ANXIETY IN STUDENT NURSES IN THE CLINICAL SETTING:
A PHENOMENOLOGICAL STUDY

A Dissertation in
Adult Education
by
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Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Doctor of Education

May 2008
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ABSTRACT

Anxiety! A word that can mean many things to many people and many things to the same person. A word that is likely to provoke uncomfortable thoughts and feelings. Anxiety usually has an effect on a person’s well-being and unfortunately, it may be an adverse effect. Anxiety can affect aspects of people’s lives that are of the utmost importance to them including learning and performance in educational settings. As a nursing instructor, I teach student nurses in a baccalaureate program of nursing that prepares students to become professional registered nurses. I encounter student nurses who experience anxiety while learning in the clinical setting.

Hence, the primary purpose of this interpretive Heideggerian heuristic phenomenological study was to examine student nurses’ perception of anxiety in the clinical setting. More specifically, to investigate how student nurses make meaning of, interpret, and perceive their anxiety in the clinical setting. It was also the intent of this research study to investigate how student nurses contextualize, and/or understand their anxiety in the clinical setting. Situated cognition theory is the theoretical framework for this research study. The participants are from two baccalaureate programs of nursing in northeastern Pennsylvania.

This research study helps nurse educators to understand the meaning of anxiety in student nurses in the clinical setting. Research has shown that anxiety is a factor in student nurses leaving nursing education programs. If nurse educators can better understand the anxiety of student nurses, they will be able to develop curricula and
educational interventions to minimize the anxiety of student nurses and enhance learning in the clinical setting.

The main method of data collection for this research study was in-depth, unstructured face-to-face interviews with 7 student nurse participants which were tape recorded and transcribed verbatim. A secondary source of data collection from these same participants was the creation of an artform where the student nurses expressed their anxiety artistically. This metaphor creation was accompanied by a focus group interview which also was tape recorded and transcribed verbatim. Additional secondary sources of data collection were documents such as clinical worksheets, journals, pictures, and artforms. The student nurses were asked if they have such documents to help them make meaning of their anxiety in the clinical setting. Field notes were used as a supplement to data collection.

The data were analyzed using a thematic analysis. Seven themes emerged from the data and were reported in the rich descriptive words of the participants:

(a) Experiencing Inexperience, (b) Being Demeaned, (c) Being Exposed, (d) Unrealistic Expectations, (e) Being Abandoned, (f) Sensing Difference, and (g) Being Uncertain of Ability.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS .................................................................................................................. viii</td>
</tr>
<tr>
<td>DEDICATION ................................................................................................................................. ix</td>
</tr>
<tr>
<td>Chapter 1. INTRODUCTION AND PURPOSE .......................................................... 1</td>
</tr>
<tr>
<td>Introduction ............................................................................................................................ 1</td>
</tr>
<tr>
<td>Background of the Problem .............................................................................................. 3</td>
</tr>
<tr>
<td>Purpose of the Research ............................................................................................ 5</td>
</tr>
<tr>
<td>Research Questions ....................................................................................................... 5</td>
</tr>
<tr>
<td>Theoretical Framework ............................................................................................... 6</td>
</tr>
<tr>
<td>Overview of Research Methods and Design .......................................................... 7</td>
</tr>
<tr>
<td>Significance of the Study ........................................................................................... 9</td>
</tr>
<tr>
<td>Assumptions and Limitations of the Study .............................................. 12</td>
</tr>
<tr>
<td>Definition of Terms ................................................................................................. 14</td>
</tr>
<tr>
<td>Summary of Chapter 1 ......................................................................................... 16</td>
</tr>
<tr>
<td>Chapter 2. REVIEW OF THE LITERATURE ....................................................... 17</td>
</tr>
<tr>
<td>Section I: Purpose of a Literature Review .......................................................... 18</td>
</tr>
<tr>
<td>Section II: Educational Preparation for the Profession of Nursing ........................................... 19</td>
</tr>
<tr>
<td>Education of Professionals .......................................................................................... 19</td>
</tr>
<tr>
<td>Education of Professionals in Nursing ................................................................. 20</td>
</tr>
<tr>
<td>Theoretical and Clinical Components of Nursing Education ..................... 23</td>
</tr>
<tr>
<td>Section III: The Theoretical Framework: Situated Cognition Theory ...... 25</td>
</tr>
<tr>
<td>Overview of Adult Learning Theories ................................................................. 25</td>
</tr>
<tr>
<td>Situated Cognition Theory ...................................................................................... 27</td>
</tr>
<tr>
<td>Section IV: Anxiety and Stress ........................................................................... 34</td>
</tr>
<tr>
<td>Philosophical Underpinnings of Anxiety ............................................................. 35</td>
</tr>
<tr>
<td>Existentialism ............................................................................................................... 35</td>
</tr>
<tr>
<td>Fear and anxiety ........................................................................................................... 37</td>
</tr>
<tr>
<td>Origin and Definitions of the Terms Stress and Anxiety ..................................... 39</td>
</tr>
<tr>
<td>Stress ............................................................................................................................... 39</td>
</tr>
<tr>
<td>Anxiety ............................................................................................................................. 41</td>
</tr>
<tr>
<td>Difference between stress and anxiety ............................................................... 43</td>
</tr>
<tr>
<td>Stress, fear, threat, and anxiety ............................................................................ 44</td>
</tr>
<tr>
<td>State anxiety and trait anxiety ............................................................................... 45</td>
</tr>
<tr>
<td>Human Reaction to Stress and Anxiety ................................................................. 46</td>
</tr>
<tr>
<td>Fight-or-flight response ......................................................................................... 46</td>
</tr>
</tbody>
</table>
Chapter 4. PRESENTATION OF THE FINDINGS

Profile of the Participants
Data Display
Themes
  Experiencing Inexperience
    Inconsideration of inexperience
    Encountering inexperienced instructors and peers
  Being Demeaned
  Being Exposed
Unrealistic Expectations
Being Abandoned
Sensing Difference
  Differing clinical experiences
  Competition among peers
  Being Uncertain of Ability
Summary of Chapter 4

Chapter 5. SUMMARY, DISCUSSION, AND IMPLICATIONS

Summary of the Findings
Discussion of the Findings
  Experiencing Inexperience
    Inconsideration of inexperience
    Encountering inexperienced faculty and peers
  Being Demeaned
  Being Exposed
Unrealistic Expectations
Being Abandoned
Sensing Difference
  Differing clinical experiences
  Competition among peers
  Being Uncertain of Ability
Implications for Practice
Implications for Further Research
References
ACKNOWLEDGEMENTS

To all those who showed me the way so that I can show others;

To all those who believed in me;

To all those who supported me in very many ways.

Thank you to my friend Tom who proofread, and proofread, and proofread.

A special thank you to my father Tony Melincavage and brothers Joseph and Michael Melincavage and their wives.
DEDICATION

This work is dedicated to the memory of my mother Betty Melincavage who watches over from above. Thank you, Mom!
CHAPTER 1
INTRODUCTION AND PURPOSE

Introduction

Anxiety! A word that can mean many things to many people and many things to the same person. A word that is likely to provoke uncomfortable thoughts and feelings. Anxiety usually has an effect on a person’s well-being and unfortunately, it may be an adverse effect. Anxiety can affect aspects of people’s lives that are of the utmost importance to them including learning and performance in educational settings.

As a nursing instructor, I teach student nurses in a baccalaureate program of nursing that prepares students to become professional registered nurses. I encounter student nurses who experience anxiety while learning in the clinical setting. Their anxiety has become evident during various situations of the clinical day. Sometimes anxiety is apparent when the student nurse is performing procedures during patient care. At times their anxiety is evident when they are discussing their patient’s clinical situation with me on a one-to-one basis or during group discussions in my presence and the presence of their student nurse peers. I have witnessed their anxiety before, during, and after the clinical experience.

Student nurses express anxiety in different ways. Some students give voice to their anxiety. These students verbalize to me that they feel anxious and nervous. For some students, anxiety is expressed in a physical way. For example, their hands shake when doing procedures. Other signs of anxiety may include lack of eye contact or little verbalization during my interaction with them. I do acknowledge that my assessment of the physical signs of anxiety are objective but non-specific, so in these situations I have,
at times, confirmed their anxiety by asking them how they feel. It is also possible that some student nurses experience anxiety in the clinical without having outward signs.

It is my thought that students are unaware of the origins of their anxiety. I have asked them to explain why they feel anxious but sometimes they do not have an answer. This leaves me to question the source, if indeed a source exists. Perhaps the student has the perspective that the teacher is authoritative, as opposed to a facilitator. This perspective thus creates a feeling of anxiety that the student is reluctant to verbalize to me. Perhaps the student is concerned about hurting the patient. Perhaps the student has feelings of inadequacy or fears a lack of knowledge when performing a procedure. Perhaps they are worried about performing a procedure incorrectly in the presence of a patient. Perhaps the anxiety is unrelated to the clinical situation and involves a concern in the personal life of the student.

As a student nurse, I had anxiety while in nursing school. My dream, from the time I was a young girl, was to become a nurse. I applied to a four-year college program and was accepted to the college, but was denied admission to the nursing program of that college because the incoming freshmen class had reached its quota of students who wanted to enter the nursing program. At the time of admission I was told that I could enter the college and transfer to the nursing program at a later date. After two years of taking nursing related courses at the college, I was not granted permission to transfer into the nursing program. I decided that this would not be an obstacle for me to become a nurse. I applied to a diploma program of nursing and was admitted. During my three years of nursing school, I always had the feeling that if I did not succeed here, I would never become a nurse. My dream of becoming a nurse would be shattered. Then what
would I become? What would I do with my life? How would I survive? Hence, my source of anxiety may not have been the clinical or academic challenges of the educational program; it was likely my concern about failure.

It is for the above reasons that I decided to conduct this research study. Anxiety can be a barrier to optimum learning in the clinical setting (Meisenhelder, 1987). Nurse educators may be able to optimize the learning of student nurses by decreasing their anxiety. The purpose of this research study was to better understand student nurses’ perception of anxiety in the clinical setting and to understand what anxiety means for them.

Background of the Problem

To introduce the topic of anxiety, I need to begin with a brief explanation of the terms stress and anxiety. Some people use the terms stress and anxiety synonymously and interchangeably (May, 1996). Although the terms stress and anxiety have come to be somewhat indistinguishable, the meanings of these words are different. Stress is something that is objectively described and identified by a person as a physical or psychological danger. The person is afraid of a specific object (Spielberger, 1979). Anxiety, on the other hand, is subjective in nature. A person experiences a feeling of uneasiness and apprehension about an undefined threat. They feel that their self-esteem or well-being is threatened (Lader, 1984). In this introductory piece, I use the terms as used by the authors in the literature. In Chapter 2 of this research study I provide an in-depth discussion of the meaning of these terms. Also, included in Chapter 2 are in-depth discussions about anxiety and performance, and stress and anxiety in student nurses in the clinical setting.
Some student nurses experience high levels of stress in the clinical setting (Shipton, 2002) more so than in the classroom or lab setting (Kleehammer, Hart, & Keck, 1990). Anxiety has been found to be one of four major obstacles to learning in the clinical setting (Becker & Neuwirth, 2002). Mild anxiety may enhance learning but as anxiety levels increase, learning decreases (Audet, 1995).

Some students are unable to perform or they experience incomplete learning when they are anxious (Schmeiser & Yehle, 2001). Anxious students panic when they feel unable to perform a difficult task. They start to think about their sweaty palms and are unable to concentrate on the task to be completed. A panic reaction impairs cognition which may result in memory deficit (Meisenhelder, 1987).

Krichbaum (1994) and Massarweh (1999) have written conceptual pieces that address clinical teaching effectiveness in nursing. Although these conceptual pieces do not specifically discuss how to decrease anxiety in student nurses they do address clinical teaching effectiveness, which I believe is an integral piece of decreasing anxiety in student nurses. Little research has been done on the topic of clinical teaching effectiveness in nursing (Krichbaum, 1994). Krichbaum (1994) studied teaching behaviors of critical care staff nurses who served as preceptors for baccalaureate nursing students, but she did not study teaching behaviors of nursing faculty. Massarweh (1999) queries “what elements make up a good clinical teacher?” (p.44). She reports that some studies address behaviors, such as organization, using objectives, and providing feedback, which can help a nurse educator to excel as a clinical instructor, but few have identified specific techniques the nurse educator can utilize in the clinical setting to promote a positive clinical experience. These literary pieces address clinical teaching effectiveness
by staff nurses and how nursing faculty can promote a positive clinical experience, but they do not specifically address the issue of how nursing faculty can assist student nurses to minimize anxiety in the clinical setting.

**Purpose of the Research**

The purpose of this research study was to better understand student nurses’ perception of anxiety in the clinical setting and to understand what anxiety means for them. This qualitative study expands the existing body of knowledge about anxiety in student nurses in the clinical setting. Most of the current literature is based primarily on quantitative research so the experiences and perceptions of the students were not captured in a deep or meaningful way. In this qualitative study, individual interviews and a focus group interview with the same participants provided the opportunity for student nurse participants to describe their perception of anxiety in the clinical setting in their own words. This research study literally gave voice to an emotion that is experienced by many student nurses during their clinical educational experience.

**Research Questions**

The guiding research questions for this study were:

1. How do student nurses make meaning of, interpret, and perceive their anxiety in the clinical setting?

2. How do student nurses contextualize, and/or understand their anxiety in the clinical setting?
Theoretical Framework

“Every human thought and action is adapted to the environment, that is situated, because what people perceive, and how they conceive of their activity, and what they physically do develop together” (Clancey, 1997, pp. 1-2). This quote exemplifies the learning that takes place by student nurses in the clinical setting. The learning is situated in the clinical environment. It is in the clinical learning environment that students develop their perceptions about learning in that environment, where they conceive their activity, and where they consider how their actions in that environment occur. Their perceptions and actions develop together.

Situated cognition is a learning theory that informed this research study. This theory was developed by Lave (1988) and then further developed by Lave and Wenger (1999). The premise of situated cognition is that the learning process is connected to the situation where the learning is occurring. The physical and social experiences and the tools used during an experience are very important pieces of the entire learning process (Merriam & Caffarella, 1999). This quote from Wilson (1993) further clarifies how the learning theory of situated cognition informs this study, “Learning is…social in nature because it occurs with other people; it is “tool dependent” because the setting provides mechanisms [for this research study - equipment for patient care] that aid…and structure the cognitive processes; and, finally, it is the interaction with the setting itself in relation to its social and tool-dependent nature that determines learning.”

The clinical learning environment is very much connected to the learning process of student nurses. It is in the clinical learning environment where students learn the physical and social aspects of the profession of nursing and use tools to provide care for
patients. During the clinical experience students have physical contact with patients and are exposed to a physical environment that is rich with experiences that stimulate, intrigue, and tantalize all of the five human senses. Students socialize and interact with various people in the clinical learning environment. They interact with peers in their clinical group and with student nurses from other schools, students of other medical professions and disciplines, professionals of various disciplines, patients, and the significant people in the lives of their patients. During clinical experiences, students use various forms of technology and tools to deliver patient care. All of these experiences are incorporated into the learning process of student nurses. It is in these experiences that student nurses learn and experience anxiety. The anxiety that they experience may interfere with learning.

Overview of Research Methods and Design

Anxiety is a feeling that is unique to each individual. How one makes meaning of anxiety or what anxiety means varies from person to person. Since qualitative research focuses on understanding how people make meaning of their experiences, a qualitative study was appropriate for understanding how student nurses make meaning of their anxiety in the clinical setting.

The paradigm for this research study is interpretive. The researcher using this paradigm attempts to understand how the participants construct meaning in their daily lives and experiences, and tries to understand the participants’ interpretation of reality (Merriam, 2002). According to Crotty (1998), “…meanings are constructed by human beings as they engage with the world they are interpreting” (pp. 42-43).
Phenomenology is the research methodology for this study. According to Merriam (2002), “…a phenomenological study focuses on the essence or structure of an experience. Phenomenologists are interested in showing how complex meanings are built out of simple units of direct experience” (p. 7). The premise of a phenomenological study is that there is an essence about the experience to be shared. Phenomenolgical research studies attempt to unearth those inner experiences that occur in daily life, yet often are not explored, either verbally or brought into conscious thought, by those who experience them (Merriam, 2002). Researchers who use phenomenology want to understand the meaning of particular experiences of average people (Bogdan & Biklen, 2003). I have observed that student nurses experience anxiety in the clinical setting. This is an essence in their experience as students in the clinical setting. I examined the anxiety that student nurses experience in the clinical setting and described how they contextualized it and what it means for them.

The purposeful sample was 7 student nurses who had completed at least one semester of clinical nursing experience in a baccalaureate program of nursing and who have experienced anxiety in the clinical setting. The participants were from one private college and one private university in northeastern Pennsylvania.

A face-to-face interview with individual participants was the primary tool used to collect data for this research study. The qualitative interview permits the researcher to gain access to the lived experience of the participants who experienced the phenomenon of interest (Kvale, 1996). By direct interaction with the participant, the researcher purposefully encourages the participant to discuss the phenomenon (Merriam & Simpson, 2000). The interview process permits the participants to describe the phenomena in their
own words so that the researcher can consider how the participant made meaning of the phenomena (Bogdan & Biklen, 2003). I believe that by using interviews to collect data I obtained a sense of how the participants perceived, contextualized, and understood their anxiety.

Another method of data collection was the creation of a metaphor where the participants expressed their anxiety in the clinical setting artistically. When individual interviews were completed with all of the participants, the participants were then gathered as a group and were asked to express their anxiety in the clinical setting and its meaning by creating an artform. Immediately following the creation of their artform, a focus group interview occurred. The data collected during the focus group interview became part of the data collection. According to Lawrence and Mealman (2000), “artistic forms of collecting data assist the research participants in accessing knowledge that cannot be expressed in mere words” (p. 1). Field notes, which included my reflections about data collection, were used as a supplement to data collection. The metaphor creation and the use of field notes will be discussed in more depth in Chapter 3.

Significance of the Study

This research study helps nurse educators to understand the meaning of anxiety in student nurses in the clinical setting. Anxiety has been known to result in student nurses leaving nursing programs (Morgan, 2001). If nurse educators can better understand the anxiety of student nurses, they will be able to develop curricula and educational interventions to minimize the anxiety of student nurses. Students may then be more likely to continue their education and they will have the opportunity to have a rewarding career in the profession of nursing.
It is known that mild anxiety may be beneficial in the learning process. However, anxiety may interfere with the performance of a student (Schmeiser & Yehle, 2001). If a student experiences an excess amount of anxiety, the anxiety may have a negative effect, resulting in decreased learning (Audet, 1995). Some student nurses do experience high levels of stress in the clinical setting (Shipton, 2002). Nurse educators have the responsibility of teaching adult learners the profession and practice of professional nursing. If nurse educators can provide a learning environment that manifests a lower anxiety level in student nurses, the acquiring of clinical skills may be facilitated (Becker & Neuwirth, 2002). This may also result in student nurses continuing their education instead of abandoning nursing education and relinquishing the opportunity for a career in nursing.

This study addresses several gaps in the literature about anxiety in student nurses in the clinical setting. Much of the research that has been done on this topic has been quantitative. Chapter 2 of this research study includes a review of the literature about stress and anxiety in student nurses in the clinical setting. Nearly 81% (25) of the studies are quantitative, while only 19% (6) are qualitative. Although quantitative research adds to the knowledge about this topic, it does not lend itself to understanding student nurses’ personal experience with anxiety. The use of questionnaires for data collection limits the participant’s opportunity to personalize and expound their stories. Spoken personal accounts of participants can convey emotions that may not be heard or revealed in quantitative data. The personal accounts of anxiety revealed by the student nurses in this study may impact nurse educators to have an increased awareness of and sensitivity to the
anxiety experienced by student nurses in the clinical setting. This may lead nurse educators to consider ways that they can help student nurses to minimize their anxiety.

Some of the research studies in the review of literature in this current study lack a research perspective. Only two of the six qualitative research studies indicated a research perspective. These two studies used grounded theory as the research perspective. The research perspective for this study was phenomenology and investigated the lived experiences of anxiety of student nurses in the clinical setting. It provided insight into how student nurses make meaning of their anxiety.

Another gap in the literature about anxiety and stress in student nurses in the clinical setting is related to theoretical framework. Many of the studies in the review of the literature had a theoretical framework that was based in psychology and some of the studies lacked a theoretical framework entirely. Using a learning theory to understand student nurses’ anxiety in the clinical setting was a new contribution to the field. The theoretical framework for this research study is situated cognition. The theory of situated cognition considers social interactions, the use of tools, and the interaction with the setting as related to social processes and use of tools during the learning process (Wilson, 1993). Student nurses, while learning in the clinical setting, encounter social interactions and use tools during learning. It is during social interactions and use of tools in the setting where student nurses experience and learn anxiety. The anxiety that they experience may interfere with learning in the clinical setting.

Another gap in the literature is the fact that few of the studies reviewed in Chapter 2 of this research study were conducted in the United States. Over 61% (19) of the research studies were conducted in countries outside of the United States with most of the
studies having been conducted in England. Additional countries where this research has been conducted include Canada, Ireland, Africa, Scotland, Australia, and Nepal. In addition, only 6% of the studies that are qualitative were done in the United States. This information is significant in light of the small amount of research that has been conducted about anxiety in student nurses in the clinical setting in the United States. This research study adds to the body of knowledge of nursing education in the United States and has the potential to add to the knowledge about nursing education in countries outside the United States.

Stress and anxiety in student nurses in the clinical setting has been a research topic of interest in the literature primarily over the past 10 years. The timeframe for the studies in the review of literature for this research study are the years 1963-2004. Three studies were conducted in the 1960’s, 5 studies in the 1970’s, 4 studies in the 1980’s, 7 studies in the years 1990-1995, and 12 studies in the years 1996-2006. While the majority of studies on this topic have been done in the past 10 years, there is a paucity of research done in the areas of stress and anxiety of student nurses in the clinical setting.

Assumptions and Limitations of the Study

Assumptions for this research study are as follows:

(1) The learning experiences of student nurses in the clinical setting are very different from the learning experiences in the formal classroom;

(2) Student nurses are uncertain about their role in the clinical setting and about their interactions with health professionals including staff nurses and clinical instructors;

(3) The physical environment of the clinical setting (sights, sounds, smells) is a unique learning setting and experience;
(4) Student nurses who have prior experience in a health care setting experience less anxiety in the clinical setting during their educational experiences;

(5) Factors outside the educational experience, such as personal issues in a student nurses’ life (i.e. economic, marital, child care, etc.), may play a role in the anxiety that student nurses experience in the clinical setting.

There are several limitations to this research study. One limitation of this study may be the culture of the sample. In the United States, nursing is primarily a white, female dominated profession. Nurses who are culturally diverse comprise only 10% of the practicing registered nurses in the United States (Catalano, 2006). Persons in the sample who were not white and/or female may have perceived their anxiety in the clinical setting differently because of not being of the dominant culture of nursing in the United States.

A second limitation of this study is that the purposeful sample was from two nursing programs in a geographic area that was convenient for the researcher. Since the students are from schools which are located near each other, they were more likely to have encountered the same health care professionals, and perhaps some adjunct nursing faculty who teach in both schools, in their clinical experiences. It is possible that when student nurses interacted with particular individuals who were nursing faculty or health care professionals they experienced higher and/or lower levels of anxiety.

A third limitation of this study is that the researcher is a nursing instructor. The student nurses may have perceived nursing faculty as having an influence on their anxiety and this may have influenced the extent and truthfulness of their responses. I used a sample of student nurses from a school other than where I teach. However, the
possibility exists that the student nurses may not have completely revealed their experiences about anxiety because they were talking to a person who was a member of nursing faculty.

A final limitation is that the participants may not have been able to articulate their anxiety verbally. The participants were encouraged to bring written materials such as clinical worksheets, journals, pictures, or art forms to assist them to articulate their anxiety.

Despite these limitations, this study contributes to the body of knowledge in adult education and nursing education about anxiety in student nurses in the clinical setting. In particular, the qualitative approach to studying anxiety in student nurses in the clinical setting provides nurse educators with individual accounts of anxiety in student nurses in the clinical setting.

Definition of Terms

The following definitions of terms are relevant to this study:

Anxiety is a subjective feeling of uneasiness and apprehension about an undefined threat in the future. The threat is often psychological and threatens self-esteem and well-being (Lader, 1984).

Stress is a complex psychobiological process that is comprised of three elements: a stressor, perception of threat, and anxiety state. A stressor describes a situation or stimulus that can be objectively described by physical or psychological danger. The term threat is a person’s perception of the stressor as having the potential to be dangerous or harmful. Those who see a stressful situation as threatening will experience an anxiety
reaction. When a person has an anxiety reaction they experience subjective feelings of tension, apprehension, nervousness, and worry that are heightened by activity of the autonomic nervous system (Spielberger, 1979).

**Student nurses** are individuals who were enrolled in a nursing education program for the purpose of becoming a registered nurse. The student nurses in this research study were enrolled in a baccalaureate program of nursing education. They will be awarded a bachelor of science degree in nursing upon completion of their education.

