Nursing Students' Perceptions Regarding Effective Interventions

used by Nurse Educators in Assisting Students to Cope with

Anxiety during the

Clinical Learning Experience

by

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Abstract

Anxiety during the clinical learning experience is an ongoing challenge for nursing students during their education process. It has been demonstrated that nurse educators are poorly prepared to assist anxious students because of the paucity of research related to effective interventions that reduce student anxiety. The purpose of this study is to explore and describe nursing students' perceptions regarding effective interventions that nurse educators use in helping students cope with anxiety during the clinical learning experience.

Lazarus and Folkman's (1984) transactional model of stress and coping was used to guide this study. An ethnographic design, using primarily interviewing for the purpose of data collection, was the research method used to conduct this study. The sample included six full-time nursing students from a diploma nursing program, and were recruited on a volunteer basis. Analysis of the data revealed that a significant amount of student anxiety related to personal feelings of inadequacy and lack of self-confidence, primarily due to their lack of knowledge and experience. Findings revealed that students perceived that they must perform perfectly, and they fear the instructor's presence because of the evaluative component associated with the instructor's role. Effective strategies used by nurse educators in helping students to cope

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with anxiety were directed primarily at developing a trusting relationship between teacher and student. When students perceived that they could trust instructors, they viewed instructors as more approachable and subsequently felt more comfortable to seek them out for help without fear of evaluation. The implications of the findings for nursing education and nursing research are discussed.

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Chapter One

Background to the Problem

Most nurse educators would agree that the clinical setting is a major source of anxiety for nursing students (Blainey, 1990; Kleehamer, Hart, & Fogel, 1990; Parkes, 1985; Price, 1985). According to Peplau (1966), mild levels of anxiety can sharpen performance and increase students' motivation for learning. In contrast, severe levels of anxiety may result in decreased concentration, reduced attention span, impaired decision-making, and decreased ability to perform psychomotor skills (Kushnir, 1986; Moses & Friedman, 1986). Nurse educators' efforts to help students cope with severe anxiety in the clinical setting have been largely inadequate (Paterson, 1991). There is no clear direction from nursing research that nurse educators can use regarding effective interventions to help students cope with severe anxiety in the clinical setting.

Purpose

The purpose of this qualitative study is to explore and describe what nursing students believe to be effective interventions that nurse educators use in helping students cope with moderate and severe anxiety during the clinical learning experience.

Significance of the Study

Anxiety during the clinical learning experience poses an ongoing challenge for nursing students during their education process. Several nurse educators have identified that nursing students' anxiety is related to performance anxiety, that is a student may perform better under low-stress situations such as a classroom setting than under greater stress situations such as the clinical learning experience (Bell, 1991; Meisenhelder, 1987; Moses and Friedman, 1986). Studies in the nursing literature document well the sources of anxiety, but they do not address the possible underlying causes of anxiety such as the education process, the image of nursing, and women's issues (Kleehamer, Hart, & Fogel, 1990; Pagana, 1988; Parkes, 1985). In addition, the anxieties that nursing students experience are in part a response to the dramatic changes and instabilities in the current Canadian health care system. Increased acuity of client health problems, major upheavals in the profession and in the health care system regarding roles and responsibilities, and the possibility of unemployment for new nursing graduates are all factors contributing to nursing students' anxiety (Baumgart & Larsen, 1992). It has been demonstrated that nurse educators are poorly prepared to assist anxious students because of the paucity of research about what interventions are effective in reducing student anxiety related to clinical learning experiences

(Strauss & Hutton, 1983; Windsor, 1987). Knowledge of effective interventions for reducing anxiety can promote student learning and enhance clinical performance. The findings of this research study will contribute significantly in this regard.

Conceptual Framework

The conceptual framework chosen to guide this study is the transactional model of stress and coping by Lazarus and Folkman (1984), (see schematic representation in Figure 1.) In this model, stress is viewed as an imbalance between the individual's perception of the demands of the environment and the perception of his or her ability to meet these demands.

Four central constructs arising from this model are: the appraisal process; personal and situational factors influencing appraisal; the coping process; and adaptational outcomes. First, the appraisal process, or cognitive appraisal is an evaluative process where the individual determines whether an event is either stressful or nonstressful. There are three kinds of cognitive appraisal: primary appraisal, secondary appraisal, and re-appraisal. Primary appraisal consists of an individual's initial evaluation that a situation is either irrelevant, benign-positive or stressful. Stressful appraisals can take three forms: harm/loss, threat, or challenge. Secondary appraisal refers to the evaluation that an individual makes regarding the coping resources that are available when encountering a stressful

situation. Re-appraisal involves modifying an earlier appraisal based on new information from the environment or the individual.

The next construct in the model is personal and situational factors influencing the appraisal process. Personal factors include an individual's commitments and beliefs; and situational factors relate to novelty, uncertainty, predictability, and timing.

The third construct is the coping process which Lazarus and Folkman (1984) refer to as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Coping is either problem-based or emotion-based. The former involves an individual's management of the stressful problem by changing themselves or the environment. The latter refers to regulating the emotional response associated with the problem. An individual could reduce emotional distress by using strategies such as distancing, or seeking social support.

The last construct of adaptational outcomes are affected by the appraisal and coping processes and include: social functioning, morale, and somatic health. Effectiveness of a coping strategy is a major determinant of the overall quality of the person's social functioning (Lazarus and Folkman, 1984).

Lazarus and Folkman's (1984) model of stress appraisal and coping will be an appropriate framework for the proposed study. While there are other models of stress and coping that can be found in the literature (Cox, 1978; Schacter and Singer, 1962; Selye, 1956), this model has been used and accepted as a valuable model in nursing research (Beck, 1991; Pagana, 1988). In addition, Lazarus and Folkman's model (1984) will direct the research design, review of the literature, and the presentation of the research findings.

The Research Question

This study proposes to answer the following question: What are the perceptions of nursing students regarding effective interventions used by nurse educators in assisting students to cope with anxiety during the clinical learning experience?

Definition of Terms

<u>Clinical learning experience</u>: an opportunity for students to: integrate theory content from classroom into nursing practice; develop cognitive and psychomotor abilities while giving nursing care to actual clients; and become socialized into the nursing profession.

<u>Nurse educator</u>: a nurse who teaches nursing students in the clinical setting and is employed by a school of nursing (also referred to as "teacher" or "instructor").

<u>Perception</u>: an individual's personal meaning or understanding of a situation.

Limitations

The limitations of the study will be:

1.   The sample of students from one diploma nursing program who will be participating on a volunteer basis. Students who volunteer to participate may possess less anxiety and more confidence in their abilities than students who do not chose to participate, possibly creating bias in the sample.

2.   Students who elect to participate may have more anxiety than others and may require more guidance in coping with their anxiety.   They may feel that they do not receive enough help in managing their anxiety, possibly creating bias in the sample.

3.   Interviews will be limited to students' ability to recollect and express feelings of anxiety from their clinical learning experience.

Chapter Two

Review of the Literature

In qualitative research, a preliminary literature review may be conducted at the onset of a proposed study, followed by a more detailed review of the literature during data collection and subsequent data analysis (McMillan & Schumacher, 1989). Reviewing the literature in this manner reflects the inductive processes of qualitative research whereby clarification of the research problem evolves as the research progresses.

This chapter contains a literature review of research findings and anecdotal reports pertaining to the concepts of anxiety and coping in education. To facilitate understanding in the presentation of the literature, the literature review is divided into four categories, reflecting the four central constructs of Lazarus and Folkman's (1984) model of stress appraisal and coping. These central constructs are: the appraisal process; personal and situational factors; the coping process; and adaptational outcomes.

The literature was screened according to the following criteria:

1) Research studies and anecdotal reports that address aspects of student anxiety related to the clinical learning experience such as: sources of anxiety, outcomes associated with anxiety, and coping processes directed at reducing anxiety.

2) Quantitative and qualitative studies that provide sufficient information to reveal the conceptual framework, method of data collection, and analysis in the discussion of the research.

3) Research studies regarding anxiety and the learning experience conducted in fields other than nursing education (i.e., teacher education, counselling psychology).

<u>The Appraisal Process</u>

Nursing students' appraisal of anxiety-producing situations related to the clinical learning experience has been well documented. Pagana (1988) conducted a study to identify stresses and threats of 262 junior baccalaureate nursing students in their first clinical experience on medical-surgical units. A clinical stress questionnaire was designed by the researchers which revealed the following six predominating themes of stress: personal inadequacy, fear of making errors, uncertainty, the clinical instructor, feeling scared, and fear of failure. Of interest, students expressed that they found it therapeutic to describe their stress on a clinical stress questionnaire. The theoretical framework underlying this study was based on Lazarus and Folkman's (1984) model of stress appraisal and coping. Reliability and validity of the questionnaire was not reported.

In a similar study by Kleehamer, Hart and Fogel (1990) students' sources of anxiety were congruent with those found by

Pagana (1988). Data were collected from 53 junior and 39 senior baccalaureate nursing students using a Clinical Experience Assessment Form devised by the authors. This form consisted of a sixteen item Likert scale followed by an open-ended question. Reliability of the tool was established by a Cronbach's alpha reliability coefficient of .82. Construct validity of the items was achieved by factor analysis of items on the assessment form satisfactorily measuring one concept pertaining to anxiety, and content analysis of the open-ended question determined by three expert judges.

In a descriptive correlational study, Beck and Srivastava (1991) administered a Stress Inventory Questionnaire to 94 baccalaureate nursing students enrolled at the second year level or higher. Students were asked to describe a stressful incident, including how they felt, and how they coped with the stress. Stressful incidents were not limited to the clinical setting, but rather included all aspects of the students' learning experience. This instrument was a modification by the authors of the Stress Incident Record used by Firth (1986), and the Stress Scales of Firth (1986) and Frances and Naftel (1983). Reliability of the tool was not established; however, face and content validity was determined by a panel of faculty and student experts. Although different instruments were used to collect data in the studies by Pagana (1988), Kleehamer et al.

(1990), and Beck and Srivastava (1991), sources of stress related to students' clinical learning experience were similar in all. In all studies, anxiety related to performance was identified as a significant stressor experienced by nursing students.

Using a qualitative research design, Windsor (1987) interviewed nine senior students in their last semester of a university nursing program. Naturalistic inquiry was the method chosen in order to understand the students' unique perceptions of the clinical experience. Findings related to sources of stress experienced by students included: time management (i.e. feeling disorganized); lack of support from instructor; lack of preparation for clinical; personal problems; worry about being out on own (as a graduate nurse), and worry about getting a job. The author notes that one implication of this study is that the clinical instructor is an important variable affecting the students' learning experience. Furthermore, Windsor (1987) identified that few instructors are taught how to teach in the clinical area and are considered competent based on their clinical expertise and educational background. The paucity of literature regarding research-based planning and implementation of clinical education leaves nurse educators inadequately prepared in their role to assist nursing students in the clinical learning environment.

