2020

The Lived Experiences of Clinical Nursing Faculty With Student Performance Anxiety

Heather LaPoint
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Heather LaPoint

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Edna Hull, Committee Chairperson, Nursing Faculty
Dr. Donna Bailey, Committee Member, Nursing Faculty
Dr. Mattie Burton, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

The Lived Experiences of Clinical Nursing Faculty With Student Performance Anxiety

by

Heather LaPoint

MSN, Ed., University of Central Florida, 2015

BSN, University of Central Florida, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing Education

Walden University

November 2020

Abstract

The nursing shortage in the United States has led to a call for nursing education reform. Current clinical educational methods precipitate nursing student performance anxiety (PA). PA can inhibit the clinical judgment, reasoning, critical thinking, and the adaptability required for advancing healthcare initiatives and reducing the nursing shortage. PA has not been defined nor addressed in undergraduate nursing education. The purpose of this descriptive phenomenological study was to explore the lived experiences of associate degree (AD) nursing program faculty in addressing student PA as it occurs in the clinical setting. Specifically, how faculty define PA and recognize, address, and assess learning in the presence of PA. Experiences of clinical nursing faculty were viewed through the conceptual framework of Carl Rogers' humanism. Semistructured, one-on-one interviews were conducted with 11 AD program members with at least one year of clinical nursing education experience in New York state. Analysis of data followed Creswell's and Creswell's five-step process. Themes from the data included quality of the clinical environment and philosophies and behaviors of both faculty and the nursing student. Results compel reform in clinical nursing evaluation methods, role development for clinical nursing faculty, and a nursing-centric definition of PA. The results of this study affect positive social change through change initiatives in nursing education, academic administration, practice, policy, theory, and methodology, leading to a more resilient and retained nursing workforce. A more prepared nursing workforce can improve the organizations and communities they serve, thus improving human and social conditions. Future studies should explore interventions for PA.

The Lived Experiences of Clinical Nursing Faculty With Student Performance Anxiety

by

Heather LaPoint

MSN, Ed., University of Central Florida, 2015

BSN, University of Central Florida, 2013

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing Education

Walden University

November 2020

APA 6

Dedication

This study is dedicated to Don, my children, and Connie. To Don, Kendall, Kelsey, Allison, and Olivia: Without your unending love, support, and understanding, I would never have finished. Thank you for listening when I said I had to write and thank you for forgiving my absence during this journey. For Connie: I cannot thank you enough for pushing me to develop a backup plan that quickly turned into my labor of love, passion, and place in life. I would not have found myself nor be here without you. We did it!

Acknowledgments

This dissertation would not have been possible without the support and mentorship of my committee chair, Dr. Edna Hull. Dr. Hull provided invaluable guidance in developing scholarly tone and my own voice in writing. Further, she mentored me in what it means to be a scholar. Dr. Hull's wisdom will continue to guide my writing, career, and development beyond this document and well into the future. Also needing acknowledgement are my committee members, Drs. Donna Bailey and Mattie Burton. Their timely feedback, expertise, and patience in the dissertation process has been appreciated.

Last, I wish to express gratitude to the clinical nursing faculty who participated in the study. These men and women graciously agreed to participate in my study during an academic semester in the midst of a national pandemic. These tireless professionals participated out of their love for nursing education and in support of an unknown faculty colleague. Their shared experiences will drive positive social change initiatives and for that, I am grateful.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

While undergraduate nursing education requires observation, assessment, and evaluation of clinical skills, little attention has been given to performance anxiety as it occurs in the clinical practice setting. Broadly speaking, performance anxiety has been defined as a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). The implication in nursing education is that performance anxiety has the potential to negatively affect the behavior or skill being attempted by the student (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Tolbert-Washington, 2012). While few nurse educators will deny the existence of performance anxiety in nursing education, there has been scant research on the phenomenon or how clinical faculty can effectively address student performance anxiety. The lack of literature surrounding performance anxiety is particularly concerning in undergraduate nursing education where evaluation in clinical settings is critical to the academic completion and professional development of the student.

It is important to explore the phenomenon of performance anxiety within the discipline of nursing. Indeed, an exploration of the phenomenon is needed to better understand faculty experiences with performance anxiety, how performance anxiety may affect education of the nursing student, and to begin to form a nursing-centric definition for the phenomenon. Greater understanding of performance anxiety within

undergraduate nursing education will provide support for change in nursing education, academic administration, nursing practice, policy, and social change.

This chapter focuses on the phenomenon of performance anxiety. It focuses on the phenomenon of performance anxiety. Chapter 1 also provides a background on the phenomenon and definition of performance anxiety. Additionally, this chapter defines the purpose and significance of this study as it relates to nursing and its potential for impacting social change. Moreover, Chapter 1 introduces the research questions that guided the study and provides an overview of the methodological design as well as the theoretical framework of the study. Finally, this chapter provides definitions of key terms relevant to the study, assumptions, and limitations of the study.

Background

This research focused on the problem of performance anxiety in clinical nursing education. Despite recognition that anxiety in didactic learning environments has been shown to negatively impact learning outcomes, little investigation has occurred surrounding the complication of anxiety in clinical nursing education (Hutchinson & Janiszewski, 2016; Tolbert-Washington, 2012). Indeed, defining and understanding the phenomenon of performance anxiety in the context of clinical nursing education will provide support for educational changes in the discipline to best prepare future nurses.

In the last several decades, there has been increasing evidence in the literature of performance anxiety in multiple professional disciplines. Specifically, performance anxiety has been a phenomenon noted in athletes (Chaube, 2013), musicians (Helding, 2016; Levy & Lounsbury, 2011; Schneider & Chesky, 2011; Sieger, 2017), and medical

students (Malina, 2013). As reported in the literature, those professionals and students experiencing performance anxiety have poorer learning outcomes, academic behaviors, and skill performance than peers not experiencing the phenomenon (Chaube, 2013; Helding, 2016; Levy & Lounsbury, 2011; Schneider & Chesky, 2011; Sieger, 2017). Additionally, those affected by performance anxiety have higher rates of long-term professional maladaptive behaviors or leave their respective professions earlier than peers who have not experienced performance anxiety (Chaube, 2013; Helding, 2016; Levy & Lounsbury, 2011; Schneider & Chesky, 2011; Sieger, 2017; Tolbert-Washington, 2012).

Anxiety and learning have a curvilinear relationship wherein low to moderate levels of anxiety produce actionable learning (Kleehammer, Hart, & Keck, 1990). Conversely, high levels of anxiety decrease learning (Cornine, 2020; Kleehammer et al., 1990). Kleehammer et al. (1990) researched several nursing clinical experiences that increased anxiety, thus inhibiting learning, but the authors did not explore the phenomenon of performance anxiety specifically. Historically, performance anxiety as a phenomenon in nursing was not introduced until 2009 by Tolbert-Washington in her work exploring the phenomenon in the new, graduate nurse entering practice.

Since Tolbert-Washington's initial study, performance anxiety has not been formally recognized in the literature surrounding nursing education. However, student anxiety in the clinical setting has been repeatedly studied (Cornine, 2020; Hutchinson & Janiszewski, 2016; Moscaritolo, 2009; Tolbert-Washington, 2012). Further, stress and anxiety have been used synonymously in the description of nursing clinical learning

difficulties that may have been better described as performance anxiety (Tolbert-Washington, 2012; Turner & McCarthy, 2017).

Performance anxiety is a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). Studies outside the discipline of nursing have noted mistakes in judgment, multiple errors, and job dissatisfaction associated with performance anxiety (Chaube, 2013; Helding, 2016; Levy & Lounsbury, 2011; Malina, 2013; Schneider & Chesky, 2011). Moreover, those same studies have described faculty interventions beneficial in reducing performance anxiety. Defining performance anxiety in nursing education would be beneficial in developing more skilled and resilient nurses who will stay in the workforce. Similarly, understanding the clinical nurse faculty perceptions and lived experiences of performance anxiety in clinical education is required to better inform educational interventions in the reduction of performance anxiety.

To date, nursing education literature exploring the stress and anxiety of students in the clinical learning setting has suggested interventions to reduce anxiety or stress. Specifically, mindfulness, mentoring, and faculty instructional strategies have been suggested to effect positive change in learning (Cheung & Kit-Fong, 2011; Cook, 2005; Cornine, 2020; Manderino & Yonkman, 1985; Melincavage, 2011; Moscaritolo, 2009; Moses & Friedman, 1986; Schwind et al., 2017; Turner & McCarthy, 2017). However, little is known of faculty perceptions of their role in performance anxiety. As faculty are integral members in a dynamic learning relationship, it is imperative to understand the faculty experience of performance anxiety for transformative educational reform.

Positive change in learning can be effected through the examination of performance anxiety in nursing clinical education. Specifically, decreasing anxiety in the clinical learning environment of undergraduate nursing students may be associated with an increase in learning (Cornine, 2020; Lin, 2016; Moscaritolo, 2009). While performance anxiety is expected, normal, and a positive attribute when consciously prepared for, underpreparedness and high levels of performance anxiety may be debilitating to performance, learning, and growth (Cornine, 2020; Helding, 2016; Malina, 2013). Faculty-learner interactions can be inhibited when high levels of performance anxiety are present or when instructional assessment is perceived as punitive instead of developmental (Malina, 2013). Interactions between student and faculty with a low to moderate level of anxiety are important in the development of clinical reasoning, judgment, and critical thinking (Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990).

The background of this topic indicates the importance of understanding the faculty role in performance anxiety prior to suggesting interventions, as is currently present in the literature. A definition of performance anxiety in nursing is needed for consistent ability to identify, assess, and intervene when this phenomenon is present. Defining performance anxiety will also lend to consistent language use in nursing literature, thus further improving identification, assessment, and intervention when the phenomenon is present. Improvement in student learning is essential to prepare nurses for professional practice.

In this study, I sought to explore performance anxiety in undergraduate nursing clinical education. It is critical to understand the phenomenon from the perspective of faculty to understand it fully from the perception of the student. Without a consistent definition and understanding of faculty lived experiences with performance anxiety, lasting change in nursing clinical education is not possible.

While multiple studies have been conducted on performance anxiety in artists, musicians, athletes, and medical students, in this study, I examined performance anxiety in nursing students. Lasting change in undergraduate nursing education is needed to develop essential skills of practice, such as critical thinking, clinical reasoning, and clinical judgment (National League for Nursing [NLN], 2010). Development of these skills is essential to adapt to a changing healthcare environment as well as support retention of the nursing workforce (Moscaritolo, 2009; NLN, 2010; Tolbert-Washington, 2012; Turner & McCarthy, 2017). Retention of a skilled nursing workforce is essential as a strategy to alleviate the nursing shortage (NLN, 2010).

Problem Statement

The focus of this research study was the lack of literature on how to articulate, recognize, and address performance anxiety as it occurs during the facilitation of clinical learning in undergraduate nursing education. Most literature to date has addressed performance anxiety as experienced by musicians, artists, athletes, and medical students (Chaube, 2013; Helding, 2016; Malina, 2013; Melincavage, 2011; Schneider & Chesky, 2011; Sieger, 2017; Turner & McCarthy, 2017). The concept has not been fully explored nor defined in clinical nursing education. It is important to understand performance

anxiety in nursing education for educational reform. Specifically, a clearer understanding of performance anxiety in nursing education will support reform in education, administration, and policy that will effect social change.

For this study, the phenomenon of performance anxiety is defined as a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). The implication is that performance anxiety has the potential of preventing or negatively affecting the behavior being attempted or observed (Chaube, 2013; Cornine, 2020; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). While few will deny the existence of performance anxiety in nursing practice, there has been scant literature on the phenomenon and even less on strategies of how the problem can be addressed. This is particularly true in undergraduate nursing education where student performance in the clinical setting is a critical factor.

Defining and understanding performance anxiety through the experiences of nursing faculty will better inform instructional strategies to increase learning outcomes in the clinical setting (Moscaritolo, 2009; NLN, 2010). High levels of clinical anxiety in undergraduate nursing students can impair learning, psychomotor skill performance, clinical judgment, and critical thinking (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990). Skills of critical thinking and clinical judgment are learned in undergraduate nursing education, specifically in the clinical setting. Undergraduate nursing students spend three times longer in clinical experiential learning than in didactic settings, and thus, an

understanding of performance anxiety in the clinical setting is needed (Moscaritolo, 2009; NLN, 2010).

Further, anxiety surrounding evaluation in nursing programs perpetuates anxiety in newly graduated nurses, which can affect work performance in the new work setting (Tolbert-Washington, 2012). Specifically, undergraduate nursing students with internalized feelings of anxiety surrounding performance evaluation by those in a power position can have similar anxiety manifest as a licensed professional when under observation in the workplace (Tolbert-Washington, 2009, 2012). Clinical undergraduate nursing education requires observations to assess student progress. Student evaluation by nursing faculty, coupled with inexperience in the nursing role, can increase performance anxiety in the undergraduate nursing student (Tolbert-Washington, 2012). Furthermore, when nursing students experience performance anxiety, the effects of performance anxiety can continue with them as new professionals entering the workplace (Tolbert-Washington, 2012). An understanding of performance anxiety in the clinical setting will inform methods to reduce performance anxiety in clinical assessment, thus improving future role performance in the workplace (Moscaritolo, 2009; NLN, 2010; Tolbert-Washington, 2012). Nonetheless, little is known of nursing faculty perceptions of anxiety as a barrier to learning in the clinical environment (Moscaritolo, 2009). Additionally, nursing faculty may be unaware of their role in performance anxiety and in measures that can be taken to reduce the anxiety of their students. An understanding of faculty perceptions and roles in performance anxiety will inform education, administration, and policy changes to affect social change. Specifically, changes in

undergraduate nursing education could lead to a larger and stronger nursing workforce. To effect lasting social change through educational reform, a nursing definition of performance anxiety through an understanding of the lived experiences of clinical nursing faculty is required.

Purpose Statement

This was a qualitative research study. Using a descriptive phenomenological approach, the primary purpose of this study was to explore the lived experiences of associate degree nursing faculty in addressing performance anxiety as it occurs in the clinical setting. More specifically, this study is used to describe how nursing faculty address performance anxiety while supervising and instructing associate degree nursing students in the clinical setting.

Research Questions

The primary question that guided this research study was:

RQ: *What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety?*

In addition, this study addressed the following secondary research questions: How do associate degree nursing faculty define performance anxiety as seen in the clinical setting? How do associate degree nursing faculty describe their role in addressing student performance anxiety in the clinical setting? What experiences guide associate degree nursing faculty in addressing student performance anxiety in the clinical setting? What experiences guide associate degree nursing faculty clinical evaluation of students who exhibit performance anxiety?

Conceptual Framework

A humanistic approach to education, as developed by Carl Rogers, supports learners in self-actualization (Billings & Halstead, 2012; Carter, 2017; Purdy, 1997; Rogers, 1974a). Specifically, self-actualization occurs when faculty facilitate educational environments in which the learner does not perceive a threat to self (Knowles, Holton, & Swanson, 2015; Purdy, 1997; Rogers, 1974a). Rogers (1974a) posited that self-actualization assists in independent learning and behavior. Indeed, dependent behavior may occur when learners perceive educational environments to be of harm to self (Knowles et al., 2015; Rogers, 1974a).

A humanistic theoretical approach supports nursing students in the management of performance anxiety to advance self-actualization and enhance learning. Understanding faculty definition, recognition, and attempts at addressing performance anxiety through the lens of humanism will inform methods of instruction to increase self-actualization in the clinical learning environment. Increasing self-actualization will support the management of performance anxiety. Management of performance anxiety as a student is beneficial to the future nurse in the professional practice setting (Moscaritolo, 2009; Tolbert-Washington, 2012).

Nature of the Study

The primary research question that guided this study was: What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety? The phenomenon of interest was performance anxiety. The purpose of this study was to explore the lived experiences of associate

degree clinical nursing faculty in addressing performance anxiety as it occurs in the clinical setting. Recognizing this factor, a qualitative approach was used to explore the phenomenon. More specifically, a descriptive phenomenological design was used to explore the concept. A descriptive phenomenological approach allows analysis of a collection of lived experiences in order to better understand the perception and meaning of a phenomenon in context (Burkholder, Cox, & Crawford, 2016; Creswell & Creswell, 2018; Patton, 2015).

Descriptive phenomenology supports understanding of experiences through analysis of themes and patterns (Burkholder et al., 2016). Specifically, descriptive phenomenology transcends individual data to examine shared experiences (Burkholder et al., 2016). A descriptive phenomenological approach would broaden understanding in an attempt at defining performance anxiety as it occurs in clinical nursing education.

Data collection included in-depth, one-on-one, semistructured interviews with clinical nursing faculty in U.S. associate degree programs. Participants for the study were identified and purposefully selected based on their experiences with clinical nursing education in associate degree programs (Burkholder et al., 2016; Creswell & Creswell, 2018). The interviews were recorded, transcribed, coded, and analyzed for themes to better understand the participants' lived experiences with student performance anxiety in the clinical setting.

Definitions

A review of the literature determined the definition of key concepts within the context of this study.

Clinical nurse faculty: Experientially and academically prepared professional nurses who instruct and evaluate students in the clinical setting (Accreditation Commission for Education in Nursing [ACEN], 2016; Woodworth, 2016).

Clinical setting: Off-campus practical learning environments where learning outcomes are supported through direct healthcare delivery to clients (ACEN, 2016; Woodworth, 2016).

Performance anxiety: A state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017).

Assumptions

Assumptions are necessary in the completion of research. Specifically, this research included the assumption that qualitative, phenomenological methodology would assist in the provision of understanding faculty perspectives of student performance anxiety (Creswell & Creswell, 2018; Groenewald, 2004; Morse, Hupcey, Penrod, & Mitcham, 2002; Patton, 2015). Moreover, the data yielded from participant interviews provided rich context while addressing the research questions (Burkholder, Cox, & Crawford, 2016; Creswell & Creswell, 2018; Groenewald, 2004; Patton, 2015). Therefore, it was assumed that all participants accurately and honestly recounted occurrences of student performance anxiety to best convey the meaning of the lived experience.

Further, it was assumed that performance anxiety surrounding clinical skill performance exists for all associate degree nursing students. The literature denotes an

existence of performance anxiety in newly graduated nurses, athletes, musicians, artists, and students from other disciplines (Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Malina, 2013; Tolbert-Washington, 2012). However, the phenomenon of performance anxiety in nursing education has not been explored.

Moreover, anxiety in clinical nursing settings is presumed to be maladaptive and detrimental (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Tolbert-Washington, 2012). Not all performance anxiety can be deleterious to learning (Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Tolbert-Washington, 2012). Therefore, in the context of this research, it was assumed that performance anxiety experiences explored will relate to those experiences associated with inhibitory learning. Further, it was assumed that inhibitory learning experiences were educational experiences that were maladaptive or detrimental to learners or learning outcomes.

Scope, Delimitations, and Limitations

This study was delimited to associate degree nursing program faculty who instruct in the clinical setting. Further, these clinical faculty will be delimited to the United States. Additionally, the clinical faculty possess a minimum of 1 year of nursing clinical instruction experience in the clinical setting of an associate degree nursing program.

The study findings were interpreted through the conceptual framework of humanism. Results and analysis are limited by the accuracy of the concepts of the framework. By analyzing the study through the lens of a conceptual framework,

similarities and differences between the study and the concepts of the theory were explored through emerging themes (Creswell & Creswell, 2018).

Recruitment of participants was limited to participants from the United States. However, most participants were yielded from the geographical region of upstate New York. This recruitment boundary limits the participant pool and may introduce similar findings specific to the region. Further, this limitation compounds the already present limitations in transferability to other populations that are inherent in qualitative phenomenological studies (Creswell & Creswell, 2018).

One-on-one interviews provided rich, detailed descriptions of the settings, the participants, and the lived experiences to increase transferability of study results (Burkholder et al., 2016; Creswell & Creswell, 2018). However, limitations exist with interviews. Specifically, information gathered was filtered through the viewpoint of the participant and may be biased by the presence of the interviewer (Creswell & Creswell, 2018). Further, information was gathered in a predesignated forum instead of a field setting, thus limiting observation of the phenomenon (Creswell & Creswell, 2018).

Interpretive inquiry within qualitative research may include influences from a researcher's prior experiences and background (Creswell & Creswell, 2018). Validity strategies within this study included triangulation, member checking, clarification of personal biases through reflectivity, and the use of a peer reviewer (Creswell & Creswell, 2018; Hull, 2017). Specifically, interpreted themes were built on converging perspectives of participants and shared with participants after analysis occurred. In addition, reflective notes were kept in description of potential biases in analysis. These

notes informed comments on interpretative findings within the study. Similarly, the study process and potential biases were discussed with peer reviewers in the form of committee members. Committee oversight assessed interpretations as valid from the data (Creswell & Creswell, 2018; Hull, 2017).

Significance

A study on performance anxiety has broad implications with the potential of impacting nursing education, academic administration, practice, policy, and social change. Indeed, understanding performance anxiety is important to the future of the nursing workforce. High levels of performance anxiety in clinical education can impair clinical judgment, reasoning, and critical thinking (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990). Improved student learning will better prepare newly graduated nurses for professional practice wherein lower levels of anxiety are required for optimal performance and adaptability to the changing healthcare environment (Moscaritolo, 2009; Tolbert-Washington, 2012). A more prepared and adaptable nursing workforce will assist in the advancement of healthcare initiatives and lend to a reduction in the present nursing shortage (NLN, 2010; Tolbert-Washington, 2012; Turner & McCarthy, 2017).

Nursing Education

Changes in instructional strategies can influence social change. An educational social change agent seeks to effect long-term change. A call for an instructional strategy reform is present in nursing, yet evidence-based methods for lowering or preventing performance anxiety have been unexplored and unreported. The understanding of

performance anxiety through faculty experiences will better inform curricula reform and instructional strategies, thus increasing learning outcomes in clinical settings (Moscaritolo, 2009; NLN, 2010). Changes to instructional strategies that decrease performance anxiety and increase learning are beneficial to promoting the worth, dignity, and development of the academic community, students, and society. An increase in learning and skill among emerging professionals can improve human and social conditions through the creation of effective working relationships, holistic nurse-patient rapport, and nursing professionals who remain in the workforce effecting healthcare change and reform.

Academic Administration

Understanding the associate nursing degree program faculty member's role in performance anxiety will allow academic administration to better understand the needs of the faculty in their support of nursing students. Multiple resources are needed to best educate nursing students (NLN, 2010). As academic administration supports faculty development and instructional strategies in the reduction of performance anxiety, more nursing students are likely to graduate and be retained in the nursing workforce. Thus, administrative support must begin with further understanding of the phenomenon of performance anxiety to best effect lasting, positive social change.

Practice

Practice improvement with results from this study will be two-fold. First, understanding performance anxiety in undergraduate education may lead to better instructional strategies to reduce performance anxiety and develop more resilient

healthcare workers (Moscaritolo, 2009; Tolbert-Washington, 2012). These better prepared new graduates entering the workforce will be more likely to stay in nursing as well as be adaptable to the shifting healthcare environment, thus improving patient care and assisting in the reduction of the nursing shortage (NLN, 2010; Tolbert-Washington, 2012; Turner & McCarthy, 2017).

Second, an understanding of the phenomenon of performance anxiety in undergraduate clinical nursing education will further illuminate clinical moments of performance anxiety introduced by Tolbert-Washington (2009) as new nurses transition to practice in the healthcare environment. Specifically, transitioning to practice can produce high levels of anxiety if the new nurse is not supported in their new practice role (Tolbert-Washington, 2009, 2012). Understanding performance anxiety in nursing will provide support for the new graduate nurse in clinical practice, thus improving the nursing shortage through retention of the workforce (NLN, 2010; Tolbert-Washington, 2009). Additionally, the retained workforce will be better skilled with increased clinical reasoning, judgment, and critical thinking (NLN, 2010; Tolbert-Washington, 2009).

Policy

Policy makers both in the healthcare environment and in academia will be affected by the findings generated from this study. This study might affect policy change in the healthcare environment to support new graduate nurses through their transition to practice while academic policy makers may be affected in supporting faculty development in reducing nursing student performance anxiety. Both policy change environments will lead to positive social change through the reduction of performance

anxiety to improve the nursing workforce skill set and retention, thus reducing the nursing shortage while providing improved care to patients.

Social Change

Last, positive social change will occur through the results of this study. Change will be seen through nursing education, academic administration, practice, and policy. The promotion of the worth, dignity, and development of nursing students will lead to the development and betterment of the organizations and communities where they enter and continue to practice. Through further understanding of performance anxiety in nursing, lasting positive social change can begin to occur through the educational reform of the emerging nursing workforce. Further, the nursing workforce will be better prepared to improve the human and social conditions in the organizations and communities they serve.

The findings of this study will inform changes in clinical nursing education. Most literature for nursing education has been focused on didactic instruction without consideration of clinical education and needed change. Understanding performance anxiety in nursing education will produce a ripple effect of social change. Included in this change will be findings that inform curricula change, textbook development, future literature in nursing education studies, development of faculty and adjunct teaching support, and nursing students themselves. As the educational environment evolves, the patient care from those students will also evolve, thus providing long-term, positive change in healthcare.

Conclusion

Understanding the lived experiences of clinical nursing faculty in associate degree programs with student performance anxiety is integral to comprehensive nursing education reform. Previous research has highlighted the student experience and possible educational strategies to decrease anxiety and stress in the clinical learning environment, but little is known of the faculty experience. Faculty are members of the instruction-learning paradigm, and understanding faculty experiences with the phenomenon of performance anxiety will better inform curricula and instructional strategies.