**Clinical setting/environment** is where health care is provided to patients. Some examples of clinical settings include hospitals, assisted living facilities, long-term care facilities, physicians’ offices, and patients’ home.

**Clinical nursing instructor/faculty** is a registered nurse whose minimal education degree is a Master of Science in Nursing. Some clinical nursing instructors/faculty may have attained a doctoral degree in nursing or a related field such as education.

**Clinical experience** is an integral part of nursing education. It is scheduled time that is provided for student nurses to practice the profession of nursing. During this scheduled time, student nurses provide care to patients in health care settings. Student nurses practice with the guidance of nursing faculty and/or professional nurses.
Summary of Chapter 1

Chapter 1 provides an overview of this research study. An introduction, purpose of the research, guiding research questions, theoretical framework, an overview of the research methods and design, significance of the study, assumptions and limitations, and definitions of terms have been discussed. Chapter 2 provides a review of the related literature for this research study. Chapter 3 provides a detailed explanation of the phenomenological methodology and design of this study.
CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this research study was to better understand student nurses’ perception of anxiety in the clinical setting and to understand what anxiety means for them. The participants were baccalaureate student nurses who experienced anxiety in the clinical setting and who completed at least one semester of nursing education that included clinical experience.

I begin this chapter with a brief discussion of a literature review. Following this is a discussion of nursing education, which includes a description of the three levels of education to become a registered nurse and the theoretical and clinical components of nursing education.

Next, the theoretical framework for this research study, the learning theory of situated cognition, is discussed. The discussion of situated cognition includes a brief overview of several learning theories including behaviorism, cognition, humanism, and social constructivism.

Then I present a discussion of anxiety and stress which includes a discussion of existentialism, fear and anxiety, definitions of stress and anxiety, a discussion of stress, fear, threat, and anxiety, and Spielberger’s understanding of state anxiety and trait anxiety. The section on anxiety and stress also includes the human reaction to stress and anxiety with a description of the fight-or-flight response and the response of the autonomic nervous system to stress. A brief discussion of Generalized Anxiety Disorder concludes the section.
Following this, four theories about anxiety and performance are discussed. These theories are the Yerkes-Dodson Law, Easterbrook’s hypothesis, Liebert and Morris’s theory of worry and emotionality, and Eysenck’s processing efficiency theory.

This chapter concludes with a discussion of the nursing education research about anxiety and stress in student nurses in the clinical setting. In this section, the research that stress is evident in student nurses in the clinical setting, that stress is encountered in interpersonal relationships with nursing faculty and staff nurses, and that stress has an effect on student nurses’ ability to perform in the clinical setting is presented.

Section I: Purpose of a Literature Review

The purpose of a literature review is to construct a depiction of the knowledge base of a particular topic. By reviewing the literature that is relevant to a research study, the researcher investigates what is known and unknown about a topic (Burns & Grove, 2003). The literature review is used to inform the research study and the researcher (Meadows & Morse, 2001).

Through a literature review, the researcher becomes familiar with prior research and theory about the topic (Merriam & Simpson, 2000). It is important for the researcher to be cognizant of what is known about the topic while conducting research. During the research process, the researcher should be able to acknowledge and refer to concepts and theories that have been previously reported. While conducting the research, the researcher should be able to identify the variations between what is already known about the topic and what is being discovered in the present research study. Knowledge, as a product of research, should be considered within the framework of that which is already known (Morse & Richards, 2002). The literature review provides the context for the
study. All research is done within the context of what others have thought about and investigated, so the literature review helps the researcher to situate her work within that context.

**Section II: Educational Preparation for the Profession of Nursing**

In this section I provide a brief overview of education of professionals. Following this overview I discuss professional education of nurses, followed by a description of the theoretical and clinical components of education for nurses.

*Education of Professionals*

Professional education characteristically requires formal education where the adult learner engages in specialized study that is specific to a profession (Houle, 1980). Formal education typically occurs in university and community college settings. The purpose of these institutions is to grant degrees to learners who have partaken in either a full-time or part-time course of study. Adult learners are often considered those learners in higher education settings who have attained or exceeded the chronological age of 18 (Brookfield, 1988; Cohen, 1995).

During professional education, the adult learner acquires skills and values that are unique to a specific profession (Houle, 1980). Having a professional education could be considered as “…the mastery of some skills, knowledge and the understanding of principles and an understanding and acceptance of the values underlying the practice of those skills and that knowledge within a profession” (Jarvis, 1983, p. 38-39). Most professions require that a degree be granted and an examination be passed in order to practice in the profession (Rice & Richlin, 1993).
Education of Professionals in Nursing

Nursing is a profession (Rice & Richlin, 1993) that requires the granting of a degree and passing of an examination called The National Council Licensure Examination for Registered Nurses (NCLEX-RN) to practice nursing. Upon completion of a prelicensure nursing program, graduates are permitted to take the NCLEX-RN. The NCLEX-RN measures the knowledge and competence of a graduate nurse to practice nursing safely and effectively (Oermann & Gaberson, 2006). Successful completion of a licensure examination is one way to provide verification to the public that the nurse has the knowledge and skill that is required to provide safe and effective care (Oermann & Gaberson, 1998).

In the United States, the adult learner has three options from which to choose when considering education in the profession of nursing. These options are a program in nursing education which is hospital based and offers a diploma in nursing, an associate degree in nursing (ADN), or a bachelor of science degree in nursing (BSN). These three types of programs for the education of nurses accept high school graduates as students. Graduates of all three programs are qualified to take the NCLEX-RN examination (Hood & Leddy, 2003).

The diploma program is the oldest form of education for the preparation of professionals in nursing. The first diploma program for the education of nurses in the United States was instituted at the New England Hospital for Women in 1872 (Zerwekh & Claborn, 2003). As many as 2,000 diploma programs were in existence in the 1920’s and 1930’s, today only 67 diploma programs continue to educate nurses (Chitty, 2005). Diploma programs were the predominant path of education for nurses until the 1960’s...
A few of the reasons for the decreasing number of diploma programs include the growth of associate degree and baccalaureate degree programs in nursing, the financial burden on hospitals to fund education for nurses, and the ever increasing complexity of health care which subsequently requires nurses to have more academic education (Chitty, 2005).

The length of education in diploma programs varies from 1 to 3 years. This type of education takes place in a hospital school of nursing. The educational process is devised so that theory and clinical practice are introduced and taught simultaneously from the beginning of the program (Zerwekh & Claborn, 2003). Some diploma programs have agreements with college and universities to provide general education courses in environmental, physical, and social sciences. This enables diploma graduates to have advanced standing in BSN programs should they decide to continue their education (Chitty, 2005).

Associate degree programs in nursing began in 1952 as a result of a short-term solution for the nursing shortage that occurred after World War II (Catalano, 2006) as well as the movement of community colleges that was afoot at this time (Chitty, 2005). Many ADN programs are situated in community college settings and are typically 18 to 21 school calendar months in length. Associate degree programs in nursing routinely require 60 to 72 semester credits. Generally, no more than 60% of the total number of credits are apportioned to courses in nursing. Some associate degree programs in nursing require adult learners to complete general education and science courses prior to the start of nursing courses (Zerwekh & Claborn, 2003). There are approximately 900 ADN programs in the United States (Catalano, 2006).
The population of adult learners in ADN programs is usually more diverse than that of diploma programs. Prior to the advent of ADN programs, the typical adult learner in a nursing education program was enrolled in a diploma program and was generally female from a middle-class family, single, and approximately 19 years of age. Adult learners in ADN programs are generally older, and may include minority populations, men, and married women. Many of these students already have acquired a college degree in other fields and are finding a second career in the field of nursing (Zerwekh & Claborn, 2003).

Baccalaureate degree programs in nursing developed from the belief of leaders in nursing that education in nursing should move to the college and university setting and be part of higher education. Leaders in nursing felt that a BSN was needed so that nurses would be recognized as professionals along with other professions that required higher education for the completion of their education. The first baccalaureate program in nursing was established in 1909 at a time when diploma programs had already formed a solid foothold in nursing education. This first BSN program was at the University of Minnesota and was part of the University’s School of Medicine (Chitty, 2005). The Yale School of Nursing was established in 1923 and is regarded as the first autonomous college of nursing in the United States (Catalano, 2006). Presently, there are approximately 700 baccalaureate degree nursing programs in the United States (Zerwekh & Claborn, 2003).

Currently, baccalaureate programs in nursing provide education for basic students who are working toward qualifying to take the NCLEX-RN exam and registered nurses who are returning to school to attain a BSN (Chitty, 2005). Typically, the programs for
basic students to attain a BSN are 4 years in length and are taught in four-year college and university settings. These programs accentuate learning in the liberal arts, sciences and humanities and these are the courses in which the adult learner is enrolled during the first 2 years of the program. Courses in nursing begin late in sophomore or early in junior year (Zerwekh & Claborn, 2003). Baccalaureate programs of nursing for the RN student are usually offered in colleges and universities that offer basic programs in nursing. These programs are routinely designed to meet the needs of the adult learner returning to school. The RN student may be integrated with students in the basic program in nursing, may follow a separate tract that has been developed specially for RN students, or may be a blend of both. Adult learners in a baccalaureate program have an added advantage of exposure to a diverse student population because these programs are situated in four-year colleges and universities. This exposure promotes differing worldviews, an appreciation for various cultures, and a broad network for socialization (Chitty, 2005).

*Theoretical and Clinical Components of Nursing Education*

While there are several types of programs that offer an education in the profession of nursing and qualify an adult learner to take the NCLEX-RN exam, all of these programs have the common thread of having both a theoretical and a clinical component as part of the educational process (Oermann & Lukomski, 2001). The profession of nursing is a practice discipline and requires both a cognitive comprehension of theory and skill and dexterity in transferring the theory when providing care for the patient in the clinical setting (Reilly & Oermann, 1990). Therefore, education of nurses occurs in both
the classroom setting and the clinical setting where student nurses provide care to patients (Oermann & Lukomski, 2001).

In the classroom, students learn about concepts and theories that are applicable to the practice of nursing (Oermann & Lukomski, 2001). In clinical practice, student nurses use the knowledge they have learned in the classroom and apply it to actual patient situations (Gaberson & Oermann, 1999). It is in the clinical setting where student nurses gain insight into psychomotor and technical skills learned in the classroom (Oermann & Standfest, 1997). In addition, learning in the clinical environment entails learning how to problem solve, make decisions, work along side professionals in nursing and other professionals in health care, and helps the student nurse develop and internalize values that are part of and important to the profession and practice of nursing (Massarweh, 1999; Oermann & Standfest, 1997).

In summary, the education of nurses is part of professional education and adult education. It is professional in that it requires that a degree is granted and a licensure examination be passed in order to practice nursing. It is also professional because specific theoretical knowledge is required to practice as well as skills and values need to be learned to practice in the profession of nursing. The education of nurses is part of adult education because the learners in all three types of educational programs for nurses are adults partaking in study at an institution of higher education.

The previous discussion of the clinical component of nursing provides a segway to the discussion of the theoretical framework for this research study. The theoretical framework is situated cognition.
Section III: The Theoretical Framework: Situated Cognition Theory

Learning is a topic that has long been studied by many people. The study of learning dates back to the era of the philosophers Plato and Aristotle. Some of their beliefs about learning have been foundational to the development of major learning theories about adult learning. Behaviorism, cognition, humanism, and social constructivism are some of the major theories of adult learning that will be discussed in this chapter (Merriam & Caffarella, 1999). In particular, situated cognition, which is part of social constructivism will be discussed in detail because it informs this research study.

Overview of Adult Learning Theories

B.F. Skinner was the major contributor to behaviorism. His concept of operant conditioning explains that reward and reinforcement are key to learning. If behavior is rewarded or reinforced, a response is more likely to occur. However, behavior that is not rewarded or reinforced would decrease in frequency. Skinner felt that behavior is learned and that the environment can be manipulated to reinforce learning (Merriam & Caffarella, 1999). The thought of behaviorists is that the environment, not the individual, controls behavior (Elias & Merriam, 2005; Merriam & Caffarella, 1999). Learning from a behaviorist perspective means that there is a change in behavior (Pratt, 1993). Educators who utilize the behaviorist framework control the environment and design educational settings to bring forth certain responses from learners (Elias & Merriam, 2005). The teacher identifies the material that the learner should learn, plans the conditions for learning, and then evaluates if the learner has learned the material (Pratt & Nesbit, 2000). Some educational practices that are closely aligned with behaviorism
include those that utilize behavioral objectives in instruction and competency-based education (Merriam & Caffarella, 1999).

Cognitive learning theory was developed by Gestalt psychologists. It is, quite frankly, the opposite of behavioral learning theory. In cognitive learning theory, internal mental processes are central to learning, instead of external behavior patterns. The learner has control over the learning, rather than the environment having control over the learning. Perceptions, insights and meaning are components of cognitive learning theory. A learner receives information and then interprets and makes meaning of it (Merriam & Caffarella, 1999). The focus of cognitive learning is how information is processed, stored, and retrieved by the learner and how the learner perceives, thinks, remembers, and solves problems (Flannery, 1993).

One of the assumptions of humanist learning theory is that adult learners are self-motivated (Knowles & Associates, 1984) and the emphasis is the human potential for growth. The belief that underlies humanist learning theories is that people control their destinies (Merriam & Caffarella, 1999). The learners have the responsibility to learn (Elias & Merriam, 2005) and the freedom to become what they are capable of becoming. Motivation to learn comes from within (Maslow, 1970). Learners are expected to assume the responsibility for their learning and their self-development (Merriam & Caffarella, 1999). Educators who utilize humanist learning theories are viewed as facilitators (Merriam & Caffarella, 1999) who guide the process of learning (Elias & Merriam, 2005) and are supportive and respectful towards adult learners. They create a collaborative learning environment rather than one that is competitive. The learner is understood to have a unique personality and grows emotionally and intellectually during the learning
process (Knowles & Associates, 1984). This quote by Brookfield (1988) summarizes humanist learning theory “…learning is a transactional drama in which the personalities, philosophies, and priorities of the chief players (participants and facilitators) interact continuously to influence the nature, direction, and form of the subsequent learning” (p. viii).

The fundamental concept in social constructivism is that knowledge formation and meaning-making for a learner occur in a social context. When the learner engages in social activity and discussion of shared tasks or problems, the opportunity is created for skilled members of the culture to introduce the learner to the culture. Through social interaction the learner has the opportunity to learn the reality of the culture (Driver, Asoko, Leach, Mortimer, & Scott, 1994). From a social constructivist perspective, the acquisition of knowledge involves the internalization of meaning structures of a group. Since knowledge is socially constructed, the learner may have the opportunity to increase or alter the existing body of knowledge of the group. Teaching and learning are processes that may be negotiated. Negotiation provides an atmosphere for the discussion of significant personal meanings (Candy, 1991). Situated cognition, the theoretical framework for this research study, is rooted in social constructive learning theory (Merriam & Caffarella, 1999).

*Situated Cognition Theory*

Because all activity is situated, the notion of situated activity implies that learning involves the whole person being active in the world rather than a person learning and receiving factual knowledge about the world (Lave & Wenger, 1999). The term context, as it applies to situated cognition, suggests an identifiable framework for activity
(Lave, 1988). However, individuals can experience context differently and “context may be seen as the historically constituted concrete relations within and between situations” (Lave, 1993, p. 18). The basic premise of situated cognition theory (sometimes referred to as situated learning or situated activity) is that the learner and the context where learning occurs are inseparable (Merriam & Caffarella, 1999). In situated cognition theory, physical and social experiences and the tools used in the environment are vital to the learning process (Caffarella & Merriam, 2000).

Situated learning is about the relationship between learning and the social situations where the learning occurs (Hanks, 1999). A person’s thoughts and actions are adapted to the environmental situation because insights, understanding, and physical actions develop simultaneously (Clancey, 1997). Knowing and learning, through the lens of situated cognition, are viewed as “a product of the activity, context, and culture in which it is developed and used” (Brown, Collins, & Duguid, 1989, p. 32).

Situated cognition learning theory explains learning that encompasses social interactions while one participates in the learning process (Orey & Nelson, 1994). Learning is not a “one-person act” (Hanks, 1999, p. 15). It does not occur in an individual mind, but within a participatory framework. The co-participants of the learning process distribute the learning (Hanks, 1999).

When learning is considered within the context in which it occurs, it becomes a cultural and social phenomenon (Merriam & Caffarella, 1999). Learning is essentially of a social nature (Hansman, 2001). Learning that takes place in actual life-settings, with real individuals is open to social influences (Fuhrer, 1993). While learners are exposed to social groups they undergo the process of enculturation. They copy behaviors, learn the
language, and gradually act accordingly with the norms of the group (Brown, Collins, &
Duguid, 1989).

Situated cognition theory, in a practical sense, places the learner in the
environment where the learning occurs. The learner is actively engaged in learning skills
rather than gaining theoretical and abstract knowledge that will be applied to actual
situations at a later time (Hanks, 1999). Learning involves the utilization of tools
(Wilson, 1993). The engagement of learners in authentic tasks in authentic contexts
contributes to their personal understanding and helps them make meaning of the
environment (Choi & Hannafin, 1995; Seel, 2001).

When a learner is new to a particular setting, he or she participates peripherally
(Barab & Plucker, 2002; Brown & Duguid, 1993) and engages in the process of
legitimate peripheral participation (Lave & Wenger, 1999). Legitimate peripherality
permits learners to gradually absorb and be absorbed by the culture, and provides
opportunities for learners to make the culture their own. They are given permission to
learn in the environment that provides rich experiences of the culture (Barab & Plucker,
2002; Brown & Duguid, 1993). Newcomers can gain a sense of how old-timers practice
and conduct themselves in the environment, and what it is that learners should learn to
become experts (Lave & Wenger, 1999). “Legitimate peripheral participation is…a
descrptor of engagement in social practice that entails learning as an integral constituent”
(Lave & Wenger, 1999, p. 35).

The concept of legitimate peripheral participation should not be considered in
three contrasting pairs: “legitimate versus illegitimate, peripheral versus central,
participation versus nonparticipation” (Lave & Wenger, 1999, p.35). The concept should
be taken as a whole, with each aspect dependent on defining the others. Legitimate is considered as belonging, it is a fundamental condition for learning. Peripheral participation is about a person’s location in the social world. A person’s location changes based on development of identities and forms of membership (Lave & Wenger, 1999).

The basis of the process of legitimate peripheral participation is that the learner has the opportunity to participate in the actual practice of the expert and thus, to participate in the community of practice. The learner’s participation is limited and the learner has limited responsibility for the ultimate outcome of the product (Hanks, 1999). With increasing experience, learners move from a peripheral position to a more accepted central location of the learning environment (Barab & Plucker, 2002; Brown & Duguid, 1993). Legitimate peripheral participation unveils the relations between newcomers and old-timers, and it unveils the activities and developed identities of communities of practice (Lave & Wenger, 1999). Legitimate peripheral participation provides an opportunity for the learner to simultaneously develop an identity as a member of the community of practice and to become skillful as a practitioner in the community of practice (Lave, 1991).

Communities of practice are everywhere in our daily lives. Communities of practice are at work, at home, in schools, and in relation to leisure activities. People belong to several communities of practice. Persons who belong to a community of practice are engaged in a common venture that results in shared learning (Wenger, 2001). They have a common sense of purpose (Hansman, 2001). Groups that function as a community have a common understanding of the activity of the members of the community and a common understanding about what is happening (Resnick, Pontecorvo,
Communities of practice are bound by socially constructed beliefs. The beliefs are fundamental to understanding what the community does (Brown, Collins, & Duguid, 1989).

Communities of practice take many forms. They are diverse in terms of both composition and what brings them together. They may be small, with only a few members, or have hundreds of members. Whether the community of practice is large or small, the vital element of sharing a practice is regular interaction. This does not mean that members of communities of practice need to live close to each other. Some communities of practice are geographically widespread. These communities may be connected by phone or e-mail, or may meet only on an annual basis. Communities of practice are about sharing knowledge about common problems, situations, and perspectives. The advancement of technology and globalization has made widespread communities of practice the norm, rather than the exception (Wenger, McDermott, & Snyder, 2002).

Academic disciplines, professions, and manual trades can be considered examples of communities of practice (Brown, Collins, & Duguid, 1989). Communities of practice are enmeshed in their own distinct histories and development (Lave & Wenger, 1999) and have shared histories of learning (Wenger, 2001). An integral part of the reproduction of communities of practice is to transform the newcomers into old-timers (Lave & Wenger, 1999). Communities of practice are themselves regimes of competence. They have guidelines that define a member as competent, as an outsider, or somewhere within the range of competent and outsider (Wenger, 2001).
Legitimate peripheral participation and communities of practice are complex concepts that are implicated in social structures and have relations of power intertwined in their realities (Lave & Wenger, 1999). Issues of power are part of social life (Wenger, 2001). When learning and knowing are viewed as a cultural phenomenon, they become enmeshed in the social and political aspects of the environment. This makes the issue of power and knowledge fundamental in the study of situated cognition (Merriam & Caffarella, 1999). Legitimate peripheral participation can be empowering and/or disempowering. The process of legitimate peripheral participation involves moving from the periphery to a more central location of the community of practice. When a person moves centrally, they may feel empowered. However, if they are denied the opportunity to become centrally located in the community of practice and perhaps are denied legitimacy, they may become powerless within the community of practice (Lave & Wenger, 1999).

During the situated learning process learners utilize tools that are integral to their learning (Merriam & Caffarella, 1999). Tools can be considered conceptual or material. Knowledge is considered a conceptual tool. Learners may acquire tools (knowledge) in the learning process but be inept in understanding how the tool (knowledge) is used. The ineptness stems from the fact that the knowledge is acquired in a setting that is outside the culture and outside community of practice. The learner does not have the opportunity to understand how the knowledge is utilized within the culture or the community of practice. When learners have the opportunity to utilize tools within the culture, they are better able to understand the use of knowledge and the tools (knowledge) themselves (Brown, Collins, & Duguid, 1989).
Conceptual tools have meanings that have been developed by the culture. Their meaning is a result of the negotiation that occurs within the community. Conceptual tools can be considered collective knowledge of the culture and include the insights and experiences of the members of the community of practice. To exemplify this concept, the same tools are often times utilized differently by different tradesmen. For example, physicists and engineers utilize math formulas differently and carpenters and cabinet makers utilize chisels differently. Members of communities have socially constructed beliefs and utilize tools in specific ways that are imperative to what they do. The culture of the community and the use of tools define how members of the profession view the world. In addition, the way they view the world determines the community’s understanding of the world and the tools they use (Brown, Collins, & Duguid, 1989). Activity, concept, and culture are dependent on each other when conceptual tools are utilized (Brown, Collins, Duguid, 1989; Hansman, 2001). Learning depends on the interaction with the setting relative to the social and tool-dependent nature of the environment (Wilson, 1993).

In summary, there are many processes by which a learner can learn. Some theorists believe that for learning to occur the environment needs to be managed, some believe that the individual is in control of the learning, yet others believe that learning should occur within real-life settings. Situated cognition is a theory that describes learning in authentic environments. Student nurses, during clinical experiences of caring for patients in health care settings, undergo learning in authentic environments. During clinical experiences, student nurses learn the skills and internalize the values of the profession of nursing. They are part of the community of practice. Initially, because of a
limited knowledge base, they are peripheral to the community. However, as they develop more skill, knowledge, and confidence they may have the opportunity to move from peripheral positions to a more central location in the community of practice. Hence, situated cognition theory was selected to inform this research study. The next body of literature that has been reviewed and informs this research study is the literature about anxiety and stress.

Section IV: Anxiety and Stress

Anxiety and stress are both complex concepts that have been studied at great length within a number of disciplines. As a result of extensive research on these concepts, multiple theories have been developed about anxiety (Spielberger, 1966) and substantial disagreement has arisen about the definition of stress (Breznitz & Goldberger, 1993; Selye, 1993; Tache & Selye, 1986). Some theories of anxiety include the Orthodox Freudian Approach, the Ego-Psychological Approaches, the Learning-Theory Approach, and the Existential Approach (Fischer, 1988). Likewise, stress has been studied within various disciplines with different approaches to reach an understanding of what is meant by stress. For example, the social scientist is less likely to be concerned with the production of steroids in relation to stress as would the endocrinologist. Similarly, the endocrinologist is less likely to be concerned with depression and its relation to stress as would the social scientist (Pearlin, 1993).

One of the factors that has contributed to the complexity of these concepts, is a tendency to use the terms ‘stress’ and ‘anxiety’ synonymously and/or interchangeably (May, 1996; Dr. M. Sadigh - Author and Associate Professor of Psychology at Cedar Crest College, Allentown, PA - personal communication, February, 2006). In light of the
multiple theories and definitions of stress and anxiety, it is the purpose of this literature review to focus on how the terms stress and anxiety are to be understood in this research study.

Anxiety has been studied from a wide range of perspectives. In this review, I present several categories of anxiety ranging from basic anxiety, which is experienced by many people on a daily basis to clinical anxiety which is considered a medical/psychiatric condition. While my study is concerned primarily with basic anxiety that student nurses experience in the clinical setting on a daily basis, a discussion of state and trait anxiety, and General Anxiety Disorder has been included in order to situate my research within the broader spectrum of anxiety.