In another qualitative study, Parkes (1985) interviewed 150 first year student nurses from two hospital-based programs in Great Britain. The particular type of qualitative design was not described in the report. The majority of stressful episodes described by students in their work on the hospital wards included: care of dying patients; interpersonal conflicts with other nurses, insecurity about professional skills and competence; and fear of failure. Although some of the sources of stress identified in Windsor's (1987) study differ from Parkes' (1985) findings, Parkes (1985) extended the inquiry of student anxiety by identifying underlying factors to many of these stressful situations. Examples of these factors included: inadequate support and guidance by senior nurse and clinical tutors; students lack of experience; and the demanding nature of the ward environment.

Personal and Situational Factors

Personal and situational factors are important determinants of how nursing students appraise anxiety-provoking situations. Holder (1986) examined the effects of clinical education settings on nursing students' anxiety levels, and the relationship between students' anxiety, optimum stimulation, and perceptions of clinical instructors. Ninety-four students from clinical settings in anesthesia and nurse midwifery programs participated in the study. Data related to

subjects' anxiety levels and stimulation were collected at the beginning of the study using Spielberger's State-Trait Anxiety and Zuckerman's Sensation Seeking Scale. Following six weeks of clinical education, Spielberger's State-Trait Anxiety and Katz's Characteristics of Clinical Teachers Scales were administered to the students. The findings revealed that anxiety had increased for students in both midwifery and anesthesia nursing programs during the six weeks of clinical education. Students in the nurse anesthesia program revealed higher state anxiety than their student counterparts in the nurse midwifery program. Sensation seeking was not significantly related to anxiety, and perceptions of empathy and respect of best instructors were correlated with changes in anxiety levels. While these findings suggest that the clinical setting has an impact on student anxiety level, limitations in the research design exist making it difficult to draw conclusions.

In a more rigorous study by Kushnir (1986), the effects of the presence of an instructor on student nurses' behavior was examined. A class of 28 second-year nursing students were asked to describe a stressful event encountered during their learning experience. Twenty of these students reported stressful events involving their instructors; these twenty reports were then analyzed using a qualitative approach. A finding from this study revealed that many students perceived the

functioning of their instructors to be mainly evaluative. The author explained that the presence of instructors during the learning process increases student errors due to fear of failure and embarrassment. Kushnir (1986) suggested that instructors should de-emphasize their role in evaluation of students, especially during learning. This will help reduce potential sources of anxiety and create a more supportive learning environment for students.

In the field of counselling psychology, Mallinckrodt and Leong (1992) studied the sources of stress, related stress symptoms and social support of international graduate students. The authors hypothesized that social support from the graduate program and the family would have a direct and buffering effect on stress symptoms in these students. The sample consisted of 79 men and 26 women from various graduate programs at a large eastern university in the U.S. Participants were asked to identify their first language rather than country of origin to preserve anonymity: 27% indicated Chinese; 14%, Arabic; 11%, Japanese; 6%, Spanish; 4% did not specify; and 38% indicated other languages. Five instruments were used with modifications by the authors for data collection. The Life Events Survey Scale (Sarason, Johnson, & Siegel, 1978) was used to measure stress. The Bell Global Psychopathology Scale (Schwab, Bell, Warheit, & Schwab, 1979) and The Proxy-A

Measure of Health Status (Kisch, Kovner, Harris, & Kline, 1969) were used to assess psychological stress and physical symptoms of stress, respectively. Social support from the graduate program was measured using a modified instrument from the Educational Testing Service's (1980) national survey of graduate training program. The categories of social support from the graduate program included: student-faculty relation, quality of instruction; facilities and curriculum flexibility; tangible support and relations with other students. Finally, the Quality of Family Life instrument (Bohen & Viveros-Long, 1981) measured social support from the family and included the categories of: communication and cohesion, financial resources and leisure quality, child rearing, and living conditions. Reliability and validity indicators were not reported for any of the aforementioned instruments. Statistical tests including univariate t tests, Pearson correlations, and MANOVA were used to analyze the data. The findings revealed that social support was associated with fewer symptoms of stress in international graduate students. In particular, support from the graduate program such as relations with faculty members were especially beneficial for men, and tangible support, relations with other students, and curriculum flexibility were most beneficial for women. Regarding social support related to the family, men benefited from all categories identified, whereas for women, a

strong negative correlation between quality of child care and stressful life events appeared. In addition, problems with living conditions and inadequate financial resources were strongly correlated to depression in these women. The authors suggested that female international students may have a more difficult time adjusting to the academic setting than men because of the role conflict between the responsibilities as wives and mothers in addition to the responsibilities as students. There are several limitations in the study that were identified by the authors that affect how the findings may be generalized.

Perry, Magnusson, Parsonson, and Dickens (1986) studied the relationship between perceived control and the quality of instruction in the college classroom. The authors explain that "students who perceive little control over their academic achievement, for example, may perform no better for an organized, compared to a disorganized instructor because they believe that their efforts are doomed to failure" (p. 96). Teacher expressiveness, defined in terms of physical movement, voice inflection, eye contact, and humor was described as an important component of effective teaching. The authors found that highly expressive instructors facilitated achievement and confidence in students who received contingent and low noncontingent failure feedback on an achievement

questionnaire. Level of contingent feedback on questionnaires was designed to manipulate perceived control.

The Coping Process

Following the appraisal process, nursing students attempt to manage their anxiety by means of a coping process, whereby they change something about themselves or the environment to alleviate the anxiety- provoking episode.

Lindop (1991) conducted a quantitative study to explore the sources of stress and subsequent coping strategies of 413 nursing students at various stages of a three year college nursing program in the United Kingdom. A 144 item questionnaire developed by the author was the tool used for data collection. Content validity for this tool was established through faculty and student feedback, however, reliability of the tool was not reported. Findings related to methods of coping included: talking to relatives and friends; just carrying on; and remaining calm. This list of coping methods appears brief, leading one to question whether or not student coping strategies were thoroughly assessed. A brief reference to Selye's theory of stress (1956) provided a loose theoretical framework for this study.

Price (1985) addressed the topic of coping strategies by asking 51 senior nursing students from a three year program to identify their sources of stress and related coping methods

when moving to a new ward. Data were collected using structured interviews, and coping strategies were classified using Clarke's (1984) constructs of stress and coping. Examples of coping strategies included: direct (i.e., seeking information by reading up on subjects and asking questions of staff and peers; indirect (i.e., talking to friends, moaning to peers, developing a social life, relaxation); and palliative (i.e., procrastinating, smoking more, avoiding patients, hurrying through procedures). While these findings are more comprehensive than those documented by Lindop (1991), limitations exist in the research design used by Price (1985). There is no description of the type of qualitative method used, and no criterion for the establishment of procedural rigor to give credibility to the findings.

Several studies were found that address the coping process of nursing students by testing interventions for reducing anxiety. In a study by Manderino and Yonkman (1985), a coping skills program known as stress inoculation was presented to baccalaureate nursing students. The program included instruction in cognitive skills of adaptive thinking and methods of relaxation. Students applied these coping skills under simulated stressful conditions in the lab setting. They were asked how they felt before, during and immediately following the stressful scenarios. Students reported feeling less

anxious and in greater control over their reactions following the use of coping skills applied to the stressful situations. Obvious limitations to this study exist including: lack of description related to sample size and academic level of student, inability to generalize findings from simulated lab scenario to a clinical environment, and no discussion related to criteria for analysis of students' subjective data. The cognitive appraisal model of stress by Lazarus (1966) provided a theoretical basis for this study.

In a similar study by Johansson (1991), the effectiveness of a stress management program in reducing anxiety and depression in nursing students was examined. Forty-two sophomore and 34 senior nursing student from a private, liberal arts college were randomly divided into experimental and control groups. The stress management program was based on Schachter and Singer's (1962) arousal-attribution model of stress. In contrast to Manderino and Yonkman's (1985) study, statistically significant results (p<.05) were found by Johansson (1991), supporting the use of this stress management program in reducing students' anxiety. However, Johansson (1991) acknowledges that the findings of this study have limited generalizability to all nursing students due to selection bias and small sample size.

In a non-research article, Parkin (1989) supports the use of humor as a valuable teaching strategy for reducing anxiety in nursing education. "Appropriate humor reduces anxiety, promotes rapport in the teacher-student relationship, and creates a climate conducive to learning" (Parkin, 1989, p. 229). Suggestions of strategies for employing humour in an appropriate and relevant context include: wordplay, cartoons, jokes, skits, anecdotes, parodies, riddles, puzzles, and "bogus situations".

Stephens (1992) examined the effectiveness of audiotaped imagery as an intervention for reducing anxiety and improving test performance among 159 first-year nursing students of several baccalaureate nursing programs. Lazarus' interactional model of stress (1984) was used as the theoretical basis for this study. Volunteer subjects were randomly assigned to three groups: imagery only (using audiotaped recordings), imagery/relaxation, and a control group receiving no relaxation or imagery. The Speilberger State-Trait Anxiety Inventory (1983) (STAI) was used to measure student anxiety. Internal reliability for this instrument using Cronbach's alpha coefficient is high, ranging from .83 to .92. Construct and content validity of STAI have been established by test developers. Evaluation of test performance was demonstrated through test scores of an examination. Students who had participated in the imagery were

asked to complete an open ended questionnaire following the intervention. The findings of this study revealed that audiotaped imagery alone and in conjunction with relaxation methods are effective interventions for lowering nursing students' anxiety. However, there was no statistical correlation found between imagery and test performance. The author suggests the lack of correlation could be due to the inconsistencies of teacher-made tests from the various programs administered to the subjects in this study.

In the field of teacher education, MacDonald (1993) studied the causes of stress and coping strategies of student teachers in their practicum experience. In this qualitative study, a seminar group of eleven students in a primary junior teacher education program at the University of Ottawa were invited to participate. The education program is eight months in length and the seminar group led by a faculty member meets three hours per week. Data were collected at various intervals during the eight month program via surveys, focused group interviews, observation of student teachers in the classroom practicum, and student journals. Although the type of research design was not explicitly stated, the author explained that students were asked to freely express their anxieties about becoming a teacher and the coping strategies they use to manage this anxiety. Data were analyzed by searching for themes and patterns that would

describe participants' perception of stress and coping during their teaching practicum. Emerging conceptual categories were identified which prompted questions to guide further data collection. The categories identified were presented to participants for verification and clarification. The findings revealed the following sources of stress: unclear expectations of the student role; pressure to conform to associate teacher's style to "fit into the structure"; evaluation based on ability to discipline the class; large number of assignments during practicum results in lack of time for rest, peer competition, and inconsistent feedback from associate teachers. Coping strategies used by student teachers during their practicum included: communication with associate teachers regarding expectations of student teachers; taking initiative with associate teachers; identifying goals prior to the practicum experience; and incorporating relaxation techniques such as sports, and meditation. These findings have important implications for teacher education. The study suggests that faculties of education must acknowledge their role in making the practicum experience for student teachers less stressful by clarifying expectations, advising student teachers of the need for assertive communication with associate teachers, and orienting students to the protocol involved with being a student teacher. The findings from MacDonald's (1993) study regarding sources

of stress and coping strategies among student teachers are similar to nursing students' sources of stress and coping strategies found in the nursing literature (Pagana, 1988; Windsor, 1987; Price, 1985).