Reducing performance anxiety in the clinical nursing environment can better prepare the nursing workforce. Specifically, lowered levels of performance anxiety among students may increase the students' self-actualization and lower anxiety in their workplace after students have graduated (Tolbert-Washington, 2012). Reducing the anxiety of emerging nurses can increase role satisfaction, work relationships, safe patient care, and retention of nurses at the bedside (NLN, 2010; Tolbert-Washington, 2012).

To better understand the phenomenon and previous research in relation to nursing education reform, Chapter 2 of this study provides a comprehensive review of the literature. The extensive review includes studies on the topics of performance anxiety and educational theory. Specifically, Chapter 2 includes literature support of the conceptual framework and its support of the research questions. Additionally, this chapter incorporates the strategies used to identify relevant literature on the research problem.

Chapter 2: Literature Review

Introduction

While research on performance anxiety has proliferated in recent years, there has been scant reports on performance anxiety in nursing education. This is particularly true in clinical instruction in prelicensure programs, where anxiety can be at its peak during the evaluation of clinical performance (Turner & McCarthy, 2017). Broadly speaking, performance anxiety has been defined as a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). Recent research on performance anxiety indicates that the phenomenon has the potential to limit or negatively affect a behavior being attempted while under direct observation (Chaube, 2013; Helding, 2016; Hutchinson & Janiszewski-Goodin, 2013; Malina, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Schneider & Chesky, 2011; Sieger, 2017; Speck, 1990). As the foundations of critical thinking, clinical reasoning, and clinical judgment are learned during clinical education, the understanding of performance anxiety in the prelicensure clinical environment is imperative to student development (Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; NLN, 2010; Oetker-Black et al., 2014; Speck, 1990). Furthermore, understanding faculty experiences with student performance anxiety will better inform instructional strategies to increase and enhance learning outcomes in the clinical setting (Moscaritolo, 2009; NLN, 2010).

This chapter covers the topic of performance anxiety in clinical nursing education. Specifically, the chapter offers a review on what is known and not known on the

phenomenon within and outside the discipline of nursing. Additionally, Chapter 2 includes the literature search strategy and conceptual framework for this study. Lastly, a comprehensive literature review of key concepts presents what is known and what remains to be explored on the phenomenon of performance anxiety as it relates to the discipline of nursing, specifically undergraduate nursing education.

Literature Search Strategy

The primary research question that guided this study was:

RQ: What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety?

In exploration of the research question, a comprehensive search of the literature was conducted related to concepts of performance anxiety, nursing clinical education, and humanism in educational practices. Multiple databases were searched including Academic Search Complete, Cumulative Index of Nursing and Allied Health Literature (CINAHL), ERIC, Medline, ProQuest, and Thoreau. To ensure an in-depth search, website searches were conducted of the ACEN, Commission on Collegiate Nursing Education, Google Scholar, and the NLN. Nineteen key search terms, as well as a combination of words, were used in the database searches including *performance anxiety, nurs*, test*, self-efficacy, clinical decision making, clinical education, undergraduate nursing students, humanism, confidence, clinical skills, clinical practice, faculty influence, bullying, incivility, anxiety, stress, competence*, and *conceptual framework*. Recognizing that performance anxiety has been an unexplored topic in nursing education, I retained articles with humanism as a conceptual framework experiences of student nurse

stress and anxiety in the clinical educational environment and performance anxiety in professions outside of the discipline of nursing.

Conceptual Framework

The conceptual framework for this study, as depicted in Figure 1, is based on constructs used in the theory of humanism, as developed by Rogers (1951, 1974a, 1974b). Specifically, the use of humanism in education was explored. The philosophical underpinnings of humanism as a pedagogical approach considers the reciprocal relationship between learner and learning as well as an individual's actualization and social transformation (Carter, 2018). Additionally, humanism is rooted in phenomenological foundations. A key concept in both phenomenology and humanism is the subjectivism of experience. Human consciousness separates the social from the natural world. How an experience is perceived formulates a reality within an individual. As nursing clinical instruction evaluation often includes objective assessment, the whole of the individual under evaluation is not fully assessed to include these subjective experiences. Understanding of the subjective reality of the individual nursing student may be beneficial to understanding learning for the student and any influences affecting evaluation in the clinical setting (Coutts & Rogers, 2000; Rogers, 1974a). The implication in nursing education is that there may be multiple influencing factors that affect performance of an individual that are not accurately captured in objective observation of clinical skills. Humanism in nursing education has grown in popularity as the education of nurses has grown from solely technical training to an educational process (Purdy, 1997). Exploring education through the lens of humanism allows one to

consider the interaction of the natural and the social world as it leads to growth of the learner (Rogers, 1951).

Teaching within the conceptual framework of humanism is student-directed and individualized to the learner (Purdy, 1997; Rogers, 1974b). As Rogers's model of humanism in education stresses the importance of growth of the individual, this is mimicked in nursing's need to develop skills in lifelong learning (NLN, 2010; Purdy, 1997; Rogers, 1951). To increase the success of self-actualization of the learner, humanism as an educational framework assists the student to free themselves from environmental and emotional inhibitions that are preventing fully functioning learning (Purdy, 1997; Rogers, 1974a). Rogers's humanism in education supports less restrictive and authoritarian methods with an increase in support of adaptability of the learner (Purdy, 1997). Indeed, facilitation of learning with a humanistic lens requires support of students in cognitive, affective, and psychomotor learning moments to build a sense of positive accomplishment in the learner that creates a feeling of ability to perform in the future (Rogers, 1974a).

To be an effective facilitator of learning, Rogers (1951, 1974a, 1974b) explained that a faculty member should exhibit specific characteristics. These characteristics include realness of the facilitator, prizing the learner, and empathetic understanding (Rogers, 1951, 1974a, 1974b). Realness in the facilitation of learning includes an ability to be present with a learner (Rogers, 1974a). For example, faculty members would remove themselves from a façade of expertise, meet a learner on a person-to-person level, and be cognizant of areas of personal improvement and learning in the same moment of

learning for the student (Rogers, 1974a, 1974b). Prizing the learner involves caring for the learner as a person and recognizing their personal worth, which is a component inherent in trustworthiness (Rogers, 1974a). This acknowledgement of worth in the student, this trust, is necessary to accept fear and hesitation in student academic performance as well as positive moments in academic success (Rogers, 1974a, 1974b). Last, empathetic understanding is required in considering the educational experience from the viewpoint of the student. How the student learns and what they may be experiencing in learning and evaluation moments is critical in making learners feel understood and not judged, thus influencing learning in a positive manner (Rogers, 1974a, 1974b). A faculty member who can incorporate these characteristics in instruction and evaluation will lead to the major goal of humanistic education which is the development of learning through a sense of self-actualization and personal adequacy within the learner (Carter, 2018).

Learners, as viewed through humanism, are complex beings that incorporate personal meaning, skill, and emotion in learning (Carter, 2018; Rogers, 1974a, 1974b). Learning must occur in a nonthreatening environment (Carter, 2018). Further, the environment of learning should be free from threats and include positive support, understanding, and excitement yet remain challenging (Carter, 2018; Rogers, 1974b). As related to nursing education, with the complexity of current healthcare, it is imperative that nursing students socialize to learning in a manner that supports open curiosity and acceptance for unknown areas of clinical practice while also gaining internal feelings of an ability to learn and achieve those unknown areas (Carter, 2018). Having this

developed sense of internal optimism and self-reflection allows students to develop into healthcare providers who can critically think, problem solve, and have equal cognitive, behavioral, and affective skill sets crucial in an evolving healthcare career (Carter, 2018; Rogers, 1974a).

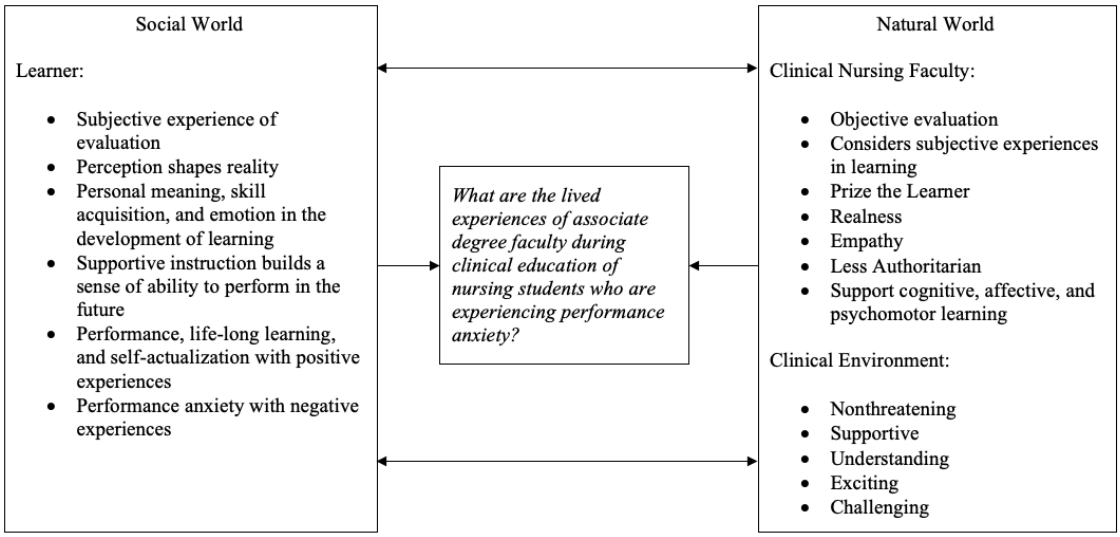


Figure 1. Conceptual framework demonstrating lived experiences of faculty addressing performance anxiety in clinical nursing education as viewed through the lens of humanism.

Literature Review Related to Key Concepts

Three major constructs discussed within the literature include performance anxiety, clinical nurse faculty, and the clinical setting. To date, published research addressing performance anxiety has primarily involved artists, musicians, athletes, and medical students. On close examination, a review of the literature produced no published articles investigating performance anxiety in undergraduate nursing clinical instruction. However, themes of anxiety and stress in clinical nursing education have been explored.

Additionally, much literature exists depicting student nurses' perceptions of stress and anxiety in clinical education with little consideration of faculty perceptions (Cornine, 2020; Melincavage, 2011; Turner & McCarthy, 2017). Hence, it is imperative to explore performance anxiety in clinical nursing education from the perspective of clinical faculty members in order to best inform educational practice. It is the responsibility of faculty members as facilitators of learning to improve learning outcomes, recognize human perceptions and feelings during the learning process, and assist learners to develop within their unique abilities (Carter 2018). Indeed, several studies posit clinical instruction strategies from the experience of the students reported (Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2013; Kleehammer, Hart, & Fogel-Keck, 1990; Moscaritolo, 2009). However, given the reciprocal relationship in education, the additional viewpoint of faculty members is crucial (Turner & McCarthy, 2017).

Performance Anxiety

Performance anxiety is a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). Most of literature addressing the topic of performance anxiety has focused on professions and students in the fields of medicine, art, music, and athletics (Chaube, 2013; Helding, 2016; Levy & Lounsbury, 2011; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). While nursing education literature describes concepts of the definition of performance anxiety, the language used in the literature is stress or anxiety with no found studies using the term "performance anxiety". However, given the evaluative nature of clinical nursing education,

performance anxiety is the more accurate term for the phenomenon (Tolbert-Washington, 2009).

Numerous studies suggest that understanding performance anxiety in clinical nursing education is important as performance anxiety can impair learning, psychomotor skill performance, clinical judgment, and critical thinking (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990). Clinical judgment and critical thinking are required for safe practice as a registered nurse (NLN, 2010). According to the literature, performance anxiety that remains unaddressed as a student can transition into performance anxiety in the workplace as a registered professional nurse (Chaube, 2013; Tolbert-Washington, 2012).

Some studies suggest that social anxiety and fears of being situationally judged can cause manifestations of performance anxiety (Chaube, 2013; Helding, 2016; Tolbert-Washington, 2012). Even if the affected learner understands the fear to be irrational, physical manifestations of tense muscles, nausea, shaking, palpitations, and paralysis can occur (Chaube, 2013; Tolbert-Washington, 2012). Cognitively, a learner may be unable to recall information or have racing thoughts (Helding, 2016). Psychologically, performance anxiety can negatively influence the task being attempted, impair learning, and perpetuate further anxiety in a future career (Chaube, 2013; Helding, 2016; Tolbert-Washington, 2012).

The literature under review theorizes the development of performance anxiety can be influenced by prior negative experiences in learning or performance (Chaube, 2013; Helding, 2016; Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2012; Levy &

Lounsbury, 2011; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017; Tolbert-Washington, 2009, 2012). Negative experiences may include feelings of inadequacy or prior critiques (Chaube, 2013; Helding, 2016; Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2012; Tolbert-Washington, 2012). These negative influences may affect self-regulation and metacognition of students (Bouffard, Boisvert, Vezeau, & Larouche, 1995; Cohen, 2012). Maladaptive self-regulation in learning not only affects situational performances during evaluation, it also causes maladaptive approaches to student learning (Cohen, 2012). As nursing clinical education is a form of high-stakes evaluation, a negative experience in this setting could result in lowered ability in self-regulation, performance anxiety, and a decrease ability to effectively learn in the long-term (Chaube, 2013; Cohen, 2012; Tolbert-Washington, 2012). This recurrent negative ability to perform is associated with metacognition of the student wherein they may have the cognitive ability to perform tasks but are emotionally incapable of doing so (Bouffard et al.,1995).

Clinical Nurse Faculty

Clinical nurse faculty are experientially and academically prepared professional nurses that instruct and evaluate students within the clinical setting (ACEN, 2016; Woodworth, 2016). It is noted in the literature surrounding nursing student anxiety that a perceived negative attitude and judgment by clinical nursing faculty increases poor performance and reduced learning (Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2013; Kleehammer et al., 1990). One study additionally noted the position of faculty during an evaluation can increase stress and anxiety while decreasing student confidence

(Horsley, 2012). Two studies further noted student perceptions of faculty experiences in nursing and knowledge of research can be intimidating (Hutchinson & Janiszewski-Goodin, 2013; Tolbert-Washington, 2009). According to the literature, faculty may be able to reduce anxiety in evaluation of clinical learning, thus increasing critical thinking and self-esteem in the student, if aware of potential performance anxiety in the student as their culpability (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009). Last, additional studies posit establishing a caring relationship with the learner is beneficial in lowering anxiety associated with performance (Hutchinson & Janiszewski-Goodin, 2013; Rogers, 1974a).

A number of studies suggest that in the clinical learning environment, faculty can reduce anxiety and increase learning by developing an accepting environment where all expressions of learning do not have to be perfect (Chaube, 2013; Harrison-White & Owens, 2018; Kleehammer et al., 1990; Moscaritolo, 2009). While some anxiety in undergraduate nursing students is to be expected in the demanding clinical environment, faculty may be able to intervene when students experience symptoms of performance anxiety during evaluation (Harrison-White & Owens, 2018; Moscaritolo, 2009). According to four studies, interventional opportunities lie within the faculty member's ability to produce a clinical setting focused on ability instead of punitive outcomes and infused with caring exchanges (Carter, 2018; Harrison-White & Owens, 2018; Moscaritolo, 2009; Thomas, 2017). Last, it is noted in the literature that a reduction of performance anxiety by clinical nursing faculty will enhance accurate evaluation of skill

versus assessment of the results of the anxiety (Hutchinson & Janiszewski-Goodin, 2013; Kleehammer et al., 1990; Moscaritolo, 2009).

Clinical Setting

The literature under review explored multiple clinical experiences that increased anxiety in nursing students to a level that impaired learning outcomes. Multiple studies suggest that first exposure to clinical experiences, fear of making mistakes, and faculty evaluation or observation were the most significantly anxiety-inducing events (Chaube, 2013; Helding, 2016; Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2012; Kleehammer et al., 1990; Levy & Lounsbury, 2011; Malina, 2013; Moscaritolo, 2009; Schneider & Chesky, 2011; Sieger, 2017; Tolbert-Washington, 2009, 2012). While these studies were not specifically an exploration of performance anxiety, anxiety surrounding clinically performed abilities is inherently the phenomenon of performance anxiety.

In addition to poor relationships with clinical nursing faculty, studies suggest student interaction with other members of the clinical learning environment can also affect levels of anxiety and lead to performance anxiety (Harrison-White & Owens, 2018; Koharchik, 2018; Thomas, 2017; Tolbert-Washington, 2009). Several studies suggest negative interactions with other nurses, medical staff, or leaders in administration can affect learning both as a student and as that student transitions into professional practice (Burkley, 2018; Harrison-White & Owens, 2018; Koharchik, 2018; Thomas, 2017; Tolbert-Washington, 2009). Performance anxiety developed in an unsupportive clinical environment can inhibit theoretical knowledge transfer to clinical practice (Horsley, 2012; Tolbert-Washington, 2009). Open communication and supportive caring of

nursing students in the clinical setting by all healthcare partners is the ideal learning environment wherein less anxiety may be experienced (Burkley, 2018; Tolbert-Washington, 2009).

Summary and Conclusions

While there is literature to support faculty culpability in anxiety of nursing students in the clinical environment, there is limited empirical literature identifying this anxiety as performance anxiety nor faculty understanding of experiences with this phenomenon. Thus, a significant gap in the literature exists in examination of performance anxiety in nursing clinical education. A further gap exists in understanding this phenomenon through the perceptual lens of those purportedly responsible for increased incidences of the phenomenon. Understanding the lived experiences of clinical nursing faculty with students experiencing performance anxiety is critical to developing a nursing workforce capable of meeting the shifting demands of healthcare while also participating in lifelong, self-directed learning.

Performance anxiety can be increased in nursing clinical education when there is a perceived lack of support for humanistic qualities within the student and a focus on objective measurement of skill (Carter, 2018; Coutts & Rogers, 2000; Rogers, 1974a). According to the literature, clinical nursing faculty could establish a caring presence with learners during clinical instruction and evaluative time periods to mitigate the effects of performance anxiety (Hutchinson & Janiszewski-Goodin, 2013; Rogers, 1974a). Furthermore, clinical nursing faculty who are cognizant of and reduce stressful encounters in the clinical learning environment may be able to facilitate the transfer of

theoretical knowledge to clinical practice as well as assist in the development of clinical judgment and clinical reasoning that is imperative in healthcare (Horsley, 2012; NLN, 2010; Tolbert-Washington, 2009, 2012). Additionally, new experiences with a lack of instructional support and poor relationships with other professionals in the clinical learning environment do not allow development of self-actualization and an ability to transfer knowledge from theoretical learning to clinical practice (Burkley, 2018; Kleehammer et al., 1990; Koharchik, 2018; Tolbert-Washington, 2009).

Chapter 3 includes the methodology used to explore the lived experiences of clinical nursing faculty with student performance anxiety. Moreover, Chapter 3 includes the research design, research questions, and role of the researcher within the study. Additionally, the methodology is explained, how participants were selected, the method and rationale of data collection used, and how data analysis occurred. Last, an overview of issues of trustworthiness and participant rights is included.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the lived experiences of associate degree nursing faculty in addressing performance anxiety among students as it occurs in the clinical setting. Chapter 3 includes the methodology used to describe how nursing faculty address performance anxiety while supervising and instructing students in the clinical setting. Specifically, the methodology is explained and is inclusive of the research design, research questions, and the role of the researcher within the study. Additionally, an overview of recruitment, access to participants, participant selection procedures, the methods of data collection and analysis, and a delineation of issues of trustworthiness and participant rights protection are included in Chapter 3.

Research Design and Rationale

The purpose of this study was to explore the lived experiences of associate degree nursing faculty in addressing student performance anxiety as it occurs in the clinical setting. More specifically, in this study, I gathered data to describe how nursing faculty address performance anxiety while supervising and instructing associate degree nursing students in the clinical setting. The primary question that guided this research study was:

RQ: What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety?

In addition, this study addressed the following secondary research questions: How do associate degree nursing faculty define performance anxiety as seen in the clinical setting? How do associate degree nursing faculty describe their role in

addressing student performance anxiety in the clinical setting? What experiences guide associate degree nursing faculty in addressing student performance anxiety in the clinical setting? What experiences guide associate degree nursing faculty clinical evaluation of students who exhibit performance anxiety?

The key concepts within this study are performance anxiety, clinical nurse faculty, and clinical setting. Performance anxiety is a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). Clinical nursing faculty are experientially and academically prepared professional nurses who instruct and evaluate students in the clinical setting (ACEN, 2016; Woodworth, 2016). Last, the clinical setting is defined as an off-campus practical learning environment where learning outcomes are supported through direct healthcare delivery to clients (ACEN, 2016; Woodworth, 2016).

Research Tradition

As a discipline, phenomenology can be either descriptive or interpretive in nature (Jackson, Vaughan, & Brown, 2018; Matua & Van Der Wal, 2015). Whichever approach is used, phenomenology seeks to investigate the hidden meaning of phenomena as told by individuals living those experiences (Matua & Van Der Wal, 2015). With the purpose to explore the lived experiences associated with key concepts, descriptive phenomenology was an appropriate design for this study. Descriptive phenomenology allows deep understanding of phenomena (Jackson et al., 2018). Through descriptive phenomenology, a researcher can provide rich, thick descriptions of individual

experiences or consciousness in which to view the world through the focus of phenomena (Jackson et al., 2018). These rich descriptions holistically capture the complex relationships existing between individuals and key concepts of qualitative studies, thus providing lived rather than conceptual understanding (Jackson et al., 2018; Matua & Van Der Wal, 2015).

Role of the Researcher

In descriptive phenomenology research studies, the role of the researcher is to gather, organize, and analyze perceptions of participants who have experienced particular phenomena (Burkholder et al., 2016; Matua & Van Der Wal, 2015; Pandey & Patnaik, 2014). In qualitative research, the researcher serves as the research instrument. Therefore, I assumed the role of observer-participant for this study.

In an observer-participant role, avoiding bias in both data collection and analysis is important (Burkholder et al., 2016; Creswell & Creswell, 2018; Pandey & Patnaik, 2014). As I am intimately aware of clinical nursing education as well as the current literature surrounding performance anxiety, there was an inherent risk for bias in interactions with participants and within data analysis. I limited bias by purposefully selecting participants who have experience with the phenomenon, but for whom I have not had previous contact with; I used a semistructured interview guide to avoid leading participants with biased questioning; and I employed bracketing. Bracketing in descriptive phenomenological research is the ability of a researcher to recognize and set aside personal biases, perceptions, and experiences surrounding the phenomenon during

the research process (Burkholder et al., 2016; Matua & Van Der Wal, 2015; Pandey & Patnaik, 2014).

Bracketing allows a researcher to understand the phenomenon through the experiences of the participants (Matua & Van Der Wal, 2015; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). To facilitate bracketing, I reflected on preunderstandings I have in clinical nursing education, journaled those perceptions, and continued to journal potentially biased comments during data collection and analysis (Burkholder et al., 2016; Creswell & Creswell, 2018; Matua & Van Der Wal, 2015; Pandey & Patnaik, 2014; Willis et al., 2016). Specifically, I journaled previous experiences as a clinical nursing faculty member with students who experience performance anxiety and my personal teaching philosophy. The bracketing of preunderstandings of the phenomenon allowed me to reduce the potential to search for specific themes supporting my preunderstandings while conducting data analysis (Creswell & Creswell, 2018; Willis et al., 2016).

Ethical Issues

Ethics in scholarly inquiry is paramount to the safety of participants (Creswell & Creswell, 2018). To ensure the ethical nature of this research study, I obtained institutional review board (IRB) approval prior to conducting the study. The approval number is in Appendix B. Additionally, participants were selected from sites without power issues (Creswell & Creswell, 2018). For example, sites were chosen where I had no relationship or previous interactions with potential participants. Last, informed consent was obtained in both written and verbal forms. Within this consent, the benefits

and risks of the study, as well as the ability to cease participation in the study by the participants, were outlined.

Participants in a study have the right to privacy, confidentiality, the right to understand the risks and benefits inherent with study participation, and the right to refuse to participate (Burkholder et al., 2016). After IRB approval to conduct the study, I contacted potential participants. After I provided an explanation of the purpose of the study and implications for social change, participants were provided with an informed consent form that included the same information I had explained verbally. Questions related to privacy, confidentiality, or other study-related inquiries were answered to the satisfaction of the participants prior to obtaining written consent for participation. All participants were provided written consent prior to participating in the interview. Participation in the study was voluntary without coercion and without compensation.

Methodology

The methodology for this study was descriptive phenomenology. An accurate description of participant experiences with a phenomenon requires reduction in potential researcher bias; hence, reflexivity in the form of bracketing occurred during the study (Burkholder et al., 2016; Matua & Van Der Wal, 2015; Pandey & Patnaik, 2014). Further, descriptive phenomenology requires in-depth interviewing of purposively selected participants to begin to understand a phenomenon (Anney, 2014; Burkholder et al., 2016; Creswell & Creswell, 2018; Kleiman, 2004; Patton, 2015; Sandelowski, 2000). Selection of participants occurred after recruitment through New York state schools of nursing, New York state nursing organizations, and social media sites such as LinkedIn,

Instagram, and Twitter. Purposeful sampling is suited to descriptive phenomenology studies as this form of sampling allows for the addition of participants until a deep, rich understanding of a phenomenon is reached (Jackson et al., 2018; Kleiman, 2004).

Once participants were selected, face-to-face or video conference, one-on-one interviews of participants were used in this study. Original selection of participants was to be limited to upstate New York to best facilitate face-to-face interviews. Face-to-face interviews of participants allowed for inclusion of non-verbal observations without which data may be limited (Creswell & Creswell, 2018; Patton, 2015). However, because of a healthcare pandemic, recruitment and selection of participants was broadened to include national participation and interviews facilitated with video conferencing. While the search was approved by IRB protocol revision to be broadened, data saturation occurred with participants solely located in New York state via video conferencing prior to implementation of a national search for participants.

Participant Selection Logic

Purposeful sampling was used in this study. Purposeful sampling in qualitative research enables the researcher to understand the problem through the viewpoint of participants who have directly experienced the phenomenon (Creswell & Creswell, 2018; Willis et al., 2016). Hence, participants were selected who have experience in the role of clinical faculty within clinical nursing education of undergraduate nursing students. Specifically, the clinical nursing faculty had experience in associate degree nursing clinical education.

Clinical nursing faculty within an associate degree nursing program were the identified population of participants for this study. Participants were purposively sampled from associate degree nursing programs in the U.S. Clinical nursing faculty with more than 1 year of clinical nursing instruction experience within the associate degree nursing program setting were selected to participate in the study.

To achieve permission to access potential participants, New York state associate degree academic institutional websites were searched for IRB and program contact information. Additionally, the use of networking social media programs such as LinkedIn, Instagram, and Twitter were employed to solicit participant inclusion. Last, participants were solicited to participate through nursing organizations. Specifically, the New York League for Nursing, the Council for Associate Degree Nursing in New York State, and the Simulation Educators of Eastern New York. Contact with these organizations and the use of social media messaging ensured a broader communication with potential participants within New York state (Namageyo-Funa et al., 2014; Shenton & Hayter, 2004). Solicitation for participation in the study through nursing organizations occurred through email (Appendix A) with an attached informational flyer (Appendix B). Solicitation for participation in the study through social media included an informational flyer (Appendix B).

After IRB approval and contact with institutional key stakeholders, potential participants were provided an informational flyer (Appendix B) within an email noting inclusion criterion, the purpose of the study, and researcher contact information. Additionally, an informational flyer (Appendix B) was posted to social media as well as

distributed through nursing organization listservs. Interested participants received more detailed instructions on participation in the study via email communications. Participant clinical education experience within an associate degree nursing program for greater than 1 year was confirmed prior to obtaining informed consent and conducting interviews.

The intended number of participants selected was 5 to 15 (Burkholder et al., 2016; Creswell & Creswell, 2018; Jackson et al., 2018; Kleiman, 2004). Selecting a smaller participant pool when conducting descriptive phenomenological studies offers a chance for more profound insights and thick, rich data involving a phenomenon (Jackson et al., 2018). The number of participants was confirmed when data saturation occurred (Burkholder et al., 2016; Creswell & Creswell, 2018; Kleiman, 2004). Saturation is noted as occurring when data analysis reveals recurrent themes from study participants who are experienced with the phenomenon (Creswell & Creswell, 2018; Kleiman, 2004).

Instrumentation

Instruments are typically quantitative in nature. This study was a qualitative, descriptive phenomenology study. Therefore, I was the instrument for data collection. Data collection was collected through face-to-face and video conference, one-on-one interviews. Interviews were audio recorded. An interview protocol included open ended questions and handwritten notes (Creswell & Creswell, 2018; Sandelowski, 2000). After the interviews were concluded, a transcription service was used to provide written copies of the interview questions and responses. The transcribed interview was shared with each participant as a form of member checking (Creswell & Creswell, 2018). Additionally, interpreted themes were shared with participants after analysis had occurred.

A variety of data collection instruments were reviewed for possible efficacy within this study. However, the instruments reviewed were not appropriate for use in this study as they would not provide insight to research questions. There is a paucity of validated instruments exploring performance anxiety from the perspective of the instructor versus the perspective of the student. Therefore, a researcher-developed, semistructured interview guide was developed for use in carrying out this study (Appendix D). Additionally, a demographic questionnaire was provided to participants (Appendix C). These tools were developed with the intent to allow participants to thoroughly describe lived experiences with the phenomenon of student performance anxiety in nursing clinical education. The use of a researcher-designed interview guide is often required in qualitative, phenomenological research in order to understand the life-world of the participant (Creswell & Creswell, 2018; Jackson et al., 2018; Kleiman, 2004; Matua & Van Der Wal, 2015; Ravitch & Carl, 2016; Sandelowski, 2000).

Using the literature review is one way to formulate main interview questions (Rubin & Rubin, 2012). The main interview questions were framed from the literature with concepts from the phenomenon of performance anxiety and the conceptual framework of humanism. The semistructured interview guide (Appendix D) incorporates questions surrounding behaviors and actions implied by the concepts of humanism as they relate to performance anxiety in clinical nursing education. The questions were formulated in understandable language for participants (Rubin & Rubin, 2012). To elicit richer, thicker descriptions from participants, the questions were ordered in a sequence to make clear the connection of concepts (Rubin & Rubin, 2012). Additionally, questions

were ordered from broad, orienting questions to detailed, narrow questions to allow participants to establish comfort with the interview process and to relay experiences without restriction (Rubin & Rubin, 2012). Last, to allow the true experience with the phenomenon to emerge, structure of the questions asked to participants varied to allow participants to express unique meanings and variations.

The interview questions incorporated the conceptual framework of humanism by asking about the social and natural world of the clinical nursing faculty, clinical environment, and learner (Carter, 2018; Rogers, 1951, 1974a, 1974b). As performance anxiety is not defined in nursing education literature, questions within the interview sought to provide a description of this phenomenon as it relates to clinical nursing education and the assessment of learning in the clinical environment (Tolbert-Washington, 2009). Further, interview questions allowed participants to express experiences with recognition of performance anxiety, contributing factors to performance anxiety, and instructional strategies to mitigate the consequences of performance anxiety in clinical nursing education.

Procedures for Recruitment and Access to Participants

Gaining access to participants is essential in qualitative research (Namageyo-Funa et al., 2014; Shenton & Hayter, 2004). After achieving IRB approval, participants were solicited from a detailed review of New York state associate degree institution websites. An email letter soliciting permission to interview participants and gain access to participants were sent to stakeholders, such as program leaders and institutional IRB's, for each institution identified as having faculty members matching inclusion criteria

(Appendix A). Within 1 week of the email letter, I emailed the program leaders to identify if faculty members have interest in participation. Additionally, I posted a study participation flyer to LinkedIn, Instagram, and Twitter soliciting additional participants meeting inclusion criteria (Appendix B). Last, I sent the same email letter soliciting participation to nursing organizations within the state of New York, such as New York League for Nursing, Council of Associate Degree Nursing in New York, and Simulation Educators of Eastern New York. With nursing organization gatekeepers, access to participants for this study was increased as the gatekeepers are trusted by participants (Namageyo-Funa et al., 2014).

Once study participants were identified, the demographic questionnaire, interview schedule, protocols, and informed consent were discussed prior to formal agreement to participate in the study. Questions and concerns from the participants were addressed verbally and via email prior to consenting to an interview. Last, all potential participants had emphasis placed on the value of their personal contribution to nursing education but did not receive financial compensation for participation (Shenton & Hayter, 2004).

Participation and Data Collection

A two hour, face-to-face or videoconference, one-on-one interview was planned with selected participants. Participant rights were protected per IRB guidelines. Interviews were audio recorded and interview notes were captured. Interviews began with the completion of a demographic questionnaire (Appendix C). Interviews were concluded when the participants indicated they had provided all information regarding their experiences with the phenomenon. I explained to participants the need to capture

experiences authentically and solicited participation in member checking of the interview transcript as well as themes after data analysis had occurred (Creswell & Creswell, 2018; Jackson et al., 2018; Lincoln & Guba, 1985, 1989; Pandey & Patnaik, 2014). Post-interview, audio recordings were transcribed and sent to participants via email to check for accuracy of information. Transcripts were adjusted based on participant feedback. Once member checking with the participant occurred, my contact information was provided to participants for any post-study concerns or questions. The participant-approved transcripts were secured in a locked file cabinet when not in use for data analysis. Electronic transcripts and email chains were stored on an external hard-drive and password protected.

Data Analysis Plan

I collected data via face-to-face or video conference, one-on-one interviews. Additionally, I used interview notes to capture nonverbal communication, bracket researcher bias, and begin to identify codes and themes in experiences (Creswell & Creswell, 2018; Jackson et al., 2018). Further, interview notes provided data for analysis should audio recording equipment fail (Creswell & Creswell, 2018).

Analysis of data followed Creswell's and Creswell's (2018) five-step process. Creswell and Creswell (2018) identified five steps to analyze data. The steps are: Organize the Data, Read the Data, Code the Data, Generate the Description and Themes, and Represent the Description and Themes.

Organize and reading the data. Organization of data included obtaining transcripts of interviews and typing interview notes (Creswell & Creswell, 2018).

Demographic data such as age and years of teaching experience (Appendix C) was analyzed and reported in narrative and table format. I read all transcripts and notes after the transcripts were validated for accuracy by participants. Reading transcripts and notes allowed an opportunity to reflect on meaning of participant experiences and to begin to make additional notes about codes and themes (Creswell & Creswell, 2018; Jackson et al., 2018). Additionally, reading all data allowed for review of discrepant and irrelevant data. Discrepant cases were included in data analysis as all data must be represented to provide rich context and thematic analysis of lived experiences of participants (Creswell & Creswell, 2018; Kleiman, 2004).

Code the data. Coding of data is the organizational process of representing larger portions of data with single words or phrases (Creswell & Creswell, 2018). The word or phrase is often generated from the language of the participant, known as *in vivo* (Creswell & Creswell, 2018). Coding of interview transcripts occurred via NVivo computer software. NVivo assisted in manual coding for easier identification of data associations and emergence of themes within and between interviews.

During coding, it is imperative to bracket researcher bias (Burkholder et al., 2016; Creswell & Creswell, 2018; Jackson et al., 2018; Pandey & Patnaik, 2014; Willis et al., 2016). During the coding process, I kept a journal to reflect on personal knowledge, previous experience, and beliefs that may be influencing data analysis (Burkholder et al., 2016; Creswell & Creswell, 2018; Jackson et al., 2018; Pandey & Patnaik, 2014; Willis et al., 2016). Additionally, I continued to read and re-read transcripts in an attempt to identify additional codes and themes (Creswell & Creswell, 2018; Ravitch & Carl, 2016).

Further, reading transcripts repetitively assisted in developing a deeper understanding of the meaning of the phenomenon and experiences of the participants.

Generate and represent the description and themes. The themes generated through coding are represented in the major findings of the study (Creswell & Creswell, 2018; Jackson et al., 2018). Themes that emerge are representative of multiple participant perspectives and experiences with the phenomenon (Creswell & Creswell, 2018; Jackson et al., 2018). A general description of the phenomenon has been generated from thematic analysis of the data (Creswell & Creswell, 2018). Specifically, thematic analysis formed complex theme connections to best inform a description of the phenomenon and participant lived experiences (Creswell & Creswell, 2018; Jackson et al., 2018). Thematic findings are conveyed in Chapter 4 via narrative passages. The discussion of findings includes specific themes that emerged during data analysis, including examples from the data to support the themes (Creswell & Creswell, 2018). Last, discussion includes interconnecting themes (Creswell & Creswell, 2018).

Issues of Trustworthiness

Qualitative research achieves rigor through trustworthiness. Trustworthiness in qualitative research is established with credibility, transferability, dependability, and confirmability (Anney, 2014; Creswell & Creswell, 2018; Fawcett & Garity, 2009; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Credibility is the confidence that the findings of the research are true while transferability is the ability of findings to have applicability in multiple contexts (Anney, 2014; Fawcett & Garity, 2009; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Dependability is the ability for the findings to be

replicated if the study were performed again as outlined in the methodology (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Last, confirmability is objective representation of findings with a reduction in researcher bias, thus representing true participant experiences (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014).

Credibility

In this study, I increased credibility of findings through adherence to methodology, triangulation, iterative questioning, debriefing and peer review, rich, thick quotes from participants, and member checks (Anney, 2014; Creswell & Creswell, 2018; Hull, 2017; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Chapter 3 outlines the methodology for the conduction of this study. A form of peer review and debriefing includes approval of Chapter 3 by dissertation doctoral-prepared committee members for alignment with descriptive phenomenological methodology (Creswell & Creswell, 2018).

Triangulation often includes multiple methods of data collection (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). However, face-to-face or video-conferenced, one-on-one interviews are appropriate methods of data collection for descriptive phenomenology studies (Burkholder et al., 2016; Creswell & Creswell, 2018). Hence, triangulation within this study was achieved through the use of interviewing of clinical faculty from multiple teaching assignment sites (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014).

Credibility was further enhanced using iterative questioning. Iterative questioning increased credibility through broad to narrow questioning while structuring questions in multiple formats to allow participants to fully relate experiences (Rubin & Rubin, 2012).

The use of rich, thick quotes enhanced credibility (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014; Patton, 2015). Additionally, debriefing with my dissertation chair and discussing my study with scholarly peers in the form of peer reviews increased credibility (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). For peer reviews to be effective, scholarly peers included colleagues who are doctoral-prepared in nursing science, but uninvolved in the current study (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Last, member checks with participants were conducted with participant review of transcripts and analyzed themes. Member checks assisted in eliminating researcher bias while accurately capturing the intent and experiences of the participants (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014).

Transferability

A unique feature of qualitative research is that it is inherently designed to have a lack of generalizability as qualitative research is a description of findings specific to a particular population or environment (Lincoln & Guba, 1985; Pandey & Panaik, 2014). However, through detailed description of methodology, sampling, participants, and sites, individuals may interpret applicability to contexts outside of a qualitative study (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Transferability was increased in this study through detailing of the methodology in Chapter 3, purposeful sampling techniques, demographic information of participants, listing the number and location of clinical teaching assignment sites, and through rich,

thick descriptions of participants' experiences with the phenomenon. Rich, thick descriptions increased external validity, or transferability, by allowing individuals to consider the findings within alternate settings, situations, or people (Lincoln & Guba, 1985; Pandey & Panaik, 2014).

Dependability

An audit trail can increase dependability in a qualitative research study (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). This dissertation document is a form of audit trail for which there is researcher oversight for accuracy and dependability in study conduction (Anney, 2014; Pandey & Patnaik, 2014). Specifically, the dissertation document outlines detailed steps to replicate the study while the dissertation process allows peer review and debriefing with committee members to establish the accuracy of findings and interpretations as supported by the data (Pandey & Patnaik, 2014).

Confirmability

Objectivity in the form of confirmability was achieved through reflexive journaling, triangulation, and audit trails (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Reflexive journaling allows a researcher to make notes concerning methodological decisions and reflect on personal biases, knowledge, and perceptions that may influence interpretation of findings (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Triangulation through the use of participants representing multiple sites increased confirmability by establishing that the findings are the participant experiences, not the reflection of researcher's background (Anney, 2014; Creswell & Creswell, 2018;

Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Last, audit trails outlined the research process from inception to completion of the study (Pandy & Patnaik, 2014). Audit trails are transparent descriptions of research processes, thus providing a form of objectivity in reflection (Pandey & Patnaik, 2014).

Ethical Procedures

Ethics in scholarly inquiry is paramount to safety of participants (Creswell & Creswell, 2018). To ensure the ethical nature of this research study, university IRB approval was obtained prior to conducting the study. Further, the ethical principles and legal responsibilities of no harm, fully informed consent, protection of privacy and confidentiality, and no deception were followed in this study (Lincoln & Guba, 1989).

No Harm

Harm occurs when participants are coerced to participate in a study, when their values are compromised to participate in a study, or when participants are denied treatment in study interventions (Lincoln & Guba, 1989). This study was non-interventional. Further, participants were selected from sites wherein power issues do not exist (Creswell & Creswell, 2018). Participants from selected sites were provided with an informational flyer (Appendix B) containing inclusion criteria, the purpose of the study, and researcher contact information. Participants could evaluate personal values and ask questions regarding the study prior to agreeing to participate. Individuals who were interested in participation were given an informed consent form outlining the benefits and risks of the study as well as the ability to leave the study at any time (Burkholder et al., 2016; Creswell & Creswell, 2018).

Participants cannot decide to join a study without full disclosure of benefits and risks (Burkholder et al., 2016; Creswell & Creswell, 2018). However, concepts of full disclosure may vary between researcher and participant (Lincoln & Guba, 1989). Therefore, determination of informed consent and approval of full disclosure statements should have oversight from an IRB. An approved informed consent document for this study from the university IRB was developed. Appendix C includes demographic data that was collected. Participants were also encouraged to seek clarification about study procedures at any time before, during, and after the study.

Individuals participating in a study have the right to privacy and confidentiality (Burkholder et al., 2016; Creswell & Creswell, 2018; Lincoln & Guba, 1989). Data from this study has been secured in a locked file cabinet when not being analyzed. Electronic data has been stored on an external hard drive and password protected. Demographic information and participant names have been stored separately from the remainder of the study data. Seven years following data collection and analysis, all paper data will be shredded, and all electronic data will be permanently deleted. Additionally, deidentified data has only been shared with participants and committee members as required for salience in the dissertation process. Knowledge of potential sharing of deidentified data in the dissertation process was shared with participants as a part of informed consent.

Truth and trust with study participants is required to solicit authentic responses to interview questions, thus informing research questions (Creswell & Creswell, 2018; Rubin & Rubin, 2012). Study participants were afforded full disclosure and transparency in this study. Participants were provided my contact information to use liberally when

questions arose regarding the study. Prior to interviews, participants were engaged in brief, professional, and respectful dialogue. Additionally, interviews were conducted in a safe, private space allowing participants one-on-one, face-to-face or video-conferenced time with the researcher to develop trust and rapport. Trust was established through clear communication, transparency with study protocols and purposes, and authentic representation of myself in the research interview (Lincoln & Guba, 1989). Despite attention to building rapport and trust, had a participant chosen to leave the study prior to its conclusion, data collected would have been destroyed and not used within data analysis.

Summary

Chapter 3 is the methodological plan for this research study. This chapter included the research design, the rationale for the methodology, the role of researcher, the plan for conducting the study, and the intent to ensure quality and rigor in the implementation of the study. Further, an outline of data analysis procedures was provided. Data analysis and findings will be discussed in Chapter 4. Chapter 4 will include detailed descriptions of participant demographics, settings of the study, how data was collected and analyzed, provision of trustworthiness, and study findings as they relate to the research questions.

Chapter 4: Results

Introduction

The purpose of this study was to explore the lived experiences of associate degree nursing program faculty in addressing student performance anxiety as it occurs in the clinical setting. More specifically, in this study I sought to describe how nursing faculty address performance anxiety while supervising and instructing associate degree nursing students in the clinical setting. The primary question that guided this research study was:

RQ: What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety?

In addition, this study addressed the following secondary research questions: How do associate degree nursing faculty define performance anxiety as seen in the clinical setting? How do associate degree nursing faculty describe their role in addressing student performance anxiety in the clinical setting? What experiences guide associate degree nursing faculty in addressing student performance anxiety in the clinical setting? What experiences guide associate degree nursing faculty clinical evaluation of students who exhibit performance anxiety?

This chapter focuses on the presentation of study data. Specifically, I provide a description of study settings, participant demographics, data collected, analysis of data, evidence of trustworthiness, and study results. Additionally, I provide a discussion of relevant findings in the context of significant literature and the conceptual framework.

Setting

The research study data were collected through interviews conducted through a mixture of face-to-face and video conference technology. One-on-one interviews were conducted with two participants face-to-face prior to a national pandemic necessitating a shift to online interviews. The unanticipated pandemic crisis led to consultation with IRB regarding needed changes to the previously approved research study. Thus, IRB approval was sought and achieved for the changes to the research protocol inclusive of the video interviews and a broadening of national participant inclusion criteria. In summary, national participants were requested to achieve data saturation in the setting of a pandemic which may have limited participation in the study as originally designed.

Following university IRB approval, individual site IRB approval was achieved at two college campuses with associate degree nursing programs located in New York state. Individual site IRB approval was forwarded to the university IRB prior to solicitation of participants. The department of nursing program leaders were then contacted via email to recruit participants from their clinical faculty pool (Appendices A & B). Similarly, New York state and national nursing organizations such as New York League for Nursing, The Council of Associate Degree Nursing in New York State, Simulation Educators of Eastern New York, and Sigma Theta Tau International, were solicited via email for participants through chapter leadership (Appendices A & B). Finally, participants were recruited via announcements of a study posted in social media sites such as LinkedIn, Instagram, and Twitter (Appendix B). Prior to starting each interview, participants were screened to ensure they met the inclusion criteria for the study.

Selected participants had the opportunity to review the study purpose, inclusion criteria, informed consent, and demographic questionnaire prior to the start of each interview. Questions and general study information were discussed with participants in advance of interviews. Written consent was obtained from each participant as well as completion of a demographic questionnaire (Appendix C). A second verbal consent was obtained prior to initiation of each interview.

Interviews were scheduled by each volunteer participant at a time convenient to their schedules. Face-to-face interviews were conducted in private locked rooms of libraries designated by the participant. Video conference interviews were conducted via Zoom software. All interviews were audio recorded. All video participants were reminded to select interview locations that would ensure privacy and security of information shared during video interviews. I ensured privacy and security of shared data on my side of the video interview by placing myself in a locked office in my home, situated in a rural neighborhood. Following the completion of each interview, audio files were immediately uploaded to a password-protected hard drive. Journal notes were then secured electronically on the hard drive and in a locked file cabinet. Field notes, demographic questionnaires, and informed consent forms were all stored in separate physical and electronic files, protected with locks and passwords, respectively. As researcher, I am the only individual with access to locks and passwords, thus further protecting sensitive data.

Demographics

The participants in this study met the inclusion criteria of working as clinical faculty members for greater than 1 year in a US associate degree nursing program. Each participant completed a demographic questionnaire (Appendix C) verifying study inclusion criteria prior to participation in the study. Other participant demographic data gathered included gender, highest level of education, specialty of education, year of graduation, continuing education, frequency of continuing education, specialty certifications, and current practice focus. Further, Appendix C included demographic data of the participant's clinical nursing students. Specifically, data included student socioeconomic, gender, age, and ethnic backgrounds. Table 1 shows the participant demographic data for this study. Table 2 shows the student demographic data for this study.

Table 1

Participant Demographics

ID	State	Gender	Years as clinical faculty	Highest level of education	Education specialty	Education completion	Continuing education format	Frequency of continuing education	Certifications	Current practice area
A	NY	F	22	MS	Informatics	2008	Webinars	Quarterly	None	OB-GYN
B	NY	F	1	MS	Leadership	2016	Online; conferences	Annually	CMSRN; WTA	None
C	NY	F	3	MS	Informatics	2015	Webinars; conferences	Monthly	RN-BC	Informatics
D	NY; NJ	F	9	DNP	Nursing education; Adult health; Pediatric NP	2017	Webinars; conferences	Annually	None	None
E	NY	F	9	MS	Nursing education	2011	Online; conferences	Annually	CNE	Psychiatry
F	NY	M	2.5	MS	Leadership	2018	Online; conferences; Current doctoral student	Monthly	CMSRN	Clinical education and supervisor
G	NY	M	6	MS	Nursing education	2016	Conferences; webinars	Biweekly	CNEcl	None
H	NY	F	35	MS	Nursing education and clinical specialist	2009	Online	Monthly	PMHNP; CNS	Psychiatry
I	NY	F	10	MS	Nursing education	2013	Webinars; conferences	Monthly	CNE	Homecare infusion; hospice
J	NY	F	7	MS	Nursing education	2019	Webinars; conferences	Annually	None	Emergency room
K	NY	F	3	MS	Nursing education	2018	Conferences; workshops	Annually	None	Home healthcare

Note. Abbreviations: ID = participant identification, NY = New York, NJ = New Jersey, MS = Master of science, DNP = Doctor of nursing practice, NP = Nurse practitioner, CMSRN = Certified medical-surgical registered nurse, WTA = Wound treatment associate, RN-BC = Registered nurse - board certified, CNE = Certified nurse educator, CNEcl = Certified academic clinical nurse educator, PMHNP = Psychiatric mental health nurse practitioner, CNS = Clinical nurse specialist

Table 2

Clinical Nursing Student Demographics

ID	SE demographic	Genders	Ages	Race
A	Middle class	Male; female	18–61+	Caucasian; Black; Asian
B	Lower class; middle class	Male; female	18–60	Caucasian; Black; Hispanic; American Indian/Alaskan Native
C	Lower class; middle class	Male; female	18–50	Caucasian; Hispanic
D	Middle class	Male; female	18–61+	Caucasian; Black; Asian; Hispanic; American Indian/Alaskan Native
E	Lower, middle, and upper class	Male; female; gender non-conforming	18–30	Caucasian; Black; Asian; Hispanic; Other
F	Lower class; middle class	Male; female	18–50	Caucasian; Black
G	Middle class; upper class	Male; female	18–40	Caucasian; Black; Asian; Hispanic
H	Middle class	Male; female; transgender; questioning	18–30	Caucasian; Black; Asian; Hispanic
I	Lower, middle, and upper class	Male; female	18–50	Caucasian; Black; Asian; Hispanic; American Indian/Alaskan Native; Other
J	Lower class; middle class	Male; female	18–50	Caucasian; Black; Asian
K	Unknown	Male; female	18–50	Caucasian; Black; Asian; Hispanic

Note. Abbreviation: SE = Socioeconomic

Participant Demographics

A unique identification letter was randomly assigned to each participant to ensure confidentiality. Access to electronic and paper participant information was password and lock protected, respectively. All demographic information was collected, labeled with a unique participant ID, and stored securely and separately from identifying information to augment participant confidentiality. All participants provided informed consent to participate voluntarily, and no employment or personal conflicts were identified in data collection and analysis that may have influenced study results.

Only participants who voluntarily agreed to participate and matched the study inclusion criteria were interviewed. Thirteen individuals requested to participate in the study. One potential participant did not meet inclusion criteria as they instructed in a baccalaureate nursing program only. One volunteer participant did not have schedule availability to participate in an interview. I explained study criteria and the need for an interview to participate in the study and thanked the individuals unable to participate for their time and interest in advancing nursing science. Eleven participants matched eligibility criteria and were interviewed. No participants left the study after agreeing to participate. Eight associate degree nursing programs were represented by the 11 participants.

Participant demographics were inclusive of nine female participants and two male participants (Table 1). Clinical nursing education experience ranged from 1 to 35 years. Ten participants reported holding master's degrees with one participant holding a doctoral degree. One participant was currently enrolled in a doctoral degree program. Graduate degree specialties included informatics, leadership, education, nurse practitioner, and clinical nurse specialist. Specifically, degree specialties included two participants holding informatics degrees, two holding leadership degrees, seven participants holding nursing education degrees of which two participants also hold nurse practitioner or clinical nurse specialist dual degrees. Graduate degree completion years are relatively recent for all participants, inclusive of 2009 to 2019. All participants teach within eight New York state associate degree nursing programs with one participant also instructing in a New Jersey program. No participants were unit-based preceptors.

Indeed, all participants were paid employee, clinical faculty members of their respective academic organization. All participants actively engaged in continuing education through face-to-face or online modalities at a frequency of biweekly to annually. Seven of the participants held national certifications in nursing practice or education areas. Last, eight participants reported holding current clinical practice positions in addition to academic teaching responsibilities.

Clinical Nursing Student Demographics

Study participants shared demographic data of an average cross-section of clinical nursing students under their instruction (Table 2). Most participants noted a mix of socioeconomic status, gender, age, and ethnic differences among associate degree nursing students. All participants did note a predominance of young, Caucasian, females of middle socioeconomic background within their clinical student cross-sections. This subjective report is consistent with demographics of nursing programs within the United States (NLN, 2018).

Data Collection

Data were collected from 11 clinical faculty from a variety of associate degree nursing programs across New York state. Selecting a smaller participant pool when conducting descriptive phenomenological studies offers a chance for more profound insights and thick, rich data involving a phenomenon (Jackson et al., 2018). One-on-one interviews were conducted via face-to-face and video conferencing technology. Interviews lasted 60-120 minutes and were conducted over a 2 month period during the spring of 2020. Participants selected for interview matched inclusion criteria of

possessing more than 1 year of clinical nursing education experience in an associate degree nursing program within the United States. While the original design of the study included solicitation in the state of New York for face-to-face interviews, the study plan was amended when a national pandemic required a broader selection pool and alternate method of data collection allowing for social distancing during study completion.

Participant recruitment began after IRB approval from individual sites and communication with key stakeholders for access to participants (Appendix A). An invitational flyer (Appendix B) was distributed through stakeholders requesting participation in the study. Interested clinical faculty members matching inclusion criteria contacted me via email expressing interest in participation in the study. Each participant was screened for matching inclusion criteria and the study was described. Informed consent and demographic information (Appendix C) were collected. At the onset of each interview, the study purpose and procedures were reviewed as well as verbal confirmation of informed consent. Additionally, the environment for interview conduction was assessed for comfort and privacy. Finally, after interview conclusion, each participant was thanked for their time, questions clarified, and plans for member checking of the transcript established. No participant was compensated for participation.

Appendix D reflects a self-developed, semistructured IRB approved interview guide used during participant interviews. The interview guide was developed to be reflective of the conceptual framework of humanism. All participants were asked the same questions from the interview guide. However, some participants were asked additional questions when relevant to exploring the lived experiences of the phenomenon

fully. Further, participants were encouraged to add any information surrounding the phenomenon to secure rich, thick data for better understanding of the lived experiences.

Interview data were captured in audio files from an external recorder, audio files from the video-conferencing technology, and in researcher hand-written notes. Audio files are stored in password protected external hard drives and written notes are secured in locked file cabinets. After interviews, the data was transcribed using NVivo software. The transcripts were secured in the same manner as electronic and written data files. After transcription, audio files on recording devices were permanently deleted while maintaining a password-protected master file on the external hard drive.

Procedure Change

Small deviations from intended methodology of the study occurred. However, deviation from methodology presented in Chapter 3 did not occur. Specific changes in original design included an intent to secure national participants and the addition of video-conference technology as a method of data collection. While the search for participants was approved by IRB and broadened to include participants across the United States, the participant pool was from New York state as originally designed. National participants were not required as data saturation was reached with participants from New York state. Data saturation was noted to occur when recurrent themes were revealed from study participants who are experienced with the phenomenon (Creswell & Creswell, 2018; Kleiman, 2004). Further, video conference technology was added when a national pandemic precluded the continuation of face-to-face interviews in the interest of safety for all participants.

Data Analysis

Analysis of data followed Creswell's and Creswell's (2018) five-step process. Creswell and Creswell (2018) identified five steps to analyze data. The steps are: Organize the Data, Read the Data, Code the Data, Generate the Description and Themes, and Represent the Description and Themes. Additionally, coding and thematic analysis were assisted with the use of NVivo software.

Organize and Reading the Data

After each interview, the audio data were transcribed utilizing NVivo transcription software. Specifically, the audio files were uploaded to a secure web platform and a transcript generated with the assistance of artificial intelligence software. The transcripts were then labeled by participant and checked for accuracy against the audio interview file. A line-by-line edit of each transcript was conducted to eliminate discrepancies between the audio file as well as remove identifying information inadvertently shared by select participants. The editing process was conducted twice for each interview transcript to ensure accurate capture of data. At the completion of editing, transcripts were shared with participants for member checking. After establishing accuracy, the completed transcripts were uploaded to NVivo software to facilitate coding and thematic analysis.

In addition to transcript generation, interview notes were typed and loaded into NVivo software to facilitate coding and analysis of data. Further, demographic questionnaires were also uploaded to the NVivo platform. Placing transcripts, notes, and

demographic data into NVivo software allowed for ease of data analysis while securing a deeper meaning of participant experiences with the phenomenon.

Code the Data

Coding and thematic analysis occurred simultaneously with transcription and editing within the NVivo software platform. As each interview was concluded and transcription generated, data analysis in the form of coding and theme generation occurred. Each transcript was coded independently as well as comparatively with subsequent interviews. After reading transcripts and notes several times to ascertain a general sense of the data, manual coding for easier identification of data associations and emergence of themes within and between interviews occurred within the NVivo software program. The use of software allowed organization of larger points of data to be represented in single words or phrases (Creswell & Creswell, 2018).

In addition to coding within NVivo, I kept a reflective journal to bracket biases within personal knowledge and experiences that may influence data analysis (Burkholder et al., 2016; Creswell & Creswell, 2018; Jackson et al., 2018; Pandey & Patnaik, 2014; Willis et al., 2016). As reflective journaling continued, reading of the data continued to identify additional codes and themes (Creswell & Creswell, 2018; Ravitch & Carl, 2016). Through repetitive reading, a deeper understanding of the meaning of the phenomenon and participant experiences was achieved.

Generate and Represent the Description and Themes

Emergence of themes in the data occurred with inductive coding. Smaller, coded units were evaluated for larger, emerging themes throughout the data analysis process

(Creswell & Creswell, 2018). Developing themes was a result of data and codes generated from multiple participant perspectives and experiences with the phenomenon (Creswell & Creswell, 2018; Jackson et al., 2018). As multiple perspectives demonstrated similar codes and themes, data saturation was reached after the 11th interview and the study was closed to participants. Themes were then organized to address the research questions of the study and convey the lived experiences of the phenomenon, as noted in the results section of this chapter. Last, discussion of the interpretation of the data will occur in Chapter 5.

Multiple themes emerged during data analysis. Specifically, themes included the quality of the clinical environment, the philosophies and behaviors of clinical nursing faculty, and the philosophies and behaviors of the clinical nursing student. Further, subthemes emerged including interactions with healthcare professionals, previous experiences, preparation, evaluation methods, communication, and relationships.

Discrepant cases were not identified, although lived experiences did vary among participants. All data were reviewed with the use of Creswell's and Creswell's (2018) five-step process. Themes emerged and were extracted based on participant reports of their lived experiences with student performance anxiety in clinical nursing education. As participant accounts are reflected of their personal experiences, no discrepant cases were noted.

Evidence of Trustworthiness

Qualitative research achieves rigor through trustworthiness. Trustworthiness in qualitative research is established with credibility, transferability, dependability, and

confirmability (Anney, 2014; Creswell & Creswell, 2018; Fawcett & Garity, 2009; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Credibility is the confidence that the findings of the research are true while transferability is the ability of findings to have applicability in multiple contexts (Anney, 2014; Fawcett & Garity, 2009; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Dependability is the ability of the findings to be replicated if the study were performed again as outlined in the methodology (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Last, confirmability is objective representation of findings with a reduction in researcher bias, thus representing true participant experience (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014).

Credibility

In this study, I increased credibility of findings through adherence to methodology, triangulation, iterative questioning, debriefing and peer review, use of rich, thick quotes from participants, and member checks (Anney, 2014; Creswell & Creswell, 2018; Hull, 2017; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). A form of peer review and debriefing includes approval of the study methodology by dissertation doctoral-prepared committee members for alignment with descriptive phenomenological methodology (Creswell & Creswell, 2018). Study procedures did not deviate from the approved methodology processes outlined in Chapter 3.

Triangulation often includes multiple methods of data collection (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). However, face-to-face or video conference, one-on-one interviews are appropriate methods of data collection for descriptive phenomenology studies (Burkholder et al., 2016; Creswell &

Creswell, 2018). Hence, triangulation within this study was achieved through the use of interviewing of clinical faculty from multiple teaching assignment sites via face-to-face and video conference interviews (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014).

Two audio files were made of each interview, one via digital recorder and one via secondary digital recorder or video-conferencing software. The secondary audio file was captured in the event the first method of recording the interview failed. Both recordings were conducted simultaneously, and the participants were made aware of the recording procedures and devices. Further, the participants were notified of the security and confidentiality of the collected data. The audio files were used to generate typed transcripts for data analysis. Similarly, I kept notes during the interview to further capture the lived experiences of the participants, bracket bias, and allow for additional questions as warranted. Notes were then typed and uploaded to NVivo software for data analysis with transcripts.

Credibility was further enhanced through the use of iterative questioning. The interview guide (Appendix D) proposed broad to narrow questioning while structuring questions in multiple formats to allow participants to fully relate experiences (Rubin & Rubin, 2012). The use of rich, thick quotes enhanced credibility and are included in the results section of this chapter (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014; Patton, 2015). Additionally, I debriefed during the interview process with my dissertation chair and discussed my study with doctorate-prepared peers in the form of peer reviews (Anney, 2014; Creswell & Creswell, 2018;

Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Last, member checks with participants were conducted with participant review of transcripts and analyzed themes.

Transferability

Transferability was increased in this study through detailing of and adherence to the methodology in Chapter 3, purposeful sampling techniques, demographic information of participants, and listing the number and location of clinical teaching sites. Study details provided allow other researchers the opportunity to replicate study protocols for the purpose of generating results applicable in additional contexts. Further, transferability is increased through rich, thick descriptions of participants' experiences with the phenomenon, as noted in the results sections of this chapter. Rich, thick descriptions increased external validity, or transferability, by allowing individuals to consider the findings within alternate settings, situations, or people (Lincoln & Guba, 1985; Pandey & Panaik, 2014).

Dependability

This dissertation document is a form of audit trail for which there is researcher oversight for accuracy and dependability in study conduction (Anney, 2014; Pandey & Patnaik, 2014). Specifically, the dissertation document outlines detailed steps to replicate the study while the dissertation process allows peer review and debriefing with committee members to establish the accuracy of findings and interpretations as supported by the data (Pandey & Patnaik, 2014). Further, participants were associated with multiple programs of nursing across the state of New York and data collected was constantly compared, thus achieving triangulation and dependable results.

Confirmability

Objectivity in the form of confirmability was achieved through reflexive journaling, triangulation, and audit trails (Anney, 2014; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Triangulation through the use of participants representing multiple sites increased confirmability by establishing that the findings are the participant experiences, not the reflection of the researcher's background (Anney, 2014; Creswell & Creswell, 2018; Lincoln & Guba, 1985; Pandey & Patnaik, 2014). Last, audit trails outlined the research process from inception to completion of the study allowing for objectivity in reflection (Pandy & Patnaik, 2014).

Results

The primary purpose of this study was to explore the lived experiences of associate degree nursing faculty in addressing performance anxiety as it occurs in the clinical setting. More specifically, this study describes how nursing faculty address performance anxiety while supervising and instructing associate degree nursing students in the clinical setting.

The primary question which guided this research study was:

RQ: What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety?

In addition, this study addressed the following secondary research questions: How do associate degree nursing faculty define performance anxiety as seen in the clinical setting? How do associate degree nursing faculty describe their role in addressing student performance anxiety in the clinical setting? What experiences guide

associate degree nursing faculty in addressing student performance anxiety in the clinical setting? What experiences guide associate degree nursing faculty clinical evaluation of students who exhibit performance anxiety?

Extensive coding and thematic analysis led to three major themes and six subthemes within the research data. Specifically, the main themes included (a) quality of the clinical environment, (b) philosophies and behaviors of clinical nursing faculty, and (c) philosophies and behaviors of the clinical nursing student. Within the major themes, subthemes include (a) interactions with healthcare professionals, (b) previous experiences, (c) preparation, (d) evaluation methods, (e) communication, and (f) relationships. Subthemes are discussed in the context of major themes within this study. While data is narratively presented by theme, Table 3 displays the relationship of research questions, themes, and subthemes.

Table 3

Relationship of Research Questions, Themes, and Subthemes

Research question	Related theme	Related subtheme
What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety?	Quality of the clinical environment Philosophies & behaviors of clinical nursing faculty Philosophies & behaviors of the clinical nursing student	Interactions with healthcare professionals Previous experiences Preparation Evaluation methods Communication Relationships
How do associate degree nursing faculty define performance anxiety as seen in the clinical setting?	Philosophies & behaviors of clinical nursing faculty Philosophies & behaviors of the clinical nursing student	Previous experiences Preparation Evaluation methods Communication Relationships
How do associate degree nursing faculty describe their role in addressing student performance anxiety in the clinical setting?	Quality of the clinical environment Philosophies & behaviors of clinical nursing faculty	Interactions with healthcare professionals Previous experiences Preparation Evaluation methods Communication Relationships
What experiences guide associate degree nursing faculty in addressing student performance anxiety in the clinical setting?	Quality of the clinical environment Philosophies & behaviors of clinical nursing faculty Philosophies & behaviors of the clinical nursing student	Interactions with healthcare professionals Previous experiences Preparation Evaluation methods Communication Relationships
What experiences guide associate degree nursing faculty clinical evaluation of students who exhibit performance anxiety?	Philosophies & behaviors of clinical nursing faculty Philosophies & behaviors of the clinical nursing student	Previous experiences Preparation Evaluation methods Communication Relationships

Quality of the Clinical Environment

The natural world of a learner can influence the level of performance anxiety and sense of worth of the learner (Purdy, 1997; Rogers, 1951, 1974). The quality of a nursing clinical environment can be integral in development of lifelong learning behaviors as well as a sense of self as a professional (Purdy, 1997; Rogers, 1974). In this study,

participants described clinical nursing environments and their effect on development of performance anxiety in associate degree nursing students. Several participants noted increased performance anxiety in students for a first experience in a new clinical environment and when a negative interaction with other healthcare professionals in the environment occurred. Conversely, clinical nursing faculty noted a decrease in performance anxiety when the faculty member had a known relationship with staff of the clinical unit and when positive interactions occurred with other healthcare professionals.

Interactions with Healthcare Professionals

Learning as a student can be negatively or positively influenced by interactions with members of the healthcare team (Burkley, 2018; Harrison-White & Owens, 2018; Koharchik, 2018; Thomas, 2017; Tolbert-Washington, 2009). Specifically, interactions with healthcare professionals in the clinical learning environment can affect levels of performance anxiety. Participants of the study provided several examples of experiences with healthcare professionals negatively influencing learning in the clinical environment.

For example, Participant A described the behaviors of reluctant staff in mentoring clinical nursing students. Specifically, Participant A reported the need to adjust clinical assignments based on behaviors of other healthcare professionals. As stated by Participant A, “There have been staff that have been like they don't like they're not particularly thrilled to have a student.” Clarifying, Participant A added,

> You know, they have like an air about them and they're kind of like. I mean, they'll take them reluctantly because, you know, that's their... It's a teaching hospital. And they really, you know, they don't really have a choice. But like

> sometimes the staff will be like, you know, they'll not embrace the... they'll leave the students out of things like they'll go in the room to do something without them.

Participant A continued on animatedly. Elaborating further, Participant A provided an example of interactions with one particular provider. Participant A continued to share,

> But like, there are some staff that, you know, are not necessarily nice to students. And I try not to put students with them. There are other options. But, so, I try to like, I don't want to put the students in a bad situation. We had a doctor at one point, and she was not nice. She wasn't always nice. Wasn't nice to the staff or students. And I tried to avoid her. So, it's like you kind of have to… I try to avoid it, like if I know what's going to be negative. But like, I can't protect them from everything.

Similarly, Participant C described negative interactions with members of the healthcare team and the need to intervene on behalf of clinical nursing students. Indeed, Participant C explained a need to speak with some staff directly when perceptions of negative interactions occurred between a learner and staff member. In a comment similar to those of Participant A, Participant C stated, "You know, sometimes there really is an issue with a staff member, sometimes a staff member is just having a bad day. You know, and I have talked to the staff and I'm like, what's going on, man?"

When asked to describe interactions with healthcare professionals in the clinical learning environment and their effect on students, Participant G reported a specific

complication with students interacting with medical doctors versus other healthcare team members. Positive interactions with physical and occupational therapists were observed by Participant G. However, negative interactions with doctors allowed Participant G to observe increased anxiety in clinical nursing students. As reported by Participant G during an online interview,

> You do have those 10% who don't like working with the students or the students who are just terrified to talk to anybody. We've seen that. So, there is a lot of anxiety when it comes to interacting with a provider. The providers. That's a different story, especially if you're a physician. Nursing students, as you well know, I'm sure are terrified to call the doctor. Who else PT, OT, the students really do not have anxiety around interacting with them. It's just the providers.

Describing a different approach in an alternate clinical setting, Participant H described a significant difference in clinical learning environments from those which consider students the primary caregiver of the patient and those that consider their staff to be specialized experts with students as passive observers. Further, Participant H shared a difference in student-staff interactions when the clinical nursing instructor was known to the staff on the unit. Specifically, learning was positively influenced when the instructor was known to staff. As explained by Participant H,

> I think interactions are variable depending on who you're working with and also the instructor's relationships with the staff. And then of course, the instructor's experience. Students on mental health. They often use students as an extra help, extra set of hands. Observational students have often commented to me on mental

> health that it seems like the nurses aren't out with the patients as much. It's absolutely true, because when students are there on mental health, the mental health nurses let the students do the primary interaction and then ask the students, what's your experiences? And they actually take that information from them. Now, I noticed in OB, it's not like that at all. Maternity postpartum, anti-partum, they're much more… The nurse is in charge of that patient and the student is I don't want to say a tag-a-long or observer, but the student is an ancillary person. They're not the primary person, from my perspective. If you go to medical-surgical units, once again, the students are primary caretakers of the patients and are treated that way by staff. From my perspective, of course, it depends on the staff member, and the staff member's comfort with whatever area they're working in, because if you know, if I was put on like a cardiac floor, I'm sure my lack of knowledge would show through and perhaps the staff wouldn't be as open to my students.

Similar thoughts reinforcing the theme of quality of the nursing environment were reinforced by Participant J. As reported by Participant J, "You're always going to have some somebody that's not welcoming, you know, somebody that is like, no, just move out of the way. Get out of the way. Sometimes the nurses will say that." Participant K also noted the occurrence of negative influences in the clinical learning environment but offered potential influencing factors to such behavior from nursing staff. Specifically, Participant K relayed system deficits that could influence nurse-to-student interactions in the learning environment. Participant K shared this experience, "When the nurses get

really stressed out or overwhelmed, I think they definitely lose their patience and they're not always as receptive to students in particular. But usually it is just the more stressed out and understaffed the unit is."

Relationships

Not all interactions with healthcare professionals are described as negative in nature, however. Several participants reported positive interactions with healthcare team members. Moreover, most positive interactions were noted when the clinical nursing faculty member was known to the healthcare team through previous or current employment relationships. Indeed, Participant B stated, "I work on the unit that I teach; which I think I'm hoping helps them." Sharing further, Participant B revealed,

> And I think that our nursing, our floor is very used to having nursing clinical both from where I teach through and other colleges throughout the area. And there's always people on the floor as the semester gets up and going. So, we're used to that. And I think for the most part, then the nurses on our floor want to support the learning of our students.

Participant J relayed a similar experience as a former employee. A known relationship influences levels of trust from staff, thus increasing the positivity of the learning environment. In particular, Participant J is known to current staff from a previous working relationship. Explaining the effect of prior relationships, Participant J shared, "When I first started out as an adjunct, the floor I had gone on was my first floor. So, it was it's [was] very nice. You know, it's very nice because they know me. They trust me, too, which is nice."

According to Participant C, the learning environment for students is positively influenced by known relationships between instructors and nursing unit staff. In particular, known staff relationships allowed Participant C to experience increased levels of trust as a nursing instructor. The increased trust allowed for increased student learning opportunities with staff. As shared by Participant C,

> And also, it was the floor that I kind of grew up on in the hospital before I took my full-time nursing informatics job. So, all the staff is really comfortable with me. And so, the director is really comfortable with me. So, it makes it a little bit easier for the students and for just for the situation and clinical because I'm very familiar with everything. So, I think it puts them at ease because I'm familiar.

Expanding on her experience, Participant C further reported that, "Some of the staff like look forward to when they show up and they're smiling. Oh, my gosh, your students are coming today, and they get really excited about it." Continuing on in a description of her experiences within the subtheme of *relationships*, Participant C reported an increase in student learning opportunities connected to positive relationships with staff. In particular, positive relationships with staff allow for learning opportunities for students that may otherwise be rarely offered. Explaining the experience, Participant C shared,

> And the more relationships you build with the nurses that are there, you know, the more they're gonna pull you in for things that are exciting. Like if something happens and like a patient ends up like in pulmonary edema or ending up having to go on telemetry, like we had a patient once who had had a bedside echo, like

those things are all very exciting. You don't normally see stuff like that. And the nurses are like, OK, where are your students, come in and bring them in the room and they get really excited to do that kind of stuff.

Building on the subtheme of *relationships*, Participant D discussed the influence of a previous working relationship on staff interactions with students. In doing so, Participant D noted graduates of the program she academically instructs for are current professional staff within the clinical learning environment. Recognizing that this previous relationship positively influences student-staff interactions, Participant D stated, "I had previously worked at [the hospital] many years ago. A lot of the same employees were still there; the same professionals. They were happy to have me back and have the students. The collaboration was very nice."

Elaborating on her experiences further, Participant D stated, "Most of the staff there were graduates of this particular school of nursing because that particular school of nursing was affiliated with the hospital. I think there was that camaraderie in that connection." Participant D also noted a distinction with age of the staff. Specifically, Participant D reported a more positive experience with those staff of a younger generation. Sharing her experience further, Participant D stated, "So, a lot of the staff were younger staff members, and they did have that connection. They took the students under their wings. And they were very good with those students."

Relaying similar experiences to those of Participant D, Participant I noted the positive influence of previous students being current healthcare professionals within the unit of academic instruction. Participant I is employed by a hospital-based nursing

program and notes the faculty role within the same healthcare system is beneficial to establishing a positive working relationship with staff. Specifically, the staff know that a positive learning experience for the students translates to positive work relationships in the future with the students when they transition to graduate nurses on the unit. As reported by Participant I,

> Our situation as faculty members at this hospital is helpful because if you have been around for a while, people start to know you because our graduates go to work there. So, we're a hospital-based program. So, you know, I would say 50 percent of the employees on any unit I've taught.

Similar to other study participants, Participant E believed a long-standing work relationship on several units within the clinical learning environment positively influenced the learning environment for students. As staff became familiar with her presence and work ethic, student experiences on those units improved. Specifically, clinical nursing students associated with Participant E were welcomed and afforded learning opportunities. Participant E offered the following statement to support her experience,

> Yes, I worked float pool for a while at the hospital, so I'd go to that floor and other floors and I've worked at the hospital in general for, oh, my gosh, 20 years or more either as full-time or per-diem. The staff all know me and welcome my students.

Participant H shared her feelings regarding clinical nursing faculty background and development. In particular, Participant H felt the clinical learning environment to be

positively influenced through an understanding of the unit culture. In order to learn the culture, Participant H believed the need for clinical nursing faculty to work on the unit within which they instruct academically. For example, Participant H stated, “And I think it’s very, very helpful to have clinical staff, to have the clinical staff be very familiar with the unit. The best way to really know the culture of a place is to work there.”

While noting the positive influence of previous relationships on current learning environments, Participant K relayed a distinction in type of relationship. Most participants noted a direct working relationship with unit staff. In contrast, Participant K spoke of an indirect working relationship that still positively influenced student learning experiences and interactions with staff. Thus, in contrast Participant K reported that,

> I did not work there, but my clinical background is home healthcare. So, for 5 years prior to teaching, I worked for a home healthcare agency. One of my roles was a nurse liaison, so I would go to that [clinical teaching] unit to coordinate referrals and patients that were being discharged home. So, I did know the providers, the staff, nurses, unit clerk and the discharge planners [before teaching].

Despite reports of positive *relationships* among staff, some participants did note a negative difference in healthcare professionals’ interactions with students and with the clinical nursing faculty themselves based on prior relationships. Negative professional interactions were noted to affect student learning opportunities, thus potentially raising performance anxiety in the learner. Providing a relevant example, Participant A recounted a previous working relationship within the unit of academic instruction.

Having taken some time away from clinical practice at the hospital, Participant A returned as a clinical nursing faculty. In her hiatus, some staff changes occurred. Participant A shared her experiences with staff after her absence. Further, Participant A described a lack of trust influencing the instructional environment. As reported by Participant A,

> Now some of the staff don't know me and don't know my abilities. And like they're like it, like some of the older staff, like, you know, they're like when I'm there, they're like, oh my God, we love when you're here. And some of the newer staff who don't even know me like that, not that they don't trust me. But they have to develop a trust with me before they'll let me do certain things, because I'd be like, oh, we got this, we'll do it. And they're kind of like, no, no, we'll do it. I'm like, no, no, no. So, I feel like over the years that I stopped working there for like the past - what has it been? About 14 years now? Like, I know. So, like it will be 14 years. Yeah. Yeah. So, I guess 13 years because I stayed a little while. But, you know, the staff don't know me as much, but now I'm going to be going back to work per diem there. So, I think that it might change that a little bit because they're gonna know me again.

Participant D had experience clinically instructing at a hospital for which she worked and a hospital for which she did not work. She instructed at a facility for which she was an employee for several years. After relocating to a new state to an area she noted to be significantly more affluent than her previous location, Participant D described

a less than welcoming attitude amongst staff at the new facility of instruction. In comparing the experiences, Participant D shared,

> One of the groups of students was at a hospital and I found that I had I didn't have any experience in this hospital whatsoever. And I noticed…that because there wasn't that connection at all. I noticed that the employees, that the staff members, the nurses were not working as a whole…were not as welcoming.

Similarly, Participant J provided periodic coverage for a colleague as a clinical nursing faculty. Normally, Participant J clinically instructed on a unit for which she was known to the staff. However, she would periodically substitute for other instructors on their assigned units of academic instruction. In these moments of coverage, Participant J experienced negative interactions with staff that can affect student learning. Indeed, the interactions were so vivid, Participant J contemplated an investigation into whether the staff behavior with students was typical and if the site should be continued to be used for clinical learning. In reflection on those per diem experiences, Participant J relayed the following:

> I subbed at a different hospital, a different hospital on a unit…. So, it was a completely different hospital than what I was used to. And I did not feel the welcome. It was more I honestly felt like we were a burden. That wasn't encouraging to me because I feared that that was happening on a daily basis and it kind of discouraged me from wanting the students to go there. And it was only like particular nurses, you know, how it goes, how some nurses were very welcoming, but others were like, nope, I don't have any patients for you. And I

> was like, I know you do. You know, like you can at least give me two. You have a full assignment. I know you at least have two for us. It was challenging, you know, it was a challenging four hours just because it felt uncomfortable for me too because I didn't know who I could go to as a resource necessarily because I was new to the unit and new to the hospital. And I just didn't have that welcome feeling when we first walked on, so…. And there were a couple of nurses that they [the students] were like, I don't want to be with that one, you know.

In summary, participants describe experiences with healthcare professionals that influence clinical nursing student learning and level of performance anxiety. Despite positive interactions influenced by faculty members' known relationships at clinical learning sites, negative interactions with other members of the healthcare team can lead to increased demonstrations of performance anxiety and inhibitory learning. It appears negative experiences happen less frequently with a relationship between the faculty member and the team on the clinical unit, however, influences such as staffing levels, work culture, and general staff personality attributes may increase the occurrence of negative staff to student interaction. Performance anxiety developed in an unsupportive clinical environment can inhibit theoretical knowledge transfer to clinical practice (Horsley, 2012; Tolbert-Washington, 2009). Open communication and supportive caring of nursing students in the clinical setting by all healthcare partners is the ideal learning environment wherein less anxiety may be experienced (Burkley, 2018; Tolbert-Washington, 2009).

Philosophies and Behaviors of Clinical Nursing Faculty

Perceptions by students of a negative attitude or judgment from clinical nursing faculty increases poor student performance and a reduction in learning (Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2013; Kleehammer et al., 1990). Further, perceived positions of power of the faculty member over the student, whether the physical location of the faculty member during moments of evaluation or from a sense of faculty knowledge level, authority, and research abilities, can decrease a student's clinical confidence and increase performance anxiety (Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2013; Tolbert-Washington, 2009). The natural world of the student can be positively influenced, thus reducing the potential for performance anxiety, through attention to the creation of an empathetic and caring faculty-student relationship, communicating effectively, and incorporation of subjective experiences in outcome evaluation so as to support cognitive, affective, and psychomotor learning modalities (Carter, 2018; Chaube, 2013; Harrison-White & Owens, 2018; Kleehammer et al., 1990; Moscaritolo, 2009; Rogers, 1974a, 1974b; Thomas, 2017). Interviews with participants produced data inclusive for subthemes of communication techniques, development of relationships, evaluation methods, and previous experiences that influence their philosophies and behaviors as clinical nursing faculty.

Communication

Open communication was noted to being integral to support a caring learning environment as well as mitigate performance anxiety. Communication of faculty expectations was a predominate data finding. Additionally, several participants noted a

need to receive reciprocal communication from students in relation to clinical experiences and expectations of faculty behavior. In this way, faculty found it valuable to manage expectations and reduce anxiety surrounding the clinical experience. Further, when anxiety producing moments in clinical learning occurred, participants reported a need to communicate compassionately and simply to facilitate positive learning and student performance in the moment.

In describing communication with students, Participant A described humanistic philosophies. In particular, Participant A noted a need to connect with students and understand their perspective as well as a need to support a student holistically. Communication to students with themes of support as a faculty member were described as important to Participant A during instructional moments. In description of experiences supporting the theme of *communication*, Participant A described the following:

> I reassure them that what they did was the correct thing. I know you're scared. I know you're nervous. I said, but you'll be fine. I said, there's nothing to be scared about. They're all looking at me. Like I said, trust me. Trust me. And so, like, I will be right with you when you do your assessment for the first time. Once you develop a comfort level, if you want to do your assessment on your own, and I've already watched you do it, then that's fine. I said, but I will be with you. I say I always assure them that I will be with them or a nurse will be with them, that they're not flying blind, you know. So, I feel like, you know, like I said, I'm a hands-on instructor. So, I feel like my job is to instruct them.
>
> .

In a continuation, Participant A described experiences supporting the theme of *philosophies and behaviors of clinical nursing faculty.* Specifically, Participant A described *communication* with students during educational moments that induce anxiety and how she attempts to alleviate that anxiety in order to positively affect learning. Further, she describes the communication she has with students imparting upon them her instructional strategies for their learning support. Participant A relayed during a face-to-face interview her communication with students,

> So, I try to like, you know, alleviate their anxiety. I know they're nervous about something before we go into a room, like if they're going in to do a postpartum assessment for the first time, before we go in, I say, OK, let's talk through what you're going to go in and do. So, we kind of like, you know, go through the steps of, you know, the assessment from head to toe, like, you know, we talk it out loud. And then when we're in there and they're doing it. But we always talk about it before we go in. Like when they're giving a shot for the first time. I'll stand right in the med room and I say to them, OK, fine. So, we'll go through it. I'll have them show me on me where they're gonna…where the landmarks are; how they're gonna find their spot. And we kind of go through the technique that they're gonna use before they go into the room. I also tell them, too, even from the get-go; I say I'm a very hands-on instructor. I'll be right there at the bedside with you. I'm not the type of instructor that's going to sit back with a clipboard going, yep, you did that right. You did that wrong. So, I do tell them that. I said, that's not my style. I said, I'm going to be right there with my hands on, you

> know, helping you, guiding you through. I'm not going to just sit there and watch it and go, you know, did that wrong, did that right. That's not, that's not... that's intimidating.

Relaying a similar *communication* experience with students, Participant B shared the need to instill trust and confidence in students she instructs. Further, she found it important to have open *communication* to decrease anxiety. Participant B described her experiences, "I make sure that they're understanding that I understand things that they might be concerned about. I feel that increased communication is always better than you know getting the wrong message and going forward with the wrong message." Further, Participant B described the type of communication used in clinical instruction to positively influence experiences. Communication was noted to be reciprocal in nature. Participant B described her philosophy of seeking learner feedback and expectations, "I want to be the instructor that helps students reach their goals of clinical. What do you expect out of clinical this semester? I get their journals. I can find out what they expect so we can work on that." Despite her new role as a clinical nursing faculty member, Participant B continued to elaborate on her experiences, guided by her philosophies. Specifically, Participant B described,

> I always want to have a positive environment and feedback. Oh, this is you know, this is a good thing that you did. And, you know, like, if I want to give criticism, what did they call it? Sandwich. Sandwich? Yeah. See, I don't have a nursing education background. So, I'm sort of learning those terms. You know, and always preface it with the good thing, then the bad thing and then reinforce the

> good thing. And you know what we can do in the future to make that happen. I think that this semester the students have higher expectations and that they verbalized their higher expectations of the school in general. And I think that's healthy, too, because we need to know what's expected of us and not just have it written down in our learning objectives, but really be able to deliver that.

In similar experiences, Participant C described a learning environment devised to encourage open communication between the instructor and the student in order to positively influence learning. Specifically, Participant C felt open communication and establishing expectations for all parties was critical to successful relationships and learning. Furthering an explanation of the subtheme of *communication*, Participant C stated,

> And I always tell them, you know, please feel very comfortable with me if you have any issues with any of the staff on the floor, because I have no problem speaking to the director about issues there. I want them to be comfortable and I want them to feel like they can come to me with questions and I want them to know that I want them to get the most out of their experience. And so, I don't want them to be afraid to come and talk to me about things that I want them to be afraid to make a mistake in front of me, because you know what? I'll even tell them stories about when I when I was a new nurse or when I was [a] student and how I didn't know this or that. And, you know, if you're afraid to ask questions like, you know, I tell them I know a lot of things I haven't been up on top of for a

> long time that I ask questions every single day about. So please don't ever be afraid. So, I just want them to be comfortable.

Sharing her lived experience, Participant C became more animated. She believed her role as an instructor was to communicate expectations of students as well as ascertain their expectations of her. Leaning forward in the interview, Participant C detailed her experience with reciprocal communication,

> I mean, I think the most important thing that I always try to do is on day one to establish expectations for them and so expectations of what I'm expecting from them and what they want from me. That way, if something happens, if either side's expectations aren't met, there is some sort of a line in the sand.

Sharing similar experiences with student anxiety, Participant C further explained her philosophies of instructor behavior when encountering anxiety in clinical learning. Participant C explains the need to recognize the learner anxiety, guide them to resources, and facilitate learning. Further, she denoted the need to relieve student anxiety so as not to translate that anxiety to patients they are caring for. Participant C shared her experiences,

> So, I say, ok, let's take a step back maybe and talk about what is making you nervous about this? Like, is it the fact that you're giving an injection, is it the fact that you're putting in a catheter? Are you not comfortable with that? OK, let's pull the policies and procedures and see if we can get you a little more comfortable with this. So, I try not to let them walk into the room, looking anxious because that anxiety the patient can see it and then the patient is gonna be

> anxious, you know. So, we try to I try to talk through every single thing that they do.

Supporting the theme of *philosophies and behaviors of the clinical nursing faculty* further, Participant C shared her beliefs that instructors should be transparent in their communication and relationship with students. Specifically, instructors are not required to be omnipotent, but are required to guide learning. As part of that guidance, Participant C shared her experience with transparency in seeking information as a novice or experience nurse. Details of Participant C's humanistic approach were provided during the face-to-face interview where the following experience was shared,

> Sometimes as they ask me questions, I don't ever make it up. I go, I don't know. So, I would say I don't know. But let's find it out together or let's figure out who we can call it or let's find our resources. You know, because I don't want them to ever think that, like one person knows everything. So, it's like nice for me to say I don't know everything, and I've worked as a nurse for 15 years and I don't know everything, you know.

Participant E described a similar instructional and communication style as Participant C. In particular, the use of open communication and reciprocal sharing of expectations were echoed by Participant E and support the subtheme of *communication*. Like Participant C, Participant E also noted a need to apply humanistic principles and maintain transparency with learners in order to positively affect learning. As shared by Participant E,

> There's a pretty open flow of communication between all of us. I always explain my expectations of them and from them. Making sure that they understood that I don't need them to do it my way. I just wanted to let them know where I stood and then learning from them what their expectations and styles were. By the end of it, they felt more confident about their own skills because they were allowed to grow them, not just carry out the tasks that I was dictating at them.

Becoming more animated, Participant E excitedly shared, "It [communication] can't be punitive in a way that makes them feel they totally screwed up because they're not going to talk and they're not going to observe it. They're going to be too afraid of me yelling at them." Explaining how she remains transparent with students and involves them in the process, Participant E continued, "So, I really try to make it that interactive process; like we can talk about the things that could go wrong or went wrong and how we can change it going forward." In this manner, Participant E relayed that anxiety decreased and student learning increased. In support of the learner, Participant E found that learning was retained and applied to future clinical performance.

Participant D gladly shared her experiences with *communication* and how those experiences shaped her behaviors and philosophies as a clinical nursing faculty member. Specifically, Participant D established expectations for students to meet in order to be successful. She relayed establishing expectations, supporting students to be successful with those expectations, and communication with students when expectations are not met in order to influence positive and non-punitive growth. Participant D shared her expectations, "I expected the students to participate in the unit as well. They integrated

themselves and that was my expectation for them. They were asking, what can I do to help?" Much the same as Participant C, Participant D also believed in facilitating learning by guiding students to resources. Participant D stated, "I'm giving you this piece of information. Now go and investigate. You know, this is what you need to do. And then when you get the answer, come on back and we'll talk it through." Last, Participant D shared how she supports, but does not embarrass, students when a clinical learning opportunity does not go as previously planned, "And whenever I do have to talk to a student, I do. I do pull them aside. I do not ever criticize students in front of other students. I do remember students telling me that it embarrasses them."

Student perceptions of instructors can influence communication. For example, Participant G described overcoming students' preconceived notions about him as an instructor. Illustrating his point, Participant G stated, "I have a reputation for being... the students are afraid of me and I'm not sure why." Further, he distinguished between everyday communication and when he has to become firmer and directive. Specifically, communication changes when students do not meet expectations. Participant G elaborated, "I set my expectations on the very first day. The only time that I become very firm and directive is when you don't come prepared. You're late for no good reason. Or you don't know your meds." In contrast, Participant G described soliciting the needs of students in order to assist them in being successful, "I also solicit my own feedback. If there's something that the students need to share with me…that it's a teachable moment and not punitive; an opportunity for punishment by the instructor."

Much like other participants, Participant H noted a need to set clear expectations with students but leave opportunity for students to make errors safely in the interest of their learning. Participant H believed this could be achieved in a humanistic manner and shared her experiences in clinical nursing education. Describing the support she provides to students, Participant H shared,

> I think we have to be very clear about what our expectations are for students. I tell people you're going to make mistakes. I mean, that's you know, you're a student. It sounds like a cliché, but it's true. They are students, they are going to make mistakes. That's why they're here, because they are not graduates yet, you know. You know, I expect to keep the expectations high, but make them very clear. I say this to them every year. I say, you wouldn't be here if you weren't capable of being here. You were chosen to be in this program for a reason. You've got the ability. So, we're going to help you be successful. You've got to do the work. But we aren't going to give up on you. We will give you another opportunity.

Beginning to speak more animatedly, Participant H continued on to discuss other factors influencing her communication with students. Specifically, Participant H believed the power dynamic between instructors and students influences communication. Student perceptions of instructor power influence communication in the reciprocal learning relationship. Further, Participant H believed this power dynamic may influence future relationships in the workplace. As Participant H explained,

> I feel that their ability to communicate with someone who they may perceive as being an authority is [a] very, very important skill, because throughout their

> career, if they feel intimidated by their instructor, they will feel intimidated by their charge nurse or the doctor in charge or their administrators. So, they have to be able to feel comfortable dealing with people who have more power over them. I mean, let's be real, instructors do carry a lot of power due to their status and due to the roles.

Additionally, Participant H described the environment she creates to deliver feedback to students. She desired to create a non-punitive, non-threatening environment in order to maximize learning and minimize anxiety. Participant H described her philosophies and behaviors with feedback. She said,

> I really feel strongly about not giving feedback to people in front of other students. I talk to them, you know, I talk to them separately. I'll just say, oh, I noticed you, you know, I noticed you've been, you know, not out on the floor as much as I thought you would be by now. What's going on there? I noticed that it took you an hour to review the charts and the chart you know; it usually takes like ten minutes. It's something like that. What's going on? You know, this is open ended. You know, just those observations usually do it.

Humanistic methodologies influencing instructional philosophy and behaviors were shared by Participant I. Much like Participants A, C, E, and H, Participant I wished to acknowledge the possible anxiety of students while supporting their growth and attempts in learning. Specifically, Participant I described an environment wherein progress, not perfection, is the expectation communicated to students. Describing her experiences during a virtual interview, Participant I shared,

I make sure that they're getting everything that they wanted to when they came here. I tell them you're going to drive your own bus. You know, we have a meeting. We sit down, we talk about availability, you know, how we're going to do clinical assignments, how we're going to evaluate. And I try to start every clinical rotation by saying, you know, this is your last semester, this your last term, your last rotation. I can understand that you're all anxious, that you're all scared. But really, all I'm asking of you every single day is to just get better. So, if you come in and you have a bad day and, you know, you were late on your meds or you were unprepared. All I'm asking for the following day is that you just improve on what you did, that you're accountable for yourself and you come back and you show me that you want to be better. Any student who just shows me that they want to be better and that they can improve, then I'm here for you, you know, because we all have to as nurses have a bad day and then come back from it. So, that shows me that you can grow. And so, I kind of hope that by saying something like that and then showing them when they do have that bad day that I can you know, I can accept that. They can accept that. We can talk through it and then they can improve that because that's what they're worried about. Right. Someone's going to fail me because I made a huge mistake, or I have a terrible day, or I cried, or whatever. So, I mean, I hope by doing things like that, I develop a good rapport. And then by being available and providing them with solid feedback, that hopefully helps them to get better and to grow. So, I have verbal conversations with them in clinical all throughout the day, and I usually will

> preface it by saying it's my expectation that in the next hour you will. Or I want you to do this and then report to me.

Similar to expectations discussed by Participant I, Participant K emphasized a belief in preparing students prior to clinical with communication of expectations in order to relieve anxieties. Participant K stated, "I think in being clear in what they should be prepared to do in clinical, so they come into clinical ready and prepared." After communicating expectations, Participant K shared she supports students in their exploration of learning while being present with them. In description, Participant K said, "And then you assure them that, you know, you've done this before in lab, you've studied, you're prepared. Let's talk about it. Let's kind of role play through ahead of time. I'm going to be with you." Combining the two concepts of setting expectations and supporting learners, Participant K elaborated, "I don't want them to think mistakes never get made. I think that they need to be prepared and then they need to feel supported and safe and they need to know that they can ask questions." Additionally, Participant K described the environment she creates to provide critical feedback to students in order to enhance their learning, but to do so in a supportive, Socratic method. Participant K stated,

> I won't ever criticize or undermine a student in front of a patient for multiple reasons. It doesn't make the patient feel good, nor does it make the student feel good. If there was a safety issue, then I would just step right in. So then outside of the room. Or if I found a private area, I would discuss with the student at first and ask them. So how do that go? Or so great job; I enjoyed working with you. How do you think that went? Tell me about it. Ask them some open-ended questions

> and then kind of go through some things that I saw that they could do differently or could improve upon. You just don't feed into it. You just say, ok, this is what happened. So, what do you think we should do next? I'm right here. Everything's ok. And you just, you just stay calm. And you have to be confident for the student, too. Because if you're not, they'll see it all over your face and you have to let them know that we all make mistakes and you have to be transparent about your mistakes and learn from them and go on. And don't let them beat themselves up for it. Because clinical, school is the time to learn.

Relationships

In addition to the communication style of participants, the development of a caring relationship with students is integral to improving self-esteem and critical thinking while reducing performance anxiety (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Rogers, 1974a). Part of the development of an authentic, caring relationship is attention to communication as well as the establishment of an accepting learning environment wherein progress is expected, not perfection (Chaube, 2013; Harrison-White & Owens, 2018; Kleehammer et al., 1990; Moscaritolo, 2009). Participants noted a desire to help and assist students in clinical learning versus a hierarchical and authoritative relationship style. Additionally, some participants noted a need to be reflective and receptive to feedback about potential power positions over students. Participants relayed a need to develop a relationship with students in which a power position did not manifest performance anxiety. Indeed, internalized feelings of anxiety in clinical learning resulting from power struggles can continue to manifest in the

workplace as a student transitions to practice as a licensed professional (Tolbert-Washington, 2009, 2012). Further, some participants noted a desire to create a community with students as a peer group to increase comfort and learning in the clinical environment.

Participant excerpts of their experiences outline the development of relationships with students in the clinical environment. Relationships then informed the development of instructor philosophies and behaviors. For example, Participant A described her motivation in student support, "I like guiding them through and helping them. I want to assure them that they will be fine." She also said, "I want to help relieve it [performance anxiety]. You know, look, I want to facilitate relieving it for students." Elaborating further, Participant A continued on to describe instructional strategies to lesson anxiety while increasing support of the student in learning. Participant A reported,

> But what I do with the students, especially like the first couple of weeks when they're new and it's a whole new environment for them, I'll put two students with the same patients. They'll say to the next student, that wasn't bad at all. So, I think that they're helping each other too, you know, once the first one does it, then they're like, oh, that wasn't so bad, so. I think working together is kind of like a little team helps them, too, because then they're not like, you know, they're not like I'm flying on their own. So, I do feel like that's been helping.

Similar to Participant A, Participant B described developing her caring relationship with students. However, she relayed a desire to be different than what she experienced with her own nursing clinical faculty, "I didn't have that sort of relationship

[with my instructors]. There were some older clinical instructors where they eat their young. Like, 'you figure it out. That's your problem.' And I don't want to have that sort of environment." Drawing further on her own experiences as a student, Participant B relayed encouraging students to support one another in their learning so as to reduce anxiety and maximize learning. Reflecting, Participant B shared,

> And I tell them that I'd like them to rely on each other and on me so that if you have a fellow student that you see who says like, 'oh, I can't get in; I can't even get my password in the computer.' Help them out. You know, I'm there to help you out. But if you know that you know the answer, just say, 'hey, you know, I've come up with this in my clinical,' or 'I had a patient once', you know, and just help build that stockpile of experience for them.

When asked about experiences with the instructor's role in alleviating or perpetuating student performance anxiety, Participant C provided, "It's my job to help alleviate their anxiety and hopefully prevent it from happening by trying to create a level of comfort in the environment so they won't feel that anxious when they have situations." Participant C described presence as being integral to developing a trusting, caring relationship with students. Participant G noted a similar experience and said, "And I usually sit with them while they make that phone call, or I'll go with them to have the interaction."

Participant C built on statements of caring presence shared by Participant G. Leaning forward in the interview, Participant C added her belief of importance in sharing non-academic information between the instructor and students while attempting to

develop a relationship. Describing her personal relationship with students, Participant C said, “I try to be as present as I can when I’m with them. I spend a lot of time with them. I get to know them and say, ‘Tell me a little about yourself.’ Then I tell them about me.” Being present for and with students allowed Participant C to “establish kind of a trusting relationship right out of the gate.” Continuing to illustrate the development of a caring *relationship* with students that informs her behaviors as an instructor, Participant C shared she “takes breaks sitting with them at lunch and chatting with them and stuff.” In this way, Participant C felt her presence allowed students to develop a feeling of comfort with her. This comfort allowed students to seek answers to clinical questions and demonstrated to students that Participant C had more of an interest “in their clinical experience rather than just sitting at the desk and chatting.” (Participant C)

In developing relationships to support positive outcomes, Participant D added the importance of soliciting student perceptions and feedback. In particular, it was noted that instructor self-perception may not match student perception, thus affecting the learning relationship. Participant D shared an interaction with a clinical nursing student wherein her self-perception was not in alignment with the student’s perception of her as an instructor. Further, Participant D shared how perceptions of the instructor may vary from student to student within the same clinical group, thus soliciting student feedback and perceptions becomes paramount to a successful, caring relationship. Moreover, student relationships may influence perceptions of power struggles. Illustrating these points, Participant D stated:

> I have heard from a young man who said you are very intimidating, and I laughed. And I said to him, 'I am? I had no idea in the world that I came across as intimidating. I thought I was the opposite. In fact, I thought I was like nurturing and kind.' But he said, '[name redacted], you have a doctorate. You're a nurse practitioner.' I said, 'education has nothing to do with that [being intimidating].' He said, 'Oh, yes, it does.' So, I think it's an individual student's perception because, in the same clinical group, I had a student who was thrilled that I was educated because she said she was going to get more education. We are intimidating. And despite the best intentions that we have, we have to constantly check ourselves. Constantly. We have to constantly.

Participant E described an informal, but caring, relationship with students. This relationship was established to remove power struggles between the instructor and the student. An informal relationship was believed to support a collegial working and learning environment which paid deference to the humans involved and not the roles of the individuals. Participant E shared, "In general, I have a pretty informal relationship with most of my students. I think they can be respectful, and I can be respectful to them in a way without calling them student so-and-so and professor so-and-so."

When asked about her experiences and role with performance anxiety, Participant E emphasized a connection between comfort with individuals and environment. Specifically, when students are uncomfortable, it is the role of the instructor to intercede and support the student in the learning moment so as to effect long-term change and confidence within the individual. Participant E shared,

> It [performance anxiety] can happen because they're with a different nurse or somebody who they don't feel as comfortable with. I think that has a lot to do with it. I see it more at the beginning of a rotation with me then towards the end. And I'm sure that has to do with the fact that once they realize I'm not going to rip them apart for doing something incorrect or, you know. But for some students, it continues, and you see it when they are going to do a new task. And every time they tackle that new task or there's two visitors in the room, that anxiety comes back and they freeze and they're not sure what to do next. But I think it can be mediated with a little bit of, just your presence to be there with them so that, you know, they're not doing it by themselves. Even though really, they are. They don't feel that they're doing it by themselves. I think my role is to be that reassurance, that constant stable force in whatever the situation is, so that I can hopefully have a positive effect on the situation and reduce that performance anxiety because it's normal.

Participant G shared a similar experience as Participant E with role definition in relationships. In particular, Participant G developed a safe space for learning in which a trusting relationship is required. In a comment similar to Participant E, Participant G stated, "Ensuring a trusting relationship with the clinical instructor. Assuring the student that they're not going to fail nursing school and live under a bridge if something happens during this procedure." Further, Participant G described the "need to create a safe environment." Specifically, according to Participant G, "That's my number one priority. Because the best learning takes place where a student can be free to express what they

need to express and hear the response and incorporate that into their affective domain." Reflecting on his background in mental health counseling and how that informs relationships and learning with clinical nursing students, Participant G added, "I feel like my job is to help that person turn [clinical difficulties] into an opportunity. I mean, the Greek root of the word 'crisis' stands for opportunity. I truly try and turn that into an opportunity for the students."

Similar thoughts reinforcing the subtheme of *relationships* were expressed by Participant H. In comparison to Participants E and G, Participant H discussed establishing safe learning environments. Reflecting on her behaviors as an instructor, which were influenced by her own experiences as a student, Participant H stated, "I never leave my students alone because I go back to my feeling as a student when you don't have someone that you can run to if you need to." Elaborating on her motivation in development of this practice behavior, Participant H further explained, "I don't want them to feel unsafe. And my big thing is, they can't learn if they don't feel safe. They've got to feel safe at all times."

In addition to previous experiences Participant H had as a student, she reported that her role development as a clinical nurse faculty member was influenced by her clinical faculty experiences over time. Participant H felt her experiences guided her to become a mentor and said, "And I really see faculty as mentors, you know. And I think that's a big part of our role." Given a nod to share more, Participant H stated she feels her role as an instructor is that of a "guide". Describing how she developed from previous behaviors into this role of instructor, she stated, "I remember feeling like I had to know

everything; I was the person they would be coming to with questions. Now I see myself more as a facilitator; that grew gradually as I became comfortable in the teaching role."

Sharing a unique viewpoint from other participants in description of her behaviors as a clinical instructor, Participant I discussed a need to make the clinical environment fun and engaging for students. She noted a distinct difference between didactic and applied learning environments allowing an opportunity to develop a relationship in which clinical learning becomes fun and less anxiety provoking. As shared by Participant I,

> Because clinical is the fun part, right? It should be, right? You know, the rest is torture. But clinical should be fun. And minimally enjoyable. A big learning environment, something that you look forward to. Maybe you're a little bit scared, but once you're done with that, you're maybe like me. And I'm really happy that I did that. You know, nobody comes out of an exam like that, but they should come out of clinical like that, right?

According to Participant I, part of making the clinical environment engaging and non-threatening involved supporting students in their mistakes. Participant I believed this to be important in developing lifelong habits to be successful in the workplace. Specifically, Participant I said, "Any student who just shows me that they want to be better and that they can improve, then I'm here for you because we all have to as nurses have a bad day and then come back from it."

Building on the subtheme of relationships, Participant J described support of students throughout clinical procedures. Referring students back to previously successful moments as well as connecting them to a positive and supportive relationship with their

instructor were relayed as successful strategies in the learning environment to reduce student anxiety. Participant J shared the following:

> Sometimes I'll go in with them when you know the situation where they're nervous to go in. And a lot of times I'll just show them that it's OK. You know, like I'll knock on the door, I'll do everything that they should be doing. I'll introduce myself and then I'll introduce a student as well. They need to know it is OK. As far as how the assessment skills go with me being in there, I just kind of have them breathe. You know, I say to them, remember when we did this in lab, you know, like we've gone through these multiple times. Remember, this is not graded. This is strictly for your purposes only. I'm not here. And I always reassure them that I don't think of them any different. You know, I'm here to help them. And I don't think that they don't have the knowledge just because they can't do something, you know. So, I try and reassure them as far as that goes.

Similar to Participants E, G, and H, Participant K described the philosophy of establishing a safe learning environment wherein the instructor is a role model. Participant K said, "I think my job is to create a safe learning environment for them that's positive. What I do is try to be a role model or demonstrate with the students and do an assessment or an intervention that we can do." Continuing on in describing the subtheme of *relationship*, Participant K noted the influence of personal philosophies and personality traits in her interaction with student learners. She stated, "Well, I guess it's my personality. I don't see a benefit to scaring students or belittling them. That's just not who I am. So, I guess that's just the way I am as a person in life in general."

Evaluation Methods

Understanding of the subjective reality of the individual student may be beneficial to understanding learning for the student and any influences affecting evaluation in the clinical setting (Coutts & Rogers, 2000; Rogers, 1974a). Indeed, how an experience is perceived formulates a reality within the individual. The development of performance anxiety can be influenced by prior negative experiences in learning or performance (Chaube, 2013; Helding, 2016; Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2012; Levy & Lounsbury, 2011; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017; Tolbert-Washington, 2009; Tolbert-Washington, 2012). If prior negative critiques from clinical faculty influence student feelings of inadequacy, self-regulation and metacognition of the student may be negatively impacted (Bouffard et al., 1995; Cohen, 2012). Specifically, students may develop maladaptive self-regulation in learning (Cohen, 2012). As nursing clinical instruction evaluation often includes objective assessment, the subjective experiences of the student may be under evaluated in their effect on the natural world of the student. Thus, without inclusion of subjective evaluation of student experiences, multiple influencing factors that affect performance and performance anxiety may not be accurately captured.

Participants of the study shared their experiences in clinical nursing evaluation methods. Most participants note an objective evaluation process of student performance. Illustrating the point of subjectivity in objective evaluation, however, Participant C stated, “They get evaluated on a scale of unsatisfactory to satisfactory plus. It is an objective rating scale, but there is a subjective component to it because I have to place

them on the scale." Working with a similar method of evaluation as Participant C, Participant D shared her experience with the objective evaluation tool and its short comings. Participant D stated, "We do formative and summative evaluation. We fill it out every week. They are rated on an unsatisfactory to satisfactory plus scale. They are new students so unless there is a safety concern, they tend to be satisfactory with objectives."

Expanding on the subjectivity of the objective evaluation tool noted by Participant C, Participant E shared her experiences with a pass/fail evaluation form. In her experience, Participant E stated, "I don't know if it could be completely objective." According to Participant E and much like Participant C's experience, an objective tool incorporates the subjective experience and opinion of the instructor. Continuing on describing this point, Participant E reported, "It left room for the person to grade whether or not they thought the student did it the right way. There was a lot of room in there for my interpretation of their application of those skills."

Participants C, D, and E described objective forms with rating scales of student performance as well as comment boxes to document subjective feedback. However, participants reported experiences with instructor subjective feedback and not evaluation of the subjective experience of the student under evaluation. As shared by Participant E, evaluation tools included, "A big chunk where I could write. Just like free write whatever I wanted about their performance." Inherently missing in many evaluation tools, as noted by participants, was the ability for student subjective experiences to be recorded. Participant J did describe an ability for students to add comments to clinical feedback documents, "So, there's like a little box basically underneath each section of our

evaluation that they can put comments in. And then at the end of each week they can initial or put comments in as well if needed." However, Participant J expanded on her experience, noting that while student comments are optional on the tool, the evaluation process is largely faculty driven.

Participant K shared similar experiences as Participants C, D, E, and K with student evaluation in clinical learning and instruction. Specifically, Participant K expressed dissatisfaction with current evaluation methods, subjectivity in objective evaluation, student subjective comments on forms, and a need for evaluation reform. Participant K felt there is a disconnect for worked asked to be completed clinically and how learning is assessed for clinical pass rates. Participant K stated,

> Right now, we have a clinical evaluation tool that's based on the QSEN competencies. I think we as a faculty have a lot of work to do because we give them a significant amount of clinical paperwork. They put a lot of time into clinical for being pass/fail. So, kind of the assumption is pretty much everyone passes if they show up and if they're safe. Now, the problem becomes, you know, that feeling you get when you really don't think someone is ready to move forward. We don't really have a way of capturing that on our tool unless they do something egregious or we've got a lot of documentation all semester of little unsafe things they've done. So, we actually have work to do. The form does allow for student comments, though.

Introducing a novel experience from that discussed by other participants, Participant B noted that nursing students document assessments well in a hospital-based

electronic medical record (EMR), but then struggle to document the same assessment in a simulated chart wherein the clinical work is graded. Participant B posited that the difficulty with student performance may be related to the evaluative nature of the simulated charting. In particular, Participant B felt that just by the nature that the simulated chart was incorporated into clinical evaluation, the students experienced high levels of anxiety that precluded them from demonstrating previous learning in electronic charting. As shared by Participant B,

> It's interesting to me that they navigate so well through the hospital EMR, but then struggle with the sim chart. And that makes me wonder if it's because of that evaluation piece? Like 'I have to get this right because my grade is hooked to it.' And I guess, you know, maybe that is like a mental stumbling block? They didn't feel prepared to use the product. And two, they were being evaluated through the product. So, it increased their anxiety.

Previous Experiences

Previous experiences of faculty members shape the lived experience as reported by participants. Specifically, previous experiences with students as clinical faculty and previous experiences as students themselves shaped the philosophies and behaviors of clinical nurse faculty. As their lived experience is formed, participants describe what performance anxiety is to them in clinical nursing education and how it informs their role as a clinical faculty member.

Performance anxiety is a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina,

2013; Schneider & Chesky, 2011; Sieger, 2017). To date, there is not a definition of performance anxiety as it relates to clinical nursing education. Rather, the defined term of performance anxiety is more clearly utilized for students in medicine, art, music, and athletics (Chaube, 2013; Helding, 2016; Levy & Lounsbury, 2011; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). Given the evaluative nature of clinical nursing instruction, understanding the lived experiences of clinical nursing faculty with student performance anxiety becomes important in developing methods of clinical education (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990).

Clinical undergraduate nursing education requires observations to assess student progress. Evaluation of learning that creates fear in the student of being judged can lead to manifestations of performance anxiety (Chaube, 2013; Helding, 2016; Tolbert-Washington, 2012). Specific manifestations may include tense muscles, nausea, shaking, palpitations, paralysis, and racing thoughts (Helding, 2016). Participants of the study shared their lived experiences with clinical nursing student performance anxiety.

Faculty as the student and role development. Participant A shared a desire to be more relatable to students than what she experienced herself as a student. Specifically, she wanted to begin by being accessible and approachable. Participant A shared, "But I think back to even like when I was in nursing school, we called our instructors by Mrs. We never called by their first name." Expanding on her experience, Participant A further reported, "And when I first started being an instructor, like 22 years ago, the staff was like, are you gonna make them call you Mrs. [name redacted]? And I'm like, "probably

not”.” Continuing on in describing the subtheme of previous experiences, Participant A felt positive reinforcement to be valuable in creating a positive memory of the learning experience. Therefore, she shared, “I reassure them that what they did was the correct thing.” Participant A felt her role in performance anxiety to be directly tied to positive interactions, stating further, “I want to help relieve it [performance anxiety]. You know, look, I want to facilitate relieving it.”

Sharing a similar philosophy as Participant A, Participant B felt strongly about student support from faculty members. Her philosophy was developed as a recent nursing student herself. Participant B disclosed, “I just want to be as a support to them. I want them to know that I'm always available because I feel, even if it was only 6 years ago, I didn't have that sort of relation [as a student].” Participant B shared similar dissatisfying experiences as a student that Participant A shared. In particular, Participant B stated, “There were some older clinical instructors where they ate their young. And I don't want to have that sort of environment. I encourage my students to always ask questions.” Based on previous experiences as a student herself, Participant B shared her current behaviors with students. In particular, Participant B described her role as less authoritarian and more of a facilitator, “When I was a student, it was ‘show me how you do this’ rather than ‘let's do it together as a team.’ And I think that's important to do it as a team.”

Participant C and Participant E both noted changes to their instructional style directly related to previous experiences as students themselves. In example, Participant C stated, “I still remember when I was a student, and I was terrified.” Similarly, Participant

E shared, “I don’t want it to be like when I was in school. It is my job to build their confidence and increase their skill set so that they're great practicing nurses.” Elaborating on her motivations based on previous experiences, Participant E continued to share, “I want them to have the skills, not just the bedside hanging an I.V. task, but that comfort in knowing they can search out problems and troubleshoot things. And confidence to be the kind of nurse they need to be.”

Having had a memory of anxiety as a student led Participant C to an instructor style that favored developing a rapport and positive relationship with students wherein open communication was prized. Speaking of her methods, Participant C shared, “I want them to be comfortable and I want them to feel like they can come to me with questions and I want them to know that I want them to get the most out of their experience.” Further, Participant C relayed experiences with students that portrayed the fallible nature of humans in practice. “I don’t want them to be afraid to make mistakes in front of me. I'll even tell them about when I was a new nurse and a student. I just want them to be comfortable.” When asked to discuss further her experience with instructional style development, Participant C noted those early student experiences as being instrumental, but also noted a growing comfort level as an instructor as being key to role development. Specifically, Participant C said,

> I think just as I got more and more comfortable as an instructor, I think that in turn they're feeding off of my comfort level. So, like if I'm brand new and I don't really know what to do as a clinical instructor, that's not going to read well on them. Because how are they gonna trust that I know? If I'm uncomfortable with

> what I'm doing, how are they gonna be comfortable in what I'm doing kind of thing? So, I think the more I did it, the more comfortable I got, the better it got.

Continuing to support the subtheme of *previous experiences* as students, Participant E posited a change in technology and generational characteristics may need to be considered in role development of nursing faculty. This development is in direct opposition to experiences as a student herself. Indeed, Participant E stated allowing technology to support students may decrease the formation of performance anxiety. However, as a student, technology in clinical learning was not embraced. She explained,

> Students became so dependent on having their cell phone with them all the time and then we're asking them to put it away. And I think as we change how we're teaching, maybe it'll come back around to allowing them to pull it [cell phone] out of their pocket as a reference. I think that starts it, their performance anxiety. Oh, 'I couldn't check that one last time before I did it.' I think their anxiety around the procedure may increase because of that. Because that's how they double check what they're doing. They watch the video on YouTube for two minutes. And when we take that tool away, we were making them more nervous going in to do things.

Further citing the need for educational reform based on previous experiences, Participant E noted that not only does clinical nursing education need to change, but the education of nursing faculty needs to change. Specifically, Participant E relayed a lack of focus on performance anxiety while seeking a higher degree to educate nursing students. She also stated that with the variety of entry level degrees to instruct students, there may

not be a focus on educational theory, thus potentiating performance anxiety development in students when various methods of instruction are utilized. Participant E described her beliefs,

> I don't think that it's [performance anxiety] touched on. It wasn't touched on. I don't think to the degree it should have been in my own graduate program for nursing education, like how to address it. You know, I think we glossed over it. I'm sure. I don't think. I don't think that we're given enough education on how to support our students and we bring faculty in who aren't trained in nursing education and they're not. They're even less prepared to do it than those with an education background. I think they could be a great clinical nurse at the bedside and have great outcomes with their patients, but they're missing that part of being trained to be an educator. Sure. And what that means and what it entails. And I don't think there's enough focus on that.

Relaying similar experiences as Participant E, Participant G shared similar philosophies, although in a different context. Specifically, Participant G drew on his experiences as a counselor to support students in the clinical learning environment. Skills developed in communication from his previous role allow for positive student interactions, more so than some other faculty. He shared,

> I was a crisis counselor for 20 years. I guess I might be a little bit more prepared on a different angle than many of the nursing instructors. I think I do have a significant advantage with my background, the counseling background, learning. And I still teach. I teach theories of psychotherapy for a different institution. And

> so, I'm still kind of in that world. And I've got 12 years in the E.R. and so, crisis intervention. I was very well prepared for the emergency room. I don't think many clinical instructors have that formalized experience unless they have children. I don't have children, so thank you, God. And as far as therapeutic communication, I have found. So, I'm going on 6 years now as an educator, a nurse educator. And I have found that therapeutic communication is very necessary for optimal student learning and that many faculty don't do it very well. Just saying. I mean, there's no diplomatic way to say that. So, it's a significant area of improvement for many faculty that I see.

Participant H had a similar background in mental health as Participant G had and drew on those experiences in role development as an instructor. She shared, "I think it's my background, you know. I think in general, people that teach mental health nursing tend to have students come to them more with their problems. I've noticed that over the years." Continuing to elaborate on her previous experiences and their influence on role development, Participant H shared how her experience as a student informed her current practice as a clinical faculty member. Specifically, Participant H spoke of experiences in supporting students in previously stressful learning moments in the following excerpt:

> I remember as a student, you know, you dreaded pre-conference. It was where you'd be asked these questions about something they'd always figure out, something that you hadn't checked, looked up, or you don't like. I remember that fear. And, you know, I really took my research seriously. And so, when I first started out teaching in the associate program, I was the same way. You know that,

that's what those were for. It was almost like, you know, not just reviewing information, but making sure students were absolutely prepared for every possible thing. Whereas over the years, I grew to realize that the students can pretty much guide themselves to what they need to know, and they know what they need to know. And if you go in to pre-conference and post-conference and kind of leave it open and leave that silence, you'll find that they will direct it and they will get to what they need to know and what they need to discuss without you even have to mention it [or] mentioned anything.

I remember when I was a student how they would say, they do that whole thing. Look to your left. Look to your right. Some of you aren't going to be here. All this stuff. I am so against that. Always have been. And I feel that when we take students into a program, we should be saying to them, 'we.' I say this to them every year. I say, 'you wouldn't be here if you weren't capable of being here. You were chosen to be in this program for a reason. You've got the ability. So, we're going to help you be successful. You've got to do the work. But we aren't going to give up on you. We will give you another opportunity.'

I think being in the student role causes anxiety for students, regardless of how old they are, because at the AD level many of these people were returning to school as adults and also their past experiences really contribute to it. So, if they were told in high school that they weren't good in math, even though dosage calc may come easily, they're going to feel like they can't do it. So, it's your previous experiences. You know, they define you. It doesn't mean that you have to let

them define you. But they're going to. I should say, not define, that they affect you. They don't have to define you.

Performance anxiety. Several participants shared what they believed to contribute to student performance anxiety in clinical nursing education. Participant A described a lack of confidence in new situations and evaluation as being factors in the development of performance anxiety. She said, "Like a lack of confidence in doing something like that [assessment]. You know, that is, so they, it's the unfamiliar, unfamiliarity and lack of confidence in their abilities because they're not used to doing something." Participant A added about evaluation, "I think that I feel like, I think they feel like having someone watch them, you know, that they're under the microscope, contributes to performance anxiety."

Sharing a similar perspective as Participant A, Participant E believed performance anxiety to be tied to student perceptions and defined the phenomenon as, "The inability to perform a task you know because you're so concerned about failure." Participant E also discussed precipitating factors to performance anxiety, stating, "Students' lack of preparation or their perceived lack of preparation leads to performance anxiety." Additionally, Participant I shared perceptions of factors increasing student performance anxiety, "The newness element, new experiences, challenges, things like that and previous interactions with other instructors influence performance anxiety.

Continuing to support the subthemes of *previous experiences* and *performance anxiety*, Participant J echoed similar experiences as Participants A, E, and I. Specifically, Participant J shared experiences with student performance anxiety developing in new

situations as well as from previous evaluations. Additionally, Participant J shared her definition of performance anxiety. As reported by Participant J,

> Performance anxiety to me is, is feeling very anxious in doing something new. I feel when a new task comes up that they have to do that they are not familiar with. They don't have the knowledge. That anxiety level is going to heighten, big time. I definitely think knowledge, so the lack of knowledge can contribute to that. You know, I like trying to think of like performances from previous, you know, like, you know, pass/failures or something like that that could lead to it.
>
> Doing a new task. Not being prepared with baseline knowledge, maybe having some prior traumas in learning or whatever it may be.

Other participants shared similar experiences of precipitating factors to the development of performance anxiety. Themes of new experiences were shared by several participants. Participant B described a first patient experience, "Most of them never have any previous experience with patients. And so, we have that, a little bit of that anxiety that, you know, how is it going to be when I work with those patients for the first time?" Participant C described a similar experience, "You know, they have something that they maybe have never done before. They're uncomfortable with that."

In description of the development of performance anxiety, Participant B noted a perceived lack of confidence in the student as well as new experiences may be contributing factors. For example, a student may be "uncomfortable with the patient" (Participant B). Indeed, "A number of my students in their clinical journals are beginning saying they felt they lacked the confidence to go in and have patient contact." (Participant

B). Further, Participant B described student perceptions of an inability to use clinical tools. Specifically, a simulated chart. While the students were familiar with the product from previous uses, Participant B stated, “They didn’t feel prepared to use the product [simulated chart]. And two, they were being evaluated through the product. So, it increased their anxiety.”

Participant E continued to share her lived experience with student performance anxiety. Specifically, she described an experience with a student wherein a new procedure was being performed. Within the experience, she perceived what she believed to be influencing factors to performance anxiety, what the phenomenon looked like, and her role in attempting to mitigate the effects of performance anxiety in the immediate situation as well as in development of lifelong learning abilities in the student. She feels, “A big, big part of my role as an instructor to be that constant and be that normalizing voice that hopefully lessens that performance anxiety.” Participant E shared,

> I had a student who had to put an NG tube in, and he was totally panicked because he had never, ever done it. He hadn’t done it in the lab. It was a brand new situation. I was a seasoned nurse and had never done it. So, as luck had it for us, not for the patient, I sent him off to look to review the process in the book, to read through the steps and what he had to do. And we had another nurse on the other side of the hallway who also had a patient with an NG tube. And I had just been telling her I had no experience. So, I went in with her and I did my first NG tube. And I only bring that up because I think it was critical to the being able to help with his performance anxiety, because if I had never done it, I don’t think I would

have been able to do the same thing. Maybe, but. So, we went in to do it and he was sweating profusely like the gobs of sweat on this poor kid, and he kept staring at the patient, you know, then he gets these big, doe eyes like, oh, my God. Deer in the headlights. So, he was just frozen. And I reassured the patient that, you know, he was a student, but he knew how to do the procedure and he'd reviewed it. And I think in the process of talking calmly to the patient to reassure the patient, the student started buying into what I was saying to him. So, he got ready to do it. He got all this stuff set up and was ready to go when he picked up that NG tube and just stared at me. And like, I don't know if he didn't know where the patient's nose was or where what he was doing. And I said to him. So, what's the next step? He just kept staring. And then it took a couple of reassurances like, OK. So, here now the patient knows what we're doing. You've explained it to him. What's the next step? And finally. He said, he told me what the next step was. He didn't do it. I was like OK, so let's do it. So, it's just that constant calm presence and bringing him back to the here and now of what's going on because you can't think through that and what to that person is a crisis into the student. It definitely was like he had to do this. He had no idea. And it's a total crisis for him. So, using that calm presence to help him come back to the here and now of what you're doing. But it is, it's frozen. I don't even know what to do next. You know, they know. But as a psychiatric nurse, you know, that's what we're trained to do when there's a crisis, when the patient is losing their ability to rationally think it's to step in with those techniques to help them get grounded and calm

> themself and continue on. And so, for me, it was very clear that this is a similar situation. While nobody was at risk, that performance anxiety for the student is a crisis situation where they're losing touch with their ability to rationally think through a situation.

Similarly, when asked about what student performance anxiety looks like, Participant A shared an example of an experience with a former student. She described, "He was doing the breast assessment. And all of a sudden, he started sweating. Like the sweat was pouring down his like, you know, the movie 'Airplane' where, you know, like that, you know, it's like a waterfall." She also noted further physical manifestations of performance anxiety in other students. Participant A shared, "I've had students that get dizzy and pass out during like a labor."

Much the same as Participant A and E, Participant C described manifestations of performance anxiety as, "She walked up and she just froze. I think there's like a little bit of a look of terror. You can see it in their face. You can tell they're really anxious or they'll just look at you." Participant G shared a similar experience with student performance anxiety, "I can feel that anxiety. I can look at them and tell when they're on the verge of tears. I can sense that they feel not good enough." Participant G goes on to explain by stating, "Most of them are shaking. They start crying." Participant H added to the description of physical manifestations of performance anxiety,

> Sometimes it will be really objective symptoms. They will be sweating. Actually, sweat in front of you. Like, glisten. Sometimes it's redness of the face. Sometimes I've had students that this has happened a lot. They'll need to use the bathroom a

> lot. You know, they need to, their G.I. system. Their urinary. You know, they're anxious and it is constant use of the bathroom. Sometimes students will just get very, very quiet. Sometimes they'll hide; sometimes they'll hide behind the nurse's station. Hiding because they're afraid. They're afraid that they're not going to be safe or they're going to be judged or whatever.

Participant I shared experiences of student presentation of performance anxiety. Physical manifestations led to an inability to perform previously mastered skills. Similar to the description provided by Participant E, Participant I described the "freezing" that occurs with students and their inability to participate in clinical learning. Specifically, Participant I stated,

> They have the theory. They certainly are able to pass their exams, but when they're challenged, when the level steps up a little bit, or becomes unfamiliar, or they get a new instructor, or they're on a new unit. The worry or the fear becomes so great that they have an inability to perform certain simple tasks. They forget what they learn. They get confused about where they are, what patient they're taking care of, you know, what med they're giving, what time of day it is. You know, they can have physical symptoms, be completely diaphoretic, flushed. You know, their speech can be altered or not even, they're aphasic almost. It [performance anxiety] impairs their function.

Several participants shared experiences wherein evaluation, or perceived evaluation by a person in power, sparked behaviors consistent with performance anxiety. Participant H stated, "Not being able to meet the expectations of the person in power."

Indeed, Participant G shared a similar experience with student perceptions of power and how those perceptions, when they lead to performance anxiety, can translate to feelings of failure throughout the nursing school experience and into professional life. Participant G stated,

> Certainly, the fact that there's somebody in authority that's going to be closely scrutinizing them. The perception that they're probably going to screw it up. The fear of not being good enough. The fear of being looked upon by their peers as not good enough and by their instructor. And to generalize the fear of failing nursing school.

Continuing to build on the subtheme of *performance anxiety* in discussion of evaluations, Participant K shared similar experiences as Participant G. In particular, Participant K stated, "It is the feeling we all get when the word evaluation is attached to something or when we feel like we're being evaluated or being watched for something that's not muscle memory or something that's new to us." Further, Participant K noted experiences with student evaluation that manifested signs and symptoms of performance anxiety. She described performance anxiety as,

> Every time I'm that fly on the wall doing the head to toe assessments, every time I can see the hand shaking, I can hear the nervousness in their voices. There's been periods where I have witnessed like the head to toe assessment being completed [in the lab] and they've been fine with it. But the minute I'm in there [patient room], it's like everything's out the window.

Participant C described precipitating factors for student performance anxiety as not being solely academic related. Indeed, the student demographics of an associate degree nursing program include students predominantly from low to middle socioeconomic status and of adult age ranges (Table 2). These students, as reported by Participant C, have life needs to meet, such as family and work obligations, in conjunction with academic requirements in a rigorous nursing program. Participant C believed the imbalance of work, life, and school demands contributes to mounting anxiety that can manifest itself in the clinical learning environment. Participant C shared,

> I think they actually really like coming to clinical, but I think just the amount of stress they're under in that 6-week period of that class like their mind.... They want their mind to be 100% there. But it's not because they're worried about, 'I have a test on Monday, and I have a quiz on Thursday, and I have this. I have a midterm and I have a final.' They're like, you know, I find them in the hallways studying and like going over different things together because they're so nervous they're not going to pass the class. So, I think that maybe they're bringing some of like, they're already a certain level of stress. And then some of them are also having issues at home that. Like I had a student once who was going through a divorce. And she ended up failing the course because she had some stuff going on at home. You know, some people might have to work like a million hours to be able to afford to go to school and support their family and I feel like they're on a different level of stress, too.

Philosophies and Behaviors of the Clinical Nursing Student

The subjective, social world experience of the clinical nursing student can influence learning. Emotional inhibitions can prevent self-actualization and full learning (Purdy, 1997; Rogers, 1974a). Supportive instruction from the instructor is desirable to lessen crippling anxiety and effect positive learning outcomes.

Preparation

Participants shared their thoughts on what may inhibit self-actualization in the learner. Common sub-themes in the data were preparation and previous experiences. Several participants relayed that a student's perception of under preparedness for a requested task or clinical experience as well as previous negative learning experiences were influential in the development of performance anxiety. Participant B said, "I have had this semester a couple of students say that they were very anxious because they weren't prepared." Indeed, Participant E noted the same student perception, stating, "Students' lack of preparation or their perceived lack of preparation leads to performance anxiety."

According to Participant H, student preparation and communication of expectations are intimately tied together. To illustrate this belief, Participant H described a conversation with students surrounding preparation, success, and expectations in the clinical learning environment. Specifically, she tied her expectations to their preparation and her continued support of the students. She stated,

> But if you come prepared, I always say if you come prepared, I will work with you. We'll get you there. But that isn't to say that you can just, you know, show

> up with no preparation and so on. That's a different ballgame. You have to keep the expectations high but make them very clear. You have to have read what you needed to read to take care of your patient.

Similar to Participant H, Participant K described making preparation expectations known to clinical nursing students in order to enhance their preparation. However, Participant K added to the discussion that students may need to be reassured they have prepared when they do not recognize that in themselves. Participant K stated,

> So, students are only being asked to do what they're prepared to do. I think in being clear in where they, what they should be prepared to do in clinical, so they come into clinical ready and prepared. And then you assure them that, you know, you've done this before in lab, you've studied, you're prepared.

Previous Experiences

Negative previous experiences may inhibit self-actualization of the learner. Participant A described previous student interactions with other clinical instructors, stating, "It's like sometimes the instructors just like send him off to do their thing and then they'll say, 'Oh, let me know if you have any questions or you know'." Participant J described a similar experience with students, noting, "You know, I like trying to think of like performances from previous, you know, like, you know, pass/failures or something like that could lead to it [performance anxiety]."

In addition to previous negative instructor experience, lack of prior exposure to clinical learning is believed to contribute to a lack of self-actualization, according to Participant B. She shared, "Most of them never have any previous experience with

patients. And so, we have a little bit of that anxiety; how is it going to be when I work with those patients for the first time?" Indeed, clinical experiences are perceived as different than other applied learning. For example, in a clinical nursing lab. Participant C shared experiences with student performance anxiety development related to the differences in practiced skills within a controlled environment versus the first experiences during clinical learning in the following situation:

> You know, a lot of times the things that they do are a lot different in their labs. Like they read. They like use the same gloves in the lab just because they don't have the equipment. You know, for practicing putting on sterile gloves. So, the first time they need to get sterile gloves on their hands, they look totally different than the ones they see in lab or like the pumps we have are totally different or like I.V. bags, they have been stabbed like 100 times like they don't. It's like a lot harder to do at the hospital because they're brand new and the seal hasn't been broken yet, those sorts of things that like they think they know how to do when they get there. And they're like, oh, my God this is completely different than what I had practiced, you know.

Summary

Chapter 4 of this research study provides analysis of the lived experience of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety. To best understand the lived experience, one primary research question and four secondary research questions were designed. Eleven participants from eight nursing programs in New York state provided rich, thick data

detailing their experiences with nursing student performance anxiety in the clinical education setting. From that data, themes and subthemes emerged to answer the research questions.

The primary research question that guided this study was *What are the lived experiences of associate degree faculty during clinical education of nursing students who are experiencing performance anxiety?* Through rich, thick data, the participants of this study detailed interaction of the social and natural world of learners. Specifically, themes comprising student preparation, faculty preparation, interaction with healthcare professionals, previous experiences of both the student and faculty member, methods of evaluation, communication, relationships, and quality of the clinical environment were important in the discussion of the lived experience of the clinical faculty members.

The second research question that guided this study was *How do associate degree nursing faculty define performance anxiety as seen in the clinical setting?* Previous definitions of performance anxiety were limited to the fields of medicine, art, music, and athletics (Chaube, 2013; Helding, 2016; Levy & Lounsbury, 2011; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). The definition of performance anxiety that guided this study was a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). From the data emerged a new, nursing centric definition of performance anxiety in clinical nursing education. The new definition includes an addition to the evaluative nature of nursing clinical education. Specifically, it is important to include in a clinical nursing education definition of performance anxiety the subjective

experiences of the learner. Subjective perceptions are important components not previously mentioned in a definition of performance anxiety. A clinical nursing centric definition of performance anxiety could be presented as a state of situational nervousness or fear when encountering perceived new experiences, critical evaluations, power-differences, or a sense of under preparedness that leads to physical or emotional inability to perform a prescribed task, function, or duty.

Research question number three was *How do associate degree nursing faculty describe their role in addressing student performance anxiety in the clinical setting?* The role of clinical nursing faculty is shaped by previous experiences faculty have as students themselves, clinical practice experience, formal education, and reflection on student experiences. Clinical nursing faculty described that role development culminates in the need to support student learning in a caring relationship, protect students from negative experiences, and develop students into lifelong learners with resilience. Additionally, faculty note a necessity to recognize their positions of power over students, a requirement to recognize and intervene when signs and symptoms of performance anxiety are present, and a duty to mitigate performance anxiety developed through previous negative learning moments.

Research question number four was *What experiences guide associate degree nursing faculty in addressing student performance anxiety in the clinical setting?* Previous experiences as nursing students themselves guide clinical nursing faculty in their role development and instructional style with students. Further, formal degrees in nursing education or certification as a nursing educator drives some nursing faculty in

methods to address performance anxiety. Similarly, clinical backgrounds in mental health were noted by a few participants as helpful in mitigation of the effects of performance anxiety in clinical nursing students. Last, some participants spoke to a humanistic perspective of thought in addressing students as humans first and learners second, thus addressing subjective perceptions of anxiety.

The fifth and last research question that guided this study was *What experiences guide associate degree nursing faculty clinical evaluation of students who exhibit performance anxiety?* Clinical nursing faculty reported an objective clinical evaluation of students with few noting a subjective account and influence on learning in evaluation. All faculty noted having lived experience with performance anxiety in clinical nursing students. In those moments, the focus became on the success of the student with the task at hand as well as supporting the student emotionally and safely. According to faculty, student support led to positive outcomes, both short and long-term, for the student and did not negatively impact the evaluation of the student. Faculty noted a need to understand the student in a humanistic experience and consider factors that may be influencing their performance in the moment as opposed to viewing an inability to perform in the moment in a punitive manner.

Chapter 5 is the conclusion of this study. In Chapter 5, I discuss the findings and limitations of this study. Specifically, I will discuss results related to the conceptual framework of humanism. Further, in Chapter 5 I will discuss recommendations and implications of study findings. Moreover, the implications will include the impact of positive social change from study results.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The primary purpose of this study was to explore the lived experiences of associate degree nursing program faculty in addressing student performance anxiety as it occurs in the clinical setting. More specifically, in this study I sought to describe how nursing faculty address performance anxiety while supervising and instructing associate degree nursing students in the clinical setting. To date, prior research involving performance anxiety has focused on other professional disciplines or student experiences with stress and anxiety (Chaube, 2013; Helding, 2016; Levy & Lounsbury, 2011; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). Little is known of the faculty lived experiences with student performance anxiety, yet faculty are charged with addressing the phenomenon in clinical education (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990). Understanding the lived experiences of nursing faculty in addressing performance anxiety as it occurs in the clinical setting is imperative to effecting long-term, positive social change in nursing and nursing education.

Data analysis revealed the quality of the clinical environment, philosophies and behaviors of clinical nursing faculty, and the philosophies and behaviors of clinical nursing students affect the lived experiences of faculty addressing performance anxiety in the clinical setting. Specifically, interactions with healthcare professionals, previous experiences of both faculty and students, preparation, evaluation methods, communication, and relationships affect experiences associated with performance

anxiety. Moreover, as factors affecting experiences with performance anxiety were identified, the faculty role in perpetuating or mitigating the phenomenon was recognized. Last, data analysis led to a more detailed definition of performance anxiety within the discipline of nursing.

In this chapter, I will provide an interpretation of the findings of the research as it relates to the literature review and conceptual framework. Limitations of the research study, recommendations for further research, and implications for positive social change in nursing education, academic administration, practice, and policy are addressed.

Interpretation of the Findings

Despite recognition of the deleterious effect of stress and anxiety in nursing didactic learning environments, little attention has been paid to educator understanding of anxiety in clinical nursing environments (Hutchinson & Janiszewski, 2016; Tolbert-Washington, 2012). Specifically, scant literature exists surrounding performance anxiety in nursing education. However, extensive evidence exists that performance anxiety inhibits learning in multiple disciplines such as athletics (Chaube, 2013), music (helding, 2016; Levy & Lounsbury, 2011; Schneider & Chesky, 2011; Sieger, 2017), and medicine (Malina, 2013). Further, those affected by performance anxiety have higher rates of maladaptive behaviors as they enter professional practice (Chaube, 2013, Helding, 2016; Levy & Lounsbury, 2011; Schneider & Chesky, 2011; Sieger, 2017; Tolbert-Washington, 2012). Therefore, it is imperative to understand performance anxiety in clinical nursing education to best inform support for educational changes and development of successful nursing professionals.

While performance anxiety has been defined in other disciplines, there is no single definition of the phenomenon in nursing. Further, the literature describes stress and anxiety from a student perspective (Cornine, 2020; Hutchinson & Janiszewski, 2016; Kleehammer et al., 1990; Moscaritolo, 2009; Tolbert-Washington, 2012), but there is no research into the faculty experiences surrounding student performance anxiety in clinical nursing education. The findings of this study provide support for an understanding of the faculty lived experiences with performance anxiety in clinical nursing education. Additionally, the findings support a nursing centric definition of performance anxiety.

In the current study, clinical nursing faculty described their lived experiences with student performance anxiety in the clinical education environment. Through individual stories, participants provided rich, thick descriptions of what performance anxiety is, multiple factors influencing performance anxiety, and their role as educators with student performance anxiety. In this section, study findings are discussed in relation to major themes and current literature.

Quality of the Clinical Environment

Study findings indicate that the quality of the clinical environment plays a role in the development of performance anxiety. Participants described negative interactions with healthcare professionals, fear of making mistakes, first clinical experiences, and perceptions of evaluations to increase performance anxiety in clinical nursing education. Multiple researchers have reported the same influencing factors on the development of anxiety in disciplines outside the field of nursing (Chaube, 2013; Helding, 2016; Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2012; Kleehammer et al., 1990; Levy &

Lounsbury, 2011; Malina, 2013; Moscaritolo, 2009; Schneider & Chesky, 2011; Sieger, 2017; Tolbert-Washington, 2009, 2012). However, this study is the first to accurately label this phenomenon and related factors as they are experienced in undergraduate nursing education. Indeed, anxiety surrounding clinically performed abilities is inherently the phenomenon of performance anxiety.

The perception of a poor relationship with a clinical faculty member is known to increase stress in nursing students (Tolbert-Washington, 2009). Negative interactions and relationships with other healthcare professionals in the clinical environment can also lead to anxiety in individuals (Burkley, 2018; Harrison-White & Owens, 2018; Koharchik, 2018; Thomas, 2017; Tolbert-Washington, 2009). The developed anxiety can inhibit theoretical knowledge transfer to clinical practice (Horsley, 2012; Tolbert-Washington, 2009). Participants in this study described similar experiences with nursing students in the clinical environment as a related factor in the development of performance anxiety. Indeed, clinical skill and communication were negatively impacted by poor relationships with faculty or healthcare professionals.

In contrast, caring and supportive relationships allowed students to successfully bridge the theory-practice gap and describe feelings of comfort and ability to faculty members. These findings are consistent with literature surrounding self-actualization of the learner when environmental inhibitions to learning are removed (Burkley, 2018; Purdy, 1997; Rogers, 1974a; Tolbert-Washington, 2009). Participants described caring methods used to reduce performance anxiety while increasing support of the adaptability of the learner, as is noted in humanistic educational methods (Purdy, 1997).

Additionally, participants described a more positive clinical environment when the faculty member is known to the healthcare professionals in the clinical environment from previous or current employment.

Philosophies and Behaviors of Clinical Nursing Faculty

Clinical nurse faculty are experientially and academically prepared professional nurses who instruct and evaluate students in the clinical setting (ACEN, 2016; Woodworth, 2016). However, not all participants reported findings matching this definition. Several participants hold graduate degrees outside nursing education and do not have formal instruction in educational theories. While participants describe supportive, caring educational environments for students, these environments were cultivated over time from personal experience. Indeed, the literature notes that educational theory in evaluation of learning stipulates faculty position in evaluation and negative perceptions of faculty judgment and power increases poor performance and reduced learning (Horsley, 2012; Hutchinson & Janiszewski-Goodin, 2013; Kleehammer et al., 1990; Tolbert-Washington, 2009). Therefore, without knowledge of educational theory, success of the clinical learning environment becomes solely dependent on experiences of the clinical faculty member to guide educational interventions. If experiences of the faculty member do not result in development of a caring educational environment, learning may be affected. Specifically, critical thinking and self-esteem of the learner may be inhibited, and performance anxiety may develop (Chaube, 2013; Helding, 2016; Horsley, 2012; Hutchinson & Janiszewski-Gooding, 2013; Levy &

Lounsbury, 2011; Malina, 2013; Moscaritolo, 2009; Rogers, 1974a; Schneider & Chesky, 2011; Sieger, 2017; Tolbert-Washington, 2009, 2012).

Humanism considers the natural and social world of the learner, to include both the objective and subjective realities of the learner (Carter, 2018; Coutts & Rogers, 2000; Rogers, 1951, 1974a). Additionally, humanism as an educational approach considers the reciprocal relationship between the learner and learning to facilitate self-actualization and social transformation (Carter, 2018). As nursing education has evolved into an educational process instead of solely technical training, evaluation of nursing should include both objective and subjective considerations in the obtainment of clinical learning outcomes (Purdy, 1997).

While some participants reported subjective comments on clinical evaluation tools or reflective journaling, clinical evaluation tools described by the participants did not accurately capture the subjective experience and personal meaning of evaluation of the learners. Indeed, the tools described by participants capture objective learning parameters, thus missing a key component of the social world of the learner in development or inhibition of self-actualization. As fear of judgment and evaluation in learning can cause development of a poor sense of self and performance anxiety, it becomes important to care for and recognize the personal worth of the learner, even in evaluation methods (Chaube, 2013; Helding, 2016; Rogers, 1974a, 1974b; Tolbert-Washington, 2012).

Understanding and defining performance anxiety in nursing education is beneficial in developing a more skilled, resilient, and retained nursing workforce.

Similarly, understanding the lived experiences of the phenomenon is important to better inform education interventions. As previously defined, performance anxiety is a state of situational nervousness or fear when an individual is under observation or evaluation (Chaube, 2013; Helding, 2016; Malina, 2013; Schneider & Chesky, 2011; Sieger, 2017). To date, there has been no published definition of performance anxiety as it relates to clinical nursing education. The literature refers to student experiences with anxiety in the clinical setting wherein the phenomenon would be best termed as performance anxiety (Tolbert-Washington, 2012; Turner & McCarthy, 2017).

Participant experiences with performance anxiety describe a need for a more detailed definition of the phenomenon as it relates to clinical nursing education. Lacking in the definition of performance anxiety as borrowed from the disciplines of art, music, medicine, and athletics, is the evaluative nature of clinical nursing education as well as an incorporation of the subjective experience of the learner. Indeed, as there is a reciprocal relationship between learner and learning, it is imperative to include the learner experience in a definition of performance anxiety. Therefore, participant descriptions of experiences with performance anxiety lend to a definition within clinical nursing education as a state of situational nervousness or fear when encountering perceived new experiences, critical evaluations, power-differences, or a sense of under preparedness that leads to physical or emotional inability to perform a prescribed task, function, or duty.

Philosophies and Behaviors of the Clinical Nursing Student

Purdy (1997) and Rogers (1974a) posited that the social world of a learner can prevent self-actualization and long-term learning if emotions become inhibitory.

Educators, therefore, are charged with attending to the subjective experience of the learner in order to best effect positive learning outcomes (Rogers, 1974a). Participants described student perceptions of a lack of preparation and prior negative experiences as being influential in developing performance anxiety. Indeed, even if faculty knew the student to be prepared or had an excellent relationship with the student, the students' perceptions of preparation or a negative prior experience led to the development of performance anxiety.

In this way, the social world of the learner exceeded the natural world experiences and could have been detrimental to learning. However, participants describe interventions consistent with humanistic educational practices that circumvent performance anxiety and focus on the learner/learning relationship. Specifically, participants described the ability to be real, value the learner's worth, and provide empathetic understanding (Rogers, 1951, 1974a, 1974b). By being present, instilling trust and accepting the learner's fear, and being empathetic in understanding the student experiences in learning, participants describe influencing learning in a positive manner throughout understanding and a lack of judgment (Rogers, 1974a, 1974b).

Interpretation of Findings as Related to Theoretical Framework

The conceptual framework for this study (Figure 1) is based on constructs used in the theory of humanism, as developed by Carl Rogers (Rogers, 1951, 1974a, 1974b). The philosophical underpinnings of humanism as a pedagogical approach considers the reciprocal relationship between learner and learning as well as the individual's actualization and social transformation (Carter, 2018). Additionally, humanism considers

the subjectivism of experiences. Indeed, the perception of an individual formulates the reality within which they live and learn.

The implication in nursing education is that the objective nature of clinical learning evaluation may not accurately capture the subjective experiences of the learner. Evaluation methods should be restructured in an attempt to capture subjective student experiences in learning. Further, instructional styles should be consistent with humanistic characteristics. Specifically, clinical nursing faculty should facilitate learning through realness with learners instead of façades of expertise (Rogers, 1951, 1974a, 1974b). Additionally, clinical nursing faculty should care for the learner as a person, thus invoking trust in the reciprocal learning relationship, and mitigating fear and perceptions of judgment in clinical learning moments (Rogers, 1974a, 1974b). Indeed, positive support from faculty is required to support students from threats in their learning environment (Carter, 2018; Rogers, 1974b). Last, supporting nursing students through humanism pedagogical interventions allows learners to meet challenges of the clinical learning environment and develop internal feelings of an ability to learn throughout their healthcare career (Carter, 2018; Rogers, 1974a).

Limitations of the Study

This was a qualitative, descriptive phenomenological study. Limitations exist with trustworthiness in the execution of the study. Specifically, the transferability of results of this study are limited. Limitations in geographic location and program type compound the already present limitation in transferability to other populations that are inherent in qualitative, phenomenological studies (Creswell & Creswell, 2018).

While the original study design was intended to be completed within the state of New York, a national pandemic necessitated a change in plan to recruit national participants. Unfortunately, the study reached saturation of data prior to inclusion of participants from across the U.S. Thus, study results are limited to one small geographic region of the country.

Similarly, the study focused on associate degree nursing clinical faculty members, thus excluding baccalaureate faculty. The focus was on associate degree nursing wherein undergraduate nursing students spend three times longer in clinical experiential learning than in didactic settings (Moscaritolo, 2009; NLN, 2010). Further, a focus on associate degree nursing programs removed any potential bias in backyard research as I am employed in a baccalaureate nursing program.

Last, one-on-one interviews were employed for data collection. Limitations exist with interviews in that information is gathered outside of a field setting limiting observation of a phenomenon (Creswell & Creswell, 2018). Further, data gathered can be biased as it is filtered through the interviewer. However, inherent in the design and execution of qualitative research is the premise that the researcher is the data collection instrument (Creswell & Creswell, 2018; Lincoln & Guba, 1985, 1989). Therefore, validity strategies of triangulation, member checking, reflectivity, and peer review allowed for a collection of rich, thick descriptions of the lived experiences with the phenomenon without introduction of researcher bias (Creswell & Creswell, 2018; Hull, 2017; Lincoln & Guba, 1985, 1989).

Recommendations

Performance anxiety in nursing education has been an unexplored topic. It is important to understand performance anxiety in nursing education for educational reform. While this study serves to provide a clearer understanding of performance anxiety in nursing education, further research is required.

Future research studies should focus on a larger and more diverse participant population. Specifically, future studies should include participants from baccalaureate nursing programs. Additionally, a wider geographic range of participants should be included in another study. As a definition in nursing education for performance anxiety has not been previously published, this study added to the body of literature with a nursing definition of the phenomenon. It is important to continue to explore if the definition is transferable across differing types of nursing programs as well as across geographic locales.

Further, with a definition of performance anxiety in nursing education, it becomes important to study educational interventions to mitigate the effects of performance anxiety. High levels of clinical anxiety in undergraduate nursing students impairs learning, psychomotor skill performance, clinical judgment, and critical thinking (Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990). Performance anxiety developed as a student can continue to affect new professionals entering the workplace (Tolbert-Washington, 2012). Therefore, studies surrounding educational interventions to mitigate the effects of performance anxiety become important in improving future role performance in the workplace as well as

developing a resilient and retained nursing workforce (Moscaritolo, 2009; NLN, 2010; Tolbert-Washington, 2012).

Implications

This study examining the lived experiences of clinical nursing faculty with student performance anxiety has broad implications with the potential of impacting nursing education, academic administration, practice, policy, theory, methodology, and social change. As high levels of anxiety can be damaging to clinical judgment, reasoning, and critical thinking, it is important to support the long-term learning of students in preparation for a career of necessary adaptability in a changing healthcare environment (Cornine, 2020; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990; Tolbert-Washington, 2012). A more prepared and adaptable nursing workforce will advance healthcare initiatives and improve reductions in the nursing shortage (NLN, 2010; Tolbert-Washington, 2012; Turner & McCarthy, 2017).

Nursing Education

An understanding of performance anxiety in nursing education is beneficial to curricula and instructional strategy reform. Indeed, nursing education reform as it relates to the harmful effects of performance anxiety will increase learning outcomes in clinical settings (Moscaritolo, 2009; NLN, 2010). This study provides a beginning understanding of faculty experiences with student performance anxiety in clinical nursing education. Specifically, findings generated from this study offers a clearer understanding of the

phenomenon of performance anxiety and its use as a defined term in nursing education as well as contributing and mitigating factors to performance anxiety.

Indeed, findings from this study can lead to nursing education reform in regard to evaluation methods and faculty instructional strategies in the clinical setting. A reform in evaluation tools and methods to include the subjective experiences of the learner is required to understand the relationship between the learner and learning (Carter, 2018). Additionally, instructional strategies that demonstrate realness, empathy, support, and caring are critical in clinical education (Coutts & Rogers, 2000; Rogers, 1974a). Further, the perceptions of the learner are intimately tied to long-term resiliency, clinical reasoning, judgment, and critical thinking required to develop and retain a safe nursing workforce (Benner, Sutphen, Leonard, & Day, 2010; Hutchinson & Janiszewski-Goodin, 2013; Moscaritolo, 2009; Oetker-Black et al., 2014; Speck, 1990; Tolbert-Washington, 2012).

Academic Administration

Understanding the faculty member's role in performance anxiety as elucidated by this study will allow academic administration to better understand the multiple resources needed by faculty in their support of nursing students (NLN, 2010). Academic administration should be cognizant of faculty development in their teaching roles. While previous experiences as a student influence role development of clinical nursing faculty, formalized orientation, education, and mentoring in an educator role is needed to fully support student learning in clinical nursing education. As academic administration supports faculty development and instructional strategies in the reduction of performance

anxiety, more nursing students are likely to graduate and be retained in the nursing workforce.

Additionally, it is important for academic administrators to support faculty relationships with healthcare professionals working at clinical sites. Supportive and collaborative relationships in clinical education are required to effect positive change in learning (Carter, 2018; Rogers, 1974a, 1974b). As described in this study, performance anxiety is reduced, and learning improved, with positive relationships demonstrated between clinical faculty and healthcare professionals. As such, academic administrative support of these critical relationships will support student learning, reduce performance anxiety, and produce a more resilient and skilled nursing workforce.

Practice

Results of this study can influence practice improvement. Specifically, instructional strategy reform will reduce performance anxiety and develop a more resilient healthcare worker (Moscaritolo, 2009; Tolbert-Washington, 2012). Similarly, understanding performance anxiety in undergraduate clinical nursing education will allow for recognition of a continuation of the phenomenon as students transition to practice as licensed professionals.

Better prepared novice nurses entering the workforce will be retained in nursing, thus reducing the nursing shortage, as instructional strategies are reformed in an attempt to mitigate the harmful effects of performance anxiety (NLN, 2010; Tolbert-Washington, 2012; Turner & McCarthy, 2017). Further, the new graduates will be more able to adapt to the shifting healthcare environment, thus improving patient care (NLN, 2010; Tolbert-

Washington, 2012; Turner & McCarthy, 2017). Indeed, new graduates transitioning to practice can experience high levels of anxiety when not fully supported in his/her new practice role (Tolbert-Washington, 2009, 2012). Through an understanding of performance anxiety, support of the student and the new graduate can allow for a retained nursing workforce to aid in the reduction of the nursing shortage (NLN, 2010; Tolbert-Washington, 2009). Last, the retained nursing workforce will be better skilled in clinical reasoning, judgment, and critical thinking (NLN, 2010; Tolbert-Washington, 2009).

Policy

Similar to practice changes, policy change in the healthcare environment will be affected through an understanding of performance anxiety. Specifically, policy change will occur in the healthcare environment to support graduate nurses through their transition to practice. Additionally, academic policy makers will support policies to support faculty development in reducing performance anxiety. Policy changes in the form of policy and academia leads to positive social change through the overall reduction of performance anxiety in the development of a resilient and skilled workforce, thus reducing the nursing shortage and improving patient care.

Last, national healthcare policy discussions lack a consistent presence from nursing voices (NLN, 2019). Advancing the scholarship of teaching in nursing education is one method to support the development of a strong nursing workforce. Indeed, the development of a strong nursing workforce is critical in ensuring more nurses have the confidence and resiliency to be leaders within healthcare policy reform discussions;

discussions which positively influence the health of the United States and the larger global community (NLN, 2019).

Theory and Methodology

Descriptive phenomenological studies allow for a better understanding of participants lived experiences with a phenomenon. Understanding of shared lived experiences informs positive social change. Further, understanding experiences through the lens of a conceptual framework provides a foundation for generation of new knowledge. Indeed, understanding the phenomenon of performance anxiety through the conceptual framework of humanism provides a beginning for larger studies of diverse participants pools, formation of interventional strategy studies, and a nursing centric definition of the phenomenon to best inform educational strategies. Future studies and educational reform will affect long-term positive social change through the creation of a resilient and retained nursing workforce.

Social Change

Last, this study will effect positive social change. Change in nursing education, academic administration, practice, policy, theory, and methodology areas will promote the worth, dignity, and development of nursing students. Effective development of nursing students leads to the betterment of organizations and communities where the students enter and continue to practice as professionals. Indeed, the understanding of performance anxiety in nursing clinical education effects positive social change through educational reform of these emerging nurses. An improved nursing workforce in

numbers, skills, and resiliency will improve the human and social conditions in the organizations and communities in which they serve in practice.

This study addresses a gap in the literature wherein a more detailed understanding is required of lived experiences of faculty with student performance anxiety in clinical nursing education. Understanding performance anxiety in this setting will produce a lasting and far reaching effect of social change. Change initiatives will inform curricula change, textbook development, future literature in nursing education studies, development of faculty and adjunct teaching support, and nursing students themselves. As the educational environment evolves, the patient care from the affected students will also evolve, thus providing long-term, positive change, in healthcare.

Conclusion

In this qualitative, descriptive phenomenology study, the lived experiences of clinical nurse faculty with student performance anxiety were explored. Performance anxiety in undergraduate nursing education has been an unexplored topic. While performance anxiety has been explored in other professions, the concept has not been fully explored nor defined in clinical nursing education (Chaube, 2013; Helding, 2016; Malina, 2013; Melincavage, 2011; Schneider & Chesky, 2011; Sieger, 2017; Turner & McCarthy, 2017). It is important to understand performance anxiety in nursing education to effect lasting, positive social change in education, administration, policy, and practice reform.

This study allowed for a clear definition of the phenomenon of performance anxiety in clinical nursing education. Based on findings generated from this study,

performance anxiety in nursing education can be defined as a state of situational nervousness or fear when encountering perceived new experiences, critical evaluations, power-differences, or a sense of under preparedness. Performance anxiety can lead to physical or emotional inability to perform a prescribed task, function, or duty. In addition to defining performance anxiety, findings of this study indicate a need for reform in clinical nursing education evaluation and attention to role development of clinical nursing faculty. Further, contributive and mitigating factors of performance anxiety were described. These factors are important when considering future research, educational reform, and faculty development. A focus on performance anxiety in clinical learning through reform to nursing education, academic administration, policy, and practice can support positive social change. Specifically, well-supported students with a reduced level of performance anxiety will evolve into a skilled, resilient, and retained nursing workforce in organizations and communities.

References

Accreditation Commission for Education in Nursing. (2018). *ACEN accreditation manual.* Retrieved from http://www.acenursing.net/manuals/sc2017_A.pdf

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies, 5*(2), 272–281. Retrieved from https://journals.co.za/content/journal/sl_jeteraps

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation.* San Francisco, CA: Jossey-Bass.

Billings, D. M., & Halstead, J. A. (2012). *Teaching in nursing: A guide for faculty* (4th ed.). St. Louis, MO: Elsevier.

Bouffard, T., Boisvert, J., Vezeau, C., & Larouche, C. (1995). The impact of goal orientation on self-regulation and performance among college students. *British Journal of Educational Psychology, 65,* 317–329. doi:10.1111/j.2044-8279.1995.tb01152.x

Burkholder, G. J., Cox, K. A., & Crawford, L. M. (2016). *The scholar-practitioner's guide to research design.* Baltimore, MD: Laureate Publishing.

Burkley, J. (2018). Adopt zero tolerance for hospital staff bullying nursing students. *American Journal of Nursing, 118*(5), 11. doi:10.1097/01.naj.0000532811.74089.c0

Carter, S. (2017). Humanism. *Research Starters Education,* 1–8.

Chaube, N. (2013). Performance anxiety in sports personnel. *Indian Journal of Health*

and Wellbeing, 4(8), 1625–1627. Retrieved from http://www.i-scholar.in/index.php/ijhw

Cheung, Y-M., & Kit-fong, T. (2011). Nursing students' anxiety and clinical performance. *Journal of Nursing Education, 50*(5), 286–289. doi:10.3928/01484834-20110131-08

Cohen, M. T. (2012). The importance of self-regulation for college student learning. *College Student Journal, 46*(4), 892–902. Retrieved from https://www.ingentaconnect.com/content/prin/csj

Cook, L. J. (2005). Inviting teaching behaviors of clinical faculty and nursing students' anxiety. *Journal of Nursing Education, 44*(4), 156–161. doi:10.3928/01484834-20050401-04

Cornine, A. (2020). Reducing nursing student anxiety in the clinical setting: An integrative review. *Nursing Education Perspectives, 41*(4), 229–234. doi:10.1097/01.nep.0000000000000633

Coutts, L. C., & Rogers, J. C. (2000). Humanism: Is its evaluation captured in commonly used performance measures? *Teaching and Learning in Medicine, 12*(1), 28–32. doi:10.1207/s15328015tlm1201_5

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed). Thousand Oaks, CA: Sage.

Fawcett, J., & Garity, J. (2009). *Evaluating research for evidence-based nursing practice.* Philadelphia, PA: F.A. Davis Company.

Groenewald, T. (2004). A phenomenological research design illustrated. *International*

Journal of Qualitative Methods, 3(1). 42–55. doi:10.1177/160940690400300104

Harrison-White, K., & Owens, J. (2018). Nurse link lecturers' perceptions of the challenges facing student nurses in clinical learning environments: A qualitative study. *Nurse Education in Practice, 32*, 78–83. doi: 10.1016;j.nepr.2018.07.012

Helding, L. (2016). Music performance anxiety. *Journal of Singing,* 73(1), 83–90. Retrieved from https://www.nats.org/cgi/page.cgi/_subscription.html

Horsley, T. L. (2012). *The effect of nursing faculty presence on students' level of anxiety, self-confidence, and clinical performance during a clinical simulation experience* [dissertation]. Lawrence, KS: University of Kansas. doi: 10.1016/j.ecns.2014.09.012

Hull, E. (2017). Conducting research in your own backyard. *Teaching and Learning in Nursing, 12*, 232–233. doi: 10.1016/j.teln.2017.06.011

Hutchinson, T. L., & Janiszewski-Goodin, H. (2013). Nursing student anxiety as a context for teaching/learning. *Journal of Holistic Nursing, 31*(1), 19–24. doi: 10.1177/0898010112462067

Jackson, C., Vaughan, D. R., & Brown, L. (2018). Discovering lived experiences through descriptive phenomenology. *International Journal of Contemporary Hospitality Management, 30*(11), 3309–3325. doi: 10.1108/ijchm-10-2017-0707

Kleehammer, K., Hart, A. L., & Keck, J. F. (1990). Nursing students' perceptions of anxiety-producing situations in the clinical setting. *Journal of Nursing Education, 29*(4), 183–187. doi: 10.3928/0148-4834-19900401-10

Kleiman, S. (2004). Phenomenology: To wonder and search for meanings. *Nurse*

Researcher, 11(4), 7–19. doi: 10.7748/nr2004.07.11.4.7.c6211

Knowles, M. S., Holton III., E. F., & Swanson, R. (2015). *The adult learner: The definitive classic in adult education and human resource development* (8th ed.). New York, NY: Routledge.

Koharchik, L. (2018). Instructor incivility toward nursing students. *American Journal of Nursing, 118*(7), 64-66. doi: 10.1097/01.naj.0000541442.76122.e4

Levy, J. J., & Lounsbury, J. W. (2011). Big Five personality traits and performance anxiety in relation to marching arts satisfaction. *Work – A Journal of Prevention Assessment & Rehabilitation, 40*(3), 297–302. doi: 10.3233/wor-2011-1233

Lin, H. H. (2016). Effectiveness of simulation-based learning on student nurses' self-efficacy and performance while learning fundamental nursing skills. *Technology and Health Care, 24,* S369–S375. doi: 10.3233/thc-151094

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: SAGE.

Lincoln, Y. S., & Guba, E. G. (1989). Ethics: The failure of positivist science. *Review of Higher Education, 12*(3), 221–240. doi: 10.1353/rhe.1989.0017

Malina, D. (2013). Performance anxiety - What can health care learn from K-12 education? *The New England Journal of Medicine,* 369(13), 1268–1272. doi: 10.1056/nejmms1306048

Manderino, M. A., & Yonkman, C. A. (1985). Stress inoculation: A method of helping students cope with anxiety related to clinical performance. *Journal of Nursing Education, 24*(3), 115–118. doi: 10.1002/j.2048-7940.1986.tb00487.x

Matua, G. A., & Van Der Wal, D. M. (2015). Differentiating between descriptive and

interpretive phenomenological research approaches. *Nurse Researcher, 22*(6), 22–27. doi: 10.7748/nr.22.6.22.e1344

Melincavage, S. M. (2011). Student nurses' experiences of anxiety in the clinical setting. *Nurse Education Today, 31,* 785–789. doi: 10.1016/j.nedt.2011.05.007

Morse, J. M., Hupcey, J. E., Penrod, J., & Mitcham, C. (2002). Integrating concepts for the development of qualitatively-derived theory. *Research and Theory for Nursing Practice: An International Journal, 16*(1), 5–18. doi: 10.1891/rtnp.16.1.5.52995

Moscaritolo, L. M. (2009). Interventional strategies to decrease nursing student anxiety in clinical learning environment. *Journal of Nursing Education, 48*(1), 17–23. doi: 10.3928/01484834-20090101-08

Moses, N. W., & Friedman, M. M. (1986). Using humor in evaluating student performance. *Journal of Nursing Education, 25*(8), 328–333. doi: 10.3928/0148-4834-19861001-07

Namageyo-Funa, A., Rimando, M., Brace, A. M., Christiana, R. W., Fowles, T. L., Davis, T. L., …Sealy, D. A. (2014). Recruitment in qualitative public health research: Lessons learned during dissertation sample recruitment. *The Qualitative Report, 19*(4), 1–17. Retrieved from https://nsuworks.nova.edu/tqr/vol19/iss4/3

National League for Nursing. (2010). *Think tank on simulation for high-stakes evaluation in nursing education.* Retrieved from http://nln.org/advocacy-public-policy/issues/high-stakes-testing

National League for Nursing. (2018). *Biennial survey of schools of nursing survey highlights 2017-2018.* Retrieved from http://www.nln.org/newsroom/nursing-education-statistics

National League for Nursing. (2019). *National league for nursing public policy agenda (2019-2020).* Retrieved from http://www.nln.org/docs/default-source/advocacy-public-policy/public-policy-agenda-pdf49b8c85c78366c709642ff00005f0421.pdf?sfvrsn=2

Oetker-Black, S., Krey, J., Underwood, S., Price, A., & DeMetro, N. (2014). Psychometric evaluation of the clinical skills self-efficacy scale. *Nursing Education Perspectives, 35*(4), 253–256. doi: 10.5480/11-739.1

Pandey, S. C., & Patnaik, S. (2014). Establishing reliability and validity in qualitative inquiry: A critical examination. *Jharkhand Journal of Development and Management Studies, 12*(1), 5743–5753. Retrieved from https://www.xiss.ac.in/JJDMS/

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed). Thousand Oaks, CA: SAGE.

Purdy, M. (1997). Humanist ideology and nurse education. *Nurse Education Today, 17*(3), 192–195. doi: 10.1016/s0260-6917(97)80132-3

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Thousand Oaks, CA: SAGE.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory.* London, England: Constable.

Rogers, C. R. (1974a). Can learning encompass both ideas and feelings? *Education, 95*(2), 103–114. Retrieved from http://carlrrogers.org/articlesbyCarl.html

Rogers, C. R. (1974b). Questions I would ask myself if I were a teacher. *Education, 95*(2), 134–139. Retrieved from http://carlrrogers.org/articlesbyCarl.html

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data (3rd ed.).* Thousand Oaks, CA: SAGE.

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing & Health, 23*, 334–340. doi: 10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g

Schneider, E., & Chesky, K. (2011). Social support and performance anxiety of college music students. *Medical Problems of Performing Artists, 26*(3), 157–163. doi: 10.21091.mppa.2011.3025

Schwind, J. K., McCay, E., Beanlands, H., Martin, L. S., Martin, J., & Binder, M. (2017). Mindfulness practice as a teaching-learning strategy in higher education: A qualitative exploratory pilot study. *Nurse Education Today, 50*, 92–96. doi: 10.106/j.nedt.2016.12.017

Shenton, A. K., & Hayter, S. (2004). Strategies for gaining access to organisations and informants in qualitative studies. *Education for Information, 22*, 223–231. doi: 10.3233/efi-2004-223-404

Sieger, C. (2017). Music performance anxiety in instrumental music students: A multiple case study of teacher perspectives. *Contributions to Music Education, 42*, 35–52. Retrieved from https://eric.ed.gov/?id=EJ1141731

Speck, B. (1990). The effect of guided imagery upon first semester nursing students performing their first injections. *Journal of Nursing Education, 29*(8), 346–350. doi: 10.3928/0148-4834-19901001-06

Thomas, C. A. (2017) Stifled learning: Nursing students' experience of incivility in clinical education. *Journal of Christian Nursing, 35*(2), 106–111. doi: 10.1097/cnj.0000000000000477

Tolbert-Washington, G. (2009). *Effects of anxiety reducing interventions on performance anxiety in graduate nurses* [dissertation]. Johnson City, TN: East Tennessee State University. Retrieved from https://dc.etsu.edu/cgi/viewcontent.cgi?article=3231&context=etd

Tolbert-Washington, G. (2012). Performance anxiety in new graduate nurses: Is it for real? *Dimensions of Critical Care Nursing, 31*(5), 295–300. doi: 10.1097/dcc.0b013e3182619b4c

Turner, K., & McCarthy, V. L. (2017). Stress and anxiety among nursing students: A review of intervention strategies in literature between 2009 and 2015. *Nurse Education in Practice, 22,* 21–29. doi: 10.1016/j.nepr.2016.11.002

Willis, D. G., Sullivan-Bolyai, S., Knafl, K., & Cohen, M. Z. (2016). Distinguishing features and similarities between descriptive phenomenological and qualitative description research. *Western Journal of Nursing Research, 38*(9), 1185–1204. doi: 10.1177/0193945916645499

Woodworth, J. A. (2016). Predictive factors impacting intent-to-stay teaching for associate degree adjunct clinical nurse faculty. *Teaching and Learning in Nursing,*

11, 147–151. doi: 10.1016/j.teln.2016.06.006

Appendix A: Recruitment Email

Date:

Dear (Program Director/Faculty Member/Organization Leader):

I am Heather LaPoint, a PhD candidate in Nursing Education at Walden University. I write to you as I am conducting an original research study exploring performance anxiety in clinical nursing undergraduate education. The purpose of this study is to explore a knowledge gap surrounding the associate degree nursing faculty lived experience with performance anxiety in clinical education. The implications for positive social change through this research are decreasing the nursing shortage by increasing a resilient and retained nursing workforce through an enhanced understanding of performance anxiety in the clinical setting.

I humbly request your assistance to solicit participants through your (program/organization). If you are willing to assist in gaining access to participants for my dissertation study, please forward the attached flyer to faculty members matching inclusion criteria for the study. Interested participants can best contact me at XXX.

Participants in the study should have more than 1 year of clinical nursing instruction experience at the associate degree level of education within the United States. I will travel to meet selected participants for a face-to-face, one-on-one interview lasting approximately 2 hours. If face-to-face meetings are not possible, video conferencing for the interview is available. The meeting will begin with completion of a demographic questionnaire. The 2 hour interview will be audio-taped and transcribed. All information will be kept confidential and secured. Deidentified information will only be shared with Walden University dissertation committee members as appropriate for the completion of the dissertation process.

Thank you in advance for your assistance in generating research to fill this important knowledge gap. Thank you as well for the opportunity to speak with your faculty. I look forward to continued communication with you.

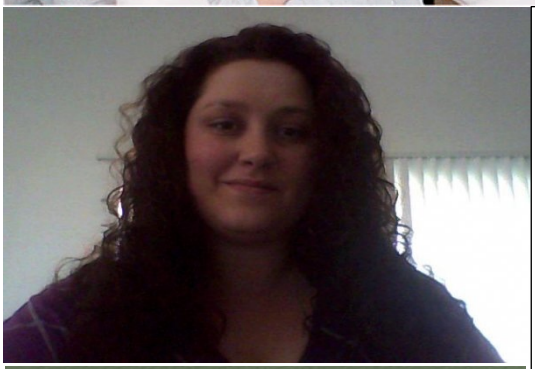
Regards,

Heather LaPoint, MSN, Ed., RN, CNE, CCRN-K

Appendix B: Informational Recruitment Flyer

Doctoral Research Study

The Lived Experience of Clinical Nursing Faculty With Student Performance Anxiety



Heather LaPoint, MSN, Ed., RN, CNE, CCRN-K

Cell: XXX
Email: XXX

Walden IRB approval number: 02-06-20-0658329 exp: 2/5/2021

- I am seeking participants for my dissertation research study.
- The purpose of this research is to address a knowledge gap surrounding the associate degree nurse faculty lived experience with performance anxiety in clinical education.
- Participants will be requested to participate in one, face-to-face or video conference, one-on-one, audio recorded interview lasting approximately 2 hours.
- If you match inclusion criteria listed below and can assist, please contact me for further information.
- Participation is voluntary and participants may withdraw from the study at any time.
- Inclusion criteria:
  - Nursing clinical faculty with greater than 1 year of experience in an associate degree nursing program within the United States

Appendix C: Demographic Questionnaire

Directions: Please complete the following demographic profile for participation in this study. Please do not include your name or identifying information. Thank you.

Participant ID: _____

1. Gender: Male ☐ Female ☐ Other ☐ _____ Prefer not to answer ☐
2. Number of years as a clinical nurse faculty member: _____ years
3. Highest level of nursing educational preparation: Diploma ☐ ADN ☐ BSN ☐ MS ☐ Doctoral ☐
4. What was your graduate nursing specialization (ie. Nursing education, adult health, etc.)?: _____
5. Year of graduation with highest level of education: _____
6. What form of continuing education do you complete?:

   _____
7. How often do you complete continuing education?:

   _____
8. What certifications do you hold?: _____
9. Do you currently practice nursing outside of academia? Yes ☐ No ☐
10. If you practice, what is your practice area?: _____
11. What types of nursing programs have you instructed in clinically?: Diploma ☐ ADN ☐ BSN ☐ MS ☐ Doctoral ☐
12. What type of program do you currently instruct in? Diploma ☐ ADN ☐ BSN ☐ MS ☐ Doctoral ☐
13. What is the socioeconomic demographic of your current clinical nursing students?: _____
14. What are the genders represented for your current clinical nursing students? Select all that apply: Male ☐ Female ☐ Other ☐ _____ Prefer not to answer ☐

15. What ages are represented by your current clinical nursing students? Select all that apply: 18-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-100
16. What races are represented by your current clinical nursing students? Select all that apply: Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Other ☐ Prefer not to answer ☐

Appendix D: Interview Guide

1. Please describe your clinical learning environment.
    a. Describe the unit.
    b. Tell me about the work culture on the unit.
    c. Tell me about interactions students have with other healthcare professionals?

2. Describe for me the relationship you have with clinical nursing students.
    a. How do you develop that relationship from the first day to the last?
    b. What is your motivation in development of a relationship?

3. Tell me about a typical clinical day with students.

4. Describe for me the environment you create or use when discussing clinical education moments with students.

5. Tell me how students are evaluated in clinical learning.
    a. Objective evaluation?
    b. Subjective evaluation?
    c. Student and faculty comments included in formal evaluation?

6. How do you self-reflect as a clinical instructor?
    a. How do those self-reflections influence your instruction strategies?

7. From your perspective, what is performance anxiety?

8. Tell me about a time you encountered student performance anxiety in clinical.
    a. What did it look like?
    b. What did you do when you encountered student performance anxiety?
    c. What made you respond as you did?
    d. What was the outcome for the student in that situation?
    e. What was the outcome for the student moving through the nursing program?
    f. What was most important to you about your experience with the student?

9. Tell me about your perceptions of your role in student performance anxiety.
    a. How did you develop your perceptions?