In this section I discuss the existential theory of anxiety, the origin and definition of the terms stress and anxiety, the theory of state anxiety and trait anxiety, human reaction to stress and anxiety, and a medical condition known as Generalized Anxiety Disorder.

Philosophical Underpinnings of Anxiety

In this section, I present the existential theory of anxiety, which is a philosophical approach to anxiety. I also discuss the terms fear and anxiety as viewed from an existential perspective.

Existentialism. The focus of existentialism is ontology which is the study of being (May, 1983). Existential theorists are concerned with the angst that arises from people’s perception between wanting to be immortal and the recognition that they are mortal (McReynolds, 1989). According to Tillich (1952) “anxiety is the state in which a
being is aware of its possible nonbeing” (p. 35). There is a threat of nothingness or nonbeing (Lazarus & Averill, 1972).

When anxiety is viewed from an existential viewpoint, people are apprehensive because of a threat to their existence. Humans are valuing beings who interpret their life, world, and identity with the existence of self (May, 1967; May, 1980). When people experience anxiety they may sense a threat to physical life, which could be death; a threat to psychological life, which could be loss of freedom; or a threat to some value that the person holds in esteem and views as an essential part of their existence. Such values could include the love of a special person, a certain status among peers and colleagues, or devotion to a particular belief, such as a scientific or religious belief (May, 1967). People who encounter a tragedy in which environmental demands are so great that they are unable to cope may also experience anxiety. Hence, anxiety is a person’s awareness of nonbeing. Nonbeing is anything which would destroy being, such as death, severe illness, interpersonal hostility, or a sudden change which destroys psychological rootedness. That is to say, anxiety is the reaction when a person realizes their existence as they know it may be destroyed (May, 1996).

The following thought process exemplifies how the existential viewpoint of anxiety may pertain to a student nurse. One of the outcomes for a student nurse during the educational experience is the likelihood of a career in nursing which may provide financial security. A student nurse may experience anxiety because of the possibility of non-being. For example, the student nurse may feel that if clinical experience results in failure, the possibility of financial security will be unattainable. If finances are unattainable, then the student nurse may not be able to have enough food to eat or a house
in which to live. If the student nurse does not have enough food to eat and/or a place to
live, death, or nonbeing may be the result (Dr. M. Sadigh – Author and Associate
Professor of Psychology at Cedar Crest College, Allentown, PA - personal
communication, February, 2006).

Fear and anxiety. In reviewing the literature about existentialism and anxiety, the
term fear is discussed. Fear and anxiety have been considered fundamental human
emotions for a very long time. Egyptian hieroglyphics writings reflected discussion
about fear and anxiety (Spielberger, 1972a). Fear is different than anxiety but there is an
interdependence between them (Tillich, 1952). When a person experiences fear, they are
afraid of a specific object (May, 1996; Tillich, 1952). When in fear, people are aware of
themselves and the object of which they are afraid. The object that is feared has a
specific spatial presence and the person can flee.

However, anxiety is an apprehension that is vague and unspecific. A person is
unable to indicate the exact object which is threatening them. This uncertainty results in
frantic behavior because a person is unable to pinpoint the exact source of danger. In
anxiety, a person looses the sense of awareness of the self and the world (May, 1996).
The person does not know what will happen, when it will happen, and because he does
not know these things he does not know how to prepare for the event (Lazarus, 1993).

To exemplify the difference between fear and anxiety I will use the following
story. Consider a child who encounters a vicious dog in his neighborhood. The child
begins to run as quickly as possible. All of his energy is directed to running from this
dog, as running is his only reasonable response. This is an example of fear. The child
knows of what he is afraid and he can act on that fear. The next day, this same child is
sent to the store by his mother. The child knows that in order to reach his destination he must walk by the house where the vicious dog lives. The dog is usually kept in the house, but the dog also runs free at times. The child has also had the occasion of experiencing the dog straining the leash to get at him. The child experiences anxiety as he approaches the corner near the house where the dog lives. He does not know if the dog is in the house, on a leash, or running free. The child is uncertain as to whether a known threat will materialize. The child is unable to direct the arousal produced by the threat of the unknown into a direct action (Epstein, 1972).

Fear is a motive to avoid danger. Anxiety is a state in which one experiences diffuse arousal in a situation that is perceived as a threat. The person is unable to channel the arousal into purposeful action (Epstein, 1972). According to May (1996), “one cannot fight what one does not know” (p. 207).

The above discussion explains the philosophical underpinnings of anxiety as understood by existentialists. When a person’s values are threatened, be it physical or psychological, their existence or being is threatened and this results in anxiety. This discussion has also explained the difference between fear and anxiety. Fear is a reaction to a specific danger while anxiety is unspecific, objectless, and vague (May, 1996). In fear, the person is capable of moving away from the object he fears. In anxiety, the object is unspecified and prevents him from moving in any specific direction or deciding on a course of action (Fischer, 1988). This discussion of the difference between fear and anxiety lays the groundwork for understanding stress and anxiety which follows in the next section.
Origin and Definitions of the Terms Stress and Anxiety

In this section I discuss how the term stress originated and how it came to be utilized in physical and mental illness, the origin of the term anxiety, and the difference between stress and anxiety. A brief discussion of state anxiety and trait anxiety theory will follow, and the section is concluded with a brief discussion of the terms fear, threat, stress, and anxiety.

Stress. The term ‘stress’ has been utilized in the English language since the 17th century. It is of Latin derivation and its original meaning was to describe distress, oppression, and hardship. During the 18th and 19th centuries, the term ‘stress’ was used to mean a force or pressure acting on an object or a person. The implication of the term stress was that stress caused strain. It was during this time that physical scientists, physicists, and engineers adapted these terms to apply in their fields. In the physical sciences the terms stress and strain were used in relation to the elastic properties of solid materials. Stress was understood to be an external pressure applied to an object (Singer, 1986; Spielberger, 1979), while strain was understood to be the internal distortion or change in the object’s size and shape as a result of stress (Spielberger, 1979). In physics and engineering, the terms stress and strain were assigned a quantitative meaning and were expressed in terms such as in lb/sq. in. or kg/sq. cm. Physicists and engineers were interested in measuring the force acting on a unit area of material. These quantitative expressions considered the relationship between the molecular structure of the material and the resilience of the material to the forces that are acting on it (Spielberger, 1979).

The consideration of life stress on physical and mental illness started in the 19th century. In the 20th century, an accomplished British physician, Sir William Osler,
applied the scientific terms of stress and strain to problems of human adjustment and behavior. Olser equated ‘stress and strain’ with ‘hard work and worry.’ He suggested that ‘hard work and worry’ contributed to the development of heart disease. He studied 20 physicians who had angina (Spielberger, 1979). Angina is severe chest pain that is due to a decreased supply of oxygen to the heart muscle (Thomas, 1997). He noted that these physicians worked constantly and encountered a great deal of pressure while being dedicated to meeting the needs of their patients. The constant pressure endured by these physicians in the practice of medicine led them to worry and anxiety reactions (Spielberger, 1979).

The above history describes how the term stress evolved from its Latin derivative to the physical sciences, physics, and engineering and into the realms of physical and mental illnesses. Psychologists borrowed the term stress from engineering and physics. The term stress became popular in psychology because stress could be defined, handled, and measured satisfactorily and with relative ease (May, 1996). During the early 20th century, the discipline of psychology became enthralled with behaviorism and psychologists began to accept rational and logical positivistic tenets about emotion. Emphasis shifted from research of subjective feelings to evaluating behavioral and physiological variables that are associated with emotion. Experiments were conducted that could evoke an emotional response and then behavior changes and associated physiological changes would be measured objectively. For example, subjects of experiments would be threatened with electric shock and then the subjects’ behavior and physiological indicators, such as blood pressure, heart rate, and muscle tension would be determined (Spielberger, 1972b). Although the term stress is widely used in psychology
(May, 1996) and by society at large (Spielberger, 1979), it does not encompass the rich meaning of the term anxiety (May, 1996).

*Anxiety.* Anxiety as a fundamental human emotion has been described in Egyptian hieroglyphic writings and in writings from the 11th century of Arab philosopher, Ala ibn Hazm, of Cordova. His work was entitled, “A Philosophy of Character and Conduct” and he writes about man’s desire to escape anxiety and remove it from his spirit (Spielberger, 1972a). In the English language, the term anxiety has been derived from the Latin word *anxius* and dates to the 17th century. Its meaning has been consistent through the years with the definition from the 17th century, “a state of agitation or depression with feelings of distress in the praecordial region” (Lazarus & Averill, 1972, p. 245).

Anxiety is a subjective feeling of uneasiness and apprehension about an undefined threat. The threat can be physical or psychological and the person’s self-esteem or well-being is threatened (Lader, 1984). This explanation of anxiety is similar to that as understood in the existential approach. Anxiety occurs when a person feels their existence is threatened. The threat could be either physical or psychological (May, 1996). When a person experiences a situation that is felt to be threatening, whether the threat is based on reality or one’s perception, an anxiety state is aroused (Spielberger, 1979). The unpleasant state of tension that is created by anxiety indicates that a person is in the presence of some form of danger (Budzynski & Peffer, 1980). The danger is not known or not recognized by the person who is experiencing anxiety (Hicks, Okonek, & Davis, 1980).
The subjective feeling that is experienced by a person in a state of anxiety is diffuse and the feeling is not easily described by the person. The feeling of anxiety is intense, unpleasant, and intolerable (Lader, 1984). The feelings of tension, apprehension, and dread give anxiety a unique sense of unpleasantness (Spielberger, 1966; Spielberger, 1979). A person feels helpless and uncertain when confronted with danger (May, 1996). This unpleasant feeling sets anxiety aside from other human emotions such as anger, sorrow or grief (Spielberger, 1979). Anxiety is an emotion that is based on an individual’s personal assessment of a threat (Lazarus & Averill, 1972).

Simple everyday tasks such as going to a dentist appointment, taking a test, or interviewing for a job are examples of situations that can be perceived as dangerous on a physical or psychological level. For some people, carrying out these simple tasks may result in feelings of apprehension, tension and worry, which results in an anxiety state. A person’s emotional reaction to a situation is based on the individual’s perception of the situation (Spielberger, 1979). When a stressful situation is perceived as a danger, the person experiences physiological and behavioral changes. These changes are a result of the activation of the autonomic nervous system, which is discussed in more detail later in this chapter, and may include but are not limited to, trembling, heart pounding, shortness of breath and dizziness (May, 1996; Spielberger, 1979). They are considered signs and symptoms of anxiety. An anxiety state is characterized by feelings of tension, apprehension and worry and by the previously described physiological symptoms (Lader, 1984; Spielberger, 1979).

Anxiety states are experienced differently in terms of intensity and duration. Moderate levels of anxiety are characterized by feelings of tension, apprehension and
nervousness. High levels of anxiety are associated with intense feelings of fear and fright, and the person displays panic behavior. The intensity and duration of anxiety states is dependent upon the person’s perception of the stressor. Even when the situation is objectively non-threatening, an intense anxiety state can result because a person interprets the situation as a threat to their self-esteem or well-being (Spielberger, 1966; 1979). One should keep in mind that the same situation may be perceived by some people as threatening and may be perceived by others as nonthreatening (Gaudry & Spielberger, 1971; Laux & Vossel, 1982). Personal appraisal of the situation and past experience determine whether or not a situation is threatening (Gaudry & Spielberger, 1971).

Difference between stress and anxiety. In this discussion about stress and anxiety, it is imperative to remember that humans are much more complex than inorganic materials that are studied in the physical sciences, physics, and engineering. Humans have the capability of anticipating the future and can interact and change in response to the environment. Therefore, some stressful situations may result in worry and anxiety reactions for some individuals and not for others. A person’s reaction to stressful situations can act as the boundary for the definitions of stress and anxiety (Spielberger, 1979).

In the physical sciences, physics, and engineering, stress can be considered as something that happens to and on the person (May, 1996; Spielberger, 1979). For example, an engineer would be concerned about whether a building can withstand the stress on it from an earthquake. Hence, stress has an objective reference. On the other hand, a person’s perception and interpretation of a stressful situation are key in the
production of anxiety. Perception and interpretation are subjective processes and are included in the meaning of the term anxiety, but not stress (May, 1996). The next section further discusses difference between stress and anxiety and includes a discussion of the terms fear and threat.

Stress, fear, threat, and anxiety. It is at this point where the overlap and confusion about the terms stress, fear, threat, and anxiety will be discussed. For this research study, the terms stress and anxiety will be understood as discussed by Spielberger (1979). Stress is a complex psychobiological process that is comprised of three elements: a stressor, perception of threat, and anxiety state. A stressor describes a situation or stimulus that can be objectively described by physical or psychological danger. The term threat is a person’s perception of the stressor as having the potential to be dangerous or harmful. Those who see a stressful situation as threatening will experience an anxiety reaction. When a person has an anxiety reaction they experience subjective feelings of tension, apprehension, nervousness, and worry that are heightened by activity of the autonomic nervous system (Spielberger, 1979).

Here, I include a discussion of the terms fear, threat, stress, and anxiety as used in the existential literature about anxiety and as described by Spielberger (1979). According to Spielberger (1979), a component of stress is a stressor, which is defined as a situation or stimulus that can be objectively described by physical or psychological danger. I infer that this can mean the same thing as fear in the existential literature because when a person experiences fear, they are afraid of a specific object. According to Spielberger (1979), an anxiety reaction is characterized by subjective feelings of tension, apprehension, nervousness, and worry that are heightened by activity of the autonomic
nervous system. This, too, is similar to the existential theorists description of anxiety in which anxiety is a state in which one experiences diffuse arousal in a situation that is perceived as a threat (Epstein, 1972).

This brief discussion of the terms fear, stress, threat, and anxiety exemplifies how these terms have come to be understood to have the same and different meanings. The multiple definitions of these terms has caused much confusion in the literature. This quote from May (1996), who wrote extensively about the existential theory of anxiety summarizes the terms anxiety and stress quite concisely: “Anxiety is how the individual relates to stress, accepts it, interprets it. Stress is a halfway station on the way to anxiety. Anxiety is how we handle stress” (p. 113).

State anxiety and trait anxiety. Spielberger (1979) references a theory known as state and trait anxiety. Investigators R. B. Cattell and I. H. Scheier identified two distinct types of anxiety which they called state anxiety and trait anxiety (Spielberger, 1966). Essentially, state anxiety is a transitory emotional state and trait anxiety is a personality characteristic. Most people experience episodes of state anxiety, however, some people have more frequent and more intense episodes than do others. Trait anxiety describes a person’s proneness to anxiety. They typically see the world as dangerous and have more frequent episodes of state anxiety that is experienced over a longer period of time (Spielberger, 1979). State anxiety refers to anxiety that occurs at a particular moment in time. Trait anxiety refers to anxiety that is part of one’s personality and can be viewed as anxious temperament (Lader, 1984).

To exemplify state and trait anxiety, consider the following statement, “Betty is anxious.” This statement could mean that Betty is anxious at this very moment and is
experiencing a transitory emotional state of state anxiety. This statement could also mean that Betty is an anxious person. If Betty is an anxious person, then her average level of state anxiety is higher than most people and she experiences anxiety states more often than other people. Keep in mind that although Betty may be an anxious person, she may or may not be anxious at the present moment (Spielberger, 1979).

I felt it important to discuss state and trait anxiety because my thoughts about anxiety are congruent with this theory. I think that people, including student nurses, may experience state anxiety in certain situations, however, they may not have a high level of trait anxiety. It is also probable that some student nurses may have trait anxiety; that is, they may be generally more prone to being anxious.

*Human Reaction to Stress and Anxiety*

In this section I discuss the fight-or-flight response in humans. I also discuss the physiology of the autonomic nervous system and conclude with a discussion of how a person who is stressed and anxious may feel.

*Fight-or-flight response.* The body’s reaction to stress, which became known as the fight-or-flight response, was first studied in the early part of the 20th century by a physiologist at Harvard Medical School, named Walter B. Cannon (Greenberg, 2004; May 1996). Cannon’s research lead to the discovery of many complex human mechanisms that protect the body from hunger, thirst, and hemorrhage. He discovered agents that interfered with regulation of body temperature, acid-base balance of blood, and plasma levels of substances such as sugar, fat, protein, and calcium. His research focused on the stimulation of the sympathetic nervous system which is part of the autonomic nervous system (Selye, 1993).
When a person encounters a stressor, the sympathetic nervous system is stimulated. The process begins in the hypothalamus of the brain which ignites a complex chain of events that involve neural and biochemical processes. The hypothalamus activates the pituitary gland which secretes adrenocorticotropic hormone (ACTH) into the bloodstream. This hormone stimulates the adrenal gland to secrete adrenaline and other biochemical agents to further arouse the body’s defense mechanisms (Spielberger, 1979) and prepare the body to flee (flight)-or-fight the stressor (Selye, 1993). Typically, these hormones are released during pain and rage (Selye, 1993).

**Autonomic nervous system.** When a person feels threatened, an anxiety state is aroused. An anxiety state is an unpleasant emotional reaction and is comprised of unpleasant feelings and thoughts. The person who is experiencing an anxiety state may feel apprehensive, tense, frightened, and nervous. A person often worries about the specific circumstances that provoked the anxiety state (Spielberger, 1979).

An anxiety reaction involves the feelings as described above, as well as a physiologic process that results in certain behaviors. Some of the behaviors associated with an anxiety reaction are restlessness, trembling, shortness of breath, muscle tension, heart palpitations and dizziness (Spielberger, 1979). These behaviors are a result of stimulation of the autonomic nervous system. The autonomic nervous system is the means by which the body endures emotional changes. This system was termed autonomic because it is a system of which humans do not have direct conscious control (May, 1996).

There are two divisions of the autonomic nervous system, the sympathetic and parasympathetic nervous systems which work in opposition to each other (May, 1996).
The parasympathetic is responsible for conserving a person’s energy and generally results in relaxation. Activation of the parasympathetic nervous system results in pupil constriction, decreased heart and respiratory rates, an increase in saliva production, and increased intestinal secretions. Conversely, activation of the sympathetic nervous system results in energy expenditure. Sympathetic activation results in dilated pupils, decreased saliva production, increased heart and respiratory rate, decreased intestinal secretions, increased blood pressure, and increased release of glucose from the liver. A person needs these things to happen in order to fight or flee danger, a response known as the fight-or-flight response (Greenberg, 2004). Stimulation of the sympathetic nervous system is usually connected to anxiety, anger, or fear. An example of stimulation of the sympathetic nervous system is when a person feels heart pounding after stepping off the curb and narrowly misses being struck by a speeding automobile (May, 1996).

Generalized Anxiety Disorder (GAD)

In this section I discuss generalized anxiety disorder (GAD) because I think it is important to differentiate between anxiety as it occurs as state anxiety and anxiety as a medical disorder. I also think it is important to differentiate between these two types of anxiety because there may be confusion about both of these terms. In this section I provide a brief history of anxiety disorders, discuss the difference between nonpathologic and pathologic anxiety, and provide a description of GAD.

Brief history of anxiety disorders. Anxiety disorders are the most common psychiatric disorder in the United States. Lately, anxiety has been the most reported psychiatric disorder in the news media. The increased media attention is due to the
terrorist threats on the United States on September 11, 2001 and the resultant political, military, and economic turmoil that has occurred since those attacks (Taylor, 2004).

Anxiety disorders are not new to the field of psychiatry. Anxiety disorders were described in the fourth century B.C. writings of Hippocrates. Also, more than 100 years ago, Sigmund Freud was the premiere physician who documented an association between symptoms of anxiety and underlying problems (Buskey, 2004). Freud coined the term anxiety neurosis (Rickels & Rynn, 2001). The term “anxiety neurosis” was the precursor of the term “generalized anxiety disorder” (Taylor, 2004). Prior to Freud’s work, anxiety was considered a physical disorder rather than a mental disorder (Buskey, 2004).

The term anxiety disorder is an encapsulating, generic term. There are several types of anxiety disorders. Four of the most prevalent anxiety disorders include generalized anxiety disorder (GAD), panic disorder, social anxiety disorder, and obsessive compulsive disorder (Taylor, 2004). Two more types of anxiety disorders include posttraumatic stress disorder and procedural anxiety, which is extreme fear of medical procedures (Antai-Otong, 2003).

*Nonpathologic versus pathologic anxiety.* Fear and anxiety are normal reactions to a perceived threat. Fear and anxiety are emotions that activate the survival response known as “fight or flight.” When this response is activated some physiologic changes occur that include increase heart and respiratory rates, sweating, and gastrointestinal upset. These responses can become persistent and disrupt the normal life of a person. This can signify an anxiety disorder (Antai-Otong, 2003).

Anxiety may be classified into nonpathologic reactions and pathologic anxiety. Nonpathologic reactions may include behaviors that are normal such as performance
anxiety, stage fright, and shyness in unfamiliar social settings (Taylor, 2004). Normal anxiety is a sign that a person has the capacity to react to danger (May, 1996). On the other hand, pathologic anxiety impairs a person’s normal function, disrupts a person’s daily activities, and lacks a connection to an anxiogenic stimulus (Taylor, 2004). In this research study, I am referring to anxiety as the nonpathologic type. However, the student nurses in my sample may have an underlying pathologic condition of which I, as the researcher, may be unaware.

_Description of GAD._ GAD is a type of anxiety disorder. It is characterized by excessive worry over minor issues (Overholser & Nasser, 2000). Worrying is the most prominent symptom of GAD (Taylor, 2004). The terms worry and anxiety are part of the diagnostic criteria for GAD, so I will define them here. Worry is defined as mental distress that results from concern. Anxiety is defined as an abnormal sense of apprehension and fear that is overwhelming. It can be marked by sweating, tension, and increased heart rate. Diffuse anxiety without a specific focus is a feature that sets GAD apart from other anxiety disorders such as panic attacks or obsessive-compulsive disorder (Buskey, 2004).

People who have GAD constantly worry. Some people are aware that their worry is uncontrolled, while other persons have it brought to their attention by family and friends. The worry that people experience with GAD is usually about ordinary, daily events, however, the worry of some persons is more global and they worry about something catastrophic happening. GAD affects work and school performance and also affects interactions with family, friends, and peers (Buskey, 2004).
In this section I have discussed the difference between stress and anxiety and the meaning of these terms for this research study. Another area of literature that informs this study is how anxiety affects performance. The review of the literature about anxiety and performance is discussed next.

Section V: Anxiety and Performance

There are multiple theories about anxiety and its effect on performance (Battmann & Dutke, 1996; Dalgleish & Power, 1999; Hockey, 1983; Krohne & Laux, 1982; Sarason & Spielberger, 1975). Many researchers who have studied anxiety have found that anxiety interferes with the process of thinking which ultimately impairs performance (Jarvis, 2006). In the clinical setting, student nurses perform skills in a public setting that includes the teacher, patients and their significant others, nurses, peers, and other health care providers. This observation and evaluation of performance by others can be stressful for student nurses (Oermann & Gaberson, 2006). It is for this reason that this body of literature has been reviewed for this chapter.

In this section I discuss four theories about anxiety and performance. The theories are the Yerkes-Dodson Law and its associated inverted U-hypothesis, Easterbrook’s hypothesis, Liebert and Morris’s theory about worry and emotionality, and Eysenck’s processing efficiency theory. The discussion of the theories is written in a chronological fashion from 1908 to 1979; however it is not inclusive of all theories that have been developed about this topic within this time frame. The reason for discussion of the dated theories is because this work forms a foundation for current thinking about anxiety and performance. The recent literature about anxiety and performance entails specific topics about the subject such as math anxiety, sexual performance, and
performance of specific occupations such as athletes, musicians, and actresses and actors and is not directly relate to this research study.

The four theories about anxiety and performance that are presented here provide a discussion for different points of view and several ways to consider anxiety and its effects on performance. The early theories about anxiety and performance are objective in nature while later theories are more subjective with concerns about worry, emotions, and memory.

*Yerkes-Dodson Law and the Inverted-U Hypothesis*

The Yerkes-Dodson Law was conceived in an experiment that was conducted in the year 1908 by Robert M. Yerkes and John D. Dodson. The goal of this research was to gain knowledge about the connection of strength of a stimulus and the rate of learning (Yerkes & Dodson, 1908). There were two assumptions for this experiment. The first assumption was that there was an inverted-U relationship between arousal and performance. The second assumption was that a relationship existed between the intensity of arousal and task difficulty and that the optimal level of arousal had an inverse relationship to task difficulty (Eysenck, 1982).

In this experiment, mice were the subjects and an electric shock served as an aversive drive (Eysenck, 1982; Yerkes & Dodson, 1908). Task difficulty was defined in terms of the mice being able to discriminate between a white box and a black box, the white-black discrimination habit. When the mice attempted to enter the black box, they would receive an offensive electric shock. The researchers wanted to determine if the strength of the electric shock resulted in the mice rapidly learning to avoid the black box. They also wanted to determine the exact strength of the electric stimulus that would be
the impetus for the mice to learn to avoid entering the black box. To prove the second assumption of this experiment, the researchers changed the brightness of the white and black boxes during the experiment to increase task difficulty (Yerkes & Dodson, 1908).

