicals at the local veteran’s hospital (VA). She loved the VA and everything about it. The clients were not only interesting but also very eager and willing to work with student nurses. One day, a student was preparing to discharge Joe, a gentleman admitted with severe congestive heart failure. Over the course of his 5-day hospitalization, the doctors and nurses successfully diuresed 52 pounds off Joe. As part of his discharge teaching, the student remembered what she learned in class about the importance of monitoring daily weights as a reflection of fluid volume status. She thought this would be important information to discuss with Joe prior to discharge. The student was more than disillusioned when Joe said that not only did he not have a scale but
he also had no money, or interest, in purchasing one. The idea of daily weights was simply out of the question, never mind the fact that Joe did not have a stable place to live and spent most of his days eating and sleeping at the local bar.

In discussing this issue with Colleen in the hallway, the student reviewed what else she learned in lecture regarding the symptom experience of heart failure. With some help, she did recall hearing that although there are well over two dozen different symptoms of heart failure each individual consistently experiences his own symptoms in the exact same order during each episode of heart failure. Yes, there was the clue! The student and Colleen went back to talk with Joe about what had been happening prior to his admission. He discussed how over a period of several weeks, he noticed having to move his belt notch over several spaces, allowing for more room. “In fact,” he recalled, “by the time I came here, I had moved my belt over 5 notches.” That’s about 10 pounds per notch. The student and Colleen worked out with Joe that he would call the VA the next time he noticed that he had to move his belt one notch over from where it was at the time of discharge. He thought that made good sense. That wasn’t exactly “by the book” but close enough.

We love the above teaching episode because it challenges instructors and students to question the nature of the content taught as well as the hidden assumptions that underlie it. Clearly monitoring fluid volume status is an important strategy for managing heart failure, probably one of the most important interventions a nurse could teach a client to continue at home. However, it’s the way we present this information that could potentially backfire with our students. Check any medical-surgical textbook and review the interventions for congestive heart failure. Undoubtedly, daily weights are often regarded as the gold standard for monitoring fluid volume status. Admit a client to the acute-care unit and daily weights will most assuredly be part of the nursing-care plan, and acute-care nurses will dutifully weigh their patients at 6:00 every morning. But what happens when a student encounters a client like Joe? Students and nurses alike become mentally immobile when they encounter the Joes of the world. Clients are negatively portrayed as “noncompliant” or “unwilling” to participate in their care.

What are we teaching in cases such as Joe’s, and what assumptions are we making? Sometimes it’s the unconscious message, the unspoken words that come across so poignantly—the subtle facial expressions or the sigh of impatience communicates to a student that Joe has stretched us to our limits.

Because most textbooks focus on the nurse’s role in managing illnesses in an acute care setting, emphasis is placed on those interventions
a nurse would expect to perform in that setting, such as daily weights, monitoring vital signs, and so on. Given the highly structured setting of acute care and clear lines of authority, little, if any, consideration is given to alternative interventions if a patient refuses. In addition, textbooks present copious amounts of information clients must learn in order to manage at home. The assumption being that the nurse will transfer his or her monitoring duties to either the client or a family member (if there is one) who will happily continue to perform these responsibilities post-discharge.

What else are we teaching? We’re inadvertently teaching a gamut of reactions we don’t intend to convey—rigidity, inflexibility, lack of creativity, intolerance, and paternalism, to name a few. We also assume that the interventions students read about in their textbooks are doable for all our clients. Isn’t this a bit presumptuous? Little, if any, discussion addresses the Joes of the world. If it does, the conversation most often centers on how to persuade Joe into weighing himself everyday. Frequently, this type of monologue is referred to as “patient education.” As nursing educators, we handicap our students if we don’t proceed beyond where the usual nursing text leaves off and help them understand that true learning, whether in an academic or therapeutic relationship, arises out of dialogue between the nurse and the client.

Viewing chronic illness through the lenses of self-regulation, caregiver concerns, and stigma helps us to engage our students in problematizing commonplace assumptions. By making what is familiar strange, we teach a strategy for disrupting existing power relations and thus promote development of nurses who can enact the college’s values of justice, truth, compassion, partnership, and community. Such critical thinking is essential if our students are to become effective client advocates, a role they will need to play regardless of the setting in which they practice. Many of our graduates will initially work in acute-care settings. Presenting nursing care of individuals with chronic health problems in the context of living a life enhances their appreciation for what clients with either acute illness or exacerbations of chronic conditions face upon discharge. The focus on tertiary prevention in the theory course emphasizes nursing management outside the hospital and provides students with valuable information about preparing clients for their return home, or in an increasing number of instances, to shelters or the street.

We are continually challenged by the daunting task of synthesizing all the content in a manner that allows students to learn the difference
between physiological, psychological, social, and spiritual care while keeping at the forefront the holistic nature of health. Originally, the course was divided into three distinct units, with the course concepts of self-regulation, stigma, and caregiver issues each representing a unit. We would then try to select which topics best represented the concept. For certain topics, this wasn’t too difficult. For example, HIV/AIDS content was discussed under the concept of stigma. Diabetes was discussed under self-regulation. Other topics, however, weren’t quite so clear. Take liver disease—does it best fit with stigma (given that a great deal of liver disease is alcohol related), or is self-regulation a better fit? What about caregivers—aren’t they often impacted by family members living with liver disease?

Clearly, the entire notion of fitting content areas into categories was absurd, and the process itself negated the idea of whole person care. At best, these themes needed to be introduced at the beginning of the semester and then integrated throughout the rest of the semester. Currently, our first class session is spent, in part, discussing the course themes by reading the personal narratives presented in chapter 3.

Generally speaking, medical-surgical content is taught in the first class period of the week (Monday), and the mental health content is taught during the second class of the week (Friday). Colleen has greater expertise and experience in medical-surgical nursing, and Pamela has greater authority as regards psychiatric nursing. Hypothetically, Colleen is accountable for the pathophysiological content and care of the client requiring medical surgical nursing care, while psychopathology and psychosocial-spiritual care is Pamela’s responsibility. In actuality this separation is artificial and made to simplify the topics for the students. In our experience, it is the rare client who has a discrete illness and whose response to his/her illness is not manifested in all four dimensions of health. Our whole-person care frame dictates that we both attend to physical, mental, social, and spiritual aspects of any of the topics we teach.

We strive to instill in our students the ability to provide whole person care for individuals and families experiencing chronic illness and to promote the social change necessary to allow such care. Though continually teased by the temptation to simply tell our students everything we think they need to know toward that end, we have come to understand that “Education dominated by preconceived images of what must be learned can hardly be educational. Authentic teaching and learning requires a live encounter with the unexpected, an element of suspense
and surprise, an evocation of that which we did not know until it happened” (Palmer, 1990, p. 76). The course objectives guide what we hope to teach each semester, but it is only when we are able to engage our students in active dialogue that they learn what they need to know to become competent, caring practitioners.

What is distinctive about the chronic illness theory course is the **storied approach** to teaching about nursing care in chronic illness that was introduced in chapter 3. It is our particular version of what has in the last decade come to be generically referred to as narrative pedagogy. People by nature lead storied lives and tell stories of those lives (Cladinin & Connelly, 1994). Stories have value in the clinical arena because they “often convey the essence of a particular event or period of time in one’s individual or family history” and thus “are critical sources of information about etiology, diagnosis, treatment and prognosis from the patient’s point of view” (Nagai-Jacobson & Burkhardt, 1996, p. 54). In the educational setting the pedagogical value of stories, or anecdotal narratives, lies in their ability to capture student attention, involve them personally, transform them, and measure their interpretive sense (Van Manen, 1990). Because we dream and daydream, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticize, construct, gossip, learn, hate, and love by narrative, stories provide a natural and familiar form of explanation for students and thus facilitates their involvement in learning (Hardy, 1977, cited in Gere, Fairbanks, Howes, Roop, Schaalma, 1992, p. 150).

**A STORIED APPROACH**

Our storied approach to whole person care is predicated on the belief that nursing is essentially an interpersonal process concerned with humans and their relationships with themselves and their environments and how these affect their health and well being. Understanding the story of those facing chronic illness figures prominently in the nurse’s ability to intervene therapeutically. So, too, does the nurse’s understanding of his/her own story. We share stories that blend objective and subjective knowing about chronic illness to foster a narrative aptitude in our students and enhance their capacity to reflect on the meaning of that experience and their reactions to it. What follows are descriptions of a number of types of stories, or narrative strategies, we have found quintessential in helping our students grasp essential nursing science
and understand the lived experience of individuals and families coping with chronic illness.

**Grand Narratives in the Empiric Mode**

Our storied approach does not preclude lecturing, and in reality many class periods include a segment in which one of us, or a guest speaker, relays information in a conventional didactic format. We live in the real (i.e., material) world and thus cannot escape the need to convey concrete, factual material in our course. Assuring that our students become adept nurses requires that “It depends” perpetually modify the facts we teach though. Every time we convey absolute information, we do as Vella suggests and invite our students to “question, argue, and edit in light of their own life experience” (2002, p. 174).

We do relay scientific knowledge as it is portrayed in the current academic and professional literature, but we encourage our students to challenge the tentativeness of what we know, no matter how passionately we convey it. Interwoven with discussion of nursing care in chronic illness is exploration of how the knowledge we are assuming is constructed. Much of what we now presume was once controversial, and the things we most take for granted are the very ones we most need to question. Whatever seems natural, obvious, self-evident, or universal actually has a history, a reason for being the way that it is. That reason, and the subsequent effects of “the way things are” can reveal much about a given society’s power structure. Those things we come to take for granted embody particular values by determining what is or is not normal.

**Setting the Tone Stories**

The invitation, let alone the expectation, that students critique or challenge their professors’ thinking can be an intimidating for both parties. A free exchange of ideas, feelings, and ways of doing things is contingent on a safe milieu. We regularly assert that confidentiality is just as essential in the classroom as it is in the clinical setting. So, too, are a nonjudgmental attitude and openness to diversity. At the most basic level, we move our students into a narrative frame by expressing interest in them, listening when they do speak up, and applauding when they have the courage to ask questions.
We really do care what our students do and do not understand about the experience of chronic illness. Sometimes to get them to reveal their uncertainties we have to prime the pump by revealing ways in which we are fallible. Colleen loves to tell about the time when we were introduced to the portable defibrillator during our last CPR recertification. After verbally walking though the procedure for its proper use in a cardiac arrest and practicing several times, Pamela felt confident enough to have the instructor evaluate our abilities. We preformed brilliantly, right up to the point where Pamela, after conscientiously checking that Colleen was clear of the device so that the shock could be safely delivered to the fictitious victim, enthusiastically hit the wrong button and turned the defibrillator off! Though we require students to be prepared and function in class and clinical in a competent manner, we want them to know mistakes are inevitable, seldom irreparable when owned up to, and often promote significant learning.

Sometimes we offer a narrative as a means of elucidating more ephemeral concepts, such as spiritual care. Stories can also convey an acceptance that there are times when even an experienced practitioner doesn’t know what to do. And, they can underscore that nursing intervention in chronic illness often needs to take the form of being with, rather than doing to, the client. Such was the case one semester several years ago when Pamela supervised a group of students on the inpatient psychiatric unit at our local VA hospital.

**A Moment of Grace**

One semester, a fellow well known to the staff was readmitted to the unit in a decompensated state after having been in the community for about a year. His extreme agitation fueled their fear that, as with multiple previous admissions, he would become a “disposition problem” and they would be stuck trying to manage the milieu, which would inevitably escalate in response to his persistent and unremitting psychosis. When everyone predicted it would be months before he would settle down and a suitable placement would be found, I judged them harshly for setting up a self-fulfilling prophecy. After several weeks, I had an opportunity to walk in their shoes and was humbled by the challenge they faced daily, hourly, and moment-to-moment.

Though one could see some signs of improvement, the fellow continued to be irritable and had regular outbursts each day. He would wander the unit mumbling, usually incoherently, and occasionally would intrude on the physical space of others or threaten them directly with a closed fist. His shabby appearance revealed an inability to attend to his personal hygiene or to cooperate enough to allow others to assist him.
One morning, I happened on him in the dinning room, sitting all alone. Breakfast was over, and all the other patients had moved into the dayroom or left for their various appointments. Though the patients tended to be very tolerant of one another’s shortcomings, their patience for his contentious ramblings was waning. The nurses left him in the dining room, both to give the other patients respite and because they hoped the lesser stimuli there would calm him. Not wanting to leave him all alone, they parked him in front of an old time comic video, thinking it might somehow hold his attention. They were too busy to stay with him, but checked in periodically.

Having progressed to a point where they required little of me, my students were all off attending to the needs of their assigned patients. I alone had the time to sit with this distraught fellow. During his best periods, he muttered quietly to himself. This was punctuated by frantic, nonsensical outbursts, though at several points I could make out an utterance like “No, no! Let the boy have the food. He’s starving.” Knowing that he was a World War II veteran, I surmised that he was somewhere in Europe reexperiencing the trauma of war. His suffering was palpable. Occasionally he looked at me in a rather menacing manner, and I had to steady myself to remain with him. I don’t know if I was trying to reassure him or myself as I periodically told him very softly, “You are safe here.”

When he would appear to notice the video, I would ask him about the characters. Mostly he responded with gibberish but several times surprised me with a laugh. He would momentarily connect with the characters on the screen, calling them by name. After each name, I would whisper, “That’s right.” He would then turn, and though he didn’t really relate to me, I felt some acknowledgment of my presence. I continued to sit with him. Though I had the time to do so, I didn’t have a clue what I was doing.

He tired of the video and began to walk around. As his movement increased, so did his agitation. He headed toward the dayroom, barking orders at some unseen marauders. I tensed with a sense of obligation to calm him and protect the other patients. I gently encouraged him to take a seat. Much to my amazement, he complied. He perched on a chair at the periphery of the dayroom. I pulled another close to continue my vigil. His shouts softened a bit, and he teared up. “No, no! Let the boy eat first! He is starving.” He grasped his head in his hands and shook it back and forth. “No, no, no. Let the boy have it.” Now he was sobbing. I wished to comfort him, but I didn’t know how. I just sat there while his weeping escalated to loud, mournful wails.

Noticing his distress, one of the nurses brought him some medication. At first the offer of the drug annoyed him, but the nurse said it would help. Was it with resignation, hope or some other emotion that he took it? I couldn’t tell, but I knew the relief it might provide would not arrive immediately or be permanent. Having a little more time before my students would return, I continued to sit with him. The momentary lull afforded by his swallowing was broken when he recommenced his lamentation. Witnessing his deep despair began to take its toll. Not knowing how much longer I could bear
it, I turned inward. Silently I pleaded for divine intervention. "Please do not let him suffer any more than he can bear!" I felt my eyes filling with tears. He turned to me fully and said definitively and exceptionally clearly, "What you are doing is helping." We sat in silence together for a few minutes. My students returned to the unit, and to my awareness. Now they needed me more than he did. I thanked him for sitting with me, and excused myself. The rest of my day was draped with tremendous gratitude for having shared a moment of grace.

We view teaching and learning as sacred activities. Ideally, the content in the classroom is shaped by clinical and personal experiences of both faculty and students.

**STUDENT STORIES**

Even when presenting in a didactic mode, we continually integrate theoretical content with stories from our own lives and practice. We invite students to share their stories to the extent that they are able. We encourage them to discuss how they are applying what they are learning in the theory course to clinical situations in their chronic illness clinical course, and how interactions with real clients in the clinical course shapes their understanding of the more abstract concepts in the theory course.

An assignment, in which we have students write a series of three brief accounts of their own experience with chronic illness allows us to get to know them and to discern their grasp of course concepts at the beginning, middle, and end of the course. We never cease to be amazed by how candid our students are, and reading about the adversity some of them have faced in their personal lives helps put the student experience in perspective and humbles us.

*The Wrath of Fibromyalgia*

Before I started nursing school, I didn’t know what fibromyalgia was, nor did I really care. I didn’t even know what it meant when people said they had a chronic illness. I just got really irritated hearing her complain all the time about how tired she was always feeling or about her aches and pains. She wasn’t any fun, and I sure couldn’t rely on her to come to any of my sporting or other important events at school.

You are probably wondering whom I am talking about right now. Well, it’s my mother, who has been burdened with fibromyalgia for the last 10 years.
I look back on my behavior now and I am ashamed of myself. For God’s sake, this is my mother I am talking about. I love her but I kept looking at how this illness affected me, and not how it was ripping the life out of her. Something that I didn’t realize before was that this illness dropped my mother into a deep depression for the first 5 years after her diagnosis. I just felt like she didn’t want to be a part of my life. I couldn’t understand that the illness was holding her back.

My mother’s fibromyalgia caused severe muscle tension in her upper body, especially her neck and back. That caused her to get migraines that put her out of commission for at least a day. My mother was able to develop a dialectical self where she could feel tingling in her upper back and neck signaling the onset of an attack. Then she would be able to take it easy, and with the proper medicine, the effects would be lessened. She would also get lower flank pain that would prevent her from even walking. She still takes muscle relaxants, and for a while she also took antidepressants. Before nursing school, I couldn’t understand the full impact of side effects from these drugs. They knocked her out, and she would be asleep more than she was awake. Sometimes she’d skip the medicine, even though she knew it would help, because she didn’t want to spend the whole day in bed. She always had to weigh the pros and cons.

I understand now that having good days, and bad days are part and parcel of chronic illness. On bad days, Mom slips into the illness routine, though, and it is hard for my family to understand that this is worse for her than it is for us. She’ll stay in bed all day because that’s easier than dealing with the physical, emotional, and mental pain. Like any chronic illness, fibromyalgia is an energy drainer.

I am happy that the disease hasn’t had any direct effect on her cognition and that she can pursue her goal of becoming a social worker. I am so proud of her. She takes a couple of classes each semester and is actually scheduled to finish at the same time I’ll be graduating. She works hard, even though she doesn’t feel well, but she does get down on herself when she only gets a B or has to miss a class because of a migraine. She has no idea how proud her family is of her for pursuing an education when she is burdened with a chronic illness.

My mom also tries to get help for herself by attending support groups. I can say that I am much more supportive and understanding than I was before I got into nursing school, but I have no idea what it feels like to have fibromyalgia. I think that it is really good for her to vent her frustrations with people who understand where she’s coming from. She has a lot of anger related to her illness. She really doesn’t feel it’s fair and is frustrated that there is no cure. She struggles as well with having to convince others she even has a disease. I worry what she’ll do if she hears one more time that it’s all in her head.

I think that if I had to walk a day in the shoes of someone who is chronically ill I would do a 180. I don’t want to face that I am not invincible, and I don’t want to have to depend on others to complete activities of daily living. Every
time I do patient care now, I think about this in the hope that I might become
the kind of nurse who can make a difference in the life of someone who
suffers like my mom.

We urge students to pay attention to their clients, to notice with an
open heart and mind what is going on with them, inside and out. We
take the same stance with the students, in as much as how they are
doing impacts on learning about nursing care in chronic illness. Clients
and students cannot or will not always share the depth of their experi-
ce, though, and it is not possible or necessarily advantageous to know
everything about each one. At times, fragile students reveal more than
they intended, or their peers wanted to know, about their own personal
battles with chronic illness.

Like clients, students sometimes share too much information—TMI,
as we lovingly refer to that particular phenomenon—and can flood
the classroom, inappropriately divert student attention, and impede
learning. Many of the topics explored in class evoke strong emotional
responses that can catch students by surprise, lower their defenses, stir
up unresolved issues, and leave them feeling quite vulnerable. We have
to be constantly attentive to the affective tone in our classroom, reign
in those students whose urgency to voice their experiences impinges
on others, and make space for the more introverted members to share
if they wish. As faculty, our responsibility extends beyond the 2 hours
of each class period, and we make ourselves available to help students
contain any concerns that arise in response to the course material, or
to refer them to others who can help them to do so.

**CASE STUDIES: PUTTING PATHOPHYSIOLOGY IN THE
CONTEXT OF A WHOLE PERSON**

Before the advent of the chronic illness classes, the “liver content” in
the Edgewood nursing curriculum was covered in a traditional medical-
surgical nursing course. The colleague who was responsible for the
course asked Colleen to present the topic, because she had much expe-
rience working with individuals whose health was compromised by liver
disease. As was often the case, she began her preparation by reading
the chapter in the course textbook, taking notes on the content she
felt was particularly important. As a fairly experienced lecturer, her
intent was to present the standard lecture on liver failure, that is, review
physiology, discuss pathophysiology, and identify nursing care issues using the nursing process as the basic format. Before she had completed her first page of notes, she was already disengaged. Wondering how she could make the material remotely interesting, she reflected on how she had learned about liver disease. That led her to write the following case study as the format for the lecture and discussion.

Although the case study focuses on an acute care experience, it tells the true story of a man named Ben. Imagine how difficult it must be for students attempting to understand the complexities of liver failure, having never even seen someone with the disease. Ben’s story imparts the reality of someone trying to live a life with a deadly disease, and provides students the opportunity to comprehend a different perspective while applying nursing knowledge. Interspersed with Ben’s story are Colleen’s notes that segue into class discussion about the realities of providing care for someone as unique as him. The clinical discussion topics are presented in bold type.

**Ben: Living a Life With Liver Disease**

I’ll never forget Ben. I was a student at the VA when I first encountered him. He was living with advanced cirrhosis and would require frequent hospital admissions to manage the numerous medical problems that kept coming up. It seems that on this particular day, Ben had consumed a large quantity of beans and other sources of protein in the hospital cafeteria and literally passed out in his bowl of bean soup. He was admitted to the medical floor, comatose. His medical diagnosis was hepatic encephalopathy. The medical goal was to decrease his serum ammonia levels. This was when I first met Ben.

Ben was a nursing instructor’s dream comes true. What instructor doesn’t enjoy challenging his or her students with the complex pathophysiology of liver failure? I can hear her now. Why does he have ascites, why is he on a protein restricted diet, why is he hypoglycemic, why is he receiving spironolactone and not lasix, why is he getting lactulose, and why is he bleeding—why, why, why, why? Where do I start? All that seems so medical. Sure, I needed to know all that, but let’s look at Ben first. Who is this guy?

Ben was in his late 60s. He was by all intents and purposes a bum, a street person. His wife had died several years ago, and he had no children or any other relatives. He was literally alone. I don’t know the circumstances surrounding Ben’s alcohol consumption, it really seems rather unimportant at this point, but he has a past and present history of consuming large quantities of alcohol. Does it really matter if it’s brandy or gin? Ben was an engineer in his other life, but is seems, somehow, things just got away from him. He lives in a flophouse on the city’s south side. Occasionally, his landlady would offer him a meal.
Clinical Day 1

Ben was comatose. His ammonia level was over 100 (normal is 30–70 µg/dl). He was receiving lactulose, folic acid, vitamin K+, and thiamine. I distinctly remember the lactulose. It comes in a thick sticky liquid and was given down his nasogastric tube. It causes unbelievable diarrhea. Everyone seemed to think that was great, except for me. I had to clean it all up. Ben was rather apple shaped, with a large ascitic abdomen and no body fat. His coccyx was rapidly becoming excoriated because of his diarrhea. That was my first day.

Discussion
Medications
Ascites
Nursing Care

Clinical Day 2

Regardless of his situation, Ben was a likeable guy. He was totally disrespectful of doctors and nurses. “You can all go to hell” were his first words when he awoke. I was surprised to see the rapid recovery in just 2 days. Ben was awake, appropriate (most of the time), and eating. Forty-eight hours of lactulose every 6 hours had decreased his NH3 to 40. It was sad to see how alcohol had destroyed his body. On rounds, the residents asked him to perform various neurological tests: touch hand to nose, stretch arms out in front with eyes closed, and so on. Ben performed them all poorly. Once outside the room, the residents laughed at him. It hurt. The progress notes said Wernicke-Korsakof syndrome, asterixis, and so on. It didn’t sound good. Ben had been placed on a low protein/low sodium diet, with a 1,500 cc fluid limit. He ate everything place in front of him and then went to the cafeteria and ate more! Eggs were his favorite. He drank water out of the fountains with no regard for his fluid limit. His doctors would yell at the nurses because he kept gaining weight. Ben weighed 155 pounds, most of it ascites fluid. His dry weight was probably 140. To solve the water problem, the residents had the water shut off in his room. Ben didn’t seem to mind; he’d had a hard life, and he could get all the water he wanted down the hall or in the cafeteria. It was more of a problem for the nurses not having water in his room than it was for Ben.

Discussion
Diet therapy
Neurological impairments
Management strategies

Clinical Day 3

Ben’s potassium had been rising. It was now up to 6.1 mEq. On rounds, the doctors were discussing diuretic management. Ben had been on spironolactone (aldactone) as a diuretic. It was thought that this was the most likely cause of his increased K+. They decided to stop his spironolactone and to
try diuresing Ben with lasix. While this bedside conversation was occurring, Ben kept asking about going home. He could care less about what his potassium level was. He just wanted to leave. I kept wondering what that meant for a homeless person. He really didn’t have a home. Ben’s room didn’t have the usual assortment of cards, gifts, or flowers. No one came to visit. I doubt that anyone even knew he was in the hospital. Would his room still be there or would the landlady give it to someone else? I made a mental note to check into this. What an odd feeling. Ben had managed to befriend several of the other patients, though. It was not uncommon to see them laughing together while watching TV in the dayroom at the end of the hall or even engaging in a rousing game of cards. Too bad he was so sick, but, you know, it didn’t seem to matter to him. Life had a different meaning for him. His hematocrit had started to drop. Although it was never very high to begin with, usually around 33%, it was now down to 25%. His doctors suspected bleeding. The most likely source was from his esophageal varices. They were discussing treatment options amongst themselves. Funny, no one ever asked Ben what he wanted done if he had a huge bleed. Because of his neurological damage, they felt he was incompetent.

**Discussion**

**Role of aldosterone**

**Portal hypertension: management options**

**Meaning of illness to person**

*Clinical Day 4*

Ben wasn’t in his room when I arrived. He had been transferred to the medical ICU during the night. He had gone into hepatorenal syndrome. I didn’t understand what the kidneys had to do with liver failure, but somehow his kidneys had suddenly decided to fail. I was told that hepatorenal syndrome is untreatable. It’s usually at this point that medicine throws in the towel; there is nothing more to offer. “Offer”—what an interesting notion. What exactly was it that we offered Ben? We shut off his water, nagged him about everything he ate, and periodically stuck needles in his arm. He, in turn, obliged us with a toothless grin. Now we offer him death. He died shortly after his arrival in ICU. I didn’t quite understand why he was transferred to the ICU to begin with. Can’t people die in their rooms? My nursing instructor said it was a good learning experience. I guess it must have been because I still remember Ben 25 years after his death. During my nursing career, I have since seen dozens of Bens; I’ve given large quantities of lactulose and transfused more esophageal bledders than I care to remember, but I can’t forget Ben. Today, we transplant people like Ben. I wonder what he would have done if this had been an option 25 years ago?

**Discussion**

**Renal failure**

**Caring and curing**
After writing about Ben, Colleen found that preparing material for theory classes became easier and more interesting to the students and to her. Students preferred stories about people to the standard lecture format. She wrote about Glenn—a farmer with an eighth grade education trying to manage his expensive, complex, and ever changing medical regimen for severe hypertension; Candy—a nursing student with rheumatoid arthritis; Dickey—a cheese maker turned truck driver living with diabetes; and Uncle Lee—who died from emphysema. (These cases can be found in Appendix A.)

Colleen’s stories serve as the basis for classroom discussion. Students receive written copies of the cases to help them prepare prior to class and to use for the purposes of note taking in class. Students bring in their experiences with clients from clinical and also converse about other people they know who are living with chronic illness and experiencing similar situations. This format simultaneously fulfills two functions. It provides students the opportunity to study nursing content in an applied context, which aids retention. It also offers students the chance to gain knowledge about integrating nursing care according to the individual/family needs—the art of nursing science. Studying how to implement sound scientific knowledge becomes equally important as learning the facts. This helps ward off potential paralysis the first time students encounter a client similar to Ben or Joe.

Differentiating acute care interventions from the issues faced by clients on a daily basis as they live their lives with chronic illness is of paramount importance. The cases emphasize how to recognize trouble as well as self-regulatory strategies that promote partnerships in care. Integrating the three primary concepts of the course—self-regulation, stigma, and caregiver issues—becomes effortless in the context of case stories.

Unfortunately, it does not take students long to become discouraged by clients who, despite all the well-intended actions on the part of the students, don’t change their actions. Students find it exceptionally difficult to understand that education does not necessarily change behavior. Undergraduates idealistically believe that clearly what’s needed is more and better patient education. Using lived experiences as didactic content allows students to appreciate the reality of our (the nurse’s) expectations as these come into conflict with the client’s reality. Several models, such as the Health Belief Model, conceptualize the complexities of health behavior. For novice nursing students, models appear too abstract and are oftentimes difficult to apply, but students do understand this very simple equation:
Values + Beliefs = Behavior

When we discuss a nurse trying to get a teenager to quit smoking, we’re attempting to change a behavior. That can’t happen very easily without understanding the values and beliefs involved. Adolescents’ values, as a result of peer pressure, include the desire to be a part of the in group or to be cool. In the adolescent belief system is the notion that they are immortal—“Everyone else will get cancer but not me”—or “I’m in control, I can quit anytime.” Adding the value of being cool to the belief of control and immortality allows them the behavior of smoking. Understanding and addressing the values and beliefs will change how a nurse approaches this issue. This simple equation helps students revisit the nursing process and assess their clients more thoroughly. It also suggests that nurses should know their clients as people before attempting to implement actions aimed at changing behaviors.

This equation is frequently referred to throughout the course during our discussions/lectures in class. Students gain an appreciation for why someone’s blood pressure is out of control despite an aggressive medical regimen prescribed. Reason: The client had to share his medication with his wife. Or why someone consistently gains 10 lbs between dialysis treatments. Reason: The client can only afford canned soup and baloney sandwiches for lunch and dinner. Understanding more than the disease and the appropriate textbook interventions is essential in learning to provide whole-person care.

Once students understand the importance of knowing their clients’ values and beliefs, learning to respect them becomes another hurdle. It is difficult to respect someone’s belief that vinegar and honey is a better antihypertensive agent than a beta-blocker, or the depression era mindset wherein frugality is so highly valued that clients cut their nitro patches in half to save money, or clients who never take prophylactic medication because it is far too wasteful. Students come to accept that maybe, just maybe, their clients are doing the best that they can, given their values, beliefs, economic status, and level of education. Despite these challenges, students learn to separate the person from their actions and to become much more grounded and realistic in the expectations they have for their clients.

Reviewing Ben’s story and the sample cases in Appendix A makes it readily apparent that not everything is covered in the scenarios presented. However, it is through the stories that students realize the content areas they should revisit and need to master to adequately
develop their knowledge of the topic. Stories are not intended to cover everything. Our stories provide examples of how we let go of content. They represent a scholarly assessment of what information students might use as a foundation upon which to further build their nursing knowledge base. As such, stories offer realistic alternatives that blend didactic content with practical application for clinical practice. Realizing that classroom instructors will never be able to cover everything, letting go of content provides a new approach that enriches classroom content and ultimately enhances critical thinking. While we let go of content, we teach our students the skills necessary to find the factual information needed, to fill in the blanks of their knowledge base, to analyze what is appropriate for each individual clients’ situation, and to evaluate the outcome.

STORIES TO PUT MENTAL ILLNESS IN ITS PLACE

Pamela has primary responsibility for presenting course content related to the care of individuals and families dealing with mental illness and addressing the psychosocial-spiritual sequela of chronic illness in general. In addition to acquainting students with the nuances of providing nursing care for persons labeled with the various psychiatric diagnoses evident in the topic list in Table 4.1, she is charged with helping students examine preconceived prejudicial ideas they have about people who have psychological impairments. Metaphorically, this necessitates having ready access to the stigma lens for each class period.

Being clear about one’s boundaries as a caregiver is essential for survival in nursing. It is especially apropos and challenging when dealing with mentally ill clients. Their characterology and symptomatology can lead them to transgress accepted social norms or render them vulnerable when the caregiver is not clear about the nature of the relationship. Developing the therapeutic use of self in our students is contingent on recognition of their own strengths and limits. Only then can they avoid projecting their issues on the clients or personalizing client reactions that really have nothing to do with them. In the clinical class, students are positioned to actually provide care that much of this learning gets enacted, but in some regards, the theory class serves as launching pad for that experience. Although the clients’ students work with in the psychosocial-spiritual component of the clinical course, it is nowhere near as scary or dangerous as they fantasize, although some clients do
present with problematic behaviors that can impinge on safety. The theory course provides a less threatening environment, one in which students can grapple with their fears and explore some of the interpersonal skills and techniques necessary for intervening with clients whose worlds may be intellectually, emotionally, socially, and/or spiritually tenuous.

Like Colleen, though to a more limited degree, Pamela intersperses her classroom teaching with cases fashioned from clinical practice. To give students a more vicarious understanding of the experience of chronic mental illness and issues at the end of life from both the client and caregiver perspective, she employs four other kinds of stories as well. The first of these could be called cases al la mode—synopses of current events reported in the popular media. Classroom discussions regularly take a turn toward pondering whether those involved in recent local or national crimes might meet the criteria for a given mental illness. We query as well how the prevalence of war and other violence, social inequities, and the general pace of life might figure in the development of psychiatric symptoms and the construction of certain diagnostic categories. Descriptions of the three other types of stories follow.

**Literary Cases**

The second type of tale Pamela employs arises from popular and professional literature. Reading *Gracefully Insane*, Alex Beam’s (2001) best selling portrait of McLean Hospital, one of America’s oldest psychiatric institutions, gives students a historical perspective on mental health care in this country. Amusing anecdotes about some of its famous and infamous patients captures their interest and draws them into factual descriptions of somatic and interpersonal therapies. Personal accounts of encounters with chronic illness like *Tuesdays With Morrie*, Mitch Albom’s reminiscence of the time he spent with his cherished dying professor Morrie Schwartz, and Pat Deegan’s exceedingly poignant story of reclaiming her sense of value in the face of being labeled with chronic schizophrenia are other examples of stories used in class. Both illustrate the notion of self-regulation. Albom’s tale also enhances student empathy for family and friends taking on the caregiver role. Deegan’s decree that “It is important to understand that we are faced with recovering not just from mental illness, but also from the effect of being labeled mentally ill” (p. 10, 1993) reiterated throughout the course highlights the extent of stigmatization of mental illness.
Video Cases

A third and frequently employed story form is that of video, both educational and popular. Table 4.2 provides a listing of currently used videos and the course topics each elucidates. Most of the videos are viewed in advance and, along with assigned readings, are intended to prepare students for class lecture, discussion and experiential activities. A few of the videos, as indicated in Table 4.2, are shown in class and serve as a more academic counterpoint to Hollywood’s rendition of the various disorders.

Pamela makes available online optional worksheets that students may use to assess whether they have grasped essential concepts from the readings and videos. Her PowerPoint lecture notes, accessible online, double as worksheet answer keys. Each topic area has associated “critical questions” that help ready students for class, and give them an opportunity to earn points toward their final grade. The questions call for reasoned judgment and have no definitive answers, though points may be deducted if answers are incomplete or inaccurate.

A brief overview of the class period devoted to “Nursing Care of the Client with Psychosis: Case Example—Schizophrenia” helps illustrate how the readings, videos, worksheets, and critical questions are used in the psychosocial-spiritual component of NR3340. As preparation, the students read a chapter in a psychiatric nursing text that describes relevant DSM-IV and nursing diagnoses, presents hypothesized etiologies, and explores a variety of treatment strategies and nursing interventions. Many students will then complete the associated worksheet to test their comprehension. Next they view *A Beautiful Mind*, a popular movie that takes a number of liberties in portraying the mathematician and Nobel Prize winner John Nash’s struggle with schizophrenia. It does, however, illustrate the trajectory and symptomology of the disorder, as well as some of its interpersonal and social ramifications. Afterwards, the students are ready to grapple with the following critical questions that serve as a springboard for classroom discussion:

1. John Nash was a Nobel prize-winning mathematician who developed a groundbreaking economic theory and struggled with a debilitating thought disorder. Give some examples from the movie, *A Beautiful Mind*, that substantiate that John Nash suffered from both positive and negative symptoms of schizophrenia.
2. Farrell and colleagues note that, “Because the reality distortions of psychosis create a potential risk for agitation or violence, safety
### TABLE 4.2 Films and Video Cases You Can Use in Class

<table>
<thead>
<tr>
<th>Content Topic</th>
<th>Video Case</th>
<th>Critical Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Mental Illness</td>
<td>Back Wards to Back Streets: This 1980 video documentary, produced, written, and directed by Roger Weisberg, Public Policy Productions, portrays the plight of many patients who ended up homeless or in inadequate housing subsequent to the Supreme Court decision to deinstitutionalize them. Some examples of successful community mental health treatment programs are also described.</td>
<td>1. Access the National Alliance for the Mentally Ill (NAMI) Web site (<a href="http://www.nami.org">http://www.nami.org</a>) and click on their stigma alerts listing. Identify one listing and indicate whether you were surprised, delighted, annoyed (etc.) that NAMI tagged the identified party. 2. Deegan (1993, Recovering our sense of value after being labeled. <em>Journal of Psychosocial Nursing, 31</em>(4), 7-11) notes that once you’re labeled with a mental illness “everything you do gets understood in reference to your illness” (p. 9). Give an example from your own experience that either supports or negates this stance. 3. After viewing Back Wards to Back Streets, identify several pros and cons of deinstitutionalization.</td>
</tr>
<tr>
<td>Social Construction of Stigma</td>
<td>A Beautiful Mind</td>
<td></td>
</tr>
<tr>
<td>Psychotic disorders</td>
<td>A Beautiful Mind</td>
<td>1. John Nash was a Nobel prize-winning mathematician who developed a groundbreaking economic theory and struggled with a debilitating thought disorder. Give some examples from the movie, <em>A Beautiful Mind</em>, that substantiate that John Nash suffered from both positive and negative symptoms of schizophrenia.</td>
</tr>
</tbody>
</table>

(continued)
TABLE 4.2 (continued)

<table>
<thead>
<tr>
<th>Content Topic</th>
<th>Video Case</th>
<th>Critical Questions</th>
</tr>
</thead>
</table>
| Mr. Jones: the value of this melodramatic view of bipolar disorder lies in Richard Gere’s believable renditions of depression and mania and, ironically, in the implausible romance between him and his therapist. The later phenomenon provides ample fuel for meaningful class discussions about ethical treatment and the boundaries of therapeutic relationships. | 1. Identify—  
   a. At least three behaviors Mr. Jones demonstrated in the community that would help support Dr. Bowen’s assessment on admission that he has a bipolar affective disorder and was in a manic phase.  
   b. At least two symptoms of depression he evidenced at Howard’s house and in the hospital that support a diagnosis of depression.  
   2. In completing a mental status exam of Mr. Jones, how would you describe his insight and judgment? |

2. Farrell and colleagues note that “because the reality distortions of psychosis create a potential risk for agitation or violence, safety is of paramount importance” (1998, p. 190). They note as well the importance of rapport in working with psychotic individuals (1998, p. 191). What were some of the things that John Nash’s family and friends did to decrease his underlying (although sometimes indistinguishable) anxiety?  

3. In what ways does the movie help to overcome and/or reinforce stereotypes about schizophrenia and mental illness in general?
### TABLE 4.2 (continued)

<table>
<thead>
<tr>
<th>Content Topic</th>
<th>Video Case</th>
<th>Critical Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3. Both Mr. Jones and his friend Howard demonstrated some skill in managing crisis situations. Howard was successful in getting Mr. Jones out of precarious circumstances on the roof. Mr. Jones saved Dr. Bowen’s life by intervening when Mr. Altman assaulted her. Identify at least two things each man did that enhanced the likelihood of a positive outcome.</td>
</tr>
<tr>
<td>Safety Concerns</td>
<td>Replays of relevant clips from <em>A Beautiful Mind</em> and <em>Mr. Jones</em> that depict points at which each of the main characters poses a threat to himself or others are shown in class.</td>
<td></td>
</tr>
<tr>
<td>Case Model:</td>
<td>Iatrogenic Disease</td>
<td>Screening for tardive dyskinesia video shown in class.</td>
</tr>
<tr>
<td>Restraints and</td>
<td>Substance-Related Disorders</td>
<td>28 Days</td>
</tr>
<tr>
<td>seclusion</td>
<td>Case Model: <em>Multiple Substance Abuse</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>As Good As It Gets</td>
<td>1. In what ways does Melvin fit DSM-IV-TR criteria for obsessive-compulsive disorder?</td>
</tr>
<tr>
<td></td>
<td>Case Model: ODC</td>
<td>2. One of the main themes of NRS 340 is how the experience of chronic illness challenges self-regulation. How did Melvin’s various symptoms (i.e., behavioral quirks) enhance his sense of control and how did they detract from it?</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Content Topic</th>
<th>Video Case</th>
<th>Critical Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality Disorders</td>
<td><em>Girl, Interrupted</em></td>
<td>3. Suppose Melvin needed to be hospitalized on an acute medical-surgical unit following a hernia repair. What advice would you give the nursing staff providing his care to help prevent exacerbation of his psychiatric symptoms and facilitate his recovery?</td>
</tr>
<tr>
<td>Case Models: obsessive-compulsive, narcissistic, borderline antisocial personalities</td>
<td>Personality disorders video shown in class</td>
<td></td>
</tr>
<tr>
<td>Dissociative Disorders</td>
<td><em>Prince of Tides</em></td>
<td></td>
</tr>
<tr>
<td>Case Models: PTSD and DID</td>
<td><em>Dying to Be Thin</em> shown in class</td>
<td>1. Self-regulation: Although binge-eating disorder has been proposed for inclusion in the next version of the DSM, obesity is not a mental illness. What, if any, impact do you think legitimizing binge-eating as a medical label might have on the incidence of obesity in this country?</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
<td>2. Caregiver Concerns: After completing assigned readings, briefly discuss what you would do if you noted any of the early signs or health consequences in a friend or family member. What are some of the things that help you or keep you from addressing a possible eating disorder in someone you care about?</td>
</tr>
</tbody>
</table>
### TABLE 4.2 (continued)

<table>
<thead>
<tr>
<th>Content Topic</th>
<th>Video Case</th>
<th>Critical Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Disorders of Childhood or Adolescence Case Models: ADHD and autism</td>
<td><em>Behavioral Disorders in Children</em> and <em>Ordinary People</em></td>
<td></td>
</tr>
</tbody>
</table>

3. Stigma: After completing assigned readings, respond to the following question. In what ways do the attitudes apparent in the two articles alleviate or promote stereotypical views of people who are obese?

1. How does the physician on the *Behavioral Disorders of Children* video who discusses the therapeutic effects of ritalin explain the fact that a chemical stimulant results in a child’s achieving more organized, constructive behavior?

2. What are some of the most important things you’ve learned about therapeutic relationships this semester that will help you intervene with individuals like the four children in the video and their families?

3. The video *Ordinary People* was made in 1980. Identify some stigmatized views of mental illness that were depicted in the video and indicate whether they continue to be prevalent today.

4. Identify a priority nursing diagnosis for each of the three Jarrett family members and one nursing intervention you could use to address it:
   - Conrad:
   - Beth:
   - Calvin:

Facing the Wit
End of Life Case Model: professional caregiver concerns
*Caring for Mo*—shown in class
is of paramount importance” (1998, p. 190). They note, as well, that the importance of rapport in working with psychotic individuals (1998, p. 191). What were some of the things that John Nash’s family and friends did to decrease his underlying (although sometimes indistinguishable) anxiety?

3. In what ways does the movie help to overcome and/or reinforce stereotypes about schizophrenia and mental illness in general?

The class period begins with a showing of a 60 Minutes (3/31/00) interview by Mike Wallace with John Nash, his wife, and his younger son Johnny. Pairing this video with A Beautiful Mind affords an opportunity for students to contrast Hollywood’s version of John Nash’s life with his own. Pamela then proceeds to an interactive lecture about schizophrenia and other psychotic disorders from a PowerPoint presentation that includes still shots from A Beautiful Mind and links to relevant websites. Students interject with their insights and questions. They have open access to the notes and websites throughout the semester, and those who want to learn more about Nash’s life and the most current theories and practices related to schizophrenia can do so at their leisure.

The just described sequence is reenacted in many of the psychosocial-spiritual class sessions. Table 4.2 includes Critical Questions used with some of the topic areas and their associated videos. The characters in the videos are like clients the students come to know and understand better over the course of the semester as they learn more about the nature and treatment of mental illness. The fact that some of the video characters are based on the lives of actual people makes them more believable. Susanna Kaysen, like John Nash, is a former McLean patient. The video Girl, Interrupted, described in Table 4.2, is based on her book of the same title, which details her almost two year hospitalization there. Students appreciate that in addition to the stories about McLean offered by Beam, Kaysen, and Nash, Pamela has her own story about teaching a psychiatric nursing clinical there in the early 90s.

Caring for individuals with mental illness can be perplexing and demanding, as clients may be rejecting or evoke feelings in the caregiver that interfere with the therapeutic process. Donald Oliver maintains that both technical knowledge and ontological knowing involve concepts, skills, and attitudes, and, thus, effective teaching strategies include cognitive, psychomotor, and affective elements (cited in Vella, 2002, p. 150). The written and video scenarios noted up to this point do evoke visceral responses and provide avenues for exploring possible action and intervention.
Impromptu Stories

Intervening effectively with persons whose mental processes can be manifested in bizarre and sometimes threatening ways requires command of one’s own thoughts, feelings, and actions, which requires lots of practice, much of which will be afforded in the clinical course. The fourth story form—dramatization—adds an interactive dimension to classroom cases and gives students a preview of how they might react to inevitable encounters with frustrated, angry, hostile, sad, otherwise emotionally wrought clients in clinical. Occasionally, Pamela has collaborated with the college’s theatre department or individual students in the course to surprise the rest of class with a topic-relevant client scenario. More often, she intersperses impromptu role playing with the other three types of stories to engage students in challenging situations without actually placing them in harm’s way. Integrating neologisms into a lecture on psychosis, periodically striking strange postures, or appearing to attend to internal stimuli give a fuller feeling of what it is like to sit with someone who is actively psychotic. Acting depressed (e.g., evidencing psychomotor retardation or becoming tearful) or manic (e.g., speaking in a rapid, pressured manner and pacing around the classroom) while lecturing about mood disorders not only promotes student attention, it forces them into the story. Shouting at them in the midst of talking about how to manage someone who is angry catches them off guard, just as clients often do.

That such theatrics evoke strong student responses, even when they know it is an act, highlights a fundamental principle in the mental health arena—emotions are contagious! Effective nursing, regardless of the setting or the population being served, requires being able to manage affectively charged situations. Classroom dramatics provide an opportunity to explore how one’s thoughts and feelings might lead to action, or immobilization. They are not without some risk though, as Pamela discovered just a few semesters ago when she entered the class period designated as Safety Concerns in a fictitiously bad mood.

Infectious Anxiety

I do not like to admit the relief I felt when that particular group of students graduated. In the year after they moved on from NRS 340 and 341, I would sometimes see a bunch of them together and would reexperience the feelings of immense inadequacy I had the day I violated my cardinal rule, SAFETY FIRST! I espouse that all the time, in the classroom and in clinical settings.
I tell students that a physically and emotionally secure milieu is essential for therapeutic work and learning and that the nurse or teacher has significant responsibility for creating it.

What was I thinking that day? I do vaguely remember feeling uneasy, even before I entered the classroom, but I disregarded the feeling. This was ironic, in light of my continual preaching, “Listen to your gut.” I had done this at least 10 times before, and I told myself this was just the usual initial stage fright. I took a deep breath and entered the classroom. I started off being just a little pissy. I didn’t offer my usual greetings or really look at anyone. I walked straight to the lectern and kind of slopped my bag down. I rummaged through it as if I couldn’t find something quite important. I remember sighing and frowning a lot. As usual, it took a few minutes before anyone seemed to notice. Then, the familiar quizzical looks. Oh yes, she’s astute and would pick up right away that I am acting. After all, the schedule says we’ll be addressing safety concerns today.

Quickly, it was evident that others are on to me too, and I worry that I will not evoke the tenuousness that facilitates learning. I ratchet it up a level or two. A student comes in late. I shot her a dirty look and shook my head at the rest of the class. She sat down quickly while I launched into “I don’t want to hear about parking. I know it stinks. I was here on time.” I escalated further, probably pacing around the classroom and getting in the students’ space. The exact details are fuzzy now, lost in retrospective shame.

I do remember thinking they all saw me for the phony I was. After talking about anger in an irritable tone I started darting questions at the students. I cut off midsentence those who dared respond, or followed up their comments with massive corrections. I was surprised and pleased when Missy, brave soul, came to the defense of a previously dismissed student. “I think what she was trying to say,” but by then I was stuck in character. I cut her off with “Don’t speak for others!” I misconstrued the ensuing laughter to mean universal recognition of my inept acting. It was only when Missy suddenly bolted out the door that I was jolted into the awareness of how unsafe the classroom had become.

Horrified, I stopped dead in my tracks then nodded approval at Sue who motioned that she was going to check on Missy. She exited. Not knowing what to do I blurted, “I was just acting. You knew that right?” I saw lots of nods, some knowing smiles, but just as many expressions of uncertainty. I gesture for a timeout in football fashion and sit down. I take a deep breath. “How you guys doing?” More nods. “I scared you didn’t I?” More nods. “Do you think Missy is okay?” I ask, not wanting to abandon the rest of the class. More nods, but even more shoulder shrugs. “I hope she’ll come back,” I say “but I trust that she will do what she needs to do.” I was talking more to myself than to the students. Truth was, I did not have a clue what to say or do.

After what seemed a very long silence, the wisdom of one of my beloved teachers came to me. Whenever encountered with a tough situation—find a way to talk about it. I invited the students to express their feelings. Some asserted that they knew right away what was going on and found it amusing.
Some vacillated back and forth between amusement and anxiety, others were bewildered. Some were worried for me and wanted to help but didn’t know how. A few were really angry that I would do such a thing. It took all my energy to just hear them out and not try to defend my actions.

Missy and Sue returned. The tracks of her tears were readily apparent, Missy said she was okay but needed to leave. While she and Sue pack up her books, I asked her to come and see me later. She agreed readily, then left. Sue sat down and says Missy is upset because she has always been sensitive about talking more than others in the class. Baffled, I did a quick internal check—does she talk more than anyone else? That is not my assessment, but now I grasp why she looked so wounded. My arrow struck her Achilles’ tendon.

The rest of the class and I talked for a while longer. I confessed that I was the instigator of the infectious emotion that overwhelmed us, and took responsibility for having violated what should have been a safe place. Noting my remorse, some students immediately melt with forgiveness, others are nonchalant; others still looked annoyed or otherwise upset with me. With about 20 minutes of class time remaining it’s apparent we’d said as much as we could and I excused the students.

I dashed down to one trusted colleague’s office and confessed my sin. The students who had just left my class were scheduled to reconvene in her research course in just 15 minutes. I wanted to prepare her for any residual fallout, but in the security of her presence, I melted down. She assured me that I am not the worst teacher ever, and ponders the likelihood of the students’ attending to what she has planned. She decides to begin her class by acknowledging the turmoil in my class and gives the students the option of not meeting. They readily take her up on the offer—no surprise.

The experience really humbled me; in the immediate aftermath, it was for the worse possibly, but overall, it was for the better. I was a bit inhibited for the rest of the semester and engaged in fewer role-playing antics than I normally would have. Missy did come to talk with me individually and shared her concern that her classmates perceived her as a monopolizer. I doubt that my assurance that I did not regard her as such made any difference, but there was no change in her level of class participation. When the issue of safety came up in the context of subsequent course topics, I sometimes referred back to the contagiousness of emotion we had experienced earlier without again precipitating chaos.

The comedienne Carol Burnett is credited with saying that comedy is just tragedy plus time. Time has helped me to see how comical the situation was, especially the part where I allowed my distress to get the students out of their research class. Most of the students were not that affected by the experience. Being able to laugh at myself has helped me to see where I went astray. I had prior knowledge that four of the students in the class had been diagnosed with anxiety disorders (Missy and Sue among them), and I had tried this theatrical stunt far earlier than in previous semesters. The students had not yet trusted me enough for me to pull such a punch.
Colleen always says you can learn just as much from a bad role model as a good one. I’d rather be a good role model, and I hope that most of the time I am. Nonetheless, I am grateful for the humility that comes with acknowledging that knowledge and experience do not provide immunity from making mistakes.

Each of the story forms described so far allows our students some access into what it means to live a life with chronic illness. The grand narratives, deriving principally from the required texts and other assigned readings, are basically flat. The subsequent kinds of stories open students to fuller dimensions and greater depths of providing whole person care. In the artificiality of the classroom, they help evoke the thinking, feeling, and even behavioral responses students will need when faced with real clients in the real world. Including guest presenters in our course schema gives students a chance to interact with those who either have personal experience with chronic illness or provide care to those who do. It allows us an opportunity to express the college value of partnership, and it allows the students to ask questions they are afraid to raise with clients or with their professors.

STORIES IN THE FLESH

As with role-playing and other theatrical devices, relying on guests involves some risk. Like the old television commercial touting the cathartic benefits of prunes, we continually ask “Is one enough, are four too many?” Colleen sometimes fantasizes about composing the medical-surgical component entirely of guest speakers, each presenting their experience in living with _____ (fill in the blank). We have no shortage of available, relevant, and fascinating speakers, and no specific formula for determining the right number or mix. Student evaluations over the years have, however, led us to conclude that course continuity and student interest tends to break down if either one of us has more than three guests a semester in our individual components.

We have heard from enough experts or folks with amazing stories whose unfamiliarity with our course objectives or with public speaking made for boring, irrelevant, or confusing presentations to be cautious about turning our classroom over to just anybody. Luckily, we can be very selective and now have a slate of reliable, engaging personalities who are ongoing partners in our teaching endeavors. In any given semester, we tend to bring in new presenters for no more than a class
period or two. Although each presenter has a particular content area
that they address, due to student interactions and questions, repeat
performances are never the same.

The stories of our visiting colleagues magnify what we can show
students about whole person care through the lenses of caregiver con-
cerns, self-regulation, and stigma. For example, two fellow teachers
at the college who have undergone organ transplantation share very
different tales of the ups and downs with their health and their health
care providers. Their gratitude for the lives they would not be living
without modern technology helps illustrate the benefits of the biomedical
model. Their strict medication regimens and associated side-effects
suggest the down-side and stimulates discussion of the nurse’s role in
helping clients do cost-benefit analyses in discerning treatment options.
That both have the personal fortitude and essential financial and inter-
personal resources to allow successful transplantation calls into question
the equity of who does or does not qualify for second chances in life.

Whether by design or fate, the greatest majority of our guests are
nurses. Some of them deal with chronic illness as part of their work
and/or have personal experience with it. An advance practice nurse
hired by a local hospital to design and implement a discharge program
for people with congestive heart failure spoke about strategies he devel-
oped to prevent the frequent recurrent hospitalizations often experienced by this population. Hearing how the program has improved client outcomes and saved the institution thousands of dollars helps students understand the meaning of tertiary care and the power nurses have to enhance the lives of those living with chronic illness.

Another individual, whose nursing career was cut short by incapacitating depression, came to our class in her current role as the coordinator for a mental health consumer advocacy program. Her upbeat presentation belied the students’ misconceptions that people with mental illness never get better. Also defying stereotypical views, a high powered nurse manager responsible for a local multiservice mental-health program educated the class about anxiety and dissociative disorders by sharing how his somewhat turbulent adolescence landed him in Viet Nam at age 19. After hearing his story of being taken hostage by a psychotic fellow-American soldier during his first week there, students had a visceral sense of how trauma figures in the development of post traumatic stress disorder (PTSD).

Each semester some of the guest speakers know the students and vice versa. A member of our nursing faculty shared her family’s rocky
journey through the mental-health system trying to get services for her brother, who was diagnosed with schizophrenia. Colleen became a guest lecturer in Pamela’s class, Nursing Care of the Client With a Mental Disorder of Childhood or Adolescence. She talked about the challenges her son Adam and the whole family face as a result of his severe attention deficit and hyperactivity disorder. This willingness to be vulnerable in front of one’s students promotes a sense of connection, underscores the pervasiveness of chronic illness, and models how candid discussion of the joys and burdens of tending to a loved one with a stigmatized condition can reduce caregiver strain.

Such vulnerability and its concomitant benefits are also apparent when the visiting scholar comes from the ranks of the learners. Three of our presenters are previous students who come back to share knowledge and expertise gained in the courses and from powerful personal experience. Carrie readies students for the chronic illness courses by helping Pamela teach a section on crisis intervention in NRS 310. Her extensive understanding of suicide prevention and intervention came as the result of her only sibling taking his own life at age 21. Her presentation made clear both the devastation that follows such loss and how bringing meaning to that occurrence promotes healing. It also made students acutely aware of their own susceptibility to stress and of the importance of taking care of themselves as they learn how to care for others.

Similarly, Greg’s frank discussion of his long history of substance abuse and how it has several times threatened his professional license, awakened students to potential pitfalls in nursing. Posting a “résumé” of the 20-some drugs he has abused along with the amounts taken at the height of his drug career on the chalkboard and discussing how readily he could access and use them on the job conveyed volumes about the issue of impaired providers. It also drove home the point that the incidence of substance abuse is greater among nurses than it is in the general population.

Maradee taught about end-of-life concerns with a PowerPoint presentation filled with photos she took in an Edgewood art course and memories of being a hospice volunteer. Her conversion from what she describes as an arrogant do-gooder to a humble servant conveyed a message more readily heard from a peer than a professor.

The stories of these three students-turned-teachers appear in greater depth in chapter 6. What they have to say to their successors is especially powerful, because (1) they can empathize with the current lot of the
students, (2) their accomplishments are so inspiring, and (3) they are incredibly articulate in expressing how they have been transformed by their experiences. Their successes convince the incumbent students that they too can survive the chronic illness courses, and stokes their desire to contribute to society in equally significant ways.

That all of the above mentioned teaching partners speak firsthand of the despair of losing one’s self-regulatory capacity, the effects of living with a stigmatized condition, and/or the stresses inherent in nursing gives them great credibility in students’ eyes. Although it is not uncommon for the students to ask after a guest’s departure, “What do we really need to know for the test?” their course evaluations indicate that the stories shared by these amazing people have transformative effects. In all likelihood, many students would say our most regular coconspirers, John and Adrian, who were introduced in chapter 2, have the most profound effect on them, though. They are indeed some of our most provocative coteachers, in the most positive way.

Since the inception of the theory course, John and Adrian have shared what it means to live a life under the shadow of HIV+ status. Both men have met the diagnostic criteria for AIDS at some point in their illness, and as is apparent in chapter 2, both manage their illness, and lives, quite differently. They candidly discuss their lifestyle and the abuses it has often earned them, even in the health care field where they were both employed for many years. Students listen attentively throughout their discourse, unable to comprehend how stereotypically negative views of homosexuality could ever apply to such wise and entertaining sages. They wonder as well why two people who openly acknowledge the physical toll it takes on them persist in coming to NRS 340 twice a year. They require a minimum of 14 hours of sleep a night to function and it takes them a day or two to regain their stamina after a 2-hour speaking gig in our class.

The generosity of our visiting scholars is unmistakable, especially in light of the fact that they receive no monetary remuneration. Each one is uniquely qualified and suited to teach about some aspect of chronic illness and whole person care, and each one shares the commonality of being altruistically motivated to do so. Thus, it is not so surprising when our expressions of gratitude are met with their thanks for providing a forum that allows them to help shape future nursing practice. The importance of this is particularly evident in John and Adrian’s summation of why they come to speak to us.
John

So why do Adrian and I agree to speak out? What do we have to offer that is so special? I don’t know that we have anything unique beyond ourselves to offer. There are as many other unique stories that can be told. We have grown together and reached significant points of commonality in our process that has placed us in the unique position of being available to speak out; it is a matter of circumstances, chance, and choice.

I think it is important to realize when you are dealing with an individual with an illness that they are so much more than their illness. Individuals carry their past and present on their shoulders.

I ask you to beware of judging others. There are behaviors that are clearly unacceptable and these limits need to be set for all individuals, but these limits will seldom be the issue you need to deal with. More likely, you will be confronted with some individual who stimulates a gut response from you. In our case, you may share the gut response that gay people are sinners and choose their identity, rather than being born that way.

You may have a deepseated belief that we are “unclean” or are “untouchables” and undeserving of care and concern. You may have grown up around these attitudes, believe yourself to be immune to them, and still find they have affected your interaction with the individual in question. Something about the way someone is dressed or cares for themselves may influence you to judge them in a particular manner. It’s not that we don’t all do those automatically, but if you are unaware of it and act out of this blindness, you are not caring for an individual. Instead, you are caring for a preconception—your preconception.

Live my life better than I did, and then you may have the right to criticize or judge me.

Adrian

I speak to educate. Education is a key part to understanding. Bigotry and hatred are usually the products of ignorance, and by speaking to nursing classes I hope to make vague concepts a reality.

I remember my first days in nursing, I was afraid of just about everything and every patient around me. One thing I have learned through my personal experience with a chronic disease is that there isn’t a thing that you can ask or say to me that hasn’t run through my head. I think about death, I think about being sick and disabled. I sometimes think about being hooked up to machines keeping me alive and wonder what kind of life that would be for me and for the people that love me. I get angry when a medical professional announces that they know what I’m going through. That’s impossible, how can any of you know what it is like for me to live through this?

None of you know the devastating affects the AIDS pandemic has had on my life. I’m not sure, but I wonder how many of you have lost hundreds
of friends, watched countless young people die from a disease that your
government and president wouldn’t even name? Do you understand the
depth of my anger and hurt? Do you understand the shame and guilt that
religious groups can cast upon you for loving who you love or being who
you are? It runs deep. Do you understand that after listening to medical
professionals joke about their patient’s sexual orientation there is a certain
basic mistrust that I carry with me just as surely as I carry my pj’s and
toothbrush?

Twice a year, I come in and discuss things with you that most people try
to keep private. Why? There are an infinite number of answers to this question,
but I have only a few reasons to make myself this vulnerable. I come in and
lay my soul bare so that you can safely ask questions that are knocking about
your brain. I come in because right now, there is an alarming trend among
people to put AIDS/HIV on the back burner because there are drugs. AIDS/
HIV still kills. AIDS/HIV still makes life incredibly difficult and still makes
one sick as hell.

There is no cure. I hear how excited people are about a possible vaccine.
I’m not very excited; a vaccine won’t do a thing for me or the millions of
people like me that have AIDS/HIV. I speak to you because no matter how
much information there is about odds and chances of getting AIDS/HIV, in
reality, when you get it, the odds and chances are meaningless. I speak to
you because if I had a genetic disease I might seem more acceptable to you.
I speak to you because someday, you could be taking care of me, and hopefully
you will remember me and give me that extra care that may just get me over
the hump.

I speak to you because I know your instructor would hunt me down if I
didn’t. Besides, I get taken to lunch if I do a good job; at the very least I get
coffee and snacks.

I speak to you because after almost 20 years, AIDS/HIV has taken its toll
on me, and I don’t have the energy to do the big-ticket items. I speak to you
because I can. I also speak for selfish reasons. Speaking makes me feel like
I am doing something in the war on AIDS/HIV. It makes me feel good. I
speak for my own well-being. If I do good things, good things will happen
to me, I think it is called karma. I tell you my stories so that you can put a
face on this most evil disease.

CONCLUSION

The stories we share in the theory course are important for at least two
primary reasons. First, they allow us to weave textbook information into
meaningful contexts; that is, the experiences of whole people leading
real lives both encumbered and enhanced by chronic illness. Stories
address tertiary prevention, daily management, family concerns, and
nursing roles in a way that students can readily grasp. The tales of trial, tribulation, and even triumph we share will move some of our graduates to work in the chronic care arena. A greater number may well opt for acute care settings, but the numerous personal accounts in the chronic illness theory course of how nurses can make or break a life after discharge will hopefully remind them of the importance of listening carefully to the patient’s story.

The second reason case stories are important is because students remember Joe, Uncle Lee, John Nash, Carrie, Maradee, Greg, Adrian, and John, and the cast of other characters they meet in the course. They will have to review the content presented on any given topic area in order to pass the NCLEX exam, but they do not forget the stories of disease progression, its long-term consequences and impact on family, and the associated losses. Students remember the narrative long after they have forgotten the minute details of the nursing management of any disease entity.

Charmez (1991) describes the experience of chronic illness as encompassing good days and bad days. “A good day means minimal intrusiveness of illness, maximal control over mind, body, and actions and greater choice of activities. . . . Illness remains in the background, whereas a bad day means the opposite. Illness and regimen take center stage. On a bad day, people cannot ignore or easily minimize illness” (p. 50).

Similarly, our teaching consists of good days and bad days. On bad days we get stuck in singular thinking and the myth that covering the content means we must actually vocalize every relevant concept and concern related to the topic at hand in order for our students to understand. A good day is when the stories we share allow the content and process of our teaching to fit together seamlessly.

REFERENCES