Adaptational Outcomes

The outcomes following the stress appraisal and coping processes of nursing students in the clinical learning experience can have an impact on their self-confidence, performance, and pass/failure of the clinical course. Bell (1991) explored the effect of preclinical skill evaluation on student anxiety and performance when applying the skill in a patient situation. Thirty volunteer first-semester junior nursing students from a baccalaureate program were randomly assigned to treatment and control groups. Students in treatment groups participated in preclinical skill evaluation which involved instructor feedback provided to students after performance of the skill of female cauterization in the laboratory setting. Students in the control group viewed a videotape demonstration of the skill; students were neither encouraged or discouraged from contacting the instructor, and no contact was initiated by students with no initiated contact from the instructor. Anxiety was measured by the State-Trait Anxiety Inventory (Spielberger, Gorush, Lushen, Vagg, & Jacobs, 1983). A performance checklist was developed by the author to measure skill performance. Anxiety

was measured again following the first experience performing this skill in the clinical setting. Questionnaires were given to students in treatment groups to elicit attitudes regarding their perceptions of the treatment. Quantitative results showed no significant difference between groups in terms of anxiety. However, qualitative data elicited from questionnaires indicated that the students who received preclinical skill evaluation stated that they were less anxious and expressed more self-confidence about performing the skill in the future. A limitation of this study was the volunteer method of subject selection. It is possible that those individuals who volunteered to participate in the study may have less anxiety and more self-confidence than their student counterparts who did not volunteer.

Megel, Wilke, and Volcek (1987) conducted a similar study by examining the relationship of performance errors to student anxiety when transferring the skill of injection administration from the laboratory to clinical setting. Similar instruments were used as in Bell's (1991) study to measure anxiety and performance. Findings revealed no significant change in the number or errors between the laboratory evaluation and the first clinical performance. In addition, anxiety level was not related to skill performance. Similar to Bell's (1991) study, the authors suggested that the findings could be limited due to the fact that

volunteer subjects may already possess greater self-confidence and lower anxiety than their non-participating classmates.

Summary

In the review of the literature about student anxiety during the clinical learning experience, the quantitative and qualitative studies reviewed consistently identified anxiety as a serious concern for nursing students. The majority of these studies related students' perceptions of the sources underlying anxiety-provoking situations in the clinical learning experience. Some studies were designed to test the effectiveness of various interventions used by nurse educators for reducing student anxiety; (i.e., stress inoculation programs, use of humour, and audiotaped imagery). The results of these studies are severely limited due to problems inherent in the research designs; (i.e., small sample size, inability to generalize findings to clinical settings, and lack of established reliability and validity for selected instruments). An additional concern is that nurse educators may not be adequately prepared to incorporate the specific interventions recommended by these researchers. Interventions such as the use of deliberate humour, relaxation exercises, and audiotaped imagery are not commonly taught to clinical teachers in preparation for their role (Paterson, 1991). It has been documented that nurse educators are not formally taught how to teach in the clinical learning experience but are

considered competent based on their clinical expertise and educational achievements (Diekelman, 1990; Paterson, 1991; Windsor, 1987). Although some interventions have been tested to reduce anxiety, they do not reflect a clear understanding of nursing students' perceptions regarding effective interventions used by nurse educators that are helpful to reduce students' anxiety during the clinical learning environment. Most research studies rely on questionnaires to obtain data relating to effectiveness of interventions for reducing anxiety, rather than asking nursing students for their perceptions of which interventions had been effective and why these were beneficial. The review of the literature has clearly indicated the need for further study about interventions which are effective in reducing students' anxiety in the clinical learning experience.

Chapter Three

Methods

A qualitative approach using an ethnographic research design was the method used to guide this study. Ethnography is the study of cultures (Spradley, 1979). Culture, in the context of ethnographic research is defined as "the acquired knowledge that people use to interpret experience and generate social behavior" (Spradley, 1979, p. 5). Research in the cultural context of nursing provides an opportunity to identify and describe concepts and constructs that are culturally relevant in caring for the self and others (Aamodt, 1982). Ethnography has its roots in cultural anthropology, dating back as far as the 5th century, B.C. when notable sociologists and anthropologists described the diversities in human behavior (Aamodt, 1982). The aim of ethnographic research is to understand another way of life from the native point of view (Spradley, 1979); to ascertain the meaning of actions and events from the people that the researcher is seeking to understand. Ethnography is an appropriate research method for studying human life, particularly in relation to educational experiences (McMillan & Schumacher, 1989). Ethnography has been used to explore the perceptions of nursing students regarding reality shock (Stanko, 1981), and their socialization into the nursing profession (Melia, 1982). The use of this method was conducive to identifying the

perceptions of nursing students regarding effective interventions by nurse educators in assisting students to cope with anxiety in the clinical learning environment.

Data Collection

The primary method of data collection utilized in the study was interviewing. McMillan and Schumacher (1989) explain that interviews may be used as the primary strategy for data collection in ethnographic studies. The ethnographic interview involves the use of open-ended questions that elicit the participants' meanings; i.e., how individuals in their social context interpret their worlds and how they explain or make sense of important events in their lives (McMillan & Schumacher, 1989). Unstructured interviews guided the format during the interviewing process. The researcher asked respondents the following broad opening question: "Think back to times when you have felt anxious in the clinical area and a clinical instructor helped you to feel less anxious. Tell me about your experiences". Polit and Hungler (1991) explain that the aim of unstructured interviews is to describe the respondents' perceptions of their world without imposing the researcher's views on them. The interviews were tape-recorded after written consent was obtained from the participants. Interviews were transcribed verbatim by the researcher, and a copy of the transcript was mailed to the participants. A follow-up interview

was conducted to provide an opportunity for verification and clarification of the participant's responses from the first interview. Initial interviews were approximately one hour in length, and follow-up interviews were approximately a half hour in length. Interviews were conducted at a location chosen by the participants, one that was private and free from distraction. Two interviews were conducted at the participants' homes, and the remaining four interviews were conducted in a small study room in the library at Kwantlen College.

The ethnographic interview process is reflexive in that the interviewer is part of the research, not separate from it (Aamodt, 1982). Lamb and Huttlinger (1989) explain that the researcher can become personally involved in the research process yet still must obtain an objective standpoint throughout. The investigator used the Reactivity Analysis Framework (Paterson, 1994) as a guide while being critically reflective about her own past experiences, values, perceptions and the effect these have on the research process. This was achieved through written entries in a personal journal following each interview.

Spradley (1991) emphasizes the importance of the development of rapport between the researcher and the participant during the interview. Rapport is important because it lays the foundation for trust which is necessary for participants to share thoughts and feelings openly with the

researcher. Developing rapport is a process and involves four stages: apprehension; exploration; cooperation; and participation (Spradley, 1991). The interviewer facilitated the development of rapport with participants at the onset of the research process and during the presentation of the study during their class time when inviting students to participate. Valuable time for developing rapport was also utilized during phone conversations with participants when arranging interview meetings. One method of rapport building entailed approaching participants in a friendly and non-threatening manner. Conversation was often on a personal level discussing topics unrelated to the interview such as family life, hobbies, and questions about how they are feeling in general. Humour was also used to facilitate rapport.

The Sample

The participants for the study included six full-time nursing students enrolled in the Diploma Nursing Program at Kwantlen College, a community college in British Columbia. One participant was enrolled in the part-time program and switched over into the full-time program during the last course of the program. The investigator sought permission from the director of the research and planning department at Kwantlen College, Surrey Campus for access to nursing students (see Appendices A and B). Participants were recruited on a volunteer basis from

the senior level of the nursing program. All students that volunteered to be in the study were accepted. Participants included five female students and one male student. There was no restriction given to age or cultural background. The investigator is currently employed in the nursing program at Kwantlen College. The participants in the study have not had previous contact, and will not have future contact with the investigator. For this reason, senior students were chosen as participants, in the hope that they will soon graduate after the study is complete, limiting the possibility of future contact with the investigator in any capacity at the college.

Data Analysis

The constant comparative method of data analysis in the tradition of Glaser and Strauss (1967) was used to analyze data in the proposed study. In this method, the researcher codes data while looking for patterns by: comparing incident with incident, incident with category, and category with category. Similarities and differences among incidents and categories emerge whereby subsequent relationships among categories are clarified (Hutchinson, 1988). Although this method of data analysis was developed for use in grounded theory research, it is also appropriate in ethnographic research (Grove, 1988).

Guba and Lincoln (1981) explain that scientific rigor in qualitative research is not defined in terms of reliability and

validity but rather in terms of credibility, confirmability, auditability and fittingness. In ethnographic interviews this refers primarily to returning to the participants for clarification of data, ensuring that the native's view is not misinterpreted (Aamodt , 1982).

Ethical Considerations

Students who chose to participate in the study may have benefited through the sense of well being gained when they were able to share personal experiences regarding their anxiety. They also contributed information that may help other nursing students cope with anxiety related to the clinical learning experience.

Polit and Hungler (1991) outline three main standards for protecting the rights of human subjects: beneficence, respect for human dignity, and justice. Beneficence refers to freedom from harm and freedom from exploitation. Respect for human dignity includes the right to self-determination and the right to full disclosure. Justice includes the right to privacy (anonymity), and confidentiality. Prior to data collection, participants were asked to read and sign a consent form indicating their acceptance to participate in this study. The consent form (see Appendix C) included a complete description of the study, and informed participants that they could withdraw from the study at any time. In addition, it was

emphasized that involvement in the research study was strictly confidential, and would have no effect on grades or other evaluations. Confidentiality was maintained by assigning a code to each participant, so that participant names were not used. Only the researcher knew the code. Transcripts, without names of participants were shared with the chairperson of the thesis committee and were locked in a drawer to which only the investigator possessed a key.

Chapter Four

Research Findings

This chapter is a presentation of the research findings related to nursing students' perceptions of effective interventions used by nurse educators in assisting students to cope with anxiety during the clinical learning experience. Initial and follow-up interviews were conducted with the six participants. All students were in their preceptorship, the final course prior to graduation. Two major categories emerged from the data: sources of anxiety; and strategies to minimize anxiety. Most of the stories regarding anxiety that participants cited involved situations where they experienced lack of knowledge and self-confidence. Usually, these situations related to performing new skills, and adjusting to something new (i.e., new ward, or new instructor).

Sources of Anxiety

All the participants described several sources of anxiety. The data revealed the following sources of anxiety: the experience of performing skills for the first time; the first day in a clinical course; impending graduation; lack of knowledge; and low self-confidence, concurrent biology courses; inability to answer an instructor's questions; ward staff and student dynamics, several aspects regarding the instructor's behavior and role such as: expectations, presence during a skill,

evaluative component, lack of rapport with students, reprimanding students in front of others, phoning students at home, and the instructor's power base. The remainder of this chapter contains a selection of participants' accounts that describe their sources of anxiety.

All the participants expressed that performing skills for the first time was a common source of anxiety. Anxiety in the performance of skills was related to personal expectations, fear of failure, doing something wrong, and lack of knowledge. Most participants identified urinary catheterizations as the skill they were most anxious performing for the first time.

> Because you haven't done the skill before you feel you have to do it right the first time. Because if you haven't done it right, perhaps you feel that you haven't studied enough.

> You can't predict what's going to happen, and you're not a hundred percent sure of the way things go, not sure what the norm is the first time you do a skill, not sure what is normal and what is abnormal.

Four of the six participants identified the first day in a clinical course as a source of anxiety. They described feelings of uncertainty about what to expect when encountering a new course, a new ward, and a new instructor.

> You don't know what to expect. You don't know the nurses, you don't know the routines, the ward, and may not know what to expect from the instructor. If you had a

previous bad term, this one has a lot more riding on it, making you more anxious at the beginning.

All but one participant identified the impending graduation as a contributing source of anxiety during their clinical experience. The sole participant who did not feel anxious regarding graduation explained that she will be employed following graduation on the ward where she studied during her preceptorship.

> I already know the routines, the staff, and what's expected of me. I know the staff will still be there for me as a resource.

The remaining five participants felt anxious anticipating their graduation primarily due to the transition from the student role to assuming sole responsibility for client care.

> You are scared because you don't have somebody there, no preceptor or instructor or someone that is yours to ask for help. You are an employee, no one is there to make sure you do things, and not forget. When you graduate you are going to have to be responsible.

The participants stated that their anxiety about graduation was minimized when they had the opportunity during their program to perform the skills that they will encounter as a graduate nurse.

> I may be a bit more nervous assisting doctors because I haven't done that as a student. I really believe they should let you do everything when you're in school. It's

ridiculous to go as a graduate nurse and not have those skills behind you, such as a morphine push.

The participants agreed that a lack of experience and lack of opportunity to practice skills resulted in low self confidence regarding these skills, and a weak knowledge base that in turn promoted anxiety. No previous hospital experience prior to enrollment in the program was another factor that participants reported as contributing to their lack of knowledge and low self confidence, especially at the beginning of the program.

> At the beginning of the program you're put into your first area and this is a foreign environment for you. It's not what you've done before. It's not somewhere you've been before. It's a new thing. Are you going to do it right, or are you going to encounter some kind of a problem? Do you feel comfortable enough to go and scream for somebody? At the beginning, you just don't know.

All the participants agreed that the concurrent biology courses demanded a great deal of time and concentration that impacted on preparation and planning related to clinical courses. Weekly biology quizzes often impelled students to use their break time during clinical to study.

> Biology has to be the worst. We used to always say if you can make it through biology, you can make it through anything. When we went on break we would study for biology in clinical because we had to.

> There wasn't a lot of time to concentrate on preparing for clinical assignments, such as reading ahead of time or

planning for the clinical day because most of our time and efforts were spent studying for biology.

Most of the participants indicated that an external source of anxiety was the inability to answer an instructor's questions. This led to participants perceiving a lack in their knowledge base and a lack of self-confidence.

> That's got to be the worst thing because you're stumped, and your mind is blank. Like I don't know, give me a clue, don't just leave me standing here.

> I didn't feel confident with myself because the content was covered. When I was asked a question I didn't always have the entire answer, or the answer that she wanted. I probably should have known it, and I did kind of know, but I just didn't have it completely understood.

Dynamics between ward staff and students were identified by three of the participants as a source of anxiety during their clinical experience. Conflicts regarding clinical judgments between licensed practical nurses and students, intimidation by staff, and isolation of students by staff were sources of anxiety cited by the participants.

> Staff did not let students into the world of nursing. They did not go for breaks or socialize with students. It's difficult because you want to really learn what it's like to be a nurse, to be incorporated and treated just like peers would be treated and brought into that world, but you're not. Instead we were there to do our own little thing with one patient.

> Questioning looks from staff make students feel like an inch tall. Staff did not offer help or make suggestions. This makes students feel uncomfortable because they're

not sure if what you're doing is right. You feel isolated, scared, and inferior to staff. They know what they're doing and you don't.

All the participants emphasized that clinical instructors are a major source of anxiety, mainly because of their expectations, presence during skill performance, evaluative component, and sometimes lack of rapport with students.

There are expectations of instructors that you need to keep a skill at a mastery level. So that when the opportunity comes up in clinical, you're going to be able to perform it at that level. This is stressful because you may not have performed the skill for months, and have not had time to practice it, and the expectations is that you will perform it at the mastery level like in lab.

Two participants explained that the instructor's presence during skill performance was anxiety provoking because they could not interpret the instructor's nonverbal behavior indicated.

We went into the patient's room and she just stood at the back and just watched me do everything. She didn't give you any kind of input whatsoever, like whether you're doing it right or wrong. And if you did something she'll look at you like "You're sure you want to be doing that?" kind of look, but she wouldn't say anything. So meanwhile you're freaking out thinking, "Am I doing this right?" But she wouldn't tell you. After we did it, she'd take you aside and say, "This was fine, and this wasn't." And I said to her, "What about when you gave me that look?" And she said, "No, that was fine." It was really kind of strange.

The students stated that they feel anxious about performing skills in front of the instructor, in part due to intimidation and being evaluated.

> The instructor hanging over your shoulder makes you feel inferior. You have to look up to them. The instructor is an authority figure.

> She intimidates me. She does not make me feel like a worthy human being. It was just her, the way she looks at you. She won't look you in the eye. To me, looking a person in the eye when you're talking to them about something very important is a good practice. Eye contact is very important.

> I felt intimidated. It's like a boss watching from the background to ensure everything is done correctly. But with other instructors, they're more of a resource. They're there if you don't know how to do something. I always feel more comfortable going up to other instructors and asking them how to do something that I'm not sure of than I would have with her. Because with her, if I had gone up to her and said, "I don't know how to do this. Can you please explain this to me?", I would have felt like she would be putting that little mark against me somewhere. That's just how she made me feel.

The participants identified that instructors who do not build a personal rapport with students and make no attempt to get to know students contribute to increased anxiety among students.

> Some instructors do not take a personal interest in students, "It's my job." This makes learning very hard and then you feel like you can't go to them for help or if you have a problem.

Two participants reported anxiety provoking situations that involved the instructor reprimanding students in front of other staff during the clinical learning experience. The participants indicated that this affected their self-esteem.

> She had made a mistake and hung the wrong IV bag. The instructor yelled at her in front of all the nurses. It made her feel really bad about herself. She ended up just walking away after. The instructor hadn't finished saying what she was saying, and she went into the back room and cried. I can understand how my friend felt. The way my instructor would have handled it is to pull the student away to the side and discuss it with them and say, "It's important to check the doctor's order so what you can do now is go back and change the bag." You don't make a scene in the nursing station and then everyone knows you've made a mistake. It can ostracize you, and them you feel bad about yourself, and then you don't know if you should go on and do the next thing when you start feeling like that.

Two participants expressed that instructors who phone students at home were a source of anxiety regarding their clinical learning experience.

> I was supposed to start the course at the end of February, and I got sick. I was not able to start it. I was trying to begin the course, and the particular instructor at the time kept pushing me, and kept phoning me, "Are you going to make it, Are you going to make it?" It added to the stress.

> One instructor would call me three to six times a week at home anywhere up to ten o'clock at night or seven-thirty in the morning. I used to unplug my phone Monday mornings. I hated Mondays because I could count on my instructor calling.

One participant articulated that instructors carry power and can make decisions that can affect students' entire lives. She stated that it is not always safe to express feelings to nursing instructors. The participant described one situation where punitive action was taken against several students by the faculty.

> We weren't allowed to verbally make a presentation of our case, and they bring down this decision that totally can destroy your life. From the time you've been a little girl you wanted to be a nurse and you're almost there. Then like that, somebody takes it away. You feel violated, you feel raped. We didn't feel safe to say, "Look, you guys are being unfair."

Teacher Strategies to Minimize Student Anxiety

The second major category that emerged from the data regards strategies to minimize anxiety. Two subcategories were identified in this category: the teacher's response; and the teacher-learner relationship.

Teacher's Response

The teacher's response refers to specific strategies implemented by teachers that assist students to cope with anxiety. The participants identified a wide variety of strategies that were helpful such as: instilling confidence; providing feedback; offering help during a skill; asking students about their feelings and listening to their responses; normalizing students' feelings; providing prompts when quizzing students;

stating expectations; demonstration of a skill; reviewing skill with students; providing support and reassurance; and role-modeling.

The six participants reported that the instructor played a significant role in building students' confidence in the clinical learning environment. They stated an instructor could instill confidence in a variety of ways such as: by providing encouragement and support; by trusting students; by giving positive feedback; and by displaying and articulating the instructor's own confidence in students.

> An instructor's confidence in the student is going to lead to a student having an increase of confidence in herself.

> By not standing behind you all the time watching every single moment. Giving some leeway, for example letting us do a.m. care independently in second level, like you're O.K. with that skill to do it on your own. Trusting your abilities, if you don't know you will ask for help.

> A lot of feedback from instructor about skills helps to build confidence. For example, saying "That's a good thing you asked that or picked up on that." It helps the student feel like "I'm doing what I need to do, to do my job well."

All the participants expressed that the type and method of providing feedback to students was important in helping students to feel less anxious. It was agreed that positive feedback about their performance was appreciated, as well as

suggestions for ways to improve. A friendly and calm tone of voice when giving feedback was valued.

> The way an instructor talks to you is important. Instead of saying "Do it this way", they might say "Why don't you try this?". It's in the tone of voice. A curt tone of voice when giving feedback regarding a skill is intimidating. A quiet, even tone and pleasant voice is not scary, and you are more apt to take it in. It's more on a one to one level, rather than the instructor as authority figure. An instructor is not better than the student even though the instructor has more knowledge.

> An instructor may say "You did this right and this right but perhaps next time, why don't you try this way and see if that works better for you?". Rather than saying you did this wrong.

One of the most common reported strategies that participants identified as being helpful in reducing anxiety was an instructor who would offer help to a student who is performing a skill.

> Assisting students during a skill such as holding a flash light or pouring sterile water during a catheterization makes it much less intimidating. It takes the threat away. They're not there to judge you or watch you. They're there to help you get through it.

> The instructor told me she would be my "gopher" while I did the skill. I treated her as an assistant. She would also steer me in the right direction and reminded me of things during the skill.

Most of the participants acknowledged that instructors who asked about their feelings and listened to students'

responses were viewed as helpful. The participants stated that this gave the instructor opportunity to normalize students' feelings.

> When my first patient died, my instructor was wonderful at helping me to cope with everything. She said I was human for crying. If I don't cry, I don't feel. She asked how I was feeling, and kept checking in with me to talk. During post conference, she had all the students talk about their feelings out in the open about how to deal with someone dying. Students were able to share with each other during this time.

All the participants emphasized that instructors who provided prompts and clues when quizzing students assisted in minimizing student anxiety.

> When an instructor supplies a clue or half the answer, if the student needs help to find the answer, it jogs your memory. It can get the answer out of you and you feel like "I did it." It was there all along.

Three of the six participants expressed that it was helpful when instructors explicitly stated their expectations at the beginning of a clinical course.

> They should sit you down at orientation and say, "This is what I expect from all of you. Now what do you expect from me as an instructor?" This helps because you know where you are going, what to aim for that semester, otherwise it is guesswork. Am I supposed to be at the same level, how am I supposed to move ahead, which way? Each instructor is a little different, and expectations will be a little bit different with each instructor.

Instructors should tell students at the beginning that they don't have to do everything perfectly the first time.

One participant expressed that watching an instructor demonstrate a skill in the clinical learning environment helped to decrease anxiety when the student performed the same skill.

> She showed me how to use the electric breast pump rather than me trying to figure out what to do and making myself a little bit more anxious. She just showed me how to use it and then after that I had no problems with it.

Most of the participants identified that reviewing a skill with the instructor before going into the client's room helped to lessen their anxiety when they performed the skill.

> It helps when the instructor walks you through the skill before going into the room. You talk about what you're going to do before doing it. Talking with your instructor helps to verify knowledge about the skill and helps to trigger your memory about the skill.

All the participants expressed that they yearned for support and reassurance from their instructor. According to the participants, this was exhibited in a variety of ways such as: consoling a student; normalizing feelings; providing feedback; and "going that extra mile" for the student.

> When my first patient died, I felt totally out of it, I lost it, I broke down. My instructor at that time took me aside. I got a lot of support from her. I felt really bad for crying but she said you're human for crying. It made me feel really good because I knew she understands what I'm going through. She put her arms around me and gave me

a hug. She was wonderful at helping me cope with everything.

It was reassuring when my instructor said, "You can do it. You'll be fine. Let's go do it." She's the kind of person that would congratulate you and say you've improved.

I had a little conflict with the RN because I thought the patient was receiving too much Demerol. I told the instructor about it and she supported my judgment.

She went that extra mile to help me. Then I felt like I could come to her because she went that extra mile. She was an advocate for me and was willing to get in and argue for me, to help out. There was a shoulder to cry on.

One participant expressed that the support the instructor conveyed was very useful in helping the student to cope with anxiety, and facilitated feelings of comfort with the instructor.

When I got anxious about having so many medications to give out and other things to do all at once, she would say, take a five minute break. Sit down. Get your thoughts together and organize how you are going to do everything. And if you need help, then let me know and we'll get help. You don't have to do this all on your own. But organize your time so you're doing what you need to do the most, what you feel you need the most practice in. That made me feel like I wasn't thrown into the situation and I didn't have to be able to do it all on my own. It encouraged me to do skills I hadn't done rather than avoid them, because I felt comfortable enough with her to do a complicated skill such as catheterization. I could feel comfortable with her being there because I know she'd guide me through it if I was getting anxious.

Three participants identified that viewing their instructor as a role model was helpful in coping with their anxiety.

It started bleeding when I took the needle out and I thought, "What do I do?" Nobody told me this could happen. She just grabbed something out of her pocket, put it on, and continued talking away to the patient. I thought, "Whew, she's there and she knew what to do."

One patient had a cervical fracture and nobody wanted to deal with him because he was a serious case. He wasn't being looked after, hadn't anything to eat, hadn't been seen by a doctor. I was stressed because I didn't understand how someone could be left lying there like that. My instructor got involved in the case. She called Shaughnessy and got them going on that. She said, "Sit next to me and listen to what I'm going to say to them." My instructor was doing something about it and keeping me involved in it, not just saying, "O.K., forget about this patient, I'll give you another assignment." She encouraged me to listen to what she was saying and she encouraged me to talk to the doctor about how the family was feeling about the patient's care. I really liked that about that instructor.

Teacher-Learner Relationship

A predominant subcategory revealed in the data involves the teacher-learner relationship. The participants concur that the rapport developed between teacher and student is instrumental in helping students to cope with anxiety. The participants identified that feeling comfortable with the instructor was an essential ingredient in developing this rapport. Feeling comfortable with the instructor was regarded by participants as a major factor in perceiving the instructor as approachable and trustworthy. The participants described the following elements in developing feelings of comfort: knowing

the instructor; knowing the student; respect; partnership; humor; instructor as friend; and socializing on break time.

Most notably, the participants expressed that students who felt comfortable with their instructor perceived their instructor as more approachable; that is, they could feel at ease to ask a question or to ask for help.

> Sometimes you have questions that you think maybe you should know but you don't. But with some instructors you may not feel comfortable asking them a question and some instructors you do because you are more comfortable with them. In any aspect of life if you feel more comfortable with someone, you're obviously going to feel more free to address issues with them than someone else you wouldn't feel comfortable with.

Two participants identified that feeling comfortable with the instructor was important in establishing students' trust in the instructor. One of the participants acknowledged that knowing previous instructors better than a current instructor was a factor in feeling more comfortable with the former.

> Sometimes you don't feel like you can go to your instructor and say I have a problem, I need help. Instead you go to your past instructors and ask for help because you feel comfortable with them. You feel you can trust them.

> That instructor was probably the easiest to talk to as an adult, like just saying, "How are you doing or how are things in your family?" That sort of thing. The role was not just instructor-student, but it was more of another person to another person. That kind of conversation

helped because I felt, you know that I could trust this person obviously a little more than someone I didn't know anything about. I have had instructors that strictly wanted to be entirely professional. It was just instructor and student, that's it. There was no type of conversation outside of the professional aspect. It just seems easier when you know the other person, and they have the same type of concerns you have.

All participants agreed that knowing the instructor was imperative for developing feelings of comfort with the instructor. Knowing the instructor involved learning about the instructor's interests and life outside nursing.

Getting to know the instructor as a person, such as sharing what they did on their free time makes them less intimidating, especially because the teacher is in a judging position. Knowing the instructor can make you feel you can depend on them to help you.
I just felt there was a special rapport there. We got along well. I knew something about her life, she knew something about mine. You always sit down at the beginning of clinical and your instructor goes through "this is who I am," and they read off all the letters after their name, and where they went to school, and where they worked. But yeah, who are you? Because that rarely happened, and it did with this particular person. She actually told you something about her. You know the fact that she was married, and had kids, how old they were and what her week consisted of. You knew about her father and mother and in-laws, everything. It really developed a special kind of rapport, because even though you knew that she was an instructor and she was evaluating you, you just felt comfortable because this was a person, not just an instructor.

Two of the participants expressed that getting to know the instructor was helpful in developing respect. Respect led to students feeling more comfortable to approach the instructor.

> When an instructor tells the students that she hasn't been in a particular clinical area in a long time, students respect the instructor for saying this and this makes students feel much more comfortable to approach her and be honest about themselves and what areas they are not good at.

One student expressed that working in partnership with an instructor is important in creating feelings of comfort.

> She would talk to us like we were there to work on things together. It wasn't like "you're my students, and you do your thing, and I'm going to be here to watch and see if you do it right." It wasn't like that. It was like, "We're all here to learn and if you need help call me and if there's something you're not sure about let me know and I can help you with that."

> It just makes you feel more comfortable with the person because if the instructor is willing to say, "Let's look it up together." It's like working on something together. Instead of saying, "You look it up and we'll talk about it later."

Most of the participants identified that humor helped to create feelings of comfort with the instructor.

> To me, if someone can infuse humor into situations, I always feel more comfortable with them. I'm a little more nervous around people who are serious all the time. That made her very approachable also.

All the participants reported that instructors should get to know the students because this facilitates the development of the relationship and makes them more approachable.

> I would want an instructor to be interested in me and interested in my life. If they would ask me about my family, or what my average week was like, they show that they are interested in me not just as this nursing student that's showing up for clinical twice a week, but that I'm actually somebody besides that outside of school. It makes me feel the instructor is much more approachable because I feel like there's that interest there, and then I'll be able to come to her and talk to her and she'll be empathetic.

> She'll just sort of know you, and know that something's wrong. She knew if I needed to talk. Not all instructors can do that. That's what made her one of the best because she knew you.

Most of the participants expressed that knowing the instructors and the instructors, in turn, knowing the students was best achieved when interacting on a one-to-one level, individually with each student. One participant explained that this was important because it indicated that the instructor cared about the student.

> I would like to have more one on one time with my instructor to say this is who I am, this is what I need, and to try and get to know them better, rather than just jumping in and nobody knowing each other, and then starting to know each other just as the course is over.

> In a one on one situation, they will ask you what experience you have had, if there is anything you are not comfortable with. Sort of an overview of how you are

feeling going into this hospital for the first time. And encouraging you maybe half way through the course to have a little sit down with you and say O.K., how are you feeling now? It makes you feel that they care. You are not just a bunch of students, but you know they care about you, and you know that they are going to be there for you.

This mutual getting to know each other also helped students to perceive their instructors as less authoritative and subsequently less intimidating. Students viewed instructors whom they knew as on an equal level with the students, rather than being superior.

As the program progressed, we felt more comfortable with the instructor and, therefore, did not perceive the instructors as above the student or as an authority figure. They were equal.

The instructor is not a student. She has more information to give us than we to her, so we're not really the same level. But they should not be authoritative or dominating. The difference is you can respect the instructor because she has knowledge and I can go to her and ask for help.

Three participants viewed the instructor in part as a friend. Speaking with instructors and getting to know them like friends helped to build feelings of comfort, and subsequently helped students perceive instructors as more approachable.

When you know the instructor better, more like a friend the student feels comfortable to go to the instructor and ask for help.

However, the same participants valued the role of the instructor and did not want the instructor to assume only a friendship role.

> It's a hard combination. I think you should have 70% instructor and 30% friend. An instructor should always be an instructor.

Most students agreed that instructors who socialized with students at break time helped to create a relationship where students felt comfortable and provided them with a sense of being treated as a person.

> Sitting and joking with students on personal time such as coffee breaks make students feel more comfortable to go up and talk with instructors. The instructor is treating the student as a person, not just a student. Instructors who sit with other nurses create a wall between instructor and students and then the student does not feel comfortable to talk to the instructor.

Summary

In this chapter the findings of the study were presented from the perceptions of six nursing students. Two major categories with subcategories were identified: 1) sources of anxiety; and 2) strategies to minimize anxiety- teacher's response, and the teacher-learner relationship. The participants identified several sources of anxiety that they experienced during the clinical learning experience. Most anxiety was related to students' lack of knowledge and clinical experience,

lack of self-confidence regarding clinical performance, and feeling intimidated by the nursing instructor.

Participants reported a variety of teacher strategies that were helpful in assisting students to cope with anxiety. Strategies that related to the teacher's response focused on building students' self-confidence by providing support and encouragement, and giving students' positive feedback regarding their clinical performance. Other strategies regarding the teacher's response included offering help to students during skill performance, and providing prompts when having difficulty answering instructor's questions. Strategies that related to the teacher-learner relationship were largely related to interpersonal skills. Ability to build a rapport and a sense of comfort with students appeared to be significant interpersonal skills needed by instructors. The development of a positive teacher-student relationship appeared to correlate with students' perceptions of an approachable instructor. Participants identified that an approachable instructor who treated them with respect was very important in helping students to feel less anxious.

CHAPTER FIVE

Discussion and Implications

In this chapter, an analysis of the research findings presented in Chapter Four is presented. Lazarus and Folkman's (1984) model of stress appraisal and coping will guide the structure and presentation of the analysis according to the four central constructs of the model: the appraisal process; personal and situational factors; the coping process; and adaptational outcomes (see Appendix D for author's schematic drawing of Lazarus and Folkman's stress appraisal and coping model). Implications for nursing education and recommendations for future nursing research are identified at the end of the chapter.

The Appraisal Process

The appraisal of stress may be categorized as either harm/loss, threat or challenge (Lazarus and Folkman, 1984). The majority of participants' reports of stress involved situations suggesting threat. For the purposes of this study, threat is defined as anticipated harms or losses that cause damage to an individual's self esteem (Meisenhelder, 1987). Researchers (Pagana, 1988; Parkes, 1985; Windsor, 1987) have documented clearly the sources of stress perceived by students in the clinical setting (i.e., insecurity about professional skills and competence, fear of failure, lack of support from the clinical instructor, fear of making errors). The findings in this study are

congruent with those found in the literature. Participants emphasized sources of stress regarding first time experiences such as performing new skills and beginning a new clinical course. Personal expectations of doing well, and fear of failure were factors participants cited as underlying their anxiety regarding performing new skills.

Performance anxiety has been documented as a major factor that interferes with learning (Bell, 1991; Megel, Wilken, and Volcek, 1987; Stipek and Kowalski, 1989). Students who are anxious when performing a skill focus so much on their anxiety that their hands may tremble, they may forget knowledge they already possess, and they may lose confidence in their ability to perform the task competently. Fear of failure and fear of making errors are critical factors that underlie nursing students' anxiety during the clinical learning experience.

Several researchers have concluded that nursing students may feel threatened by the evaluative role of their nursing instructors (Infante, 1985; Kushnir, 1986; Wilson, 1994). Instructors hold the power to make decisions regarding whether a student will pass or fail, and also pass judgment regarding student's competencies especially when errors are made. Students acknowledge this power as a threat to their self-esteem. Participants in this study revealed that instructors wield power making critical decisions that can affect students' lives. They

implied that some instructors may misuse or may not acknowledge power and its impact associated with their role. No studies were found that investigated the issue of power and how nursing students or instructors perceive the power differential between instructor and student. Reilly and Oermann (1992) explain that students who view their instructor as a threat may choose to 'play the game' to survive the system. Survival, rather than learning, becomes their focus. Wilson (1994) concurs that students want to 'look good' academically in front of their instructors; that is, it is not what you know but it is what the teacher thinks you know that matters. In this study, instructors' expectations have been shown to be another significant source of anxiety for nursing students during their clinical learning experience. Wilson (1994) found that students are often uncertain regarding what knowledge or behavior is expected by clinical instructors. This leads to a continuous process of students trying to find out what the instructor wants. Findings from this study are consistent with those found by Wilson (1994) in that students spend much effort trying to anticipate instructors' expectations. Participants in this study explained that it would be beneficial if instructors would state their expectations at the beginning of the clinical course.

Researchers (Infante, 1975; Wilson, 1994) have determined that many students inaccurately perceive teachers' expectations.

They have found that many students believe that they must perform all skills perfectly and answer all instructors' questions correctly because this is ultimately how they will be evaluated. Participants in this study support these findings and, in addition, they explicitly stated that instructors' expectations are a direct source of anxiety for students in the clinical learning experience.

Infante (1975) suggests that instructors should create a 'climate for learning' in which less than perfect behavior is required, emphasizing that there is a wide margin of safety that is acceptable. Instructors are concerned that nursing care provided by students is safe, and that standards of the nursing profession are upheld. Instructors are not clear about what is the acceptable margin of safety, in part because nurse educators expect students to care for patients before they have the knowledge or skill to do so (Infante). In their approach with students, instructors may imply a set of unrealistic expectations. Nurse educators must clearly identify the acceptable margins of safety to students so that students feel less anxious during the clinical learning experience. Instructors should inform students at the beginning of the course that making errors is part of learning. When an error is made the instructor should focus on what can be learned regarding how to prevent it and how to correct it, rather than reprimanding the

student and using it as a mark against them in evaluation of the students' competence.

<u>Personal and Situational Factors</u>

Personal and situational factors work interdependently to determine the extent to which stress, and in this case threat, will be experienced (Lazarus and Folkman, 1984). Participants related most of their anxieties to low self-confidence regarding clinical competencies, lack of experience, and a weak knowledge base. Flagler, Loper-Powers, and Spitzer (1988) define self-confidence as "the person's trust or belief in his or her ability to function as a professional nurse "(p.342). Gaining experience with new skills and mastering these skills is one way of developing self-confidence (Diekelman, 1990; Flagler, Loper-Powers, and Spitzer, 1988). Van Hoozer (1987) explains that practice and repetition through a variety of strategies improves retention of information and promotes transfer of learning to new situations. Nursing instructors should devise learning activities to ensure that students are exposed to many different situations that provide opportunity to gain experience with skills. Fothergill-Bourbonnais and Smith Higuchi (1995) acknowledge the importance of selecting appropriate learning experiences for students but emphasize that limited direction is available for teachers to apply this knowledge. They discuss four factors that teachers should consider when planning

clinical learning experiences: curricular goals; the learning environment; teacher expertise; and learner characteristics. In a response to the need for research-based knowledge for teachers to organize clinical education experiences, a recent study by Dunn, Stockhausen, Thornton, and Barnard, (1995) revealed that learning experiences provided to students in a two week block format at the end of a semester resulted in far superior student learning outcomes compared to one or two days of clinical every week for fourteen weeks.

The findings of researchers support those of this study that a lack of self-confidence is commonly experienced by nursing students (Copeland, 1990; Flagler, Loper-Powers, Spitzer, 1988). While these researchers demonstrate the importance of fostering self-confidence in nursing students for the purpose of professional development, they do not identify low self-confidence as a factor that directly relates to student anxiety. Since anxiety is not addressed by researchers directly as an outcome of low self-confidence, an important link is missing. Clinical instructors need to acknowledge that effective interventions to help students cope with anxiety may directly foster students' self-confidence. No studies have been found that address nursing students' perceptions of their self-confidence at different levels in a nursing program. Self-esteem, or how students perceive themselves, has been given very little

attention in the nursing literature. This concept may be important in considering possible factors that relate to student anxiety during the clinical learning experience.

Participants in this study expressed that their lack of knowledge influenced their level of anxiety. Fear of not knowing what to do in certain situations and not being able to answer instructors' questions perpetuated the feelings of anxiety. Students need to be informed that gaining knowledge is a process that develops over time and with experience. Benner's (1984) work describes how an individual acquires knowledge and skill in clinical nursing, whereby an individual passes through five levels of proficiency from novice to expert. According to Benner, a student uses principles learned in the classroom at the novice stage, and over time uses past experiences with patient situations to develop competency and proficiency at the expert stage. Students need to be given time to learn from their experiences, and questioning of students should be a time for learning, not instilling anxiety. Questioning students using prompts or clues provided by the instructor can foster learning and self confidence in students (Flager, Loper-Powers, and Spitzer, 1988;), whereas questioning students often creates anxiety in students when it is perceived by students as evaluative (Pagana, 1988; Wilson, 1994). Instructors should be able to identify student anxiety and know

how to assist students to manage their anxiety. In some situations, students require professional counselling to help them, and instructors need to know their own limitations and abilities when intervening with student anxiety. This is a difficult challenge for nursing instructors because it has been documented that they are not formally taught in their education process about how to effectively intervene in student anxiety (Strauss & Hutton, 1983; Windsor, 1987). There are no guidelines for instructors to assist them in making decisions regarding how to intervene in student anxiety.

The Coping Process

Participants reported a host of teacher strategies that were effective in helping them cope with anxiety during the clinical learning experience. Lazarus and Folkman (1984) refer to two types of coping: problem-based and emotion-based coping. Students who use problem-based coping manage anxiety by changing their environment. Students who engage in emotional-based coping manage anxiety by reducing emotional distress through distancing or seeking social support. Elements of both types of coping may be in effect as instructors intervene to assist students to cope with anxiety.

Participants stated that often their instructors were the major source of their anxiety and students did not feel comfortable expressing their feelings to them. Instructors need

to acknowledge that they might be a source of anxiety in nursing students. They must accept that their position, their teaching methods, or their way of interacting may create anxiety for some students. Students are encouraged to be assertive in the clinical learning experience with staff and patients. Rarely are they encouraged to be as assertive when it involves interacting with the instructor. Instructors need to give students permission to confront instructors about perceived sources of anxiety. Instructors should also provide positive reinforcement when students use assertive skills, to foster this behavior in the future. Students need to be taught "how to" confront authority figures. Such a skill would be helpful throughout their nursing career.

O'Shea and Parsons (1979) identified effective and ineffective teacher behaviors that impact on student learning. Flagler, Loper-Powers, and Spitzer (1988) described teacher behaviors that enhance and hinder self-confidence. Similarities between this research and findings in this study related to instructor strategies for helping students cope with anxiety suggest a link between these areas of research. Participants in this study emphasized that instilling confidence in students and displaying the instructor's confidence in students were effective strategies that instructors used to help students cope with anxiety. This strategy was perceived as helpful because it

provided support and encouragement for the students and they felt that the instructor had trust in their ability to provide competent care. When students perceived their instructor had confidence in them, students felt more confident. This confidence helped to reduce the anxiety they experienced. Copeland (1990) suggests concrete methods of providing support and encouragement such as accentuating the positive aspects of the clinical day and re-inforcing positive behaviors. Participants in this study concurred with the teacher behaviors identified by Copeland. Support and re-assurance from instructors were evident in teacher behaviors such as consoling students and providing feedback to students. Consoling students indicated that instructors understood what students were experiencing. Kong (1983) explains that understanding students is crucial when instructors interact with students because "it implies the ability to listen, to accept, to respond and to interact with other people free from one's own value constraints or expectations" (p. 16). Participants in this study expressed that instructors who asked students how they were feeling and listened to their responses were perceived as helpful in reducing their anxiety during the clinical learning experience. Edwards (1991) explains that listening to students helps them to identify their sources of anxiety and helps facilitate relief. In addition, Edwards describes a variety of listening skills that

instructors should use when interacting with students such as: paraphrasing; perception checking; summarizing; and I-statements. These are no different than therapeutic communication skills that nursing students are taught to use when interacting with clients. Nursing instructors should be reminded to use these skills when interacting with students, just as they would when interacting with clients.

Providing positive feedback was an effective strategy used by instructors to help reduce anxiety in nursing students. Van Hoozer (1987) explains that providing feedback is helpful because it can increase motivation and usually improves subsequent performance. Reilly and Oermann (1992) assert that students value feedback from the teacher, especially if there is a trusting relationship between the teacher and student. Participants in this study expressed that feedback regarding suggestions of how students may improve in a clinical situation were valued when given in a friendly and calm tone, and accompanied with some positive feedback. Instructors should be cognizant about the type of feedback and how it is conveyed to students in effort to facilitate an effective strategy for helping students cope with anxiety. Stipek and Kowalski (1989) suggest that instructors should focus on students' efforts in performing a task rather than the outcome of the task. As a result, the evaluative component, often cited as a cause of performance

anxiety would be de-emphasized, and students may strengthen their belief in the effectiveness of effort and performance may be improved.

Inability to answer instructors' questions was a source of anxiety described by the participants because it reinforced low self-confidence related to a weak knowledge base. Participants identified an effective strategy used by some instructors that involved providing prompts or cues to students to help them arrive at the correct answer. Support of these findings are documented in the nursing literature (Smythe, 1993; Van Hoover, 1987). Providing prompts or cues help students locate answers using knowledge that they already possess, but previously thought they lacked. Instructors should concentrate on helping students recognize and value their existing knowledge base by assisting students with prompts to "tease out" information students possess. Instructors should also make clear the purpose of questioning; i.e., learning not evaluation.

The significance of the student-teacher relationship in the prevention and the minimization of anxiety has been well-documented in the nursing literature (Karns and Schwab, 1982; Reilly and Oermann, 1992; Smythe, 1993). The participants in this study unanimously agreed that this relationship is paramount in helping students to cope with anxiety during the

clinical learning experience. Participants commonly reported that 'feeling comfortable' with the instructor was a factor that determined students' perceptions of instructors as approachable and trustworthy. Being approachable was important because students then felt uninhibited to ask instructors a question or to ask for help. Wilson (1994) found that students either approached or avoided instructors depending on how confident or competent they felt. In addition, fear of approaching the instructor was related to students' perceptions that it was exposing an opportunity for students to be evaluated. It is difficult for students to trust instructors if they fear that asking questions may make them look bad because they do not know the answers. Flagler, Loper-Powers and Spitzer, (1988) suggest that instructors should make a distinction between time allotted for teaching and time allotted for evaluation. Instructors should clarify with students that, during clinical time on the ward, the focus of interactions with students will be for the purpose of learning. Evaluation time could be scheduled at the end of the clinical day. While this idea seems feasible in theory, it will be a challenge for nursing instructors to implement this intent in the spontaneous, unpredictable environment of clinical teaching.

The element of trust appears to be critical in the development of the teacher-student relationship. Reilly and Oermann (1992) assert that trust is important in this

relationship because it communicates confidence in students' abilities. Students are, therefore, more inclined to seek out new experiences in the clinical setting. On occasion, the participants were explicit about using the word "trust" in regard to feelings about the instructor, but more often implied the concept of trust by referring to 'feeling comfortable' with the instructor. This finding is in keeping with Hsieh and Knowles (1987) who found that students who described 'feeling comfortable' during their interactions with preceptors were alluding to the concept of trust. Participants in this study described that 'feeling comfortable' with the instructor involved knowing the instructor and the instructor knowing the student. Participants wanted to know their instructors personally; that is, what their life outside nursing comprised of, including their interests, hobbies, and family life. This knowledge helped students to perceive their instructors as less intimidating and less like an authority figure. There was no literature found that explored the notion of the student knowing the teacher as a means of facilitating the teacher-student relationship. However, Hsieh and Knowles (1990), who studied the student-preceptorship relationship, found that the sense of trust between student and preceptor increased in proportion to how much they knew of one another. The willingness and openness of instructors to share their personal lives with students do not appear to be recognized in

the literature as a valuable strategy for helping students to cope with anxiety. There is, however, sufficient literature regarding the significance of the teacher knowing the student in facilitating the teacher-student relationship (Berman 1988; Kong, 1983; Paterson & Crawford, 1994). Participants in this study expressed that instructors who took time to get to know students felt more comfortable with these instructors and perceived that they cared about the students. Participants explained that instructors' efforts to 'get to know students' are achieved through a variety of means such as spending time with students at coffee breaks during clinical, asking students about their family life and activities outside of school, and talking with students one-on-one.

Diekelman (1990) refers to 'dialogue' as a component in building relationships between teachers and students. Dialogue refers to talking and reflecting about situations together so that a mutual sharing and learning exists between teacher and student exists. Smythe (1993) suggests that teachers may learn a great deal by engaging in dialogue with their students in terms of rethinking concepts or practices that instructors once thought to be understood, and questioning commonly held assumptions. Mutual learning helps to break down the barriers between teacher and student. In addition, the student may also appreciate that learning is a life-long process.

Participants expressed that talking with the instructor one-on-one helped to facilitate the process of getting to know one another. Smythe (1993) explains that one-on-one relationships are most meaningful because there is opportunity to know each other well. Learning to know each other is an ongoing process that takes time. Paterson and Crawford (1994) recognize that limited clinical time is a constraint to knowing the student. Participants acknowledged that the short length of clinical courses meant that students have to get to know a new clinical instructor every time they begin a new course. Perhaps instructors should be assigned to follow students through several courses. Such an arrangement would require modification of traditional faculty timetables. The teacher's academic or clinical preparedness for courses never taught before would also have to be considered.

Participants in this study identified that working in partnership with the instructor was an effective strategy used by instructors that helped students to cope with anxiety. Offering help to students during skill performance was perceived as beneficial because the instructor was viewed as a guide and assistant, rather than an evaluator. Instructors must not overlook the importance of working with students in partnership, whereby collaboration and teamwork serve to

remove the fear and intimidation that many students experience towards their instructors as evaluators.

Hsieh and Knowles (1990), in their study regarding student-preceptor relationships, found that preceptors who practice 'self-disclosure' are comfortable to discuss their own limitations and concerns with preceptors. Students in the study who acknowledged and expressed their feelings to preceptors felt their self-disclosure was a step forward in alleviating some of their anxiety. Smythe (1993) explains that sharing thoughts and feelings between teacher and student facilitates the development of a trusting relationship. The participants in this study identified that they developed respect for instructors who were honest with students when disclosing information about their limitations regarding clinical areas in which they have little experience. Sinclair and Ryan (1987) identified that teacher anxiety influences anxiety experienced in nursing students, and interferes with student attitudes and performance. Instructors should make an effort to participate in self-disclosure dialogue when interacting with students. The extent of self-disclosure is a very subjective and individual decision. Instructors must develop their own level of comfort in establishing the boundaries to create the appropriate balance between the professional and personal relationship. The benefits of self-disclosure reap rewards for both instructor and student by

promoting feelings of relief experienced when sharing anxiety with another, and ultimately by strengthening the teacher-student relationship.

Adaptational Outcomes

The three adaptational outcomes that are affected by the appraisal and coping processes are: social functioning, morale, and somatic health (Lazarus and Folkman, 1984). Determining the effectiveness of a coping strategy is important in establishing the overall quality of an individual's social functioning. The participants in this study revealed that the anxiety they experienced affected their self-confidence, their ability to perform competently, and the fear of failure. Lazarus and Folkman (1984) explain that morale involves how people feel about themselves and the conditions in their lives. This is closely related to the concept of self-esteem, a topic that received brief mention in the literature, but one that is generally overlooked in relation to anxiety. Coping effectiveness requires there to be a good match or fit between coping efforts and a person's values, goals, and preferred styles of coping (Lazarus and Folkman, 1984). There was no research located that addressed students' values, goals, and coping styles in relation to their perceived anxiety during the clinical learning experience. In addition, there was no literature found that addressed the effectiveness of coping strategies used by

students when managing their anxiety. Instructors need more information about the influence that values, goals and coping styles have in relation to student anxiety, and how to measure the effectiveness of instructor's strategies when helping students cope with anxiety.

One participant in this study acknowledged to the researcher that as a result of taking part in this study, she felt a great sense of relief because she had the opportunity to express her feelings of anxiety to someone. She admitted that until she was asked to explain how instructors helped her to cope, she had focused most of her energy over the last two years feeling upset and frustrated. She had forgotten until the research interview about the positive aspects of her nursing experience. Pagana (1988) similarly found that many students commented that they found it therapeutic to describe their feelings of stress on the research questionnaire. It appears that there is very little formal opportunity for students to express these feelings to instructors. Students must feel, however, that a trusting relationship exists between themselves and instructors before students feel safe and willing to share their anxieties.

Implications for Nursing Education

Nurse educators have an important role in assisting students to cope with anxiety during the clinical learning experience. Nurse educators must acknowledge the significance

of anxiety for nursing students, not only to identify that anxiety exists but to understand how it feels for students. Understanding and empathy will begin the development of a trusting teacher-student relationship (Reilly & Oermann, 1992). Instructors need to allow sufficient time during the clinical learning experience to foster the development of this relationship. One strategy instructors may use is to meet with students one-on-one at the beginning of every clinical course to ask students about their feelings of anxiety. At this time, instructors could begin to get to know students by asking them questions about their families, hobbies and life outside of nursing school. Instructors could share information about themselves and express some of their limitations or concerns to students. The first day of orientation in a new clinical course is an opportune time for instructors to discuss their expectations of students. At this time, instructors should inform students that making errors is part of learning, and that perfection is not a standard that must be or can be achieved. They should encourage students to view the clinical learning experience as a time for learning, and de-emphasize the time associated with evaluation. They should also inform students that instructors would like to assist students while performing skills, to accentuate learning rather than evaluation.

Nurse educators need to be taught about how to intervene effectively to help students cope with anxiety. Since most nurse educators are not taught how to teach (Diekelman, 1990; Paterson, 1991), it is not surprising that they lack skills in assisting students to cope with anxiety. Workshops should be conducted for educators to learn about strategies such as how to develop a trusting teacher-student relationship. Knowing the attributes of this relationship is the first stage of learning how to prevent or minimize student anxiety. The next stage depends on the instructor's ability to implement such a relationship. This ability is influenced by the instructor's personality, ability to interact with others, possession of a sensitive disposition, and perhaps an intuitive way of knowing, that is, knowing without conscious reasoning. Selection committees involved in hiring nurse educators should assess for these abilities during the hiring process.

Implications for Nursing Research

This study entailed interviewing six participants in a college diploma nursing program. Replication of this study using a larger number of participants, including baccalaureate students, would be useful to gain a broader understanding of nursing students' perceptions. This study did not address the age or cultural background of the participants. Consideration of age and cultural aspects of the participant population would be

valuable in ascertaining if differences are apparent regarding their perceptions of effective interventions used by nurse educators in assisting them to cope with anxiety.

Findings from this study indicated that students want to know the instructor. Further research is needed to study how students come to know the instructor and what factors facilitate and impede this process. This study focused on students' description of effective strategies that nurse educators use when intervening with student anxiety. More research is needed to explore the effectiveness of specific strategies: that is which strategies are most and least effective, and the reasons for this. While some studies address the effectiveness of various interventions used by nurse educators, results are limited due to problems inherent in the design (i.e., small sample size). Research in this area could be very useful for instructors when planning strategies to help students cope with anxiety.

The findings from this study identified a link between self-confidence, self-esteem and anxiety. Further research is needed to understand the relationship between these concepts. Uncovering these links may be helpful in determining other foci for identifying effective strategies when intervening in student anxiety.

Implicit in the findings of this study are students' personal values, goals and coping styles that determine their ability to

cope. Further research is needed to investigate the relationship of values, goals and coping styles to the ability to cope during the clinical learning experience. Knowledge of these findings could affect how instructors develop their strategies for assisting students to cope with anxiety.

Summary

The purpose of this qualitative study was to explore and describe the perceptions of six nursing students regarding effective interventions that nurse educator use in helping students to cope with anxiety during the clinical learning experience. The literature review revealed previous quantitative and qualitative studies that identified sources of anxiety in nursing students, and strategies used by nurse educators in helping students to cope with anxiety. Studies that address coping strategies are severely limited due to problems inherent in the research design, and because they do not elicit nursing students' perceptions of which interventions had been effective and why they were beneficial. An ethnographic design, using primarily interviewing for the purpose of data collection, was the research method used to conduct this study. The transactional model of stress and coping by Lazarus and Folkman (1984) was utilized as the conceptual framework for this study. The model also formed the structure for presentation of the literature review and research findings.

Analysis of the data revealed that a significant amount of student anxiety related to personal feelings of inadequacy and lack of self-confidence, primarily due to a lack of knowledge and experience. Findings revealed that students perceived they must perform perfectly, and fear the instructor's presence because of the evaluative component associated with the instructor role. Effective strategies used by nurse educators in helping students to cope with anxiety were directed primarily at developing a trusting relationship between teacher and student. When students perceived that they could trust the instructor, they viewed the instructor as more approachable and subsequently felt more comfortable to seek them out for help without fear of evaluation.

Conclusions

The clinical learning environment is a very significant component of nursing students' professional education. The inherent anxiety that students experience during this aspect of their education process warrants acknowledgment and effective intervention from nurse educators. However, it is apparent that nurse educators are poorly prepared in their role to assist students to cope with anxiety during the clinical learning experience. Effective interventions based on research rather than personal experiences of nurse educators are needed to

establish a guide for them when intervening in student anxiety. This study has contributed significantly in this regard.

The research has focused on the perspectives of nursing students. Listening to students' perspectives regarding anxiety is an important first step in learning how to help them. Valuing nursing students' perspectives not only is critical in the development of effective interventions for assisting them to cope with anxiety, but also facilitates the development of teacher-student relationships, an important element in reducing student anxiety. Nursing instructors must be committed to interacting with students in partnership rather than assuming authority and power to effectively assist students to cope with anxiety during the clinical learning experience.

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APPENDICES

Appendix A: <u>Explanatory Letter for Agency Consent</u>

Appendix A

Explanatory Letter for Agency Consent

Mr. John Bowman
Director, Planning and Research
Kwantlen College, Surrey Campus

Dear Mr. Bowman,

My name is Cheryl Burnstein. I am a student enrolled in the Master of Science in Nursing program at the University of British Columbia. As part of my master's program, I am writing a thesis on nursing student's perceptions of effective interventions used by nurse educators for reducing nursing students' anxiety in the clinical learning experience.

I am requesting permission to interview six full or part-time nursing students in the diploma nursing program at Kwantlen College. Participation of students will be strictly on a volunteer basis. If permission is granted, I will provide a verbal explanation of this study to prospective volunteers during students' class time; and to faculty during a team meeting. Initial interviews will be tape recorded and participants will receive a copy of the transcribed interview. A follow-up interview will take place for verification and clarification of participants' responses. Each interview will take approximately one hour, and will be conducted at a location chosen by the participants. Participants may benefit from participation in the study through the sense of well being gained when they are able to share personal experiences regarding their anxiety.

I am currently employed as a nursing instructor in the diploma nursing program, on a contractual basis. The participants in the study will not have had previous contact, and will not have future contact with me in the capacity of nursing instructor. Senior level students will be invited to participate in the study, in hopes that they will graduate soon after the study is complete and I will have no future contact with them. I will not serve on any disciplinary committee involving the participants.

For the purposes of the U.B.C. Ethical Review Committee, written proof of agency consent is required for approval of the

study. Please find enclosed an agency consent form which requires your signature of approval. If you would like more information regarding my study, please feel free to contact me at home:
261-1133 or work (voice mail 9397) or my thesis chair-person Dr. Barbara Paterson at work: 822-7490.

Sincerely,

Cheryl Burnstein, B.Sc.N.

Appendix B: <u>Agency Consent Form</u>

Appendix B

Agency Consent Form

I, the undersigned, give permission to Cheryl Burnstein to conduct her study titled "Nursing Students' Perceptions of Effective Interventions Used by Nurse Educators in Assisting Students to Cope with Anxiety in the Clinical Learning Experience" at Kwantlen College.

Signature:
Date:

Appendix C: <u>Participant Information and Consent Form</u>

Appendix C

Participant Information and Consent Letter

Title of Study: "Nursing Students' Perceptions of
Effective Interventions Used by
Nurse Educators in Assisting Students
to Cope with Anxiety in the Clinical
Learning Experience".

<u>Participant Information and Consent Letter</u>

Dear Student:

My name is Cheryl Burnstein. I am a student enrolled in the Master of Science in Nursing program at the University of British Columbia. As part of my master's program, I am writing a thesis on nursing student's perceptions of effective interventions used by nurse educators for reducing nursing students' anxiety in the clinical learning experience.

You are being invited to participate in this research study. The study consists of a tape-recorded interview exploring your thoughts and feelings about anxieties you have experienced in the clinical learning experience and how a clinical instructor helped you to feel less anxious. You will receive a copy of the transcribed interview and will be asked to meet on one more occasion to provide verification and clarification about your responses given in the initial interview. Each interview will take approximately on hour, and will be conducted at a location chosen by you.

You may benefit from participation in the study through the sense of well being when sharing personal experiences regarding your anxiety. In addition, you may be able to help other nursing students cope with their anxiety in the clinical learning experience.

Confidentiality will be maintained by assigning a code to each participant, no names will be used on tape or in transcriptions of interviews. Only myself and my thesis committee will have access to the data.

Your participation is strictly voluntary. You may withdraw from the study at any time without jeopardizing your position as a student. Participation in the study will not have any effect on grades or other evaluations.

Thank you in advance for your assistance in furthering research in nursing education. Please feel free to contact me if you have any questions or concerns: (work: 599-2222, voice mail 9397 and home: 261-1133); or you may contact my thesis chairperson Dr. Barbara Paterson at work: 822-7490.

Sincerely,

Cheryl J. Burnstein

I, the undersigned, have read and decide to participate in the research study conducted by Cheryl Burnstein. In addition, my signature indicates that I have received a copy of the consent form.
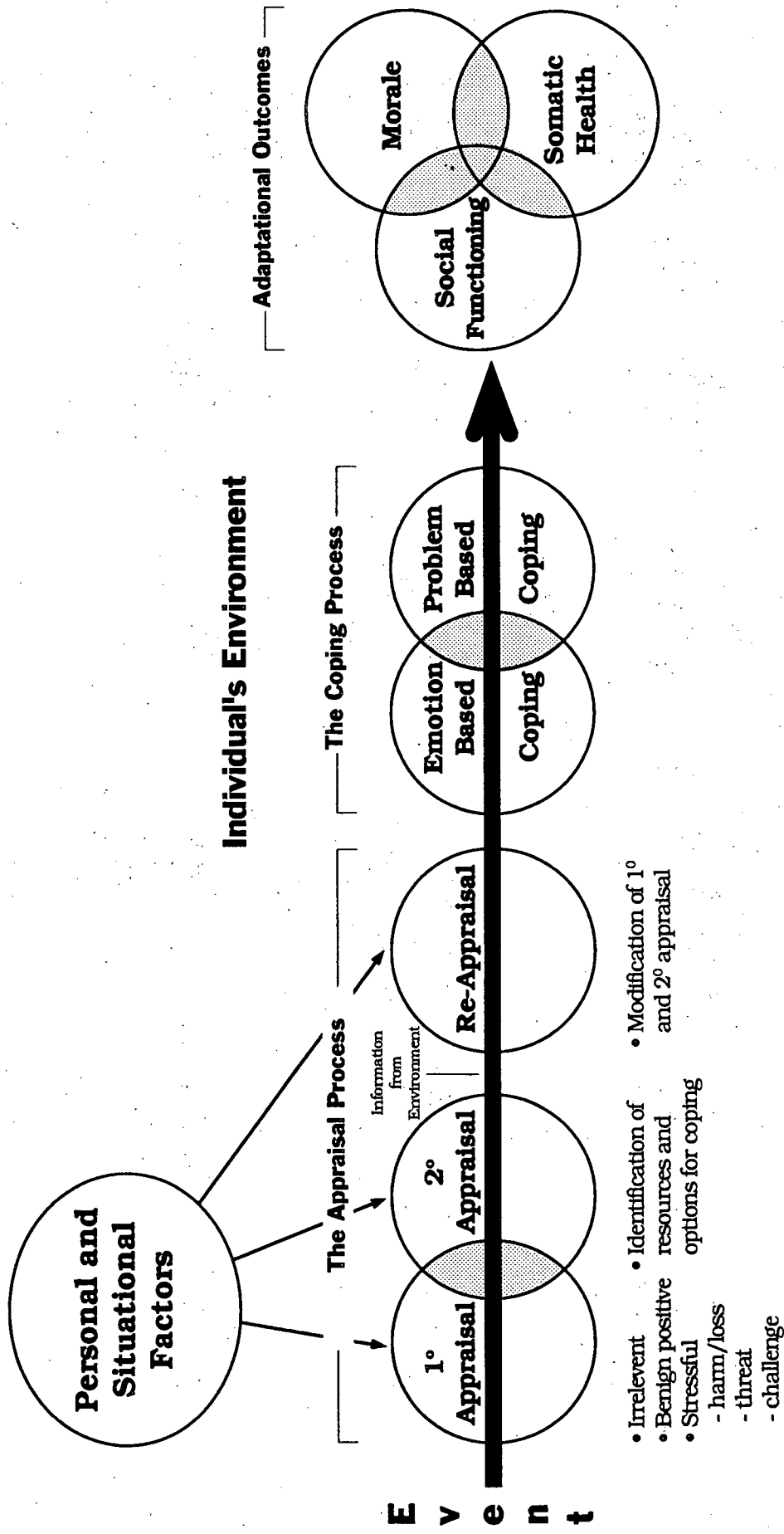
Signature:

Date:

Witness:

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Appendix D: <u>Schematic drawing of Lazarus and
Folkman's (1984) Stress Appraisal and Coping Model</u>

Schematic Drawing of Lazarus and Folkman's (1984) Stress Appraisal and Coping Model