The end result of this experiment showed that the relationship between arousal and ability to learn tasks was an inverted-U shape. When arousal levels were low, performance levels were low. When arousal levels were high, performance levels were also low. Optimum performance was achieved when arousal levels were at a moderate level (Fisher, 1996; Yerkes & Dodson, 1908). In regard to task difficulty, it was found that simpler tasks may be more readily carried out while enduring a stronger stimulation, but a more difficult task may be more readily carried out while enduring a weaker stimulation (Yerkes & Dodson, 1908).

Although this experiment by Yerkes & Dodson (1908) may be offensive and cruel to animals, it does illustrate two points. The first point is that a moderate level of anxiety improves performance. The second point is that easier tasks may be performed with more efficiency under higher levels of anxiety while more difficult tasks may be performed with more efficiency under lower levels of anxiety.

**Easterbrook’s Hypothesis**

J. A. Easterbrook developed a hypothesis about anxiety and performance in 1959. The main premise of this hypothesis is that an increase in anxiety results in a reduction of the range of cues that are used during a situation. The hypothesis is based on cue utilization and task difficulty. The term cue utilization refers to all of the environmental cues that a person may observe, give attention to, or react to during a situation. The cues may be relevant or irrelevant to the task (Easterbrook, 1959; Eysenck, 1984).
Easterbrook (1959) proposes that difficult tasks have more relevant cues than easier tasks. The reduction of the range of cues reduces the amount of irrelevant cues that are utilized resulting in improved performance. However, when irrelevant cues are eliminated, there is a further decrease in the number of cues that are used and this affects the relevant cues. When this occurs, performance declines (Easterbrook, 1959; Eysenck, 1984; Lundberg, 1982; Weinberg & Ragan, 1978).

This hypothesis offers an explanation for the inverse relationship between optimum level of anxiety and task difficulty as proposed by the Yerkes-Dodson Law (Eysenck, 1985; Neiss, 1988; Weinberg & Ragan, 1978). Difficult tasks involve a higher number of relevant cues than do easy tasks. When attention to cues is narrowed during states of high anxiety, performance of difficult tasks is more challenging than the performance of simple tasks (Eysenck, 1982). The Yerkes-Dodson Law makes the prediction that arousal affects performance, while Easterbrook considers attention narrowing as the explanation for the prediction (Eysenck, 1983).

**Worry and Emotionality**

The theory of worry and emotionality has been discussed in the test anxiety literature. Test anxiety has been researched in reference to performance in achievement settings (Laux & Vossel, 1982) and one characteristic of test anxiety is concern about one’s performance in an evaluative setting (Sieber, O’Neil, & Tobias, 1977). Test anxiety is generally viewed as anxiety that occurs when learners are taking paper and pencil tests. In this chapter, I apply the concept of test anxiety to any evaluative process implemented in assessing a student nurse’s performance in the clinical setting.
The test anxiety literature is replete with theories about anxiety and performance. One of the theories describes anxiety as a two-component concept consisting of worry and emotionality. This theory was first described by Liebert and Morris in 1967 (Morris, Davis, & Hutchings, 1981). Worry is associated with the cognitive part of anxiety (Liebert & Morris, 1967; Sarason, 1984). Worry causes people to think about their performance (Laux & Vossel, 1982). When people worry during a test, they are self-focused and disturbed by task irrelevant ideations (Laux & Vossel, 1982). They begin to think about the consequences of failing the test (Eysenck, 1996). They may express doubts about their ability to perform (Dweck & Wortman, 1982) by verbalizing such things that they are stupid and that they may not be successful in passing the test (Eysenck, 1982; Sieber, O’Neil, & Tobias, 1977).

Emotionality is associated with the autonomic reactions that occur when a person is being evaluated (Liebert & Morris, 1967). During evaluative situations people become aware of physiologic changes that occur in the body. These changes result in feelings of tension, nervousness, and uneasiness (Eysenck, 1996; Morris, Davis, & Hutchings, 1981; Sarason, 1984).

In sum, this theory about anxiety and performance considers both the cognitive and physiological occurrences in an evaluative situation. The term worry is a cognitive process where a person becomes more focused on self during the evaluative situation. Worry about one’s performance and interference of thought by irrelevant ideas rather than anxiety has an adverse effect on performance. The awareness of physiological changes that occur during an evaluative situation is similar to Spielberger’s (1979)
explanation of the effect of emotion on the body and the arousal of the autonomic nervous system that results in feelings of tension and apprehension.

**Processing Efficiency Theory**

The processing efficiency theory was initially presented by Eysenck in 1979 and then expanded by Eysenck and Calvo in 1992. This theory about anxiety and performance blends the perspective of several theorists. One of the assumptions in this theory is that there is a difference between state anxiety and trait anxiety and that state anxiety is determined by trait anxiety in combination with the threats that are felt by the person in a particular situation. Another assumption is that worry, as defined in the preceding section, and cognitive activities that are irrelevant to the task will always have an adverse effect on the quality of performance. The reason for the decline in the quality of performance is because the irrelevant cognitive activities vie for space with relevant information in the processing system. A third assumption is that highly anxious people will compensate for worry by expending more effort during task performance (Eysenck, 1979).

The processing system that is referred to in this theory is the working memory capacity. The working memory evolved from the concepts of attention and short-term retention. The working memory has four components, namely, “...a central executive, which is essentially an attentional system; an articulatory loop or verbal rehearsal system; a visuo-spatial scratch pad or ‘inner eye’; and a primary acoustic store or ‘inner ear’” (Eysenck, 1985, p. 580). It is the central executive component that is widely used for cognitive tasks, the articulatory loop permits storage of a limited amount of information,
(Eysenck, 1982; Eysenck & Calvo, 1992), while the remaining components are specialized processing systems (Eysenck, 1985).

The processing efficiency theory takes into account the effort that is expended during worry. Worry is a motivator that is controlled by the working memory system. Worry leads to the expenditure of effort in helping a person to strategize to improve performance (Eysenck & Calvo, 1992). Eysenck (1996) admits that the details of this process are unclear; however, it is likely that when a person realizes that their performance is at or below a minimal level, a person will assign additional resources to performance of the task. The allocation of effort helps improve performance and reduce worry about performance. From these assumptions, it is concluded that those who have high anxiety will worry more than those with low anxiety and will therefore realize that their actual performance is substandard to their expected performance. These assumptions lead to a discussion of the foundations of this theory which are performance effectiveness and processing efficiency (Eysenck, 1996).

Performance effectiveness refers to the quality of task performance (Eysenck, 1996; Eysenck & Calvo, 1992) and is concerned with such things as speed and accuracy (Eysenck, 1996). Processing efficiency is the relationship between performance effectiveness and the effort that is expended during task performance (Eysenck, 1996; Eysenck & Calvo, 1992). The difference between performance effectiveness and process efficiency is a key piece of this theory because the effects of anxiety on effectiveness and efficiency are different (Eysenck, 1996). Highly anxious people tend to expend more effort during task performance; therefore processing efficiency will be reduced more than performance effectiveness (Eysenck, 1982; Eysenck, 1996). Eysenck and Calvo (1992)
admit that this may be difficult to prove in practice because process efficiency cannot be considered in a direct mathematical sense. MacLeod (1999) concludes, “according to Eysenck, worrying represents a resource-consuming task-irrelevant cognitive process, maintained by the allocation of working memory capacity, and it is the depletion of working memory that underpins anxiety-related cognitive deficits” (p. 447).

The processing efficiency theory contains aspects of the three previous theories that have been discussed. This theory considers an excessive amount of worry to be detrimental to task performance as does Yerkes-Dodson Law and Easterbrook’s hypothesis. It also considers worry as consuming much of the working memory capacity in a similar way to Easterbrook’s hypothesis and Liebert & Morris’s theory about worry and emotionality. Unlike Liebert and Morris’s theory, this theory does not consider a person’s physiological response to emotions in an evaluative setting.

Conclusion

This discussion about anxiety and performance demonstrates how theories have been developed starting with an objective system of evaluating anxiety and performance and over time have developed into more abstract ways of considering the effects of anxiety on performance. More importantly, this discussion demonstrates that an optimum level of anxiety can improve performance, while a high level of anxiety can have detrimental effects on performance (Sogunro, 1998) as can low levels of anxiety. One can draw the conclusion that if student nurses are experiencing a high level of anxiety, then their performance in the clinical setting is likely to be affected in an adverse way. The literature about stress and anxiety in student nurses in the clinical setting is discussed in the next section.
Section VI: Stress and Anxiety in Student Nurses in the Clinical Setting

The purpose of this portion of the literature review is to better understand the anxiety of student nurses in the clinical setting and to determine what has been studied and what is missing from the literature on this topic. Understanding student nurses’ anxiety in the clinical setting will help nurse educators to develop a supportive environment that is conducive to learning (Oermann & Standfest, 1997).

In this review, selection criteria of the literature and three major topics found in the literature about stress and anxiety in student nurses in the clinical setting are discussed. These topics are evidence of stress in student nurses in the clinical setting, stress in interpersonal relationships in the clinical setting, and stress related to performance ability of student nurses. The review concludes with a brief summary of the research.

Selection Criteria for Literature for this Review

Here, I present the research studies on stress or anxiety in student nurses in the clinical setting. Recall that earlier in this chapter, it was discussed that the terms stress and anxiety are often used interchangeably. It is for this reason that this review of the literature includes research about both stress and anxiety in student nurses in the clinical setting. Excluded from this literature review are studies that have been conducted about stress or anxiety of student nurses in specialty areas of clinical settings such as pediatric and mental health rotations. While this is important research, the results tend to address situations that are unique to those settings as opposed to the clinical setting in general.

This review of the literature includes 31 studies about stress or anxiety in student nurses in the clinical setting. These research studies have been selected based on
terminology that was used by the authors in the purpose, research question, or title of the article. The keywords used to select research studies for this review were stress, stressful, stressors, and anxiety. One study used the word satisfaction in the purpose and was selected because the findings in this study discussed stressful relationships in the clinical setting and because it is a sentinel piece of research about stress in student nurses in the clinical setting. One study used the word concerns in the purpose and was selected because the discussion portion of the article said that the findings of this particular research study supported those of another that examined major stresses to student nurses.

The timeframe for the studies in the literature review are the years 1963-2004. Research studies as early as 1963 have been included because this seems to be the beginning of research on stress in student nurses in the clinical setting. These early studies are being considered as sentinel pieces for this review.

The first section of this review is a general discussion about stress in student nurses in the clinical setting. The next section discusses results of the research that shows interpersonal relationships between student nurses and nursing faculty and staff nurses are stressful. The final section is a discussion about stress as it relates to the performance ability of student nurses in the clinical setting. The focus areas in this section include providing patient care, lack of clinical knowledge and nursing procedures, and initial clinical experiences.

*Stress in Student Nurses*

There are two topics discussed in this section. The first is a discussion of studies about stress of student nurses in nursing education, with an emphasis on the clinical
aspect of nursing education. The second discussion addresses the psychological health of student nurses.

**Stress, student nurses, and nursing education.** Research shows that student nurses experience stress during the educational process to become a registered nurse (RN). A quantitative study conducted with newly graduated nurses showed that 88% of the participants experienced high levels of stress during their educational process (Tichy & Means, 1990). For some student nurses, the stress that is initially experienced is related to the academic portion of nursing education. However, as students progress through their nursing education, the stress shifts from stressors related to exams, assignments, and the pressure of studying to those related to clinical experience (Elfert, 1976). Several studies indicated that stress increased with each additional year of their education and that some students experienced the most stress during the final semester of nursing education (Elfert, 1976; Lindop, 1991 & 1999; Oermann, 1998).

Several studies in this review were comparative in nature. One study compared ADN and BSN student nurses (Oermann, 1998). The results of this study are consistent with other studies that show that student nurses experience more stress in the clinical setting as they progress through their nursing education. However, it also showed that although the ADN students were older and had more life and work experiences, they experienced higher levels of stress in the clinical setting than did the BSN students. The researcher speculates that the ADN students may experience higher levels of stress because of the need to tend to various commitments in their lives such as clinical practice combined with the demands of work and family (Oermann, 1998).
Two studies compared nursing education programs that were either being phased out or had already been discontinued and redesigned to create a new educational program for student nurses (Gwele & Uys, 1998; Rhead, 1995). Students in both these studies from the old and new programs experienced stress in the clinical setting. The results of the study done by Gwele & Uys (1998) indicated that students in the former nursing program experienced higher levels of stress in the clinical setting than those in the new program. The researchers contributed the lower stress levels of students in the new program to the changes made in the curriculum for the new program. Some of these changes included eliminating clinical experience during the first year, holding class during the regular university schedule and clinical experiences when the university has vacation, and third year students having three consecutive days of clinical.

While all of the above studies clearly show that students experience stress in the clinical setting, the stress may have a devastating effect. One study showed that stress in the clinical setting can be a reason for students to terminate their nursing education (Lindop, 1989).

*Stress and the psychological health of student nurses.* Some students may have a pre-existing psychiatric condition and this could be a reason that they experience stress in their nursing education programs. The data from one study indicates that student nurses had higher levels of general distress and minor psychiatric disorders than did the general public and also higher than a group of medical students in a study conducted by Firth in 1986 (Beck & Srivastava, 1991). Similarly, Kim (2003) found a correlation between anxiety as a personality trait and clinical experiences. Students with higher levels of trait anxiety experienced anxiety during clinical experiences.
Stress may have yet another devastating effect on student nurses. It may result in a psychiatric condition for some student nurses. The results of one study showed that some student nurses experienced an increase in neuroticism and psychological distress during their nursing education. The researchers think that it is possible that the increases in neuroticism could be a negative consequence of the stressful experience of student nurses in the nursing program (Deary, Watson, & Hogston, 2003).

In summary, the results of these studies show that clinical experiences are likely to be more stressful than academic experiences. Oddly, stress in the clinical setting can actually increase for students as they progress through nursing programs. This finding seems to be somewhat idiosyncratic because typically students who are in higher levels of their nursing education programs have had more clinical experiences and have acquired more skills to function in this setting.

Sadly, stress can lead student nurses to discontinue their education in nursing. This has the potential to create a void in one’s life, to create a feeling of being unfulfilled in a career choice, or perhaps create feelings of failure. Also unfortunate, is the fact that an increase in stress may lead to physical or psychological disorders for these students.

An interesting finding in this review is that a tendency toward experiencing stress may be a personality trait for some student nurses. Therefore, the possibility exists that those student nurses who experience the most stress in the clinical setting may have an existing personality trait which lends itself to a student having increased feelings of stress and anxiety in the clinical setting.

In the next sections, I begin to discuss specific sources of stress in the clinical setting as found in the results of these research studies. The first category is stress in
interpersonal relationships in the clinical setting, followed by stress related to performance in the clinical setting.

**Stress in Interpersonal Relationships in the Clinical Setting**

The results of many of the studies in this literature review reveal a predominant finding of what is categorized here as interpersonal relationships. The relationships that caused stress most frequently were found between student nurses and clinical instructors, and student nurses and staff nurses during clinical experiences. I begin with a discussion of interpersonal relationships between student nurses and clinical instructors, followed by relationships between student nurses and staff nurses.

**Relationships between student nurses and clinical instructors.** Student nurses experience stressful relationships in the clinical setting. A large percentage of stressful relationships are those between student nurses and their clinical instructors (Garrett, Manuel, & Vincent, 1976; MacMaster, 1979; Mahat, 1996). Similar to the studies in previous section, students in every level of nursing education, from the first year to the final year (Fox, Diamond, Walsh, Knopf, & Hodgin, 1963a; Mahat, 1996; Shipton, 2002), have experienced negative interactions with clinical instructors.

There are several reasons for stressful relationships between student nurses and clinical instructors. Some students felt that their clinical instructors were unsupportive, overly critical, and made them feel inadequate to provide patient care (Mahat, 1998). Some students were actually intimidated by clinical instructors, specifically in the area of quality and quantity of negative feedback (Dye, 1974). Some students were stressed if they perceived the instructor to be moody or incompetent or when they had to wait for the instructor to be available (Shipton, 2002).
Another reason for stressful relationships between student nurses and clinical instructors is that faculty observe and evaluate student nurses in the clinical setting (Kim, 2003; Kleehammer, Hart, & Keck, 1990; Shipton, 2002). Students felt that during the evaluation process instructors wanted to bring attention to only the negative aspects of their performance (Shipton, 2002). Students also reported that being questioned by clinical instructors was particularly stressful (Kim, 2003).

Insensitivity on the part of the clinical instructor was seen to be a source of stress for student nurses (Kirkland, 1998; Mahat, 1998). One interesting study indicated that differences in race between students and clinical instructors could be a source of stressful relationships (Kirkland, 1998). In this study the sample consisted of females, all of whom were African-American. Caucasian faculty members were considered “insensitive” (p. 10) and the students reported that they had poor interactions with them. Converse to this finding, Mahat (1998) presented some results of her study according to race. In her study, students who were African-American reported fewer stressors related to interpersonal relationships in general than did the students who were Caucasian and students of other races. While the results of these studies are inconsistent and exclusive to these research studies, this review in general is lacking results based on race to either support or oppose these findings.

To the advocacy of clinical instructors, those who facilitated learning were considered by student nurses to be knowledgeable and skillful in the clinical setting and were able to guide students to relate theoretical concepts to the actual care of patients in the clinical setting. They had the ability to simultaneously direct students while supporting their independence. They possessed enthusiastic, caring and empathetic
attitudes towards students. Clinical instructors who inhibited learning did not possess the attributes of those who facilitated learning (Oermann, 1998).

In summary, again it has been found that student nurses at all levels of nursing education experience stress in relationships with clinical instructors. Some specific reasons for stress in relationships between student nurses and clinical instructors include being observed and evaluated by faculty, and receiving negative feedback from the clinical instructor. Some students experienced stress when their instructors were unsupportive, insensitive, and made them feel incompetent. Some students were stressed when they felt the instructor was either moody or incompetent. Overall, a predominant finding in this review is that negative interactions exist between student nurses and clinical instructors and it is a main source of stress in the clinical setting.

*Relationships between student nurses and staff nurses.* The results of several studies show that relationships between student nurses and staff nurses are stressful. Staff nurses are registered nurses who are working in the environment where student nurses had their clinical experiences. Once again the research reveals that student nurses in all levels of education, from the first year to the last, experience stress in relationships with staff nurses (Clark & Ruffin, 1992; Gunter, 1969; Mahat, 1998; Sellek, 1982; Timmins & Kaliszer, 2002). One study revealed that stressful relationships between student nurses and staff nurses was one of the primary reasons for students to leave nursing education (Lindop, 1989).

Stressful relationships resulted when students were demeaned, belittled, and humiliated by staff nurses (Parkes, 1985; Shipton, 2002). In Parkes’ study, students said they were made to feel “…like an idiot” (p. 947) when they wanted to complete patient
care in a fashion that was aberrant to the regular routine of how things are done. Student nurses were also embarrassed in situations where staff nurses reprimanded them in front of patients or visitors and they began to cry in the midst of the episode (Parkes, 1985). In one very interesting study, student nurses were enrolled in a new, higher level of nursing education. This level of education was different from the education attained by the staff nurses. The researcher suggested that the student nurses may have posed a threat to staff nurses because of their advanced level of education. This threat may have resulted in unfavorable attitudes of staff nurses toward student nurses because staff did not know how to react to the students (Hamill, 1995).

Stressful relationships resulted when students were made to feel incompetent by staff nurses (Davitz, 1972; Evans & Kelly, 2004) and made to feel they were a nuisance to staff nurses (Shipton, 2002). Some staff nurses did not acknowledge the student nurses’ abilities to provide patient care (Evans & Kelly, 2004; Parkes, 1985). One student gives the account that she sensed something was wrong with the patient and reported this to a staff nurse. The student was told that she lacked the knowledge to be able to assess the situation accurately. A short time later, the patient suffered a stroke (Parkes, 1985).

Some student nurses felt that staff nurses were taking advantage of them and this created a stressful relationship. In one study, students felt that staff nurses developed a loathsome attitude toward them as soon as they met. They felt that this resulted in a heavy patient care assignment for the student (Davitz, 1972). Students felt that they were being mistreated by staff nurses when they demanded that student nurses help them with patient care (Shipton, 2002).
Students felt offended by staff nurses when staff nurses did not want to share their knowledge with them (Evans & Kelly, 2004) or when staff nurses did not permit students to enter their tightly knit camaraderie (Fox, et. al., 1963b). Student nurses reported that staff nurses in the operating room and post-partum areas of the hospital setting were particularly reluctant to let students be a part of their group (Fox, et. al., 1963b).

In summary, again the results show that students in all levels of nursing education have difficulty in relationships with staff nurses. These students felt demeaned, were made to feel incompetent, and felt as though they were a nuisance to the nursing staff. Some students felt that the staff nurse simply did not like them and others felt slighted when staff nurses would not share their vast knowledge or when they were reluctant to teach them. A difference in level of education for some students was considered a reason as to why the staff nurses treated them unfavorably. In one study, nurses in specialty areas were found to be particularly reluctant to welcome student nurses into their group. Unfortunately, students may leave nursing education because of the unfavorable relationships they experience with some staff nurses.

**Stress Related to Performance in the Clinical Setting**

In this review, several topics were found to be prevalent in relation to stress and student nurses’ ability to perform in the clinical setting. Specific and significant findings related to stress and performance in the clinical setting are providing patient care, lack of clinical knowledge and nursing procedures, and initial clinical experiences.

**Providing patient care.** Students from all levels of nursing education experience stress when providing patient care (Evans & Kelly, 2004; Gunter, 1969; Parkes, 1982). Student nurses reported providing care to an unspecified particular type of patient was
stressful (Gunter, 1969), as well as providing care to difficult patients (Beck & Srivastava, 1991) and providing physical care to patients (Garrett, et. al., 1976).

More specifically, providing total patient care which involved meeting the physical and emotional needs of assigned patients was found to be particularly stressful for student nurses (Sellek, 1982). Students experienced stress when personal contact was required to provide patient care (Dye, 1974). Some students experienced stress when providing care to patients who were male and hospitalized on medical wards (Parkes, 1982). The physical demands of patient care which included heavy lifting was a source of stress for some student nurses (Evans & Kelly, 2004; Lindop, 1989; Parkes, 1985).

*Lack of clinical knowledge and nursing procedures.* Some students felt they lacked clinical knowledge and/or were uncertain in their ability to perform nursing procedures. A significant source of stress for some students was the ability to transfer theoretical knowledge to the clinical setting when providing care for patients (Brown & Edlemann, 2000). Data from several studies indicated that student nurses felt they were inadequately prepared for clinical experience and this was a source of stress for them (Dye, 1974; Mahat, 1998; Shipton, 2002). They also felt they lacked clinical knowledge to accomplish patient care (Beck & Srivastava, 1991; Elfert, 1976; Mahat, 1998; Oermann, 1998). One example in which a student nurse felt she lacked clinical knowledge, was being able to respond and react appropriately in an emergent situation (Parkes, 1985).

Some students were concerned about their ability to perform nursing procedures (Elfert, 1976; Kim, 2003; Kleehammer, et. al., 1990, Parkes, 1985). Overwhelmingly, “all” (p. 53) students in one study felt they lacked practical skills (Hamill, 1995).
Students used the words “stressful,” “scary,” and causing “butterflies and flutters” when relaying their thoughts about performing nursing procedures (Shipton, 2002). One student gave the account that she was embarrassed by a physician when, after several attempts, she was unable to skillfully obtain a blood pressure on a patient. Another student felt “…nervous and stupid” (p. 42) while providing care to a patient who suffered a stroke. She reported she did not “…know how to treat her or move her” (Elfert, 1976). Another example of insecurity in performing clinical skills includes the possibility of causing paralysis to a patient if an injection is administered incorrectly (Parkes, 1985).

As with previous topics in this review, students from all levels of nursing education felt they lacked clinical knowledge and questioned their ability to perform nursing procedures (Beck & Srivastava, 1991; Parkes, 1985). What is quite troubling is that senior level student nurses questioned their ability to perform in the clinical setting as graduate nurses in the near future (Elfert, 1976; Kim, 2003; Shipton, 2002).

*Initial clinical experiences.* Initial clinical experiences were found to be a significant source of stress in some of the studies in this review. Providing patient care was an initial clinical experience that caused the most stress for some students (Mahat, 1996 & 1998).

Once again students in all levels of nursing education found initial clinical experiences to be stressful (Dye, 1974; Sellek, 1982; Mahat, 1998; Shipton, 2002). Interestingly, RN students found initial clinical experiences on a unit that was unfamiliar to them to be a source of stress (Beck & Srivastava, 1991; Kleehammer, et. al., 1990; Kim, 2003). Students reported that stress related to initial clinical experiences on a new
unit is due to “…fear of the unknown,” (p. 247) and that it can be frightening until one becomes more comfortable in the environment (Shipton, 2002).

Clinical experiences in specialty rotations such as community nursing, psychiatric nursing, and maternity nursing were stressful (Shipton, 2002). Experiences in community nursing and psychiatric nursing were stressful because students were unsure of their role in these areas. For those in the community setting, simply meeting the patient and explaining their role was stressful because some students had been rejected by patients. In psychiatric rotations, students were uncertain about their role because they found it difficult that their clinical experiences involved only talking to patients without having to perform nursing procedures (Elfert, 1976). Maternity nursing was stressful for some students because they had to visit prenatal mothers in the community and care for mothers and newborns in the hospital setting. Student nurses were unsure of their skills to practice in either of these settings (MacMaster, 1979).

In summary, this review shows that student nurses across various levels of nursing education experience stress in performing in the role of student nurse. The role of the student nurse is stressful namely in the areas of patient care, knowledge in the clinical area, and initial clinical experiences. For students at most levels of nursing education, providing care to certain types of patients was stressful. This included physical aspects of care and concerns were about the physical demands of providing patient care such as heavy lifting.

Students were stressed about a lack of knowledge to perform in the clinical setting. Some were concerned about transferring theory that is learned in the classroom
to the clinical setting and some felt they were simply inadequately prepared. These concerns led some students to feel they were “stupid.”

Initial clinical experiences were a concern for student nurses in various levels of nursing education. Initial experiences providing patient care, those where the clinical unit was an unfamiliar setting, and experiences in specialty rotations such as community, maternal-child, and psychiatry were stressful for student nurses.

Summary for this Review

Many student nurses experience stress in the clinical setting. Stress is experienced by student nurses who have had few clinical experiences, by student nurses in higher levels of nursing education who have had more clinical experiences, and by students who are registered nurses. Stressful experiences in the clinical setting may be harmful because of the possibility of inhibiting learning or perhaps result in a psychiatric disorder.

The predominant findings in this review were that student nurses experience stress in interpersonal relationships with faculty and staff nurses and were stressed regarding their performance ability in the clinical setting. Stress may affect their ability to perform in the role of student nurse and perhaps be a cause for terminating nursing education. A rather disturbing finding in this review is that some of the sources of stress have remained unchanged in over five decades. This may be an indication that nursing faculty members have done little to abate stress in student nurses in the clinical setting.

Summary of Chapter 2

This chapter provides a review of the literature of six areas that inform this research study. These are the purpose of a literature review, educational preparation of
professional nurses, the learning theory of situated cognition, anxiety and stress, anxiety
and performance, and anxiety and stress in student nurses in the clinical setting.
CHAPTER 3

METHODOLOGY

Purpose of the Study

The purpose of this research study was to better understand student nurses’ perception of anxiety in the clinical setting and to understand what anxiety means for them. The guiding research questions for this study were:

1. How do student nurses make meaning of, interpret, and perceive their anxiety in the clinical setting?
2. How do student nurses contextualize, and/or understand their anxiety in the clinical setting?

Research Paradigm

Anxiety is a phenomenon that is experienced by many individuals in various settings and moments. The meaning of anxiety is unique to each individual. Qualitative inquiry may be used to understand a phenomenon (Patton, 2002). The focus of qualitative research is to understand how people make meaning of their experiences; therefore a qualitative study is the best approach for this study. Experiences occur within contexts and interactions, therefore, qualitative researchers cannot predict an outcome. Instead, they try to understand the lived experiences of the participants. In other words, qualitative researchers want to investigate how the participants view the experience from their personal perspectives (Merriam, 2002). This study focused on how anxious student nurses make meaning of their anxiety.

The research paradigm for this study is interpretive. Individuals construct reality while they are interacting with the social worlds in which they live. This is a central
characteristic of qualitative research. People make meaning in their daily lives. The researcher tries to gain a view of the world from the perspective of the participant. The researcher attempts to understand how the participants construct meaning in their daily lives and experiences, and tries to understand the participants’ interpretation of reality. The construction and interpretation of a person’s reality occurs over time and one’s interpretation of reality changes over time. Qualitative researchers seek to understand the participants’ interpretation of their reality at a certain time and within a certain context (Merriam, 2002). They typically do so by collecting data through interviews, observations, and documents relevant to the setting or the participants (Patton, 2002).

One of the characteristics of qualitative research is that the process is inductive. Through the qualitative research process concepts, hypotheses, or theories can be built rather than deductively obtaining postulates or hypotheses to be tested, as is done in positivist research (Merriam, 2002). Qualitative researchers do not set out to prove or disprove theories or hypotheses, rather, they are looking for an in-depth understanding of how the participants in a study make meaning of a particular phenomenon; typically they find particulars, and analyze the data according to themes. These themes can be used to build theory, or they can simply be used to more deeply understand the phenomena that are being investigated and to increase knowledge about the research question (Merriam, 2002; Bogdan & Biklen, 2003).

Qualitative researchers collect descriptive data. Descriptive data is data that “take the form of words or pictures rather than numbers” (Bogdan & Bilken, 2003, p. 5). In the analysis of the data, qualitative researchers try to preserve the experiences of the participants by providing rich descriptions. Qualitative articles and reports usually
contain direct quotes and the researcher attempts to describe a person’s individual situation or view of the world in a narrative format (Bogdan & Biklen, 2003). Some examples of the data of a qualitative research study include interview transcripts, field notes, photographs, videotapes, personal documents, memos, and other official records (Merriam, 2002; Bogdan & Biklen, 2003).

Interview transcripts were the primary data for this qualitative research study. Documents such as clinical worksheets, journals, pictures, and artforms were a secondary source of data collection in the study. Field notes were also used as a supplement to data collection. These methods of data collection will be discussed more fully in the data collection section of this chapter.

Research Methodology

While most forms of qualitative research are interpretive in that they aim to find out how individuals or groups interpret or live their reality, qualitative research itself can be informed by different aspects of philosophy or social thought, including, but not limited to phenomenology, critical theory, feminist theory, and postmodernism (Merriam, 2002). The research perspective for this study is phenomenological.

Over time, the term phenomenology has taken on several meanings. It can be referred to as a philosophy or a research methodology (Patton, 2002). In this section, I discuss the philosophy of phenomenology, followed by a discussion of Schools of Phenomenology, including Husserl, Heidegger, hermeneutics, and heuristic inquiry.

Philosophy of Phenomenology

“…Phenomenology is the study of the lifeworld – the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it”
The lifeworld can be explained as daily experiences in their immediacy independent of pre-reflective explanations of the experiences. Phenomenology concerns itself with understanding the meaning of everyday experiences in the lives of ordinary people (Kvale, 1996; VanManen, 1990).

Anything that enters our consciousness can be considered a “lived experience.” Phenomenology is about studying the “essence” of phenomenon by a person’s description of their lived experience of the phenomenon. The word “essence” means “the inner essential nature of a thing, the true being of a thing” (VanManen, 1990, p. 177).

Phenomenology attempts to describe the meaning of the phenomena through a subject’s description of lived experience. People interpret their experiences in relation to what their experience means for them (Merriam, 2002). Phenomenology does not attempt to understand what caused the experience, how the experience happened, or how the experience is related to other experiences (Kvale, 1996; VanManen, 1990). An understanding of the phenomena is enhanced by a subject’s description of the lived experience about the phenomena. Seeking to understand the particulars of a lived experience enables one to understand the essence of the phenomenon (VanManen, 1990).

It is through intentional acts of consciousness that a person reflects on a lived experience (Kvale, 1996; VanManen, 1990). Reflection on a lived experience is a retrospective process rather than an introspective process. A person cannot reflect on an experience while they are actively going through the experience. Therefore, descriptions of lived experiences are recollective and retrospective of experiences that one has lived through and experienced (VanManen, 1990).
Phenomenology does not attempt to understand meanings that are specific to certain cultural or social groups. It attempts to explain meaning of individuals who have experienced a phenomenon in the course of their daily lives (VanManen, 1990).

Schools of Phenomenology

Here, I discuss the phenomenological perspectives of Husserl and Heidegger (Patton, 2002). I conclude with an explanation of the school of phenomenology that is most closely aligned to my beliefs about phenomenology and discuss how hermeneutics and heuristic inquiry inform this research study.

The reason I choose to write about Husserl’s and Heidegger’s philosophy of phenomenology is because of the dilemma about bracketing. I agree with Heidegger’s philosophy on examining phenomena. Phenomena are interpreted by persons based on the influences of their activities in and their interactions with the world in which they live. It is not possible to entirely bracket life experiences from phenomena to arrive at phenomena in its “pure” sense as described by Husserl. I think that daily experiences are influenced by socio-cultural-political factors. One cannot separate phenomena from these influences because they are intertwined and affect how one views and describes phenomena. “The real, lived experience, is given in the perceived world, and this is what must be described” (Merleau-Ponty, 1956, pp. 61-62). In light of Heidegger’s philosophy, this study was informed by hermeneutics. In addition, this study was informed by heuristic inquiry.

Husserl’s philosophy of phenomenology. Husserl’s philosophy of phenomenology has come to be known as descriptive phenomenology. Husserl believed that phenomena should be described and explored as uncensored, pure phenomena.
Descriptive phenomenology acknowledges that which is essentially subjective, it recognizes that meanings and values are created in experiences, and it broadens one’s perspective of the world and self (Spiegelberg, 1975).

The slogan “to the things themselves” is associated with Husserl’s tradition of phenomenology (O’Connor, 1993; Spiegelberg, 1975). Husserl believes that in order to understand phenomena in its pure sense, or get “to the things themselves,” one must set aside or bracket one’s views and beliefs about the world. Husserl refers to one’s views and beliefs about the world as one’s natural attitude. A person’s natural attitude is one’s taken for granted perception of the world. The natural attitude prevents a person from viewing the world as phenomenon. In the natural attitude, persons are focused on goals, purposes, and pursuits of their lives rather than considering how the world presents itself (Gurwitsch, 1966). Husserl suggests that persons see the world as it really exists rather than how it is constructed (Gearing, 2004).

To describe pure phenomena, Husserl suggests phenomenological reduction. Phenomenological reduction would permit examining phenomena in its purest sense. Scientific conclusions, facts, and hypotheses are considered only as phenomena. The attempt of phenomenological reduction is to inquire about the essence of the phenomena. In phenomenological reduction, knowledge of scientific data or knowledge of the world is suspended so that the true essence of the phenomena can be understood (Husserl, 1907/1964). The phenomenon is to be examined as an essence without the interplay of its reality (Spiegelberg, 1969). Reality is bracketed out of the phenomena.

*Heidegger’s philosophy of phenomenology.* One of Heidegger’s thoughts about phenomenon is that phenomenon itself is not apparent but it remains hidden as the
meaning of what is shown (Spiegelberg, 1969). More formally, his definition is “that which shows itself in itself” (Hedin, 1997; Heidegger, 1927/1996). The method of uncovering the meaning of phenomenon is interpretation. Interpretation operates under the assumption that what is being interpreted has meaning (Spiegelberg, 1969).

Heidegger’s philosophy is known as interpretative or hermeneutic phenomenology (Boelen, 1975; Gearing, 2004).

In contrast to Husserl’s philosophy of phenomenology, Heidegger disagrees with the concept of phenomenological reduction (Gearing, 2004; Spiegelberg, 1975). Heidegger uses the term being-in-the-world to explain his philosophy (Heidegger, 1927/1996). Human beings exist together with the world in a close, living, intimate relationship. They have not simply been inserted into the world (Spiegelberg, 1969). Human beings, by their interaction with the world, are being-in-the-world. Being-in-the-world is a spatial relationship between humans with humans and with objects in the world (Hedin, 1997). Humans participate in being, and being cannot be controlled or observed by another. Therefore, Heidegger’s phenomenology is not simply descriptive as is Husserl’s, but it is interpretative or hermeneutic, and serves to unravel the complex structure of being (Boelen, 1975). Heidegger’s belief was that phenomenon must be discovered by people’s living in the world (Hedin, 1997). Heidegger felt that it was not possible to bracket out the context of phenomenon, but that hidden meanings of phenomenon could be interpreted within context (Gearing, 2004).

Hermeneutics. Hermenutics seeks to understand the conditions that were occurring when an act or behavior occurred that make it possible to interpret the meaning of the act or behavior. The meaning of an act or behavior is dependent upon the cultural
context in which it occurred and the cultural context in which it is interpreted. Hermeneutics provides a framework for interpretive understanding and directs attention to the context in which an act or behavior occurred. Hermeneutics challenges the notion that an interpretation is always the truth or is always absolutely correct. An interpretation will always be solely an interpretation and should not be considered an absolute truth. Hermeneutic researchers construct reality on the basis of their interpretations of data with the assistance of the participants who provided data for the study. Hermeneutic researchers interpret the meaning of something from a certain standpoint or situation (Eichelberger, 1989; Patton, 2002).

I am a nursing clinical instructor who has encountered student nurses who are anxious in the clinical setting; therefore, I interpreted the data from that standpoint. As an instructor, I am aware that some students are anxious and that the clinical environment may have an impact on their feeling of anxiety. Hence, I have a certain standpoint and awareness of anxiety in student nurses in the clinical setting. It is through this lens that I have interpreted the data. In addition, during my education as a student nurse (more than 20 years ago), I too experienced anxiety in the clinical setting. This is another standpoint from which I have interpreted their reality of this phenomenon.

Heuristic inquiry. Heuristic inquiry is a form of phenomenological inquiry that recognizes and includes the experience of the researcher regarding the phenomenon being studied (Patton, 2002). “The self of the research is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge” (Moustakas, 1990, p. 9).
The major element of heuristic inquiry is that the researcher must have personal experience with and a passionate interest in the phenomenon that is being studied. The combination of personal experience and interest brings forth an understanding of the essence of the phenomenon. Heuristic inquiry is quite unique because it permits the recognition of the personal experiences, reflections, and insights of the researcher. Heuristic inquiry exemplifies how the researcher is the primary instrument in qualitative inquiry and places the experience of the researcher in the study (Patton, 2002).

The phenomenon of anxiety in student nurses is something with which I have had personal experience and something in which I have a personal interest. The reasons for this were explained in the above section about hermeneutics and stem from my experience as a nursing clinical instructor and a student nurse.

Participants

Among the types of sampling for research, random sampling and purposeful sampling are the most common. Random sampling, more typical of quantitative research, is sampling that selects participants that are representative of the general population. In qualitative research, purposeful sampling is typically used, and certain subjects are chosen because they can provide information about issues that are central to the research study (Bogdan & Biklen, 2003; Merriam, 2002). For this study, a smaller purposeful sample was chosen in order to seek out the in-depth data necessary to provide analysis of the meaning of the lived experience of the participants sought out in a phenomenological study.

The purposeful sample for this study was 7 student nurses who have experienced anxiety in the clinical setting. The participants were from two baccalaureate nursing
programs in northeastern Pennsylvania who completed at least one semester of clinical experience in their nursing education. One nursing program was in a private college and the second nursing program was in a private university. Approval was obtained from the Institutional Review Boards at each of these schools. Student nurses who experienced anxiety in the clinical setting were self-identified. I went to the classrooms of student nurses and explained the research study. Student nurses were asked to participate in the study and volunteered to participate based on their own perceptions of experiencing anxiety in the clinical setting.

There are no precise, exacting rules for sample size in qualitative inquiry. Sample size is dependent on the purpose of the study, what will be credible, and what can be done with the allotted time for the study. More so than sample size, the information richness provided by the participants will generate validity, meaning, and insight about the phenomenon. It has been recommended that sample selection continue to the point where no new information is obtained from participants. This technique exemplifies the emergent nature of qualitative research (Patton, 2002). For this research study, I interviewed 7 participants. Since this is a qualitative, phenomenological research study, 7 participants provided enough information to adequately cover the phenomenon of anxiety in student nurses in the clinical setting because I obtained stories from a small number of student nurses who commonly share the phenomena of anxiety in the clinical setting. After the seventh interview new information was not obtained from participants.

Protection of the participants for this research study was done in accordance with The Pennsylvania State University Office of Research Protections. An informed consent was presented to each participant, accompanied by an explanation of the consent. Each
participant was required to sign the consent. A copy of the informed consent was retained as part of the research records, and the participant was given a copy. Due to the emergent nature of qualitative research and the interview process, it is impossible to have a specific informed consent. Participants were assured that their identity will not be disclosed and that all results will be kept confidential. Each participant was given a pseudonym. The participants were informed that they have the right to withdraw from the study without any consequences.

The risks to participants were minimal. Participants expressed their perceptions about anxiety in the clinical setting which could have been emotionally upsetting. If this occurred, I planned to offer emotional support because I have experience dealing with anxious student nurses in the clinical setting; however, this was not necessary during the interview process. If during the interview process I felt the participant was a danger to self or others, I would have called 911 (emergency personnel); however, this was not necessary. All procedures for this research study were within the guidelines of the institutional review process.

Data Collection Techniques

As mentioned above, in qualitative research the primary means of data collection are interviews, observations, and documents that are related to the study (Merriam, 2002). Those that were used in this study are discussed further below.

*In-depth Interviews*

Interviews with individual participants were the primary tool used to collect data for this research study. I believe that by using interviews to collect data I obtained a sense of how student nurses perceive, contextualize, and understand their anxiety.
Interviews permit the researcher to go to a greater depth than other techniques. When a researcher interviews, it is possible to establish a connection with the participants and use deliberate encouragement to gain information that participants would not be able to reveal by any other method (Merriam & Simpson, 2000). The interview process is used to gather descriptive data that is in the participants’ own words. These data can help the researcher develop a perspective about how the participant interprets a phenomenon (Bogdan & Biklen, 2003). Interviewing also provides the researcher with the opportunity for immediate clarification from the participants during the interview process (Merriam, 2002). When a participant described a situation or used terminology that was unclear or unfamiliar, or demonstrated body language which raised questions, I was able to further explore the meaning of these during the interview process as these situations arose.

There are three types of interviews: highly structured, semi-structured, and unstructured. Highly structured interviews are interviews where specific questions and their order are determined before the interview. In an unstructured interview, the researcher has a topic of interest to explore; however, neither the questions nor the order of questions is decided upon prior to the interview. The semi-structured interview is a combination of these two types of interviews. The semi-structured interview is guided by questions to be asked of all participants; however, neither exact wording nor order of questions is determined prior to the interview (Merriam, 2002).

The unstructured interview was used for this research study because it provides the researcher with the opportunity to investigate a phenomenon as the participants speak. When investigating a phenomenon, it is nearly impossible for the researcher to know what is important to the participants. For this reason, the researcher’s questions about the
phenomena are derived from immediate conversation with participants (Patton, 2002). This method was appropriate for this research study because anxiety is a phenomenon that means different things to different people. Information and meanings about anxiety are likely to emerge in the course of the interview. This approach enabled the participants to share their own perspective of their anxiety in the clinical setting.

Although unstructured interviews were conducted with participants, I did have a list of questions about anxiety in student nurses in the clinical setting in case the participant was unable to discuss or reflect on their anxiety in the clinical setting. I did not need to refer to this list during the interview as the participants were able to talk effortlessly about their anxiety in the clinical setting. Some participants did want me to ask them a question to start the interview. I typically asked them to describe a day when they felt anxious in the clinical setting. From that point forward the participants were able to discuss their anxiety in the clinical setting without the need to ask them questions from the list that I prepared. At the end of the interview, I reviewed the list of questions to ensure that I obtained information about topics related to anxiety in student nurses in the clinical setting. In addition, questions about demographic data of the participants, such as age, ethnicity, and previous health care experience were included on this list and were asked of each participant.

When the researcher utilizes the interview for data collection, the researcher becomes the main instrument for data collection and data analysis. This is especially true when heuristic inquiry is used. With this perspective, the personal experiences and insights of the researcher is shared with the participant during data collection (Patton, 2002). Self-disclosure can elicit disclosure. Although I used very little self-disclosure,
my personal experience with anxiety of student nurses in the clinical setting likely helped
the participants to share richer, fuller, and more comprehensive depictions during the
interview process (Moustakas, 1990).

The individual interviews were approximately one hour to one and one-half hour
in length. Each interview was tape recorded. The interviews occurred in a quiet
classroom or meeting room on the campus where the participants attend school. The
rooms were located where background noise was at a minimum and where the
participants could talk confidentially.

Documents and Focus Groups

Documents are also a primary means of data collection in qualitative research
(Merriam, 2002). Documents can be either already present in the lives of the participants
(such as journals, or student papers) or generated during the research process (L. Tisdell –
Author and Associate Professor of Adult Education at The Pennsylvania State
University - personal communication, March, 2004). Documents were a secondary
source of data collection in the study.

Prior to meeting for the individual interview, the student nurses were asked if they
had documents that would help them make meaning of their anxiety in the clinical
setting. Examples of documents include clinical worksheets and reflective journals.
Students typically write patient diagnosis, treatments, and medications on clinical
worksheets. The reason for asking the participants to bring this type of document was to
help them reflect back to a particular time when they felt anxious in the clinical setting
and to re-live the experience. Student nurses sometimes write journals about their patient
care experiences as a course requirement and/or for personal reasons. These documents
help participants reflect on situations they have forgotten about, or have forgotten the
details of, and are helpful to the participants to make meaning of their anxiety in the
clinical setting.

The student nurses were asked to bring documents to the initial interview. Most
of the participants said they did not have any documents. One participant brought a
journal. The journal she had written was a requirement for her mental health clinical
experience. She read it before the interview and reflected on the anxiety that she
experienced in the beginning of her mental health rotation and how her anxiety lessened
by the end of the rotation. This prompted a conversation about some experiences in
mental health when she felt anxious. The rich, descriptive quotes became part of the
data.

One way to generate documents during the research process is to have the
participants use a metaphor creation and analysis method. Walsh and Charaniya (2000)
refer to this method as Collaborative Inquiry Metaphor Creation and Analysis Method
(CIMCAM). It uses simple art materials to help participants communicate their ideas
metaphorically (Walsh & Charaniya, 2000). According to Lawrence and Mealman
(2000), “artistic forms of collecting data assist the research participants in accessing
knowledge that cannot be expressed in mere words” (p. 1). Metaphors are used by
individuals to gain entrance to their knowledge and as a means to communicate their
knowledge and to create new knowledge (Lawrence & Mealman, 1999).

The CIMCAM method of data collection has guidelines for data collection set forth
by Walsh and Charaniya (2000) that were followed. It makes use of a combination of a
focus group and a generated document in the research setting. When individual
interviews were completed with all of the participants, one focus group interview with the same participants took place. While all the participants were invited to the focus group interview; four of the seven participants attended.

The participants were asked to express their anxiety in the clinical setting by creating an artform. Simple art materials such as construction paper, glue, stickers, clay, and markers, etc were provided for the participants. During the first step of the data collection process, participants verbally shared some general aspect of their anxiety in the clinical setting. Next, I explained the metaphor creation process to them. Each participant was then given time to create an artistic form that metaphorically described their anxiety in the clinical setting. They were given the freedom to select whatever art materials they wished to use.

Upon completion of the art form, the participants shared the meanings of their artistic metaphors. They each discussed their artform and at the end of each participants’ description I asked the other participants if they had any comments about the artform or the discussion. Finally, the metaphorical art forms were collectively analyzed for how they relate to each other and examined for further meanings that could be derived from them collectively (Walsh & Charaniya, 2000). I asked the participants to consider each artform and asked their thoughts about what they were seeing and hearing. I asked them to consider if other people’s thoughts made them think about different things or commonalities of their experiences. This sharing of metaphors was tape recorded as a focus group interview. The data was then included in the raw data of this research study.

Because anxiety is as an emotion, it is my thought that using art to express this emotion can be a method of having the participants make meaning of their anxiety in the
clinical setting and to collect data. This method likely helped the participants to express the meaning of their anxiety metaphorically and artistically and to express feelings that they may not have been able to articulate verbally.

*Field Notes*

Field notes were used as a supplement to data collection, although used minimally in this study. Fieldnotes of observations are typically used as a primary source of data in ethnographic studies, where the researcher is studying a culture and/or group dynamics. But since this is a phenomenological study, the only field notes that were made use of in this study, are notes about what happened during individual interviews and the observations of the CIMCAM experience. These included things the researcher heard, saw, and experienced while collecting data. The field notes were considered as a personal log to help me review the development of the study and remain aware of how I may have been affected by the data collected or perhaps influenced data collection (Bogdan & Biklen, 2003).

*Data Analysis*

In qualitative research, data collection and initial data analysis take place simultaneously; however, once data collection is complete, a deeper level of data analysis occurs. The individual interviews and the focus group interview were transcribed by a professional transcriptionist. I then listened to each interview tape recording while reading the transcription to check for accuracy of the transcription. The tape recordings of the individual and focus group interview will be kept for three years after the final dissertation defense. I will then destroy each tape by cutting it.
All of the individual interview transcripts were analyzed for themes and categories to capture the stories and the essences of the participants’ experiences. First, I coded each individual interview initially after the tape was transcribed by writing codes in the margins and creating analytical memos. For example, if the participant spoke about staff nurses as a cause for anxiety, I would simply write staff nurse. If they said they were concerned that they would not perform procedures on patients correctly, I wrote the word procedures in the margin. I then examined the transcripts of the individual interviews for the emergence of common themes across all of the individual interviews. The common themes that emerged in the individual interviews were then examined for placement into categories. With the development of categories, the data was then analyzed for incidents that are particular or pertinent to that category. When the data that is relevant to the category had been placed categorically, the data in these categories were examined for various dimensions. Core categories were then derived from the already existing categories. These core categories were used to organize and present the findings of this study (Bogdan & Biklen, 2003). Seven themes emerged from the data and are discussed in detail in Chapter 4.

The transcript from the focus group interview was analyzed as discussed in the above paragraph. This data was then compared to the data gathered from the individual interviews as a way to confirm credibility for this study, as discussed below. The data from the focus group interview was included in the raw data of this research study.

**Dependability Strategies**

Methods should be in place to determine if the findings of a study are accurate. Dependability strategies are important aspects of the research process and are ways to
determine accuracy in both qualitative and quantitative research. Typically, to determine internal validity in quantitative research, the researcher questions if they are observing and measuring what they think they are observing and measuring. Dependability of a qualitative research study usually asks if the researcher is interpreting the reality of the participants accurately. Because the researcher is the primary instrument of data collection and analysis in qualitative research, several questions arise such as the researcher interpreting the data accurately, the certainty of the researcher presenting results that match the collected data, and the reliability of the researcher (Merriam & Simpson, 2000; Merriam, 2002).

In qualitative research, there are several methods to increase dependability. These include, but are not limited to, triangulation, member checks, peer review, audit trails, and prolonged engagement in the situation being studied. Triangulation and member checks were used to determine credibility in this study. Triangulation is also a method to enhance confirmability; therefore this method along with audit trails were used to enhance confirmability for this study and will be discussed below (Merriam, 2002).

Triangulation can be conducted in the following four ways: the use of multiple and different sources, methods, investigators, and theories (Lincoln & Guba, 1985). For this research study, I used different methods of data collection to confirm credibility. The data collection methods that I used were individual participant interviews, existing documents, and the creation of an artistic metaphor associated with a focus group interview. The data from these methods of data collection were analyzed for consistency and further clarification of themes and categories, as was discussed previously.
According to Lincoln and Guba (1985), member checks are the most important way to ensure dependability of a research study. Member checks can occur throughout the research process or when the findings have been determined. An interview can be played back for the participant for their reaction, or findings can be taken back to the participant and they can be asked if the data was interpreted accurately (Lincoln & Guba, 1985; Merriam, 2002). For this study, I took findings back to all of the participants to determine if the data had been interpreted accurately as their lived experience of anxiety in the clinical setting. Although I interpreted the data, the participants of the study were able to determine that their experiences were included in the findings (Merriam, 2002). Five of the seven participants responded that their lived experiences and their stories were interpreted accurately. Two respondents did not reply to the e-mail or a follow-up phone message regarding their thoughts of the interpretation of the data.

Triangulation, as discussed previously, and audit trails are two ways to ensure confirmability in qualitative research. The audit trail is a way to explain how the researcher arrived at the results. When researchers use the audit trail to confirm what they have seen, they write about how data were collected, what led them to derive the categories, and the process of decision making during the research study. This requires that the researcher formulate a written record throughout the inquiry (Merriam, 2002). To conduct an audit trail, I wrote field notes about data collection and data analysis. I reflected on and wrote about myself as a researcher, what occurred as I collected data, and how I decided on themes during data analysis.
Summary of Chapter 3

Chapter 3 includes a restatement of the purpose and research questions for this study. A discussion of qualitative research and the interpretive paradigm was provided. An in-depth discussion of phenomenology as the research methodology was included. The selection of participants, data collection techniques and data analysis for this research study have been described.
CHAPTER 4

PRESENTATION OF THE FINDINGS

The purpose of this research study was to better understand student nurses’ perception of anxiety in the clinical setting and to understand what anxiety means for them. The guiding research questions for this study were:

1. How do student nurses make meaning of, interpret, and perceive their anxiety in the clinical setting?

2. How do student nurses contextualize, and/or understand their anxiety in the clinical setting?

In this qualitative study, unstructured interviews were conducted with 7 student nurses. Following completion of the individual interviews one focus group interview with the same participants was conducted. Immediately prior to the focus group interview the participants created an artform which reflected their perceptions of anxiety in the clinical setting and then the participants discussed their artform creation in the focus group interview. The interviews provided the opportunity for the participants to describe their perception of anxiety in the clinical setting in their own words. The interviews were audiotaped and transcribed verbatim.

The findings of the study were e-mailed to all of the participants for their review to determine if the data had been interpreted accurately as their lived experience of anxiety in the clinical setting. Five of the seven participants responded that their lived experiences and their stories were interpreted accurately. Two respondents did not reply to the e-mail or a follow-up phone message regarding their thoughts of the interpretation of the data.
Profile of the Participants

All participants were student nurses from one private college and one private university in northeastern Pennsylvania. They were enrolled in a baccalaureate program of nursing education. A profile of the participants is provided here. The participants are introduced in the order in which they were interviewed. Pseudonyms were assigned to protect the identity of the participants and to maintain confidentiality.

Denise is a 22-year-old white woman. She began working as a nurse aid the summer after her freshman year of college just prior to starting clinical in the nursing program.

Megan is 21-year-old Hispanic woman. She began working in the health care setting delivering meal trays to patients. She has worked for three years as a nurse aide in various patient care units.

Peggy is a 21-year-old white woman who began working as an Emergency Medical Technician at the age of 17 and continues to work in this area. Her clinical experiences as a student nurse started two years later when she was 19 years old.

Sarah is a 20-year-old white woman. She has been working as a nurse aide on an oncology unit for two years. This work experience began the summer prior to beginning clinical experience in the nursing program.

Amanda is a 28-year-old white woman. She works in the emergency department of a hospital.

Lisa is a 22-year-old white woman. At the age of 12 she began volunteer work at an assisted living facility. She began to work as a nurse aide in an assisted living facility the summer prior to beginning clinical experience in the nursing program. She has
worked for the past year as a nurse aide in an intensive care unit. She also volunteers in the hospital.

Betty is a 21-year-old white woman. Betty has had several positions related to health care prior to starting clinical experiences in the nursing program. She worked as a physical therapy assistant and in the office of an oral surgeon and a gynecologist. She also did volunteer work as a transporter in a hospital.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>Previous Health Care Experience</th>
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<tr>
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<td>White</td>
<td>Yes</td>
</tr>
<tr>
<td>Sarah</td>
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<td>White</td>
<td>Yes</td>
</tr>
<tr>
<td>Amanda</td>
<td>28</td>
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<td>White</td>
<td>Yes</td>
</tr>
<tr>
<td>Lisa</td>
<td>22</td>
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<td>White</td>
<td>Yes</td>
</tr>
<tr>
<td>Betty</td>
<td>21</td>
<td>Female</td>
<td>White</td>
<td>Yes</td>
</tr>
</tbody>
</table>

This chapter includes the findings of the research study. The interview transcripts were analyzed by using a detailed thematic analysis. Seven themes emerged from the data. The themes are Experiencing Inexperience, Being Demeaned, Being Exposed, Unrealistic Expectations, Being Abandoned, Sensing Difference, and Being Uncertain of Ability. The data display on the following page summarizes the major findings of the study.
Data Display

Themes
   Experiencing Inexperience
      Inconsideration of Inexperience
      Encountering Inexperienced Instructors and Peers
   Being Demeaned
   Being Exposed
   Unrealistic Expectations
   Being Abandoned
   Sensing Difference
      Differing Clinical Experiences
      Competition among Peers
   Being Uncertain of Ability
Themes

This section provides the participants’ perception of their anxiety in the clinical setting. There are 7 themes that emerged from the data: (a) Experiencing Inexperience, (b) Being Demeaned, (c) Being Exposed, (d) Unrealistic Expectations, (e) Being Abandoned, (f) Sensing Difference, (g) Being Uncertain of Ability.

Experiencing Inexperience

The participants contextualized their anxiety in relation to experiencing inexperience in various situations in the clinical setting. They talked about feeling anxious about their own inexperience in the clinical setting and that people in the clinical setting were inconsiderate of their inexperience. They also talked about feeling anxious while encountering inexperienced faculty and peers. These are the dimensions of this theme that emerged from the data.

Inconsideration of inexperience. The participants spoke of instructors and staff who were inconsiderate of the students’ inexperience in several situations in the clinical setting. Betty was anxious about talking with experienced staff nurses and physicians in the clinical setting. She worried that her inexperience would be revealed and relayed these thoughts,

…every time I open up my mouth I’m not sure if I’m offending the nurse or the physician with what I’m saying. You could think that you said everything right and they’ll come snap back at you because you know you’re a new nurse, what the hell are you supposed to know or I’m an old nurse, I’ve been practicing 30 years on my same unit on my same wing and who the hell are you to tell me that you know…
Two participants felt the instructor was inconsiderate of their inexperience when the instructor was being inpatient and rushing them through things. Amanda said, “…I’ve had my instructor say, ‘I’ll do it. It’ll be faster.’ She continued, “It’s not about being faster it’s about me learning how to do it…” Similarly, Denise talked about being rushed when talking about instructors and staff nurses who have a negative attitude. She said,

…if you know that the person (instructor or staff) is laid back you feel more confident in yourself, than if the person is really uptight and always on you and condescending and negative and is rushed and doesn’t want to take the time to allow you to do something. It takes us a really long time to do things. It takes me forever to hang a tube feeding because I’m not fast at it. I don’t do it every day and I haven’t done it every day for 20 years of my life…it’s something that I need time to learn how to do and when you feel rushed and that that person who’s above you, responsible for you, if they have certain attitudes, a certain rushed nature about them it just makes you feel a lot more anxious, definitely.

Lisa was anxious about making the staff mad because of her inexperience. Lisa shared this experience,

…I know my sophomore year that was the first time that they really had sophomores in the hospital…I think some of the staff was on edge having sophomore nursing students with their patients. So some of them were very protective of their patients which made you a little nervous because I thought that if I messed up they would be really mad and that would be a reflection on the school as a whole.
Amanda expressed a desire for an instructor who would be supportive of student inexperience. She said,

…we need someone who’s going to come in the room and not make fun of us for being nervous or not make fun of us for not knowing everything about something because we’ve never done it before. Someone who’s supportive…

Amanda also said “…in a lot of my clinical experiences…I’ve been let loose.” When asked to clarify the term “let loose” she said, “just put out there and being told ‘this is your assignment, see ya later, see ya at break, find me if you need something.’” She continued,

…we’re all still unsure of ourselves, even though the instructor might see something in us that makes her think that we are better at coping alone than needing someone there to hold our hands. But still, I listen to a patient’s heart sounds and lung sounds and I hear something (abnormal), I’m still at that stage where I hear it and I recognize it but I want somebody to validate it because I want to know that was crackles (an abnormal lung sound) or that was rhonchi (another abnormal lung sound) and now I know what it sounds like for next time. It’s nice to have that validation…I’m fairly certain that I’m correct but I’m not an expert yet and I don’t do this 40 hours a week every week and somebody that’s been there and done that gives me a sense of reassurance that I’m on the right track and I’m not completely out in left field…

Encountering inexperienced instructors and peers. Some participants felt anxious when they encountered instructors or peers who were inexperienced. Several participants felt the instructor was inexperienced with patient care while one participant felt the
instructor was inexperienced with the grading policy in the clinical setting. Lisa shared her perception of two instructors, who she feels were inexperienced in patient care. She revealed,

…because the instructor wasn’t a pediatric nurse. She worked in women’s health. So that made it a little harder because I had questions like ‘how do I do this?’ and she really wasn’t sure. That made me even more anxious when I’d go in and do something on an infant, a little pediatric toddler, and she wasn’t as sure.

Lisa then talked about another instructor with whom she had clinical in another setting. She explained,

…I had acute care nursing (providing nursing care to very ill patients) and my instructor was an oncology nurse. So, I’m asking her about these rhythm strips (recordings of the heart beat), ‘is it this (rhythm)?,’ ‘do we give this and this (medication)?’ and she didn’t know…the more they know about the field I think the more you get out of clinical. Whereas if your instructor really doesn’t know what’s going on you can try as hard as you can to really understand your patients and what’s going on, but if you don’t have someone to tell you ‘oh that’s correct’ then what’s the point? You don’t want to think that but it turns out that way sometimes.

Amanda also shared her thoughts about the inexperience of a clinical instructor. She said,

…just like the hospitals are not always hiring the best nurses, they’re hiring bodies, I feel like [name of university] is doing that as well…it’s really disappointing when you’re in a med-surg rotation …and it’s not even that
instructor’s background what we’re doing. The instructor was never a critical care or an acute care nurse.

Betty explained that she felt anxious when she had to provide patient care with an older version of equipment that is infrequently used in some health care settings. She was anxious because of the inexperience that the instructor had about how to properly use the equipment. Betty said,

…what made me more anxious was my instructor said, ‘I haven’t seen this kind of set up in 15 years.’ It was one of those old [brand of equipment] suctions (suction machine used to extract secretions from the lungs, abdomen, or wound) that haven’t been on the unit for 20 some years. She said, ‘nobody uses this type.’ She said ‘umh, I have to figure this out because I haven’t seen this in forever…’

Peggy described three incidences, involving two different instructors, when she felt the instructor was inexperienced in patient care. One incident was about how to correctly perform part of an eye exam, another about a type of feeding tube (tube inserted into the abdomen to provide nourishment) that a patient had, and a third about how to safely position yourself in a room with a patient who has mental illness. Peggy stated that one of these instructors, “was just way out in another field” and she feels that instructors should be a “model.” She continued with,

…that’s why they’re instructors because they’re supposed to be the highest level of competency, I feel. I mean to teach someone else I feel like you have to be proficient in your field in order to be able to answer all the questions for someone else.
For one participant, an instructor’s inexperience with grading in the clinical setting created an anxious feeling. Betty explained that the nursing program at her university recently hired “a lot of outside help (instructors).” She felt that the newly hired clinical instructor was unfamiliar with the clinical grading policy. She explained, …not everybody knows the policies and what we were taught in class of what the policies are going to be so when the clinical instructor grades you or pass/fails you it’s like every person grades differently so it wasn’t a fair gamut.

The following story provides a vivid description of how Betty contextualized her experience with this clinical instructor and grading. Betty had to perform a fingerstick blood glucose on a patient while the instructor watched. This procedure involves using a lancet (tiny needle-like device) to pierce the patient’s finger in order to obtain a small drop of blood for measurement of the patient’s blood glucose level. Betty understood the concept of how to do the procedure; however, the lancets were different from those she had used in the past. She explained,

I didn’t know how to work the particular sticks (lancets)...I’d pull off the tab but I’d be pulling out the stick thing with it and it wouldn’t click right, it was just a funny contraption and I didn’t quite understand…I went through four of them and she (instructor) said, ‘what are you doing?’ (in a whispered voice) and she’s looking at me like I’m an idiot...we came out of the patient’s room and she said ‘you failed clinical today’ and I went ‘I what?’ She said ‘you failed clinical today please sit over there and review your notes and make sure that you’re ready for medications.’ And I said ‘I failed clinical?’ and she said, ‘we’ll see if you pass for the semester.’ And I’m like I failed clinical based on I can't get the stupid
glucose thing to freakin’ snap out, I said (to myself), I can fail clinical if I didn’t come prepared for the day or if didn’t have my 40 page paper prepped for the day or something, if I didn’t have everything. I had everything prepped and ready and I came in and I knew everything, was excited and had my medication cards out and my meds all ready and I’m like I failed clinical because I can't get the glucose mechanism sharp (lancet) to work. I’m like you’ve gotta be freakin’ kiddin’ me.

Two participants were anxious about encounters with inexperienced peers. Peggy talked about a conversation with peers regarding the Community Health experience (where student nurses make visits to homes to care for patients). She became anxious when one of her peers questioned whether or not student nurses were permitted to perform cardiopulmonary resuscitation (CPR) on patients. She said,

…we were talking about giving CPR and I said ‘oh yeah I’ve done it a couple times’ and the one girl says ‘oh I didn’t think we were allowed to’ and I am like ‘you weren’t allowed to?’ That made me feel uncomfortable because I thought what if I’m in a house with her and I have to do CPR and I can't do it adequately on my own…that made me anxious, people who are floating through and don’t really know.

Peggy continued with, “...some of these people have these great grades and then they say ‘oh my ventilator is beeping. What do I do?’ They can't apply it and those people make me nervous…”
Sarah also spoke of an incident with an inexperienced peer in a Community Health experience in which she felt anxious. Sara explained that she as well as her peer was unsure of themselves and she was looking to her peer for support. She explained, …there was a clinical situation in Community Health where I was with a student who knew her stuff but I think she was insecure about her approach to everything. It helps when you have someone who’s as outgoing or even more so than you are because you could coach each other along and be like ‘oh yeah, you’re doing a great job with that.’ She would just sit there and it’s like ‘oh gosh’ you’re looking for some sort of back up to make sure that you’re on the right track and you’re not getting that positive feedback…you’re there to support each other. That’s why they paired us up.

In summary, the participants felt anxious when staff nurses, physicians, and instructors were inconsiderate of their inexperience. They were anxious about being chastised for their inexperience and that they would make staff angry because of their inexperience. Because of their inexperience they wanted instructors to validate their patient assessment findings. They also felt anxious when they encountered inexperienced instructors and peers in the clinical setting. Encountering instructors who were inexperienced with patient care, equipment, and grading policy resulted in participants feeling anxious. In addition, encountering peers who were inexperienced in their responsibilities as a student nurse made them feel anxious.

Being Demeaned

Participants talked about feeling anxious during encounters in which they were demeaned. In speaking about these encounters, the participants made the connection of
being demeaned with the authority held by those who made them feel this way, namely physicians, staff nurses, and instructors.

Lisa relayed the following story that depicts how she was demeaned by a physician. Lisa reported to the nurse that the patient had signs of a blood clot in the leg. The nurse directed Lisa to tell the physician. She recounted,

…I said to the doctor ‘I want to let you know you know this, this, and this’ and he was just saying ‘uh huh’ while looking through the chart…the doctor wasn’t listening… I don’t know if it was because I was a student and he felt that I didn’t know what I was talking about…

When asked about physicians Sarah said that most physicians do not want to talk to student nurses. Sarah said,

…nursing students might get a head nod in the hallway but that’s pretty much the only communication you have….there aren’t a whole lot of them that’ll talk to you …there aren’t a lot of them that will openly talk to us about the patients which is hard because the patient will say, ‘oh I saw my doctor was here what did he say about me?’ I have absolutely no idea. I’m the last person they would tell…

Similarly, Amanda talked about being demeaned by physicians. She said, “a lot of doctors aren’t really interested in teaching student nurses different things…the student nurses are kind of invisible.”

Sarah expressed that there was that “intimidation factor” when needing to speak to physicians. She said the patient may ask her, “when will I be discharged?” and she
commented that she will “just bite the bullet…and ask the physician.” When asked to further clarify the term “bite the bullet” she replied,

…you really want to run away and hide in the corner but you have to go up and talk to the doctor. You can't let your fears take over you especially in the clinical setting because things can change from one minute to the next. You have to really be on top of your things. And for how scary something might be you really just have to do it, especially if that’s what the patient wants.

When asked to speak to what scares her about approaching a physician, Sarah said, “I think it’s just knowing how much school they went through and knowing how many accomplishments they’ve made and you just feel like ‘oh I’m just a wee little nursing student. I know a fraction of what you do.’”

Similarly, Betty commented on the knowledge level of nurses versus physicians, the thread of authority and how that contributed to anxiety and being demeaned. She said,

…knowing what not to step on and what’s over stepping your boundaries because there’s only so much you can do as a student and there’s only so much you can do as a nurse too. There’s still that barrier…you have to skate around some doctors, kind of the old school, make it look like it was their own idea and say ‘oh we have this, this, and this what do you think we should do?’…what I’ve learned is to make it the physician’s idea…or play this cat and mouse game…you can't say ‘the patient needs this, this, and this’ because you’re over stepping your boundaries. According to the physicians ‘you didn’t go to med school, you don’t know.’…I think the hard part for a lot of nurses is learning those dynamics and
what your role is…you can’t go up to a physician and say ‘I think the diagnosis is this as evidenced by our little nursing diagnoses.’ It doesn’t quite work that way because most physicians would be insulted…the last three years it’s been really hard to know how not to offend somebody but also bring up problems…

Denise explained that she has been demeaned by rude physicians. She has experienced a physician grabbing a chart right out of her hand while saying, ‘that’s mine.’ She said the physician did not have the courtesy to ask her for the chart or let her finish what she was doing before taking it from her.

When talking about her upcoming preceptorship, Megan commented, “everyone gets yelled at by a doctor….“ She said that getting yelled at by a physician would make her feel “worthless” and “inadequate” and make her question “…is this going to happen again when I’m on my own as a nurse?” She said that an incident like that makes working in the hospital setting less desirable and that is where she really wants to work. She further commented, “…doctors scare me…I guess it’s that old mentality that you’re inferior to the doctor….“

Even though Megan has concerns about being yelled at by a physician in the future, she has already considered how she might handle that situation. She explained, “I can't yell at them…I’m in a professional setting I need to be professional and deal with it but am I going to let them yell at me? No. I’m going to put them in their place. I’m not like other people who will take it. It’ll make me very anxious and I’ll be very emotional about it but I’m not going to have the same doctor yelling at me whenever he sees me, whenever he wants. No, I will let him know ‘you’re having a bad day you take it elsewhere. I’m a professional just like
you’re a professional. We’re here for the same purpose of taking care of patients and you’re not going to demean me’…I’m not going to have my job that I love be made miserable because of someone that’s miserable.

Sarah talked about staff nurses and her perception of authority and being demeaned. She said,

I think a lot of times there’s a lot of anxiety working with the staff at the hospital because… the nurses feed on their young. I don’t know if they feel like they have to break us in because they had a hard time or they’re just, I don’t want to say on a power trip because that sounds mean, but maybe because now they’re the authority. They’re like ‘Ooh! Here’s the new ones here, gotta give them a bit of a hard time.’…It’s hard when you don’t have a really ideal relationship with the staff…

Likewise, Betty commented, “sometimes older nurses don’t want anything to do with you and the worst is when they belittle you just to bring humility to you because that’s the way they were taught…”

Betty also shared two incidents in which she was demeaned by those who have authority. One incident was with a staff nurse and one was with a nurse aide. Betty and the staff nurse had performed a procedure on a patient and Betty explained that “the nurse was not very nice about it.” Betty knew that a professional and friendly relationship existed between the instructor and the staff nurse and she was also aware that these two people were authority figures. She explained,

…the nurse…was the clinical instructor’s former student and was the prodigy and the help for everybody…I couldn't say anything to my instructor because she
helps out with our group and I knew she wanted to go talk to my instructor about me. What was I supposed to do? I couldn't even talk to her about this because I have to deal with my instructor and she teaches X, Y, and Z courses. I couldn't go and complain about somebody because politically that's not what you do…

Betty shared a second story in which she was made demeaned by a nurse aide. She explained,

…the nurse aide was offended. She was one of those people that gets offended when younger people come on and they’re going to have jobs that are higher than her…She is from the old school of respecting elders no matter what their status is. She came out and pointed her finger and yelled at me, ‘why is your patient collapsed in there right now and you’re not in there…it’s not my job to be in there…where’s your instructor I’m going to get you in trouble.’

Betty further explained that she and the instructor had recently been in the room, assessed the patient, and that they had spoken to the physician about this patient. Betty said, “I was anxious for a second but then I realized that she’s trying to one up me….” Betty said that these types of incidents, “just make me shut up about certain things.”

Megan talked about being demeaned when she was asked to clarify the term “mean preceptor.” While clarifying this, she mentioned that she was also concerned about her grade that she could get from this person with authority. She said,

…poking fun at you with her peers. Being very demanding. Having me do more than she would do instead of helping if she sees me in trouble…you have to work as a team…If she would be sitting and chit chatting and on the internet or
whatever while you’re breaking your back there…working with someone whose personality clashes with mine…and then not getting a good mark for that.

Amanda shared a story about an instructor who she said “made jokes at my expense” and called her a rather troubling name. Amanda was demeaned and felt helpless in this situation. She did not react to the instructor’s behavior because she wanted to be respectful and she knew that this person was giving her a grade. She shared this inimical experience,

There is an instructor who has made jokes at my expense…She called me ‘retarded’ in front of a group full of people. She has made fun of me for being loud in the elevator…and she does it to other students too it’s not just me…I don’t think she’s malicious and trying to hurt my feelings but she does…It makes it hard to approach her for things because if I asked her a question once and she called me ‘retarded’ is she going to call me that next time…

For Amanda the term “retarded” has far more personal significance than simply being an insulting and diminutive declaration. Amanda explained,

…my sister-in-law is mentally retarded. She functions at a toddler level and I find that use of the word offensive. It was really hard for me to deal with the name calling because I didn’t want to say anything back to her because there is that respect because she’s my teacher. While I probably should have said, ‘you using that word makes me uncomfortable,’ I’m still very much that kid in third grade that doesn’t talk back, that just accepts it and realizes I’ve just got to make the best of this situation.
Amanda continued the story and discussed her thoughts about the instructor as an authority figure when she encountered this same instructor the very next semester. She said,

…and then to get my schedule this semester and see that I had her again…I went to the nursing department and there wasn’t much they could do for me. They asked, ‘why didn’t you complain last semester?’…I didn’t want to make it an issue during the semester. That’s someone who’s grading me…So that added to my anxiety the first day because I was worried if anyone confronted her about the things that I had said because they can be easily traced back to me.

Lisa shared a detrimental story when she relayed negative comments made by one of her instructors. Lisa told her instructor that she would be doing some clinical experience in the emergency room (E.R.). The instructor said, “…I won’t be able to sleep at night because you told me you’ll be in the E.R.” Lisa was demeaned because the instructor essentially told her that she lacks the knowledge and skill to be there and that the instructor did not want Lisa to care for her should she be a patient in the emergency room.

In summary, participants were demeaned in encounters with physicians, staff nurses, and instructors. They have been demeaned by the verbal and nonverbal actions of some of these people. In some cases, they have been demeaned simply because of the level of authority or level of education of others. Some were afraid to react because they feared their grade may be affected. They also felt worthless and inadequate. One participant has even thought ahead as to how she might handle a situation in the future
when she is demeaned. The most disturbing of all these stories is when one participant was demeaned by an instructor because of name calling.

**Being Exposed**

Some participants shared stories in which they felt anxious when their failures or lack of knowledge would be exposed and be made known to other people in the clinical setting. Participants spoke of being exposed by instructors, staff nurses, physicians, and in one case by the participant herself when providing care to a patient.

Megan talked about being exposed by the instructor. When asked about performing procedures, she said she was concerned that she would do something incorrectly and then the instructor would talk about it in front of her peers during post conference (group meeting with the students and instructor held at the end of the clinical day). Megan says,

…some instructors, they’ll tell your group in post-conference of your failure that day…sometimes they’ll point you out and that’s embarrassing in front of your peers because everyone looooves to talk about what this person did wrong in their clinical day. So just being a failure in front of my peers worried me.

Megan said that usually the instructor would not specifically identify the person who did something incorrectly but she said that other students who were present in the room at the time would know who the person was “…and then that would cause further gossip within the class.” She indicated, “…the instructor may not have thought it was going to be detrimental to the student. They just wanted to use it as a learning experience for everyone, but it’s still something that’s embarrassing.”
Megan shared another story in which she felt anxious because she and her peers were being embarrassed in front of the staff when the instructor was asking the group questions. She recounted, “…when she asked questions of the group it didn’t seem like she wanted to teach you it seemed more like she wanted other professionals, co-workers to hear her drilling you, that’s what it felt like.”

Answering questions correctly was another concern for several participants and an encounter in which they felt anxious about being exposed with instructors and physicians. Lisa voiced concerns about being criticized by the instructor if she would be unable to answer questions; however, she found that the instructor was willing to help her along the way. She said,

…she would grill you with tons of questions, I was afraid that she’d make me feel bad if I did not know how to do a certain procedure or why a lab value was abnormal…she would ask me questions and if I didn’t know them I would try to work through them and come to an answer and she was willing to work with you.

Megan shared a story when she felt anxious because she too was concerned that she would be unable to answer the instructor’s question and perhaps her lack of knowledge would be exposed. However, she did well in answering the questions even though it took her a while to think through the answer, and she also found that the instructor was willing to help her to answer the questions. She explained,

…I remember one time her (instructor) saying, ‘oh Megan I see in your chart that your patient is having an EGD (test in which a lighted tube is used to examine the esophagus and stomach). What is that?’ I didn’t know. I had done all my research the night before but it was something new. And something we hadn’t
been taught yet… I said, ‘Oohh!’ But then as I thought about it with the history of the patient I was able to put it together and she lead me through it ‘oh you know esophagus okay, that’s good, what’s after that’ and I was able to answer the question correctly but it took me long because I was so anxious about saying something that wasn’t right.

Megan also encountered an instructor who was unwilling to help her answer questions. She shared her experience regarding how she felt about an instructor who she felt put her “on the spot” and expected her to know the answer to something that she had not yet been taught in class. She said a situation like that “made me more anxious.” She said there were times when she was afraid she would answer incorrectly and was “worried about feeling dumb in front of my peers” and also about not having “good merit with that instructor.” Megan further discussed, “…knowing that she was that kind of instructor, that she was on edge all the time took away from my experience because then I was more fearful to answer the questions or to ask her questions.”

When talking about the instructor evaluating her in the clinical setting, Amanda too felt anxious when she thought that she would be unable to answer an instructor’s question. She thought that her instructor would think that she had not prepared enough to care for patients in a newborn nursery and that could result in failing clinical for the day. She shared this experience,

…the very first day of newborn nursery, of course I’m nervous and anxious because I know that she’s going to ask me questions and yeah I read it but it was a 60 page chapter in the book and a 100 and some slide module from [name of classroom teacher] and all of these things that I had to look at. Am I going to
remember everything and if I don’t is she going to think I’m not prepared and send me home and fail me for the day…if I couldn’t answer the questions obviously she might think I didn’t prepare even though I did. So I went in there and I was just like ‘oh God let her ask the things that I know, that I committed to memory. I don’t want to get sent home’…

Similarly, two participants expressed that they felt anxious about being exposed when answering questions for the physician. These participants were not anxious so much about answering incorrectly, as they were about not having information readily at hand to address the physician’s question. Megan explains, “…I just get nervous of not knowing the answer and irritating them because they’re always on the run. They want their information, they want to write their orders and then move on.” Sarah shared similar thoughts when she talked about being unable to answer physicians’ questions about a patient. She said, “…sometime they ask, ‘what was the patient’s weight this morning?’” and maybe I wasn’t the person who weighed the patient…I feel like, ‘oh my gosh, I should have known that.’ Sarah continued, “…maybe they’ll ask me something that I don’t know and there’s anxiety that you’re just not going to represent yourself or your school well and that’s definitely something that would be a worry.”

In some instances, the participants felt anxious when exposed by staff nurses with whom they were working. Peggy shared an experience when she felt discredited by the staff nurse in front of a patient. Peggy explained,

…(some) nurses that were involved in what you were doing…they would start asking all these questions and you’re thinking okay now I look dumb and this patient is not going to let me do this, not going to let me do that because I don’t
look competent. I don’t look as though I can do it on my own and the last thing they want is for me to be handling their two minute old baby.

Peggy further explained that she had concerns about encountering this patient in the future and the patient’s perception of her knowledge. She continues,

…you never know when you’re going to see that patient a month later in your next clinical rotation, with her new one-month-old baby in the pediatric unit... or if I had community health and I had to go into their house that week to do their baby check up. They’d look at me and think you didn’t even know what the baby’s heart rate is supposed to be why would you know that?...

In a very disturbing story, Betty shared an incident in which she was exposed by a staff nurse in a public area of the patient care unit. This encounter happened immediately after Betty and the nurse changed a wound dressing on a patient’s leg. The nurse accused Betty of looking too confident. She said,

She took me out in the hallway and yelled at me enough for everybody in the hallway to stop... I’ll never forget it. She reamed me out, she said ‘you’re not supposed to look confident, you’re supposed to ask me more questions’...it was so embarrassing that she took me out in the hallway and screamed that everybody stopped to watch us...it was soo embarrassing. And that was probably one of the worst clinical days I had.

Betty, while sobbing, told some of her peers in the clinical group, “I’m quitting nursing school...I’m done with this...I’m switching my major.” When relaying the story to her mother who is a physical therapist, her mother said, ‘I can’t believe they did that to you.’
Some participants used the terms harsh and mean to describe certain people in the clinical setting. When asked to clarify these terms, concerns about being exposed when needing to share their mistakes with the nurse, asking the nurse questions, and the nurse’s perception of their knowledge level surfaced. Denise and Megan both shared stories. Denise said,

…those things definitely define somebody who’s harsh… somebody that you feel like you can't talk to if you made a mistake. It’s someone who you’re thinking ‘Oh God! I can't make a mistake because if I go talk to them they’re going to ream me out maybe in front of everyone’…

Megan was concerned about her upcoming preceptorship with a staff nurse. She was concerned that the relationship she had with the preceptor could affect her learning. She said,

…it’s just you and a nurse and I’m nervous about having a mean nurse as my preceptor. I like to have someone that I could ask questions of and not feel inadequate if I don’t know the correct answer…if I ask her a question I don’t want her to look at me as though ‘you should know that’…if I ask too many questions will she think I’m unprepared…I’m just worried about…doing the best I can and not learning because I don’t feel comfortable with that preceptor.

Likewise, Lisa was concerned about her preceptorship in the Emergency Room and feeling anxious in relation to what the staff may think of her knowledge level. She related,

…I never put in an NG tube (nasogastric tube – tube inserted through nose into stomach to drain stomach secretions) before, I only put in two or three foley
catheters (tube inserted into bladder to drain urine) in my whole student nurse experience. I was very nervous about that because I know in the Emergency Room there are a lot of patients that come in and could be a gastrointestinal bleed and you put in NG tubes and …I was afraid if the nurses would say ‘come over here and do this’ and I would have to say ‘I don’t know how to do it’ that they would think or say ‘you don’t know how?’...

When asked to discuss experiences in which she felt particularly anxious, Sarah revealed that she was uneasy about asking the staff nurse questions. Sarah explained, “…maybe you have a question about a medication or something and you almost feel like you’re hassling the nurse if you’re going to ask them, you feel a little intimidated going to them with certain questions.”

These statements about being afraid to show your knowledge to staff nurses and being criticized by staff nurses emerged during the focus group interview. One participant said,

…because you’re afraid…there’s some of those nurses who are rough and tough and you want to show what you can do but then you’re also kind of nervous and if you show what you can do and it’s wrong then they down you…

A second participant explained,

…I know what I want to say but I’m not always good at executing how I’m going to say it and sometimes it’s just easier to not try at all than to try and be criticized… that fear of being criticized keeps you from showing what you have.

When asked how she feels when she is criticized, she said, “oh gosh, horrible. It’s really discouraging.”
In one case, a participant felt as though she was exposing her lack of knowledge when providing care for the patient. When asked to clarify the term “nerve wracking” Lisa referred to the following story in which she felt she would appear unpracticed to the patient which in turn would lead to the patient mistrusting her capabilities. She said,

…I was very nervous… I was afraid I was going to put the blood pressure cuff on wrong, I was going to look stupid and that my patient wouldn’t trust me…that’s what made me nervous because I knew that I knew my skills but I was afraid that if I didn’t do it right that I would come off to the patient that I didn’t know what I was doing and then they wouldn’t trust me and there would just be a cascade of events from there.

In summary, the participants experienced anxiety when they felt their failure or knowledge level would be exposed to their peers, instructors, physicians, and patients. They were embarrassed as individuals and even felt embarrassed when part of a group. They were concerned that their peers would talk about them to other classmates. They felt embarrassed, discredited, and mistrusted in various situations. In several instances they were worried about the instructor’s, staff’s, physician’s, patient’s and peer’s perception of them and their abilities to be a good nurse and provide good nursing care.

Several participants felt anxious when needing to answer questions, so much so that in one case, a participant was worried about failing the clinical day because of being unable to answer questions. Interestingly, a participant felt anxious when one instructor was unwilling to help her answer questions and when another instructor was willing to help her answer questions. In one very disturbing case, sadly, a participant wanted to quit nursing school because of the anxiety and embarrassment she experienced at the hand of
a staff nurse. Fortunately, this participant was able to talk to her mother about the incident, but it was unfortunate that the incident and the need to worry her mother occurred at all.

**Unrealistic Expectations**

Some participants interpreted their anxiety in relation to unrealistic expectations that people in the clinical setting have of them. Several participants expressed that staff nurses had unrealistic expectations, some participants discussed instructors that had unrealistic expectations, and one participant spoke about peers that had unrealistic expectations. This quote by Denise provides an introduction to this theme. Denise said, “…there’s a difference between expecting what you should expect from a student for the level of clinical that they’re at… and just expecting too much from the student for the level that they’re at….”

Amanda expressed how she feels when the staff nurses have unrealistic expectations of student nurses,

…sometimes people look at you and you have to say, ‘I don’t know what to do about that.’ I think they forget what it was like to not know the ins and outs and they say ‘what do you mean you don’t know what to do?’…and they’re dumbfounded that you don’t know…I’m not in the hospital every day. It’s not part of my world yet. It’s becoming part of my world but I’m practicing. It’s like being part of a team where you go a couple of nights a week and you practice in the hopes that one day you’re gonna get into the game. That’s kind of how I feel, like I’m going to be in the game after all this but right now I’m showing up and I’m training.
Peggy described a specific incident in which she felt the staff nurse had unrealistic expectations of her. She provided the following account,

I had taken a patient’s temperature and it was high and the nurse said, ‘I was just on the phone and told her mother that she didn’t have a temperature!’ And I thought, ‘you should have asked, this is your patient you should have come in here and asked.’ What am I supposed to do run out there and say she’s got a temperature of 101 which is what she’s been running… it makes you feel anxious because did I do something wrong? Shouldn’t I have done that? Should I have gone out and told her? Is she going to let me do more now? Is she not going to let me do more now? She should have said something, that’s her job and she’s ultimately responsible for this patient...

Denise described an incident she had in the pediatric setting in which the nurse had unrealistic expectations of her. She said,

The first day of pediatrics the nurse said, ‘didn’t you chart your vitals yet?’ Chart my vitals, I didn’t even get my vitals, where’s the dynnamap (electronic device for assessing blood pressure) on this floor or I don’t even know how to get a blood pressure on a kid when they’re squirming…just those expectations. The pediatric nurses have been doing this day in and day out for 20 years and this is my first day and I think I know how the dynnmap works but you’re expected to have already charted that and started your bath or something like that. So I remember getting a little overwhelmed the first day of pediatrics, a little teary eyed…
Sarah spoke about how she thinks the staff nurses have unrealistic expectations of student nurses particularly when the staff nurses are extremely busy. She said,

…I think a lot of the issues too that might come up with staff is because they’re definitely stressed out. They have 6 or 7 patients per nurse and that’s definitely a lot of work for them. So I think sometimes they’ll take that out on the students. If there’s something that’s not done, they say, ‘oh why didn’t you do this?’ We’re not really established in our nursing thinking yet so we don’t always know when to take it to the next step.

Similarly, Betty said, “the nurses are so busy with patients…” and she commented that they are working with students from various schools of nursing. She said what makes it even more difficult for the nurses is that each group of students has a different skill level based on their level in the nursing program. She said at sophomore level, students can only take vital signs (temperature, pulse, respirations, and blood pressure). She continued, “It’s very hard and sometimes disheartening to say ‘hey I’m from [name of university] this is what we do, this is what we don’t do.’” Sometimes you get disgust and sometimes you get ‘oh ok.’ She said that she gives the nurses “…a lot of credit because they have so many students from different schools.” Betty also shared her thoughts of how student nurses “make their way up the ranks” from beginning student to senior level student and how expectations of students at each level change. She commented,

…(the nurses say) ‘well why didn’t you do this, you should’ve done this or you should’ve prepared this’ and I think as student nurses… you really don’t know what you’re doing …you don’t have enough autonomy or responsibility to do
stuff on your own but you kind of make your way up the ranks a little bit as a senior nursing student because the nurses come on the floor and they’re like ‘oh a senior nursing student! Oh great they can do this, this and this!’ You’re more of a help than a sophomore nursing student, where the nurses think, ‘I have to teach them and they don’t know anything and they’re just gonna stand there and take two hours to do a bed bath and it’s going to be a disaster.’

Betty spoke of two more incidents in which she felt the staff nurse had unrealistic expectations of her. In the first incident Betty was helping the staff nurse perform a wound dressing on a patient. She said,

…the nurse was not prepared for the wound dressing. I went with her and did the wound dressing and I was the one doing it but she was watching me and she didn’t have sterile scissors and she didn’t have this, that, and the other thing in the room, didn’t have the right kerlix (type of bandage). As a student how am I supposed to know that on my third day of clinical what I need to do a wound dressing change? That’s just not expected and she knew what level I was at…

In the second incident, Betty was having clinical experience in the pediatric unit. She had spent some time talking with a young mother. When she relayed the information that she obtained from the mother to the nurse, the nurse said that social services needs to know that information. Betty agreed to relay the information via conference call. Betty said, “…so I called and there was a conference call about this girl….” Betty said that when she returned to the unit the next week the nurse yelled at her. Betty said, “…I got in trouble because there was no note on the chart….” Betty stood up for herself and said,
…your hospital didn’t want us writing notes on the chart because we weren’t
good enough to write notes on the chart. We were told as student nurses that we
couldn’t chart here…I did say to the nurse ‘hey should we chart something about
this?’ and she said, ‘oh no it’s just a conference call, no big deal.’…we weren’t
supposed to chart on the pediatric charts because we weren’t the RNs of the
hospital and they didn’t want to co-sign for us. So that was not our fault at all and
they were fully aware of that…

Denise made these comments when talking about staff nurses who have
unrealistic expectations of student nurses. In this example, she was talking about the
nurse’s unrealistic expectation of her when performing a skill that the nurse mentored her
the previous week,

…the nurse said) ‘okay Denise you hung this IV bag last week or you were
proficient in it last week with me looking over your shoulder, you should be able
to do this now.’ And it’s been a week, you kind of get rusty even with a week of
not doing something day in and day out.

Several participants spoke of instructors who have unrealistic expectations of
students. Denise provided this example in which she is talking about “prep.” This term
refers to the preparation that students do the evening before the clinical experience.
Students review the patient’s chart and medications in order to be prepared to provide
care for the patient. After the review of the chart, they then refer to textbooks to gain an
in-depth understanding of the patient’s diagnosis, disease process, and medications. For
most students, prep for clinical experience takes hours to complete. Denise explained,
…they (students) would do the prep work for the clinical experience and the instructor would find a hole in the prep work that they did and ask them a question about something they didn’t have the information about and say ‘well go look it up. How are you going to care for this patient if you don’t know this information?’ You have X amount of hours of sleep the night before, you need to sleep but you also need to have your prep work seamless. Knowing that expectation is on you can make it nerve wracking…

In a similar vein, Betty shared these thoughts about the unrealistic expectations surrounding clinical prep and sleep. She said,

…you go to the hospital the night before and you can’t go there earlier than 5 PM, you get this patient, you look up all their information and every possible thing, every drug and its side effect and know them inside and out…you have to eat dinner somewhere in there…and then prepping for maybe six hours and not getting to bed until 2 AM and waking up at 5 AM to carpool with everybody else to get to the hospital…

Some participants voiced concerns about prep itself and prep and sleep during the focus group interview. These are the comments that emerged, “…anxiety…when you start with prep the night before…not enough sleep the night before…feeling anxious when I didn’t do enough work, I didn’t do enough prep…and then you get in panic mode real quick…anxiety could cause you to forget things. You might have prepared as much as you can and if you’re that anxious…you’re going to forget things.”
Sarah too spoke of an instructor who had unrealistic expectations of her. She explained that the instructor expected her to take her thinking beyond the information she was taught and to think as an expert nurse would think. Sara explained,

…I can’t dissect every little thing…my patient was post CABG (Coronary Artery Bypass Graft – surgery to bypass a blocked artery in the heart) and he was taking walks for exercise. He said he walked ten minutes every day around the block. And she asked me ‘how far was it?’ I said ‘I don’t know. He said it was ten minutes a day’ and she says ‘what you should do when you leave his house is get into your car put the speedometer back to zero and drive around the block once to see how many miles it is.’ And I was like ‘oh my gosh’ just little things like that where you’re getting criticized for not thinking to do that and from what we were taught they didn’t really prepare us to do anything like that. It can get discouraging when you get criticized for things like that.

Megan spoke of an instructor who had unrealistic expectations when the instructor directed her to assist peers when they did not want to perform certain types of care for their patient. She said, “…you shouldn’t be sent as a student…to go help that person who doesn’t really want to do it and you’re ending up doing most of it.”

Amanda and Denise talked about experiences in their mental health rotation in which they felt unrealistic expectations were placed on them. They said that the first clinical experience occurred before they even had their first classroom session for mental health. Amanda said,

The first day (of mental health clinical) was stressful because you haven’t learned anything in class yet. You’re there and you don’t know what appropriate
conversation topics are. They just tell you to go out and talk to the patients and
you’re like can I ask them why they’re here, can I ask them to talk about what’s
wrong with them, do I stay away from that, I don’t know therapeutic
communication yet. You try to read ahead and you try to understand it but some
of it just doesn’t click…

Similarly, Denise shared her experience with the mental health rotation. She said,

…my mental health rotation scared the living crap out of me. I had that clinical
before I even had class so that was a complete nightmare. I felt like a little duck
following around mamma duck, was petrified to go in a room, couldn’t go in a
room my first day because we hadn’t had class. We had no preparation, the class
was the following Monday and we had clinical on a Thursday evening…we all
just stood there frozen at the patient’s door.

While the stories about instructors having unrealistic expectations thus far have
been real incidents, Denise spoke about an occurrence in which she was worried that the
instructor might have unrealistic expectations of her. She was worried that she needed to
be always doing something. In this example, Denise was talking about having a
preceptorship with a staff nurse. In preceptorship experiences, instructors visit the
student while the student is working directly with a staff nurse. She said that she was
anxious about taking a short break and that the instructor would arrive to visit her only to
find her idle. She explained,

…something that’s stressful for me in clinical is knowing that my instructor may
show up on a day that I’m with my preceptor and I don’t know what day that is.
I’m always on my toes and I definitely feel guilty if my preceptor will go and take
a break and sit down and say ‘okay let’s grab some chairs.’ I feel the need to constantly be doing something because I’m afraid that my instructor is going to walk in and think ‘oh this horrible student is just sitting all day and not doing anything.’ But that might be the five minutes that they see and it might just be a lull in a very chaotic day.

In summary, the participants felt that staff nurses and instructors had unrealistic expectations of students. When students admitted that they did not know something, staff for the most part were unable to understand. Unfortunately, in two incidents the participants were chastised by staff nurses who should have been accountable for their own actions in the clinical setting. Interestingly, the participants were able to understand that the staff nurses are quite busy and that unrealistic expectations of students can stem from that.

Some unrealistic expectations that instructors had of students include extensive prep which resulted in lack of sleep the night before clinical, being expected to think like an expert as a student nurse, being expected to help peers who did not want to perform certain tasks, and being worried about taking a break and the perceived unrealistic expectation of needing to constantly be doing something in the clinical setting. An experience that is quite unfortunate is the mental health rotation where students were scheduled to have clinical without any prior introduction of expectations in that setting.

**Being Abandoned**

Several participants perceived anxiety in relation to clinical experiences in which they were abandoned. The participants expressed that they felt anxious when the instructor was either engaged with other students on the patient care unit or seemingly
vanished from the patient care unit. They felt anxious that they were missing learning opportunities and that they were not providing proper care for the patient when the instructor was occupied or inaccessible.

Amanda shared these comments when talking about an instructor who was occupied with other students. She said,

Last semester there were one or two people that were very monopolizing of the instructor’s time…you could never pull our clinical instructor away long enough to even have her come in and help you with an assessment…I felt very much on my own last semester…

Megan felt that she was losing valuable time that she could have used to provide patient care or enhance her learning in the clinical setting. She commented that instructors should “…not just stick to a certain amount of students …” She continued,

That’s an issue too sometimes. If the instructor doesn’t know how to evenly share their time with the students. That takes a lot away from your learning experience…I remember having to wait an hour to give my meds (medications) to my patient. I had them all ready, I had them all checked over and over and over again. But then you can’t leave your meds (unprotected at the nurses station) [because it is a safety issue], so you can’t do other things when you could have spent that hour teaching your patient and taking them out for a walk or something. You could have done quality nursing things or seen a procedure that was happening on the unit. But, no, if they told you I’ll be back in 15 minutes, I’ll be back in half an hour, and it took them an hour, hour and a half, that took a big chunk out of your clinical day.
Megan said that the instructor spent time either with students who were unprepared to provide patient care or helping students to provide basic nursing care such as hygienic care because some of the students simply did not want to do those things. She said,

…some students didn’t want to do that (provide basic nursing care). So they’d leave it for the end of the day and then the instructor would be in there helping them do it in order to get it done because she (instructor) didn’t want to hear it from the nurses, but that’s not what your instructor should be doing. If she wants everyone to provide the AM care (morning hygienic care) then everyone just has to do it whether they like it or not but it shouldn’t take time away from the people who have all their work done and are wanting that special time with the instructor to go over charting, or something that they need to get done like wound care.

Several participants felt that they were caught in the middle between an occupied instructor and the nurse. Amanda shared such an incident. She says,

…it’s hard when there are 7 other people that need your instructor’s help and if a bunch of you have really critical patients or patients with a lot of needs and you can’t track your instructor down it’s nice to have someone (nurse) that’s willing to take that responsibility on because not every nurse wants to do that…

Amanda says it is “stressful” when the nurse that you are working with “doesn’t want to deal with you.” She has found that some nurses avoid her or if she asks them a question they tell her to ask the instructor. When the nurse tells her to ‘ask the instructor’ she explains, “that can be more stressful because again you’re waiting in a line of 7 other
people to get five minutes of face time with your instructor to ask them to come and help…”

In a similar vein, Megan shared a story when she too felt caught in the middle between an occupied instructor and staff; however, in this instance, the staff nurses were willing to help her but she felt that by asking for their help she was impinging on the nurse’s time. She was also anxious about being in trouble with the instructor. She was very uncertain about her decision to ask the nurse to supervise her. She revealed,

Sometimes we would even ask the nurse, ‘hey can you just watch me give these meds because they’re due at 9 o’clock and it’s now 10:30 and I need to give my patient their meds.’ And then you feel crappy, you’re taking up the nurse’s time…instead of helping them (nurses) by alleviating their patient load by a patient or two, you’re taking up extra time that they didn’t budget for…because your instructor’s not around for you to say, ‘do you feel comfortable with me doing this and that with my patient?’

She felt as though she was left alone to make the decision of missing the opportunity to perform the skill or to perform the skill with the nurse and hope that the instructor would approve the decision she made. She said, “some instructors will say yes, some will say no.” She furthered explained that some instructors want “to see” students perform procedures.

Megan and Amanda both indicated that they felt their instructor recognized that they and some of their peers were competent students and were “okay standing on our own and feeling comfortable with our skills.” However, Megan felt abandoned even though she was considered a competent student nurse. She said,
…she (instructor) would put two or three of us stronger clinical students on one side of the unit, those that have a better reputation in clinical, she would put us on one side and then have the weaker ones on the other side. And then she would spend almost all the clinical day with them and you’re kind of like on your own over here...

Amanda shared the same feeling when she said this about an occupied instructor, 

…part of me understands that you’re going to have the student that you (instructor) have to spend a little bit more time with but at the same time I think as an instructor you have to say ‘you know what I’ve been down here with you for a half hour let me go make sure everyone else is okay and I’ll come back. You handle this task while I’m gone.’ And then check on everyone else and make sure they’re doing all right.

Peggy too experienced anxiety when she felt she was caught between an inaccessible instructor and nurses who were unwilling to supervise her to perform procedures. She was anxious that she was losing opportunities to perform skills and that she was creating tension between her and the nurses, her and the instructor, and between the nurses and the instructor. Peggy shared an experience she had on a pediatric unit when the instructor “disappeared.” She explained,

…the nurse would say, ‘well now you can't do it (a procedure) because your instructor’s not here. We (nurses) have other stuff to do. You can't do it now, your instructor isn’t anywhere to be found,’ and that was upsetting.

Peggy continued, “…it would make me feel anxious or nervous to even approach that nurse again because she was angry at me, angry at my professor. It was just a very, very
hostile environment.” So, Peggy, not wanting to miss an opportunity to perform a procedure because students had only 3-4 days to spend there instead of an entire semester, decided that she would page the instructor on the overhead paging system in the hospital. Peggy found that her actions angered the instructor as she described the instructor, “tearing down the hallway” saying, “I was back here, I was back here….” Peggy says that an inaccessible instructor is not a reason to feel anxious, “…I feel like I shouldn’t feel nervous because of that in the clinical setting. I mean it’s natural to feel nervous to do a procedure but we weren’t getting to do any procedures…”

In summary, some participants experienced anxiety in relation to being abandoned when the instructor was occupied or inaccessible. These participants felt as though they were missing learning opportunities and not providing adequate care to the patients. Some participants felt caught in the middle between the instructor and staff. Surprisingly, even the competent students said they were abandoned when their instructor was occupied or inaccessible.

Sensing Difference

The participants made meaning of their anxiety when they discussed differences between themselves and their peers. There are two dimensions in this theme. The first dimension entails the participants’ discussion of how their clinical experiences differed from those of their peers in a way that they felt created anxiety about their learning. The second dimension refers to sensing difference because of competition among peers.

Differing clinical experiences. Amanda spoke of a differing clinical experience when talking about experiences that her peers were having with another instructor. She said,
other groups were really being pushed and challenged to do things and they were getting to chart and they were getting to do all these things. We never had those responsibilities so there was very much a feeling of inequality between the experiences that my group was getting and other groups were getting. And there is always a little bit of jealousy…it always seems that one group gets the lead instructors for every single clinical. I’ve had the lead instructor once and that was for the course over the summer in the nursing home which really wasn’t that challenging of a course…it is frustrating because there is a difference in the level of experience…

Peggy spoke of an experience that she had with a new instructor. She worried about how her experience differed from the experience of her peers when she talked of her peers having another instructor in that same clinical experience on a different day. She explained that she was having clinical experience for a second semester on a patient care unit where she had spent the previous semester. At the end of the first semester she was providing care to two patients but at the beginning of the second semester, the new instructor would permit her to provide care to only one patient. She commented,

I had all new instructors…I was having clinical experience on the same floor for the second semester in a row…at the end of the first semester I was providing care to two patients…I had my own two patients that I had to do total care on and give all meds. I walked into her semester and…I had one patient. She would say to me ‘oh it’s 10:00 you’re done’ and I said ‘yeah, I went in there at 8:00 and I did everything I had to do, I gave all my meds, I did my feedings’ and I would just sit
there… the other group who was there on clinical on the other day had this really
good professor. The one who’s great…

In a similar vein, Megan spoke of an instructor who was new. She spoke of
having a different clinical experience with this instructor than peers were having with
another instructor. She said she felt she had “poor clinical experiences… where other
students had another experience and they know that portion of information…”

Amanda indicated that her clinical experiences were different from her peers in
relation to the clinical evaluation process. She said,

…it would be nice if they just said mid semester ‘you’re doing a good job. Keep
going what you’re doing and you’ll be fine.’…that’s definitely been stressful for
me to not get any kind of evaluation and I know other groups with other
instructors get an evaluation every week…

Similarly, Lisa also spoke of peers in another clinical group who were seemingly
getting better clinical experiences because of the unit they were assigned to. She said,

…This past semester we were placed at a hospital that we didn’t want to be
placed at for our acute care nursing and we felt that we weren’t getting
experiences as compared to some of our other fellow students somewhere else.
So I know that whole semester everybody’s mood affected everybody
else’s…everybody’s tension built off of one another. Everybody was stressed out
and then people were angry at the other students…I try to pull myself away from
that because it can really affect your mood and you can become more stressed and
then you don’t seem focused on your patient anymore, you’re focused on
everybody else’s bad mood, nobody wants to talk to me, nobody wants to help. I
know the one time I was doing a whole bunch of stuff and I needed to move a patient and I asked people (peers) to help me and they’re like ‘why didn’t you do this before?’ So that affects you. One thing I’m trying to work on is to let it roll off my shoulders because if I take it in then I’ll become stressed out and I’ll worry about that when there’s other things to worry about…I’m trying to learn not to really take to heart how other people are acting or what they say to you because most times they’re just angry and stressed out and say something off the top of their head.

Lisa was asked to clarify the term “tension.” She said,

Tension…you could tell that everybody was tense. If you’d bring up a subject, a patient, and not being able to do something everybody goes off on a tangent…I know our instructor can tell when she comes in that day of the tension that’s in our group because everybody looks angry, does not want to do anything because we’re unhappy where were at and I know there’s times where I’d be talking about it, ‘I didn’t get to do this’ and you can just tell there’s tension because someone then all of a sudden just goes on this rage of ‘well at least you got to do this and I didn’t get to do this’ and you can just tell that people are angry and you can just tell that there’s tension. Everybody’s on edge because they’re not happy and maybe one person gets to do things that somebody else doesn’t get to do and you can just tell that everybody’s angry and not happy where they are.

Competition among peers. Peggy spoke of competition among peers. She said the nursing program in which she is enrolled is “incredibly competitive.” She continued,
…there’s some people that ask questions…and other people look at them like ‘what are you asking that question for?’ So it’s that kind of stuff where it is soo competitive. That’s basically like the biggest thing. I think our program above any other is incredibly competitive…within our class, you’re constantly fighting one another, fighting one another over everything. So that, I think caused a lot of problems.

Megan was asked if there is a connection with peers and anxiety for her in the in the clinical setting. She too described competition among her peers. She replied quite agreeably,

Oh yeeeah! There’s always those really competitive students that want to be the best in everything but in not such a good way. And if you have clinical with one of those people you feel like you’re doomed. Like you have to try so much harder to be better or to be as good as you perceive those students to be. Because they shine in the eyes of the instructor. That’s the feeling you get and then you want to be just as good.

Megan was asked to clarify what it means to not feel that “you’re just as good.” She replied, “it means you’re average. You’re not a great clinical student. I may not get a nice reference from that instructor or you may not pass.”

Sarah was asked if peers could be a source of anxiety. She said “it depends on the peer.” She provided the following example in which she sensed a competitive difference with a peer on the first day of clinical experience. She described this experience,

…we were at the nursing home for our first clinical day and I was with this one girl who takes it seriously, seriously…the nurse was asking about blood flow
through the heart and this girl rattles it off in a second and I was just kind of standing there. That definitely adds anxiety because I look like I know absolutely nothing because she was so quick to jump in there. That definitely adds to it…

In summary, students sensed differences between their experiences and those of their peers and this made the participants feel anxious. Some participants felt that new instructors were providing inadequate clinical experiences when compared to other instructors. Some participants felt there was difference with the evaluation process between instructors. In some cases, the difference led to not only anxiety, but anger and jealousy in and between clinical groups. The anxiety and anger had an affect on how they interacted with each other and how the participants provided patient care. Some participants talked about how these differences were manifested in competition among their peers.

*Being Uncertain of Ability*

Participants understood their anxiety in relation to performing a variety of skills on patients in the clinical setting. Lisa expressed that she felt anxious when being uncertain of her ability to insert a foley catheter (tube inserted into urinary bladder to drain urine) and maintaining sterile technique (sterile technique is used to prevent the introduction of microorganisms into the urinary system). She said,

I know sophomore year the first time I put in a foley catheter and I remember learning in the lab on campus about sterile technique, sterile technique. I was so afraid to move from my little area with my (sterile) gloves and I was afraid to touch things. So it took me very, very long and it’s not one of those procedures that you want to take long with because your patient is all worried. But I know
the first time I was like ‘I don’t know where I’m going (where I’m inserting the
catheter), what I’m doing, I’m so nervous.’ I was concerned about proper
placement of the catheter and my sterile technique. But now nurses ask me ‘you
want to put in this foley catheter?’ and I’m like ‘sure, why not.’ I’m more
comfortable and I can do it within five minutes where as before it took me
probably 15 minutes to do it. So it helps once you practice more but the first time
you do those skills where you have to worry about sterile technique and all that
stuff it just makes you nervous and I know I would be sweating, my face would
be red because I’m all nervous but as you do it gets better.

Lisa further explained her uncertainty about her ability. She said,

…in the lab on campus, yeah they show you but it’s really different when it
comes to a person. It’s uncertainty, about am I doing this right, is everything still
sterile, am I going to cause this patient to have an infection. All those things run
through your head when it’s your first time doing that.

Lisa talked about another incident in which she felt anxious because of
uncertainty of her ability. This incident involved inserting an OG (oral-gastric) tube. She
said,

I know the first time I put in an OG tube the nurses said, ‘oh just go along side of
the endotracheal (breathing) tube and I’m thinking to myself ‘well if I go along
that one I might get in the lung.’ After I put it in I asked myself, ‘did I check for
placement, did I push the air in (part of procedure)?’ and I had them double check
just to make sure that everything was okay. But when I did it my second time I
was more confident so I think the first time you do it you’re uncertain whether or
not you’re doing it right, even though you’ve seen it, you still question your skills and what your doing.

Similarly, Betty shared her thoughts about feeling anxious about her ability to insert a NG (nasogastric tube) and how the practice session in the campus lab is very different from the real experience of performing the skill on a patient. She said,

I always get really nervous doing my first skill. I remember junior year I never put in an NG tube and an order came up for an NG tube and ‘oh no!’ My clinical instructor said, ‘all right you’re going to put it in’ and I’m like ‘I didn’t prep for this, I don’t know how to put this in.’ …I did it once in lab on the dummy and the dummy did fine… and you’re like ‘oh my gosh, this poor woman she doesn’t even know what she’s in store for.’ So I read the procedure and my clinical instructor said ‘come to me when you think you’re ready.’ And I’m like ‘all right, I have ten minutes to read this before I do this’…

Sarah shared incidents in which she felt anxious because of being uncertain of her ability to provide wound care and administer medications to patients. She said,

…there’s a lot of worry about being inadequate with certain tasks. Maybe a patient needs a certain procedure like wound care…we did a lot of observing with wound care but we never necessarily did a lot of hands on with it…you have to worry about things like that…because with a lot of the experiences that we did it was a lot of shadowing nurses. There wasn’t a lot of hands on, it was more observing…you could see how this is done but how am I going to do it?. I don’t know if I’ll be as precise with certain things…
When talking about administering medications, Sarah shared this story. She was working as a nurse aide in a facility where eventually she would be administering medications to patients in her role as student nurse. The facility had begun to use a new medication administration system and the nurses were saying that using the new system was a “hard adjustment.” Sarah shared this story about how she felt when the instructor told them that they would be administering medications,

…our instructor said, ‘make sure you’re paying attention because next week you’re going to be giving medications to patients and we’re like ‘oh my God,’ and freaking out over that…there’s definitely a lot of anxiety…but once you’re actually there and doing it, it feels more real and everything clicks…

Similarly, Lisa spoke of feeling anxious about administering medications to a child during her pediatric rotation. She said,

…this population was all new to me and everything is completely different especially with pediatrics. The first time I gave a medication I checked and double checked I don’t know how many times. Because of the medications you have to do all these formulas and you have to do all this stuff and that was all new to me so that was a different type of anxiety that I experienced because…with kids you have this whole formula…you have to do find the weight of the child, put it into kilograms, then the medication is say 5 mg per kilogram so then you have to do this and sometimes you can’t give any more than so many mg over an hour, so there’s a bunch of components. It’s different than giving meds to an adult…where your patient gets 5 mg of this medication. You know you don’t
really have to worry about the weight. So putting in all those variables into one medication can be nerve wracking.

Megan also expressed her thoughts about feeling anxious about being uncertain of her ability to administer medications. She shared an incident about administering an IM (intramuscular) injection to an obese woman. She said,

I was anxious giving IM Demerol (name of medication) during my emergency room rotation…giving my first IM in the buttocks. I had given IM flu shots in the deltoid (upper arm muscle) before and became comfortable with that. But then just being really anxious giving this IM to an obese woman. And I’m like ‘this isn’t going to get down to where it needs to be.’ I mean she was very obese, especially in her buttocks region but the nurse wanted me to give it in the buttocks…

When asked what she was most concerned about, Megan said, “I was concerned about causing a lot of pain to the patient and not doing the procedure correctly.”

Megan also expressed feeling anxious when being uncertain of her ability to suction (remove respiratory secretions from the respiratory tract using suction equipment) a patient. She said, “I was anxious suctioning. I was anxious, but luckily that was the unit that I had worked on as an aide…and I saw the nurses do the procedure enough and I looked it up in the textbook….”

When asked to further explain her anxiety about suctioning she said,

…until you’re good at it you’re going to feel anxious. I wanted to do it correctly causing the minimal pain amount of pain and irritation to the patient…get the secretions out and do it the correct way…in the least amount of time that it
needed to be done. I didn’t want to have to keep going down if I didn’t have to. If I could do it correctly the first couple of times and then the patient could rest and that made me happy.

Peggy spoke of feeling anxious when she was uncertain of her ability with moving large patients, when alarms ring on medical equipment, or when she accidentally pulled something. She said,

There have been times when I’ve had to move really large patients. You get anxious about that. You feel like ‘oh no what if I drop them. What if this happens, what if this happens. I don’t know how to deal with this.’ Sometimes like BiPAP (breathing machine) alarms or certain alarms that go off on machines that you’re not really familiar with you get nervous. You go in there, and the machine’s going off and you’re like ‘oh no.’ Or you pulled something and you’ve adjusted something and you’ve thought ‘oh no, oh no! What did I do?’…

Amanda shared an experience she had in the newborn nursery about feeling anxious in relation to uncertainty about her ability. She said,

I know that in the newborn nursery, on one of my patients, my instructor heard a murmur that I would have never caught because good Lord their hearts are going so fast it’s hard enough to count. But she just said ‘it’s something that you get used to. You take care of hundreds of babies that are normal and you start to be able to pick out the abnormal sounds.’ I resigned myself to the fact that with more practice the better I’m gonna get…

Megan commented about feeling anxious about being uncertain of her ability during her Community Health rotation (where student nurses have clinical experiences in
patient’s homes). During this rotation, students visit patients on their own without a nurse being present. She said,

I thought maybe we should be shadowing a nurse and providing all the care and doing that and have her as a resource in case something didn’t go the right way…if you see something that you don’t think is right it’s just you and the other nursing student…and then it’s your call and that would make me nervous…if I didn’t assess something correctly. I don’t have as much experience as these nurses who come out here. That really made me anxious.

Megan further explained her responsibility in this experience. She said, “…we do the physical assessment, vital signs (temperature, pulse, respiration, and blood pressure) and then whatever tasks you were there for. Whether packing a wound or assessment of the patient, just checking up on them. It was nerve wracking.”

Amanda spoke of feeling anxious and being uncertain of her ability on her first day of clinical. She said,

…the most anxiety I had was probably before that first day…you aren’t sure of yourself because you’ve only practiced taking pulses and blood pressures and listening to lung sounds and heart sounds and everything but you’ve done that on healthy 20 something year old people that are in your class and not on 80 some year old people that are in a nursing home…it’s just completely different and their pulse is going to be hard to find, where you know your lab partner’s was bounding and no problem…

Amanda shared another experience about feeling anxious about being uncertain of her ability with assessing patients. She said,
…I’m getting more comfortable. In the beginning there was always the feeling like ‘oh gosh their heart was really racing did I get the right number, should I do it again’…you want to make sure…so you might have to double check yourself and sometimes when I wasn’t sure I was like ‘I’ll come back in 15 minutes and I’ll just do it again’ and I’ll just say to the patient ‘it’s good practice for me do you mind if I take a listen again?’ and I’ll validate my response…

Amanda also said that at the end of the clinical day she has these thoughts about her ability. She said,

…you do kind of worry. I’m so new did I miss something, did I walk out the door, did I not do something I should’ve done…I want to walk out at the end of the day at clinical and feel like I did everything I was supposed to and I caught everything I should have caught…

One participant expressed her anxiety about being uncertain of her ability during the focus group interview. She said,

I kind of did overlapping borders for each year, but each color overlaps just a little bit, like sophomore year I was anxious about doing catheters and then I would do a whole bunch and then you had the summer off and you’re not really doing that and then you come back and then you kind of have that anxiety until you did one again and then it comes back to you. So the anxiety kind of goes into each year but then once you do it again…I know I would insert foley catheters, for a while and then in my senior year I was in the ER and the nurse would say ‘you want to put a catheter in?’ ‘Sure’ and then your anxiety just kind of decreased. Because I know the first time I did it I was so worried about it. It took me probably forever
to get everything all set up and now it’s just like ‘sure’ grab it and do it. So each year, like this over here shows that it builds on each other but with skills I think each year you’re a little anxious cause you had the summer off, because as a nurse aide I can’t catheterize someone. I think you had earlier anxiety but it diminishes as you get older. Because then it’s just like the whole riding a bike thing, you hop back on and you can do it again.

In summary, the participants spoke of learning and practicing how to do skills in the lab on campus; however, they felt anxious about being uncertain of their ability in the reality of the clinical setting when needing to perform those skills on a living, breathing human being. They had concerns about performing the skill properly, causing pain, or missing something on a patient which could have a detrimental outcome. One participant experienced anxiety when the need to perform a skill arose unexpectedly during the clinical day and she had little time to prepare for it. The participants said that skills initially took a long time to do, but with repeated experiences of the skill they became much quicker at performing it. For some participants who had performed a particular skill a number of times, the anxiety returned when there was a lapse in time from when they last performed the skill; however, once they started to perform the skill they felt better.

Summary of Chapter 4

This chapter includes the major findings of the research study. Seven themes emerged from the data: Experiencing Inexperienced, Being Demeaned, Being Exposed, Unrealistic Expectations, Being Abandoned, Sensing Difference, and Being Uncertain of Ability. In the next chapter, the major findings of the study and the connection with the
literature are discussed. Implications for practice in nursing education and recommendations for further research are also discussed.
CHAPTER 5

SUMMARY, DISCUSSION, AND IMPLICATIONS

This chapter accomplishes several purposes. First, a summary of the findings of this research study is provided. Second, the major findings of this study are reviewed and discussed in connection with the literature. Third, implications for practice in nursing education and suggestions for further research are given.

Summary of the Findings

The purpose of this research study was to better understand student nurses’ perception of anxiety in the clinical setting and to understand what anxiety means for them. This qualitative study expands the existing body of knowledge about anxiety in student nurses in the clinical setting. Most of the current literature is based primarily on quantitative research so the experiences and perceptions of the students are not captured in a deep or meaningful way. In this qualitative study, individual interviews and a focus group interview with the same participants provided the opportunity for student nurse participants to describe their perception of anxiety in the clinical setting in their own words. This research study literally gave voice to an emotion that is experienced by many student nurses during their clinical educational experience.

Situated cognition is a learning theory that informed this research study. “Every human thought and action is adapted to the environment, that is situated, because what people perceive, and how they conceive of their activity, and what they physically do develop together” (Clancey, 1997, pp. 1-2). This quote exemplifies the learning that takes place by student nurses in the clinical setting. The learning is situated in the clinical environment. The premise of situated cognition is that the learning process is
connected to the situation where the learning is occurring. The physical and social experiences and the tools used during an experience are very important pieces of the entire learning process (Merriam & Caffarella, 1999). It is in the clinical learning environment where students learn the physical and social aspects of the profession of nursing and use tools to provide care for patients. It is in these experiences that student nurses learn and experience anxiety. The anxiety that they experience may interfere with learning in the clinical setting.

The purpose of this research study was to better understand student nurses’ perception of anxiety in the clinical setting and to understand what anxiety means for them. This study was guided by the following research questions:

1. How do student nurses make meaning of, interpret, and perceive their anxiety in the clinical setting?
2. How do student nurses contextualize, and/or understand their anxiety in the clinical setting?

Seven themes emerged from the data. The themes are Experiencing Inexperience, Being Demeaned, Being Exposed, Unrealistic Expectations, Being Abandoned, Sensing Difference, and Being Uncertain of Ability.

First, the participants contextualized their anxiety in relation to experiencing inexperience in various situations in the clinical setting. They talked about feeling anxious about their own inexperience in the clinical setting and that people in the clinical setting were inconsiderate of their inexperience. They also talked about feeling anxious while encountering inexperienced faculty and peers.
Second, participants talked about feeling anxious during encounters in which they were demeaned. In speaking about these encounters, the participants made the connection of being demeaned with the authority held by those who made them feel this way, namely physicians, staff nurses, and instructors.

Third, some participants shared stories in which they felt anxious when their failures or lack of knowledge would be exposed and be made known to other people in the clinical setting. Participants spoke of being exposed by instructors, staff nurses, physicians, and in one case by the participant herself when providing care to a patient.

Fourth, some participants interpreted their anxiety in relation to unrealistic expectations that people in the clinical setting have of them. Several participants expressed that staff nurses had unrealistic expectations, some participants discussed instructors that had unrealistic expectations, and one participant spoke about peers that had unrealistic expectations.

Fifth, several participants perceived anxiety in relation to clinical experiences in which they were abandoned. The participants expressed that they felt anxious when the instructor was either engaged with other students on the patient care unit or seemingly vanished from the patient care unit. They felt anxious that they were missing learning opportunities and that they were not providing proper care for the patient when the instructor was occupied or inaccessible.

Sixth, the participants made meaning of their anxiety when they discussed differences between themselves and their peers. There were two dimensions in this theme. The first dimension entailed the participants’ discussion of how their clinical experiences differed from those of their peers in a way that they felt created anxiety about
their learning. The second dimension referred to sensing difference because of

competition among peers.

Finally, the participants understood their anxiety in relation to performing a

variety of skills on patients in the clinical setting.

Discussion of the Findings

The findings of this research study are discussed in relation to the literature that is

relevant to this topic. I discuss how the findings of this study relate to, expand on, or

contradict the studies that were reviewed in Chapter 2.

Experiencing Inexperience

The participants contextualized their anxiety when they spoke of experiencing

inexperience in various situations in the clinical setting. The participants talked about

feeling anxious about their own inexperience in the clinical setting and their feelings that

people in the clinical setting were inconsiderate of their inexperience. They also talked

about feeling anxious while encountering inexperienced faculty and peers. These were

the dimensions of this theme that emerged from the data.

Inconsideration of inexperience. The participants felt anxious when staff nurses,

physicians, and instructors were inconsiderate of their inexperience. They were anxious

about being chastised by experienced physicians and staff nurses for their inexperience

and felt anxious that they would make staff angry because of their inexperience. This

finding is similar to other research studies in which student nurses were made to feel

incompetent by staff nurses, and that staff nurses were reluctant to acknowledge students’

abilities in terms of providing care for patients (Davitz, 1972; