NURSING STUDENTS’ PERCEPTIONS OF INVITING TEACHING BEHAVIORS

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Clinical nursing faculty must be aware of how interactions between faculty and students during the clinical experiences can create both positive and negative perceptions from students. The relationship between the students’ perceptions of supportive or “inviting” teaching behaviors from clinical faculty needs further exploration. The purpose of this study is to determine sophomore, junior, and senior baccalaureate nursing students’ perceptions of encouraging teaching behaviors of faculty in the clinical setting. This is a replication of Cook’s (2005) study. The theoretical framework is the Invitational Education Theory (Novak & Purkey, 1984). The study will be conducted at two universities in Indiana, Ball State University, and the University of Indianapolis. There will be approximately 30 selected students, from the sophomore, junior, and senior class from each school. Two questionnaires will be completed by each student: a demographic data form, and the Clinical Teaching Survey (CTS) (Ripley, 1986). One of each of the student’s current clinical instructors’ teaching behavior will be rated. Findings will provide an increased awareness of perceptions of inviting teaching behaviors for clinical faculty.
Patient safety is a key issue for reducing medical/nursing errors. The Institute of Medicine (IOM) (2003b) addressed the patient safety issue by focusing on quality of care, leadership, workplace environment, nursing care, diversity, public health, and health professions education. Health indicators have been established by the State of the USA (SUSA) (Parnell, 2010), working with the IOM, to establish competencies that address the social and physical aspects of the environment, health related behaviors of nurses, and overall systems. Outcomes addressed include: mortality rates, healthcare behaviors and systems, cost, access, and effectiveness.

The role of leadership in safety is to identify the root cause of errors, solve problems, and make system changes (Finkelman & Kenner, 2009). Nurses are the primary providers of clinical care with bedside presence and surveillance responsibility. Consequently, nursing roles are being reframed to include a major emphasis in quality analysis, improvement, and benchmarking in creating a culture of quality and safety (Draper, Felland, Liebhaber, & Melichar, 2008).

The IOM reports also addressed the link between patient safety and nursing education. IOM (2003b) identified a gap between nursing education and practice.
outcomes. In response to the IOM reports, committees were established by IOM, as well as the American Association of Colleges of Nursing (AACN), that support educational programs to prepare nurses with a set of competencies to meet patient safety outcomes. Nurse educators are challenged to prepare nurses to perform the skills needed to reflect the competencies identified to achieve safe, quality care (American Association for Colleges of Nursing, 2008; Cronenwett et al., 2007).

The quality and Safety Education for Nurses (QSEN) report addressed the challenge of preparing nurses with the competencies necessary to improve the safety and quality of the health care systems in the workplace (Cronenwett et al., 2007). The QSEN team modified the Institute of Medicine’s competencies for nursing (patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics). The QSEN report proposed definitions that described essential features of what it means to be a competent nurse. Using the competency definitions, Cronenwell et al. (2007) proposed statements related to knowledge, skills, and attitudes (KSAs) for each competency that should be developed during pre-licensure nursing education.

The American Association of Colleges of Nursing (AACN) published revised Essentials of Baccalaureate Education of Professional Nursing (AACN, 2008), and addressed nursing competencies related to patient safety and quality. Essential II: Basic Organizational and Systems Leadership for Patient Safety and Quality Care,” speaks of integrative learning strategies. Providing leadership experiences and opportunities for nursing students requires participation in practice settings that build communication skills and shadowing a leader (AACN, 2008, p.4).
Best practices in education include the use of multiple teaching strategies, and ongoing feedback to facilitate outcomes. The best practices for clinical teaching are based on the assumption that students are best served by opportunities to work together with professional nurse mentors, preceptors, and roles models (AACN, 2008). Nursing role models practice from “...an evidence base and promote student access to a wide range of patient populations, experiences and best practice” (AACN, 2008, p. 14). The development of competent nurses in complex clinical settings is demanding, yet necessary to create an environment that is conducive to optimal learning.

To learn best practices student nurses need to be socialized into the clinical environment. The process of socialization of nursing students into practice requires purposeful connections with effective role models as well as mentors. This involves encouraging and supporting positive student/faculty relationships (Finger & Pape, 2002; Gillespie, 2002; Griffith & Bakanauskas, 1983; Stanley, 2008; Vallent & Neville, 2006; Zilembo & Monterosso, 2008). Faculty have a major role in providing emotional support, and building self-confidence and self-worth of students (Dorsey & Baker, 2004, cited in Killeen & Saewert, 2007). Confidence is a key component in learning best practice.

Understanding and adapting to the learning needs of the current generation of students is imperative to facilitate positive outcomes (Parrish, 2010). To develop strong partnerships with students, faculty need to bridge the generational gap to promote mutual understanding, personal growth, and academic success (Goudreau, Pepin, Dubois, & Boyer, 2009; Pardue & Morgan, 2008). Faculty must become aware of students’ perceptions of faculty behaviors that students consider “inviting” to facilitate the best learning outcomes (Cook, 2005; Steyn, 2006).
The Institute of Medicine, the American Nurses Credentialing Center’s Magnet Recognition Program, and the American Organization of Nurse Executives have all called for attention to nurse competencies and patient safety. Competencies include skills and behaviors, such as communication, relationship management, and building and sustaining trust (IOM, 2006). Moreover, noted nurse educators, Benner, Tanner, and Chesla, (1996), (cited in Finger & Pape, 2002), and Bevis and Watson (2000), supported a movement away from the traditional, behavioral medical-model as the main modality for teaching and learning. The philosophical shift advocates working towards a more effective means of closing the gap between the traditional, behavioral medical model, and caring-humanistic nursing philosophies in actual educational practices as a fundamental challenge. Cook (2005) has recommended that faculty/student relationships needs further investigation. This study is based on Cook’s work.

Background and Significance

In 1997, initial steps were taken to explore and improve the quality and safety of the U. S. healthcare system. President Bill Clinton’s Advisory Commission on Consumer Protection and Quality in the Healthcare Industry (ACCPQHI, 1991) was instrumental in the process. The purpose of the commission was to advise the president about the impact of healthcare delivery system changes on quality, consumer protection, and availability of needed services (IOM, 2004; Wakefield, 2008). The commission was instrumental in the initiation of necessary changes.

In 1999, the report Quality First: Better Healthcare for all Americans (President’s Advisory Committee, 1998) was written in response to the Clinton administration’s Quality of Healthcare in American Project (QHAP) (IOM, 2001). The purpose of this
report was to respond to the current health issues, and to report strategies to improve healthcare over the next 10 years. QHAP produced several reports referred to as the *Quality Chasm Series* (IOM, 2006). The reports focused on: quality of care, best practices for better health, emergency care, leadership, diversity, disparity, public health, nursing, and healthcare education that occurred over the next several years.

A report on national patient safety, *To Err is Human* (IOM, 2000), described the national healthcare safety problem, specially recognizing high levels of patient related errors. The report identified five critical principles in the design of healthcare systems including: (a) providing leadership, (b) respecting human limits in process design, (c) promoting effective team functioning, (d) anticipating the unexpected, and (e) creating a learning environment. Another report, *Crossing the Quality Chasm* (IOM, 2001a), envisioned a new health system for the 25th century (p. 4). The report stated healthcare should be: (a) safe, (b) effective, (c) patient-centered, (d) timely, (e) efficient, and (f) equitable. The goal was to raise the quality of care to unprecedented levels. In 2001, *Envisioning the National Healthcare Quality Report* (ENHQR) (IOM, 2001b) was written to describe the methodology for data collection. The ENHQR was generated “to be used as a gauge to insure the improving of performance of healthcare delivery systems in consistently providing high-quality care” (IOM, 2001b, p. 2).

In another report, *Health Professions Education: Bridge to Quality* (IOM, 2003b), the education of health professionals was viewed as the bridge to quality care. The recommendations at that time were based on the belief that education was not based on evidenced–based practices, advanced technology, diverse populations, and leadership
skills. Changes in health professionals’ education were recommended for improved safety and quality of patient care.

In 2006, the report *Preventing Medication Errors* (IOM, 2006) focused on several aspects of medication errors. The plan for change had a greater emphasis on the patient-provider relationship by encouraging patients’ participation in medical care. Another report, *Knowing What Works in Healthcare: A Roadmap for the Nation* (IOM, 2008) emphasized the necessity of accurate diagnostic, treatment and prevention services by incorporating evidenced-based practice. This report noted the importance of expanding the use of scientific evidence to assess best practices. In 2008, the *State of the USA Health Indicators* was developed that included the use of 20 key measurements of the nation’s health and healthcare outcomes (IOM, 2008e). The indicators serve as a basis for patient safety and quality care.

Nursing education reflect changes in the current healthcare environment to ensure that standards and best practices are maintained. The nursing education perspective of Cook’s (2005) study emphasized the importance of identifying a clinically-based theory to build faculty/student relationships, namely the Invitational Education Theory (Purkey & Stanley, 1991). Developing a more humanistic-based educational approach to clinical education is a more egalitarian, humanistic, and collegial-like relationship between teachers and students. The theory serves to empower and liberate both educators and students (Cook 2000, p. 16). The Invitational Education Theory is based on the humanistic education paradigm that identifies specific teaching behaviors based on mutual respect, trust, optimism, and intentionality between faculty and student. Therefore, by studying the relationships among students’ perceptions of inviting teaching
behaviors, knowledge is gained to support this theory as an educational approach to clinical nursing education.

The Invitational Education theory was the framework for Cook’s (2005) study. Cook found that there was a negative, moderate correlation between nursing students’ perceptions of clinical nursing faculty’s personally and professionally inviting teaching behaviors and students’ state anxiety, as positive faculty behaviors increased, student’s anxiety decreased. Students’ perceptions of professionally inviting teaching behaviors can provide information about faculty behaviors that facilitate learning. Further study is needed to confirm Cooks’ findings.

Problem Statement

It is essential that student nurses’ clinical experiences be done in an enriched learning environment. Faculty/student relationships are a key factor in creating a positive learning environment. An increased understanding is needed regarding faculty-student interactions, and students’ perceptions of faculty inviting behaviors that affect students’ ability to learn and perform effectively.

Purpose of the Study

The purpose of this study is to describe nursing students’ perceptions of personally and professionally inviting teaching behaviors while interacting with clinical faculty, and to compare students’ perceptions across educational levels. This is a partial replication of Cook’s (2005) study.
Research Questions

1. What are students’ perceptions of personally and professionally inviting teaching behaviors of clinical nursing faculty while interacting with faculty during clinical experiences?
2. Are there differences in students’ perceptions of professionally inviting teaching behaviors among students at sophomore, junior, and senior levels?

Theoretical Framework

Invitation Education Theory (IET) (Purkey & Novak, 1984) is the theoretical framework for this study. The Invitation Education Theory is based on the principle that education should be a process by which “people are cordially, creatively, and consistently summoned to realize their potential” (p. 7). Purkey and Novak (1984) stated that educators need to intentionally focus on signals sent to students. Educators need to adopt an “inviting” stance. Inviting communications express a sense of value, worthiness and capability. Disinviting behaviors convey to the student a sense of worthlessness and inability to accomplish goals and tasks (Purkey & Novak, 1984). This framework is appropriate for this study because this inherent humanistic perspective is conducive to the evaluation of faculty inviting behaviors. This study examines faculty inviting teaching behaviors.

Definitions of Terms

Intentionally disinviting: This pattern is considered the most negative and degrading to human functioning. The behaviors are to intentionally demean, dissuade, discourage, and defeat others. The behaviors are considered the most negative of interactions.

Unintentionally disinviting: The behaviors are not intentionally meant to be disinviting, but occur during interaction due to factors such as indecision, lack of control, or unresolved conflict. People with these behaviors or communications are said to have characteristics that appear uncaring, condescending, chauvinistic, or racist.

Unintentionally inviting: The behaviors exhibited communicate a level of trust, care, and optimism, but are not consistent or have occurred by deliberate action.

Intentionally inviting: Teaching behaviors that are consistently intentional and consistently convey trust, respect, optimism, and care, summon the student to physically, intellectually, and psychologically develop (Cook, 2005).

*Operational.* Clinical teaching behaviors: The four levels of teaching behavior within the IET framework (Purkey & Stanley, 1991) will be measured using the Clinical Teaching Survey (CTS) Ripley (1986). This is a 44-item tool to measure personally and professionally inviting behavior of clinical nursing faculty. Participants were to rate one clinical faculty member’s teaching behavior utilizing the CTS survey.

*Limitations*

Participants will only be from baccalaureate nursing programs. Nursing students from other programs such as associate degree, RN to BSN or diploma programs may have different perceptions of clinical teaching behaviors. The sampling offered limitations with surveying from only two universities in the same mid-western state.
Assumptions

1. Students accurately and honestly reported perceptions of faculty teaching behaviors while interacting with clinical nursing faculty.
2. Extraneous variables may influence students’ perceptions of teaching behaviors.
3. Faculty inviting teaching behaviors can affect students’ performance, and is important.

Summary

The clinical nursing environment is a crucial component of nursing education programs. It is important that students gain skills from clinical experience to develop confidence to progress to providing competent nursing care to clients. Nurse educators need to be cognizant of how behaviors and interactions can help or hinder the learning process. It is beneficial to gain knowledge into students’ point of view and how students respond emotionally in interactions with clinical faculty. The theoretical framework for the study, the IET (Purkey & Novak, 1984), offers a humanistic approach to teaching. It is believed that if students’ perceive clinical nursing faculty to be conveying inviting teaching behaviors, clinical performance and learning will be the enhanced. A better understanding of sophomore, junior, and senior nursing students’ different perceptions of personally and professionally inviting teaching behaviors of clinical nursing faculty is of value if modification of the educational environment is warranted. This information will be useful in the selection of clinical nursing faculty with the gained insight into students’ perceptions of inviting behaviors.

This chapter provided the introduction and background for this study, including the nature of the problem and purpose. In addition, the theoretical framework, the
Invitational Education Theory, was presented along with the research question, definition of terms, assumptions, and the significance of the study.
Chapter II

Review of Literature

Introduction

Nursing students are prone to stress due to the inherent challenges transitions that occur in college. Nursing is considered a complex and demanding field of study, and places high expectations on students. Successful clinical experiences for nursing students are critical in attaining the necessary skills to care for patients. Feelings of incompetence and uncertainty can interfere with nursing students’ ability to process information accurately, and accomplish the clinical competencies. Cook (2005) indicated that nursing students sometimes feel threatened and anxious when interacting with clinical faculty, particularly if the student perceives the faculty’s behavior is disinviting. Faculty must be cognizant of the needs and perceptions of nursing students to facilitate clinical learning. Desirable leadership qualities of faculty, including positive or inviting faculty behaviors, have been shown to have positive effects on students’ self-concept and learning ability (Cook, 2005).

Purpose

The purpose of this study is to explore nursing students’ perceptions of personally and professionally inviting teaching behaviors of clinical faculty in the clinical setting.
This study also examines differences in perceptions of personally and professionally inviting teaching behaviors of faculty among sophomore, junior and senior nursing students. This is a partial replication of Cook’s (2005) study.

**Organization of the Literature**

The literature review to support the study is divided into seven sections: (a) theoretical framework of the study, (b) Invitational Theory Applied, (c) students’ perceptions of clinical experiences, (d) students’ perceptions of faculty behaviors, (e) relationships between students and faculty, (f) relationships between students and preceptors, and (g) incivility in clinical nursing education. A summary follows.

**Theoretical Framework**

The theoretical foundation for this study is the Invitational Education Theory (Purkey, 1992; Purkey & Novak, 1984, 1998). The Invitation Education Theory, derived from the International Alliance for Invitational Education (IAIE), proposes that humans are continually evolving, and are in the process of being and becoming. The theory suggests that people are cordially, creatively, and consistently summoned to realize potential, and to develop physically, intellectually and psychologically (Purkey & Stanley, 1991). Messages are considered either positive (inviting) or negative (disinviting) in nature. Inviting behaviors suggest that an individual views someone as valuable, able and responsible (Purkey & Novak, 1984). Disinviting behaviors denote unworthiness, incapability, and irresponsibility (Purkey & Stanley, 1991).

Invitational Education is a metaphor for an emerging model of education. It consists of four value-based concepts about the nature of people and potential. The concepts are
considered core teaching elements of Invitational Education Theory within the teacher-student relationship. The concepts are: trust, respect, optimism, and intentionality (Purkey & Novak, 1998, as cited by Cook, (2005).

Trust is learned through cooperative and collaborative activity that is the essential foundation of an optimal learning process. Respect involves mutual, shared responsibility. Optimism is the belief that people possess untapped potential. Teachers have a prevailing sense of hope, and believe that changes for the better are possible. Intentionality is an invitation to offer something beneficial for consideration. Trust, respect, optimism, and intentionality create a positive learning environment (Purkey, 1992).

Invitational Education (Purkey, 1992) is referred to as a perceptual tradition. Perceptual tradition supports the idea that current understanding is affected by past experiences and viewpoints that are unique to the individual (Purkey, 1992). Self-concept is the core concept in this theory. Rogers viewed self-concept as the key to personal adjustment (Rogers, 1961). If a person experiences unconditional positive regard from others and oneself, self-concept will develop positively, resulting in increased self-esteem (Rogers, 1961).

According to Purkey and Stanley (1991), a teacher has a dominant, prevailing pattern of interaction. Invitational Education Theory describes four patterns of teaching behaviors that are recognized along a continuum: intentionally disinviting, unintentionally disinviting, unintentionally inviting, and intentionally inviting. If nursing students perceive faculty to be inviting based on positive behaviors that convey trust,
respect and optimism, the environment will be more conducive to learning. Conversely, if the students experience patterns of disinviting behaviors, the educational environment will be negative, and learning will be inhibited in some way. This theory is appropriate for this study because nursing students learn in an environment that is complex. Nurse faculty can either support or hinder student learning.

*Invitational Theory Applied*

There has been an increased emphasis on the role of education in cultivating expectations of learners’ success and teachers’ accountability for student learning. Professional development (PD) for education has been identified as essential for creating effective schools and improving learners’ performance. Steyn (2006) believed that implementing and sustaining Invitational Education (IE) will facilitate change. The purpose of Steyn’s (2006) phenomenological study was to identify what aspects influence the process of implementing and sustaining IE effectively in schools.

Steyn’s (2006) sample included nine principals, one assistant principal, and several selected teachers from each school sampled. The faculty members were from schools in Kentucky that included: two elementary schools, a 9th grade school, and one high school. In New Mexico, faculty from five elementary schools was included. All the schools were previously selected as IE award winners, and had student populations with diversity in culture, national heritage, and income levels. Data were collected through interviews guided by the research question, “Which aspects influence the effective implementation of IE in schools?” (p. 22). Data were transcribed and inductively coded. Significant
comments were grouped into units of meaning and put into major categories that were followed by grouping of sub-categories (Steyn, 2006).

The major categories that emerged included: role of leadership; role of educators; in-school conditions; out-of-school conditions; and requirements of PD programs. Sub-categories related to the role of leadership were: transformational leadership; acting as role model; significance of a vision; and creating the climate for IE. The role of educator included the following subcategories: teachers are the wheels of IE; teachers’ attitudes and commitment; and collaboration between staff members. In-school conditions subcategories were: physical surroundings; climate of the school with an environment of caring; support; and trust as key findings. Out of school subcategories included: educational mandates on performance; political mandates; and technical resources. The subcategories for PD programs were: best ways of instituting PD programs; and necessity of continuing IE inclusion (Steyn, 2006).

Steyn (2006) concluded that there was agreement upon the major aspects necessary for implementation of an IE program. The influences of leadership, the attitude of staff, and a school culture receptive to change were specific key components of IE programs in the educational environments. Improvement of educational practices involves the implementation of IE within the framework of professional development, student perceptions of the clinical learning environment warrants consideration. This theory is appropriate for educational settings in nursing. Faculty development is recommended to create an environment of faculty/student collaboration.
**Students’ perceptions of clinical experiences**

The clinical learning environment has challenges that may cause nursing students to experience uncertainty and anxiety. The purpose of Carlson, Kotze, and Rooyen’s (2003) phenomenological study was to explore and describe the experiences of first year nursing students’ exposure to unfamiliar, anxiety producing clinical experiences. The secondary purpose was to develop guidelines to support nursing students in the clinical environment.

Carlson et al.’s (2003) sample included nursing students who had no previous exposure to a clinical setting from a nursing course. The current clinical environment was the first opportunity for exposure. The sample consisted of students attending an orientation program in the Department of Nursing Science at the University of Port Elizabeth. Participants included both males and females, were 18 years and older, and had fulfilled clinical hours in the current clinical learning environment for at least 8-12 weeks prior to the interview.

Carlson et al. (2003) used unstructured interviews that were audio-taped and transcribed verbatim. The question that was asked of each student was: “Tell me how you experience your practical in the hospital” (p. 32). The central theme that emerged was that students experienced uncertainty due to lack of opportunities to develop competencies in providing nursing care. Subthemes indicated students: (a) felt insecure, not developing adequate nursing skills due to unavailability and inaccessibility of staff; (b) expressed helplessness and frustration due to the shortage and/or absence of equipment to fulfill nursing duties and meet the needs of the patients; (c) expressed
confusion because of conflicts in expectations of the nursing school faculty versus the hospital staff; (d) experienced the nature of the clinical learning program as disrupting the continuity of patient care learning experiences; and (e) felt insecure because of the lack of guidance and support by nursing personnel in the clinical learning environment.

Carlson et al. (2003) developed the following suggestions for faculty during clinical experiences: (a) decrease and alleviate feelings of insecurity, (b) ensure a student support system for clinical practice, and (c) eliminate conflicting expectations between nursing school faculty with hospital staff. Sub-guidelines included: establish a relationship of trust, promote participative learning, provide counseling services, facilitate maximum availability and accessibility, have clear, relevant policies and guidelines, and involve staff in the accompaniment of students.

Nursing students may experience stress and fear that could lead to low self-esteem. Low self-esteem can relate to expectations of students in the clinical setting. The purpose of Begley and White’s (2003) study was to explore nursing students’ perceived levels of self-esteem, fear of a negative evaluation by faculty, and to assess changes in self-esteem as the student progressed through the nursing program.

Begley and White’s (2003) sample included 72 first year nursing students in a 3 year nursing program in Southern Ireland. The study was conducted at the onset of the nursing program and then prior to completion of the program. Begley and White used a descriptive, comparative survey design. The Rosenberg Self-esteem Scale (1965, 1979) and the Watson Fear of Negative Evaluation Scale Revised (1969) were used to collect data. The Rosenberg Self-esteem Scale (1965, 1979) is considered a reliable and valid
scale for measuring respondents’ global views (cited in Begley & White, 2003). The scale addresses self-esteem from a sociological perspective. The scale is comprised of 10 items with a 4-point response format. The Fear of Negative Evaluation (FNE) Scale-revised is a 12 item scale that has demonstrated good internal consistency, test-retest reliability and strong convergent validity.

The results showed a significant increase in self-esteem and a proportionate decrease in fear of negative evaluation over the course of nursing students’ education. It was noted that although self-esteem ultimately only reached “an average level,” Begley and White (2003) speculated that the increase of self-esteem may be associated with nursing students as a group (p. 398). The result of the correlation between Self-Esteem scores and Fear of Negative Evaluation score was a negative correlation between fear and self esteem. Conversely, the authors reported that students with low self-esteem tended to be more negatively affected by negative feedback. The results revealed there was a reverse correlation, as self-esteem increased, fear of negative evaluation declined.

The authors concluded that the role of evaluation and feedback with nursing education is an important element in the development of self-esteem. Begley and White (2003) believed that one explanation for the increase of self-esteem with nursing students was a result of the nature of the interaction between the student nurse and teachers. Educators must be aware that a supportive environment includes providing affirmative feedback that encourages constructive learning in nursing education.

The purpose of Kim’s (2003) study was to identify nursing students’ clinical experiences that cause anxiety, and to examine the relationship between the level of trait
anxiety and the type of clinical experience that produced anxiety. The conceptual framework was Peplau’s (1991) Interpersonal Relations in Nursing.

Kim’s (2003) sample included 61 BSN students enrolled in the final course of the last year in college. The study took place in northern California. The participants were 87% female and 13% male. The majority was full-time, traditional students, and none were taking psychotropic drugs. Power analysis was performed to determine the sample size with power of .80.

Kim (2003) used three questionnaires in the study. The first was a self-administered demographic questionnaire that included: age, gender, marital status, hours of study and hours of work. The Trait Anxiety Scale (T-Anxiety Scale) of the State Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, & Lushene, 1983), and the Clinical Experience Assessment Form (Kleehammer, Hart, & Keck, 1990) were utilized. The T-Anxiety scale of the STAI (Spielberger et al., 1983, as cited in Kim, 2003) has 20 items using a Likert-type scale that measures anxiety proneness. The Clinical Experience Assessment Form (Kleehammer et al., 1990) measures specific clinical experiences that were considered anxiety producing. Pearson’s Correlation Coefficients were done to determine the relationship between perceived anxiety levels that produced anxiety during clinical experiences.

Findings are presented for each research questions. Question 1 was: “What are the perceived levels of anxiety experienced by senior nursing students?” The Anxiety T Scale of the STAI indicated that the majority experienced mild to moderate levels of anxiety. But none exhibited a high level of anxiety. Question 2 was: “What specific
clinical experiences are perceived as being particularly anxiety producing for senior nursing students?” Findings from the Clinical Experience Assessment showed that “being late” scored highest, followed by “being observed by instructors,” “fear of making mistakes,” “initial clinical experience on the unit,” and “talking with physicians.” The item that had the highest level of stress was “being observed by instructors.” The item “evaluation by faculty” was considered neutral (Kim, 2003, p. 150).

Question 3 was: “What is the relationship between the perceived level of trait anxiety and the clinical experience that produces anxiety in nursing students?” The relationship between the Trait Anxiety scale and the Clinical Experience Assessment form was a moderately significant correlation ($r = .40$, $p < .05$). Thus, as the level of T-anxiety increases, the more likely the student would have anxiety-producing experiences during the clinical. The highest levels of reported specific trait anxiety with students were as follows: “did not feel rested,” “did not make decisions easily,” and “feeling nervous and restless.” Kim’s findings suggested that understanding anxiety related to clinical experiences can provide rationale and insightful information of the necessity of student support including expression of feelings, allowing for adequate clinical preparation to minimize fears, and to teach student to utilize assertive skills (Kim, 2003, pp. 152-153).

Understanding the provisions of empowerment of nursing students during clinical experiences is important for faculty to facilitate student learning. Nursing students may encounter negative attitudes, bullying or horizontal violence, as well as a lack of respect. Studies on nursing students’ empowerment and disempowerment center on three areas: learning in practice, team membership, and power. The purpose of Bradbury-Jones,
Sambrook and Irvine’s (2007) study was to explore the meaning of empowerment for nursing students in relation to clinical practice experiences.

Bradbury-Jones et al.’s (2007) sample included 66 nursing students in a 3 year nursing program in one school in the United Kingdom. Students were recruited from each of the 3 years. The nursing program included both theories (50%) and practice (50%). Bradbury-Jones et al. (2007) used a critical incident technique (CIT) method to collect data. Students provided written critical incidents related to empowerment and disempowerment experiences that occurred during clinical experiences. Inductive classification was used to construct a hierarchy of categories. Data were initially coded independently with the categories and subcategories identified during this process, and then compared and revised until a consensus was reached.

The analysis process involved subjectively sorting incidents into clusters that seemed to fit together using an inductive classification method devised by Cormack (1983, 2000, as cited in Bradbury-Jones et al.). Using two levels of classification allowed balance between gaining adequate specificity and avoided over-reduction of data. The three categories were: (a) learning in practice, with the following subcategories: understanding, promotion of learning, and responsibility; (b) team membership, with the following subcategories: inclusion, being nurtured, and making a difference; and (c) power with respect, justice and having a voice.

The results suggested that nursing students’ empowerment and disempowerment can be conceptualized on a continuum of empowerment-disempowerment. A student may be more or less empowered depending on forces influencing that particular experience.
The meaning of empowerment was being able to learn as a result of being understood and encouraged. Antecedents of empowerment were mentorship, continuity, and time. Disempowerment was related to a lack of understanding, encouragement, and responsibility. Other factors revealing disempowerment for the nursing student included criticism in front of others, disrespect and a lack of justice.

Bradbury-Jones et al. (2007) concluded that empowerment has positive effects, including enhancement of self-esteem, motivation, and a positive attitude for learning. On the other hand, disempowerment results in low self-esteem, despondency, and a desire to leave the program. Supportive mentors play a pivot role in the empowerment of nursing students and are essential for successful education and development of the nursing professional.

*Students’ Perceptions of Faculty Behaviors*

Shelton (2003) proposed that to promote the retention of nursing students, faculty need to provide the caring atmosphere of a mentoring relationship and direct assistance to facilitate student learning. The purpose of Shelton’s (2003) study was to explore the differences between nursing students’ perception of faculty support and nursing student retention.

Shelton’s (2003) sample included 458 ADN students from nine nursing programs in New York and Pennsylvania. The sample included current students who were enrolled in the final semester of the ADN program, and former students who had withdrawn since the beginning of the semester prior to the data collection. The former students were at various points in the programs when the student withdrew, including first semester
students. Class sizes ranged from 13-95 students. The mean age was 30. Demographic characteristics included: 89% women; more than 40% unmarried; 50% with dependent children living with parents; and 40% with financial resources less or much less than adequate.

Shelton (2003) used a descriptive, correlation design. Nursing students were grouped according to factors of persistence: (a) Group A persisted continuously throughout the program; (b) Group B withdrew voluntarily; or (c) Group C withdrew due to academic failure. Faculty support was measured by a 24 item Perceived Faculty Support Scale, using a 5-point Likert scale. A factor analysis of the instrument revealed two factors: (a) psychological support of students directed at promoting competency and self-worth, and (b) functional support directed at the achievement of tasks to reach a level of persistence and academic success.

Results of the Perceived Faculty Support Scale, with a 24-120 possible score range, was a mean score of 83.80 for total perceived faculty support, 48.89 for psychological support, and 34.99 for functional support. ANOVA was computed to determine whether persistence groups differed in total perceived support, psychological support, and functional support. There were significant differences in total perceived faculty support among Groups A and B, and between Groups A and C, on functional support (Shelton, 2003).

The results explained the relationship between nursing students’ perceptions of faculty support and nursing students’ retention rates. Students in groups A had significantly higher total perceived faculty support than subjects in either of the other two
groups. The greatest difference was between Groups A and C. Regarding types of support received, Group A had significantly higher psychological support, as well as perceived functional support, than the other groups with no significant difference seen in the other groups.

Shelton (2003) concluded that students who reported greater perceived faculty support had a higher probability of persisting throughout a nursing program. Shelton (2003) reported that nursing students’ retention was facilitated by support that included: a caring atmosphere, being approachable, demonstrating respect, being patient, exhibiting a mentoring relationship with demonstrations of genuine interest in the students, and direct assistance that involved correcting students without belittling, and promoting self-efficacy.

The focus of Cook’s (2005) study was to explore relationships among nursing students’ perceptions of personally and professionally inviting teaching behaviors of clinical faculty. The Invitational Education Theory (Novak & Purkey, 2001) and Spielberger’s (1972) State-Trait Anxiety Inventory (STAI) provided the synthesized theoretical framework. Spielberger’s theory of anxiety proposes that state anxiety is a transitory emotional condition that fluctuates and has varying levels of intensity. An anxiety state is high when the person perceives a threatening situation. Thus, condition is considered as being characterized by subjective, consciously perceived feelings, and may result in activation of the autonomic nervous system (Cook, 2005). State anxiety reflects a transitory emotional state or condition of the human organism that is characterized by subjective, consciously perceived feelings of tension and apprehension, and heightened
autonomic nervous system activity. In contrast, trait anxiety denotes relatively stable individual differences in anxiety proneness, and refers to a general tendency to respond with anxiety to perceived threats in the environment (p. 156). State anxiety was the focus of the study.

The synthesized theoretical framework used by Cook (2005) proposes that when students’ perceptions of faculty behaviors are seen as positive or inviting, the anxiety level of the student will be lowered, and students’ performance capabilities and learning will increase. Conversely, if faculty behaviors are negative or disinviting, an increased anxiety level is created, along with a decreased potential for performance and learning potentials (Cook, 2005). In practice, Invitational Education focuses on the people, places, policies, procedures, and programs that transmit messages promoting human potential. Four levels of teaching behavior patterns are recognized: intentionally disinviting, unintentionally disinviting, unintentionally inviting, and intentionally inviting (Purkey & Stanley, 1991, as cited in Cook, 2005).

Cook explored the following research questions: (a) “What are the relationships among junior and senior level generic baccalaureate nursing students’ perceptions of personally and professionally inviting behaviors of clinical nursing faculty and student’s state anxiety while interacting during clinic experiences?” (b) “Do junior and senior level generic baccalaureate nursing students differ in their perceptions of personally inviting teaching behaviors of clinical nursing faculty?” (c) “Do junior and senior level generic baccalaureate nursing students differ in their perceptions of professionally inviting teaching behaviors of clinical nursing faculty?” and, (d) “Do junior and level generic
baccalaureate nursing students differ in their levels of state anxiety while interacting with clinical nursing faculty during clinical experiences” (Cook, 2005, p. 161).

Cook’s (2005) sample was drawn from four randomly selected schools from six regions of the United States. Ten schools agreed to participate in the study, six private colleges or universities, and four public schools. The population for the study was junior and senior level baccalaureate nursing students enrolled in nursing courses involving a clinical experience component. The final sample size was 229 students. The mean age of the participants was 26.3 years. The amount of time the student spent with the instructor was more than 6 clinical days. The grade the majority of the students expected to receive from the course was a B (46.7%).

Findings from Cook’s (2005) study indicated that junior level students rated clinical faculty higher in inviting teaching behaviors than senior level students did in both personal and professional behaviors. Junior students rated personally inviting teaching behaviors of clinical faculty higher (M= 92.8) than senior students (M=85.01). There was a significant difference in perceptions of the two groups of students on professionally inviting behavior. The junior students again rated faculty as more inviting (M=92.77) than senior students (M=88.63) (Cook, 2005).

Regarding state anxiety, the author found nursing students’ perceptions of personally and professionally inviting behaviors did influence anxiety levels. When students believed faculty expressed pleasure with the clinical group, such as showing respect for students, selecting appropriate patient assignments, and acting trustful of students, anxiety levels where lower. When students believed faculty conveyed ill-
mannered behavior, such as being difficult to talk to, and treating students as irresponsible, anxiety levels were higher. Both junior and senior nursing students had a need for positive behaviors of faculty, but there were no differences noted between the two groups (Cook, 2005).

There was a significant relationship between student’s perceptions of personally and professionally inviting teaching behaviors and state anxiety while interacting with faculty in the clinical environment. Perceptions of personally inviting teaching behaviors predicted state anxiety better than professionally inviting behaviors alone. There was a significant negative relationship between students’ perceptions of personally inviting teaching behaviors ($r=-.64$, $p <.01$) and professionally inviting teaching behaviors ($r=.59$, $p <.01$) and state anxiety while interacting with faculty in the clinical environment. If students perceive faculty to be inviting, state anxiety was lower and vice versa (Cook, 2005, p. 162).

Exploratory analysis supported that students’ ages were related to perceptions of state anxiety while interacting with faculty during clinical experiences. In regards to grade expected in the course, there were differences in state anxiety scores between the students expecting an A, B,C, or failing grade. Students that expected high grades had lower state anxiety than students’ expecting lower or failing grades. Cook (2005) concluded that students’ perception of expected grades was related to state anxiety levels.

**Relationships between students and faculty**

There is a need for faculty to be concerned with the feelings and attitudes of learners when addressing learning needs. This is a more humanistic approach to nursing
education, and calls for a reevaluation of the student-teacher relationship. The purpose of Gillespie’s (2002) descriptive study was to explore and describe undergraduate nursing students’ experiences of connections within the student-teacher relationship, and the effects of this connection on students’ learning within the clinical setting.

The study took place at a School of Nursing within a university in British Columbia, Canada. Gillespie’s (2002) sample included eight baccalaureate nursing students. The students attended both full and part-time. Six were female and two were male. One student was in the first year of study, three were in the second year, two in the third year, and two in the fourth year. Unstructured interviews were conducted that lasted approximately 1 to 2 hours. A series of trigger questions guided the interview. A field group in which six to eight students participated allowed for more information retrieval. Interviews were audio-taped and transcribed verbatim. Constant comparative analysis was used to analyze data. Demographic data were also collected.

Findings revealed the nature of the student-teacher relationship was egalitarian, and was comprised of both personal and professional components. Regarding the personal component, there was a need for appropriate boundaries. Boundaries are flexible, contextually determined, and guided by two principles. The connected relationship remains focused on student learning, and sharing personal information is appropriate if based on the learning experience. The formation of the relationship is influenced by several factors that include mutual knowing, trusting, communicating, and respecting. The dimensions of student-teacher connections are based on competence, compassion and commitment. A fit between teaching and learning style, personality, interests,
communication styles, background, and values are also important to the formation of connection (Gillespie, 2002).

Gillespie (2002) concluded that a student-teacher connection has a positive influence on clinical learning experiences. The inherent qualities of a connected relationship and ways of teaching result in a supportive environment that facilitates growth for the student not only professionally, but personally. An increase of self-worth, self-esteem and self-confidence, and a move toward self-actualization are potential outcomes of a positive connection (Gillespie, 2002).

To further understand ways to enhance the educational experience of the nursing student it is important to better understand the relationships between students and staff nurses. The purpose of Vallent and Nevile’s (2006) study was to explore relationships between student nurses and nurse clinicians.

Vallent et al.’s (2006) sample included 11 student nurses at the end of a 3 year BSN program in one institution. Data were gathered from three focus group interviews that were audio-taped. Data were analyzed, and categories were developed revealing key categories and themes. There were five categories identified: (a) “being invisible in the relationship,” (b) “not stepping on toes,” (c) “lost opportunities for learning,” (d) “nurturance,” and (e) “reciprocity.”

The findings of the study (Vallent et al., 2006) revealed information relevant to the categories. “Being invisible in the relationship” meant being ignored or forgotten. There was an identified feeling of sense of loss of identity as a person as a student nurse. Words were used by students that described the way students felt including: “frustrating,” “soul
is destroyed,” and “upsetting” (p. 26). “Not stepping on toes” (p. 27) was identified as the need to tread carefully, and balance the need to learn without drawing personal attention that would result in punishment. “Lost opportunities for learning” (p. 27) involved the belief that the clinical setting is an important arena for learning. Time constraints and not spending enough time with individual patients limited experiences. The busyness of the nurse clinician and the necessity of the demanding environment also limited the experience. Nurturance from staff emerged in positive situations that would overcome anxiety, and result in the gain of confidence (p. 28). There was a need to know students well enough to be aware of strengths and deficits. Lastly, “reciprocity” was identified, meaning that when a common belief was shared that was promoting, guiding, and supporting students would be proactive toward learning (p. 29).

Vallent et al. (2006) concluded the attitudes of both the student nurse and the nurse clinician influence relationship formation. It is imperative that student nurses enter practice settings with a positive attitude toward learning. Conversely, the attitudes of nurse clinicians are equally vital to ensure a practice environment is conducive to learning.

*Relationships between students and preceptors*

Finger and Pape (2002) initially utilized the Invitational Teaching Survey (ITS) to assess various teaching practices as perceived by students. The authors adapted the ITS to the preoperative setting, and renamed it the Invitational Operating Room Teaching Survey (IORTS). The authors suggested that preceptorship experiences that are positive increase recruitment, retention, and subsequently the number of nurses into specialized
areas. The purpose of the study was to identify whether the Invitational Operating Room Teaching Survey (IORTS) is a reliable instrument in specialty clinical areas, specifically the Operating Room (OR). The tool examined preceptees’ attitudes toward preceptors and characteristics of effective preceptors.

Finger and Pape’s (2002) sample included 113 nurses who had experience in a helping/learning relationship in the previous 2 years. The sample was drawn from seven midsize hospitals in central North Carolina. The nurses were from preoperative care areas within the hospitals. In this sample, 56% held associate degrees, 65% had OR experience, and 74% had more than 5 years of experience in nursing. The majority (91%) did not know the preceptor previously, and 26% had no experience with a preceptor previously.

Finger and Pape (2002) used the IORTS to measure the presence of preceptors’ personally and professionally inviting practices in a teaching/learning relationship. The 5 point Likert scale has a response set of 1 through 5, with 1= very seldom, and 5 = very often. Mean scores of 3.8 or higher were considered more inviting.

Findings from Finger and Pape’s (2002) study revealed that there was a high internal consistency of the IORTS, (r = 0.9775). The IORTS is useful in evaluating preceptorship programs, improving adult learning, and enhancing teaching practices and behaviors. Hence with the use of this instrument, preceptees’ attitudes toward preceptors may be examined and inviting practices determined.

Findings revealed the inviting preceptors’ behaviors that received the highest scores on the IORTS, with a range mean of 3.8 to 5.0, included: demonstrated up-to-date
knowledge, encouraged self-confidence, learned preceptee’s names, answered questions clearly, expected successful performance, presented understandable objectives, and efficient with work time. It revealed the disinviting behaviors, including preceptees’ belief that preceptors lacked enthusiasm (Finger & Pape, 2002). A specific finding was that preceptors who were professionally proficient expected successful performance from preceptees. The same preceptors tended to make decisions without consulting preceptees about personal needs, and did not provide adequate procedural review. Inviting behaviors of the preceptors included being personally dependable, professionally knowledgeable, and setting goals appropriately (Finger & Pape, 2002).

The authors concluded the findings supported the use of the IOTRS to provide feedback to preceptors about teaching behaviors and practices. Findings suggested the need for a different precepting model for novices than for experienced nurses. Invitational teaching practices were determined to be a way of improving teaching practices for preceptorships that may potentially result in the improvement of recruitment and retention. Thus, nurse preceptors should be encouraged to evaluate inviting and disinviting tendencies in teaching behaviors (Finger & Pape, 2002).

*Incivility in clinical nursing education*

Creating an enriching culture in academia requires communications, interactions, and respect from both students and faculty. In contrast, academic incivility jeopardizes not only the welfare of faculty and students, but the surrounding community. Clark and Springer (2007) investigated the problem of incivility, specifically in the university-based nursing education program, from both the perspective of the student and faculty. The
research questions were: (a) what behaviors do nursing students and faculty perceive as uncivil in the academic environment? (b) Do nursing students and faculty perceive the same behaviors as uncivil? (c) Is there a relationship between age and perception of incivility? and, (d) To what extent do students and faculty perceive incivility as a problem in nursing education? (p. 9).

Clark and Springer’s (2007) sample included 32 nursing faculty, and 324 nursing students from a metropolitan university in the northwestern United States. Sample characteristics included: 41.7% were 26 to 35 years old, and 34.9% were 18 to 25 years old, with only 6.5% older than 46. The majority (83.6%) were women. The majority were completing requirements for an associate degree in nursing, with more than half planning to pursue a baccalaureate degree. Participants were to designate to what degree certain behaviors were perceived as uncivil, as well as the frequency that the same behavior was perceived in the last year. A Likert scale was used ranging from 1 to 4 with always =1, usually =2, sometimes =3, and never = 4.

The Incivility in Nursing Education (INE) survey (Clark & Springer, 2007) was developed by the authors to measure: the degree to which faculty and students perceived certain behaviors as uncivil; the frequency the uncivil behavior that had occurred in the last 12 months; what student and faculty behaviors were considered beyond uncivil; and the extent to which students and faculty perceived uncivil behavior as seen as a problem in nursing education. The Defining Classroom Incivility survey, developed by the Indiana University Center for Survey Research (2000), was used to measure several of the defining items in the study. Items from the Student Classroom Incivility Measure (known
as the SCIM-Part 3) were used to rate uncivil faculty behaviors in the classroom (Clark & Springer, 2007).

A Row-mean-score was utilized to compare perceptions of nursing students with perceptions of faculty on uncivil behaviors. Findings revealed that some students’ and faculty’s behaviors were viewed differently among students and faculty. Clark and Springer (2007) reported that in all cases faculty were less likely than students to consider student behaviors as uncivil. Perceptions regarding uncivil faculty behaviors differed. Faculty were more likely to view faculty’s behaviors as civil, while students were more likely to view faculty’s behaviors as uncivil. Students’ perceptions of uncivil faculty behaviors included: faculty canceling class without warning, and faculty delivering fast-paced, non involving lectures. Age-related responses revealed there were no statistically significant differences noted on the basis of age for both faculty and students.

The majority (61.5%) of both nursing faculty and nursing students believed uncivil behavior was a moderate problem. The extent that participants believed that faculty or students were more likely to engage in uncivil behavior revealed that most participants believed that students were slightly more likely than faculty to engage in uncivil behavior (p. 5).

Clark and Springer (2007) reported that cutting class was the most frequently cited student behavior that was not considered uncivil, because there was no disruption to the class. Leaving class early was the most frequently cited faculty behavior not considered uncivil by the students, rather it was viewed as a positive faculty behavior. The findings of uncivil behaviors categorized as “beyond uncivil” were alarming. More than half of
the students and faculty had observed, or knew of students challenging faculty knowledge or credibility, and taunts and disrespect from students. Faculty challenging other faculty’s knowledge was the most frequent faculty behavior considered beyond uncivil, with the second being faculty taunting and being disrespectful to students.

Incivility in academia was considered a problem by more than 70% of the participants reported as a moderate to severe level. It was therefore concluded that this is a problem that must be addressed. Open communications, policy development, establishing consequences, clear expectations, and current, ongoing education of the subject were suggested implications (Clark & Springer, 2007).

Incivility is an interactive process where both parties share responsibility. Academic incivility was defined by Clark (2008a) as any speech or action that disrupts the harmony of the teaching-learning environment. More research is needed to understand nursing students’ and faculty’s incivility, how it impacts the educational environment, and how it can be prevented. The purpose of Clark’s (2008a) phenomenological study was to describe nursing students’ perceptions of faculty incivility and the emotional and behavioral impact on students. An additional goal was to construct a conceptual model to illustrate the findings.

Clark’s (2008a) sample included seven nursing students, four women and two men, representing four northwestern universities. Two of the participants were enrolled in the final semester, four had previously graduated, three had BSN degrees, and one had a MSN degree. One participant left the nursing program prior to completion. The time between the indentified uncivil behaviors was 2 weeks to 7 years.
Clark (2008a) used face to face, one on one interviews to inquire about nursing students’ lived experiences with uncivil interactions with nursing faculty. There were two research questions: (a) What faculty behaviors do students perceive as uncivil? and (b) How do nursing students respond emotionally and behaviorally to perceived faculty incivility? (p. 285). Interviews were transcribed verbatim, significant statements were formulated into meanings, and themes were extracted and identified until saturation of data was attained. Findings were organized into a final cumulative statement or core category. All participants were reviewed and provided verification to ensure validity.

Clark (2008a) stated that three major themes emerged regarding faculty incivility: (a) “behaving in demanding and belittling ways,” (b) “treating students unfairly and subjectively,” and (c) “pressuring students to conform to unreasonable faculty demand.” Three major themes were identified as students’ emotional responses to faculty incivility: (a) “feeling traumatized,” (b) “feeling powerless and helpless,” and (c) “feeling angry and upset.”

Clark (2008a) concluded the most important finding was the positive impact that supportive and caring faculty have on nursing students that are experiencing incivility. There is an inherent need to develop best practices in nursing education for preventing and effectively managing incivility. Clark’s (2008b) Incivility in the Nursing Education Conceptual Model was designed to depict the interrelatedness of concepts and display how incivility is perceived and responded by nursing students.

Clark (2008b) introduced a conceptual model to illustrate how stress, attitudes, and lack of effective communications and intentional engagement may contribute to the
“dance” of incivility in nursing education. The purpose of this study was to examine nursing faculty and students’ perceptions of the factors that lead to incivility in nursing education, the types of uncivil behaviors each group exhibits, and remedies for prevention and intervention.

Clark’s (2008b) sample included 194 nursing faculty and 306 students representing 41 states that attended a national nursing conference. The following demographic characteristics were included: ages ranged from 19 to 72; 89.7% were women; 86% were non-Hispanic white; 47.6% of the students were in associate degree programs and 43.8% in bachelor degree programs.

Clark (2008b) used the Incivility in Nursing Education Survey (INE). This survey includes both quantitative and qualitative items. Questions included faculty and student demographic characteristics, perceptions of incivility, and frequencies of the behaviors. The qualitative portion included four open-ended questions to gather participants’ opinions about why and how faculty and students contribute to incivility, and other information with the intent of shedding light on the problem at hand.

An interpretive qualitative method was used to analyze the data from the narrative responses. The faculty’s and students’ responses were analyzed separately, and then sorted into categories. The categories for each group were organized, and then formulated into comprehensive themes that followed the illustration in a conceptual model. The conceptual model was introduced in the study to illustrate how stress and attitudes contribute to faculty and student’ incivility and how effective communication can enhance the “dance” of civility (Clark, 2008b).
The themes that emerged related to students’ incivility were grouped into two areas: “stress,” and “attitudes of entitlement.” Results were ranked from the most frequent to the least frequent. The students’ perceptions of “stress” were described, followed by the faculty’s perceptions of that stress. The “attitude of entitlement” was presented in the same order. Themes of students’ perceived stress included: (a) “burnout from demanding workload,” (b) “competition” and (c) “feeling compelled to cheat for placement in programs, grades and scholarships.” Themes of faculty’s perceptions of students’ stress included: (a) “burnout from demanding workloads,” (b) “role stress,” and (c) “competition.” Students’ responses related to attitude of entitlement included: (a) “refusing to accept personal responsibility,” (b) “assuming a consumer mentality,” (c) “having the perception of being “owed” an education,” and (d) “making excessive excuses for failures.” Faculty responses regarding students’ attitude of entitlement were: (a) “assuming a ‘know-it-all’ attitude,” (b) “assuming a consumer mentality,” and (c) “believing that students have the perception of being owed an education” (Clark, 2008b, pp. 41-42).

Findings related to factors contributing to faculty incivility were “stress” and an “attitude of superiority.” Specifics of faculty stress revealed: (a) “burnout from demanding workloads,” (b) “high faculty turnover and lack of qualified educators,” (c) “role stress,” and (d) “exposure to student, faculty and administrator incivility.” Students did not identify faculty stress as a contributor to faculty incivility (Clark, 2008b, p. 43). The author concluded that the “dance” metaphor was the ideal way to describe the reciprocal nature of incivility in nursing education. There is a “dance” between faculty
Clinical experiences for nursing students are important elements of educational preparation. Research toward identifying perceptions of effective clinical teaching behaviors is beneficial to understanding the best environment for the clinical experience. The literature review includes studies on the Invitational Education theory, and how it is applied to nursing; students’ perceptions of clinical experiences and faculty behaviors; the relationships between students and faculty, and between students and preceptors; and incivility in clinical nursing education.

The complex and challenging clinical learning environment requires attention by clinical faculty to teaching approaches that are the most conducive to learning. Steyn (2006) believed that applying Invitational Education (IE) was effective in the nursing environments. Findings describing IE included the roles of transformational leadership; acting as a role model; and school conditions as necessary for IE inclusion.

Students’ perceptions of clinical experiences were explored by Carlson et al. (2003). The phenomenological study addressed the problem of challenges in the learning environment that are absent from the classroom situation that may cause nursing students to experience uncertainty and anxiety. Students experience uncertainty due to lack of opportunities to develop nursing competencies. This deficit results from feelings of insecurity because students are not able to adequately access staff to positively reinforce
performance. Begley and White’s (2003) findings revealed a significant increase in self-esteem when a proportionate decrease in fear of negative evaluation occurred over the course of nursing student training. Kim’s (2003) study identified nursing students’ clinical experiences that caused anxiety, and examined the relationship between the level of trait anxiety and the clinical experiences that produced specific types of anxiety. Findings suggested that the majority of students experienced mild to moderate levels of anxiety with none experiencing high anxiety. “Being late,” followed by “being observed by instructors,” were the issues that ranked highest on producing anxiety in the clinical setting (Kim, 2003, p. 150).

Bradbury-Jones et al. (2007) used a critical incident technique to investigate nursing students’ empowerment and disempowerment. Bradbury-Jones et al. (2007) concluded that positive effects of empowerment include: increased self-esteem, motivation, a positive attitude for learning with antecedents of mentorship, continuity, and time. Disempowerment was related to lack of understanding, encouragement, and responsibility.

Students’ perceptions of faculty behaviors were explored by Shelton (2003). Findings suggested that there was a relationship between nursing students’ perception of faculty support and nursing students’ retention. Students with greater perceived support, such as having a caring atmosphere, had a higher probability to persist throughout a nursing program.

Cook’s (2005) study compared the relationship between juniors’ and seniors’ perceptions of inviting faculty behaviors and state anxiety with faculty in the clinical
environment. Findings from this study revealed that junior students rated clinical faculty higher in inviting behaviors than senior level students. There were no differences noted regarding state anxiety while interacting with faculty between the two groups.

The relationships between the students and faculty were explored by Gillespie (2002). The author described the undergraduate nursing students’ experiences within the student-teacher relationship, and the effects of the relationship on student learning in the clinical environment. Findings revealed the nature of the connected student relationship was egalitarian, and comprised of both personal and professional components. The student-teacher connection has a positive influence on clinical learning experiences and the personal growth of the student. Vallent et al.’s (2006) findings revealed that student nurses who have positive relationships with nurse clinicians have enhanced learning. Also, students who showed interest in learning resulted in a positive relationship with faculty (Vallent et al., 2006).

Finger and Pape (2002) utilized the Invitational Teaching Survey (ITS) in the development of the Invitational Operating Room Teaching Survey (IORTS) to assess teaching practices as perceived by nursing students. The findings showed that the IORTS was useful in evaluating preceptorship programs, improving adult learning, and enhancing teaching practices and behaviors. It was identified that inviting preceptor behaviors included demonstrating up-to-date knowledge, being dependable, and encouraging self confidence, while disinviting behaviors included lacking enthusiasm (Finger & Pape, 2002, p. 9).
Incivility in nursing education jeopardizes the welfare of both faculty and students. In Clark and Springer’s (2007) study the problem of incivility was investigated. Utilizing the Incivility in Nursing Education Survey (INE), Clark and Springer (2007) found that in all cases faculty were less likely than students to consider student behaviors as uncivil. Perceptions of what was considered uncivil differed between the two groups. Faculty were more likely to view faculty behaviors as never or sometimes occurring, while students viewed faculty behaviors as usually or always occurring. Both groups believed uncivil behaviors were moderate (61.5%), and both believed students were slightly more likely than faculty to engage in uncivil behavior. More than half of the faculty and the students observed, or knew of students that challenged faculty knowledge and displayed taunts and disrespect from students. Incivility in academia was considered a problem by more than 70% of the participants in the study (Clark & Springer, 2007).

Clark (2008a) used face to face interviews to describe nursing students’ experiences with uncivil interactions with nursing faculty. Three major themes emerged identifying incivility: (a) behaving in demanding and belittling ways, (b) treating students unfairly and subjectively, and (c) pressuring students to conform to unreasonable faculty demands. Results indicated that students’ emotional responses to faculty incivility included: (a) feeling traumatized, (b) feeling powerless and helpless, and (c) feeling angry and upset.

Clark (2008b) found that stress from incivility emerged as the highest rated theme for both students and faculty. Factors that lead to nursing student stress included burnout from demanding workloads and competition. Findings revealed faculty believed: (a)
faculty stress was mainly from demanding workloads, and (b) high faculty turnover were the highest contributing factors for faculty incivility. Interestingly, students did not include faculty stress as a contributing factor to faculty incivility (Clark, 2008b).

This chapter has presented a review of the literature pertaining to the study of Invitational Education in nursing training. Based on that review, a conceptual model was developed with a research question and hypotheses of proposed relationships.
Chapter III

Methodology

Introduction

To have an optimal learning experience for nursing students while the student is immersed in the challenging, often anxiety-laden clinical environment, the most appropriate faculty-student interactions must be utilized (Cook, 2005). Gaining an awareness of how teaching behaviors are perceived by students is beneficial for clinical faculty to be the most effective facilitator and role model when guiding students to become competent nurses.

Problem

It is essential that student nurses’ clinical experiences be done in an enriched learning environment. Faculty/student relationships are a key factor in creating a positive learning environment. An increased understanding is needed regarding faculty-student interactions, and students’ perceptions of faculty inviting behaviors that affect students’ ability to learn and perform effectively.

Purpose

The purpose of this study is to explore nursing students’ perceptions of personally and professionally inviting teaching behaviors of clinical faculty in the clinical setting. This study also examines differences in perceptions of personally and professionally
inviting teaching behaviors of faculty among sophomore, junior and senior nursing students. This is a partial replication of Cook’s (2005) study.

Research Questions

1. What are students’ perceptions of personally and professionally inviting teaching behaviors of clinical nursing faculty while interacting with faculty during clinical experiences?

2. Are there differences in students’ perceptions of professionally inviting teaching behaviors among students at sophomore, junior, and senior levels?

Population, Setting and Sample

The population for this study will include sophomore, junior and senior nursing students in baccalaureate programs at Ball State University, Muncie, Indiana, and the University of Indianapolis, Indianapolis, Indiana. Both universities are accredited by the Commission on Collegiate Nursing Education (CCNE). Ball State University represents a public university, while University of Indianapolis is a private university. Students will include both males and females, and be either full or part-time. All students who meet the study criteria from the two schools will be invited to participate. Criteria for inclusion are that students are enrolled, and currently completing a clinical rotation. All of the students from the sophomore, junior and senior classes from both schools will be asked to participate. The anticipated sample is 30 sophomores, 30 juniors, and 30 seniors from each school.

Protection of Human Subjects

The proposal, abstract, and protocol will be submitted to Ball State University and University of Indianapolis Institutional Review Boards (IRB). The deans, directors and
chairpersons from both nursing programs will provide appropriate approval for program and student participation. A description of the study will be provided verbally and in written form. The date of initial participant contact will be after a designated class period approximately 10 weeks into the semester. The questionnaires will be placed in a collection box as students leave the room to maintain confidentiality. No names will be disclosed and negative consequences will not transpire due to involvement in this study. No risks have been identified in the study. Completion of the questionnaire will indicate consent for participation. The students can withdraw at anytime, and grades will not be influenced by participation/non-participation. This study will potentially result in increased understanding of inviting clinical faculty behaviors and facilitate focused attention to improve students’ anxiety during clinical experiences.

Procedures

After approval from Ball State University’s and the University of Indianapolis’ IRBs, letters of introduction to the research project will be sent to each of the school’s nursing representatives. The purpose, criteria for inclusion, time requirements, anticipated sample, and the instrument information, with samples, will be included in the mailing. A preliminary meeting with both school’s director/dean will be scheduled to discuss procedures, instructions and questions. The researcher will attend a regular faculty meeting to share all necessary information. Packets of information containing an explanation of the study and invitation to participate, demographic data forms, and the Clinical Teaching Survey will be reviewed. The researcher will distribute both the instruments to faculty.
The forms will be distributed by the researcher to the students at each of the three levels before or directly after class. Instructions will include the necessity of selecting a clinical nursing faculty with current involvement, and how to rate the instructor using the CTS form. This would occur following the completion of the demographic form.

Research Design

This study is a descriptive, comparative design. This type of design will be useful in comparing the differences among sophomore, junior and senior baccalaureate nursing students’ perceptions of personally and professionally inviting teaching behaviors of clinical nursing faculty. Comparative designs should be used when two or more groups are compared on the same variable or criterion. A descriptive design describes a problem from different angles (Burns & Grove, 2009).

Instrumentation

There will be two instruments utilized in the study. One is a 15-item demographic data questionnaire, and the other is the Clinical Teaching Survey (CTS) designed by Ripley (1985). The CTS was originally derived from an instrument used in the classroom known as the Invitational Teaching Survey (ITS), developed by Amos, Purkey and Tobias (1984). The ITS was modified by Riley (1985) to be better suited for clinical environments. The final version of the CTS consists of 44 items rated using a 5-point Likert type scale ranging from 1 to 5. The CTS has five subscores consisting of categories of commitment, consideration, coordination, proficiency and expectations. Contained within each subscore are the items reflecting invitational teaching behaviors that are grouped into clusters. The main subscale clusters for personally inviting teaching behaviors are commitment and consideration. For professionally inviting teaching
behaviors, clusters are associated with coordination, proficiency and expectation. The total CTS score ranges from 44 to 220. The ranges from personally and professionally inviting teaching behavior sub-scores are 22 to 110. Higher scores reflect student’s perceptions of more inviting teaching behaviors and lower scores indicate perceptions of less inviting teaching behaviors.

Data Analysis

The statistical methods that will be used to analyze the data will be descriptive statistics and one-way analysis of variance (ANOVA). ANOVA is an appropriate method as it examines the differences among groups by comparing the variance between the groups with the variance within the groups (Burns & Grove, 2009). The F test will be used to compare variations among the groups on means.

Summary

It is important to understand nursing students’ perceptions of personally and professional teaching behaviors of faculty. The theoretical framework for this study, Invitational Education Theory (Purkey & Stanley, 1991), allows the focused examination of teaching behaviors, specifically “inviting” and “disinviting” clinical teaching behaviors of nursing clinical faculty. The study was developed to evaluate perceptions of nursing students regarding perceptions of clinical faculty among sophomore, junior, and senior nursing students. The sample, containing approximately 180 nursing students will use the CTS to measure the outcomes with ANOVA to determine the differences between groups.

Due to the complexities involved in clinical experiences in nursing education, it is important that the elements of the educational environment are appropriate to facilitate
best learning outcomes. The aim of this study is to allow increased clinical faculty awareness of the perceptions of nursing students regarding clinical faculty behaviors to culminate in the improvement of nursing education competency.
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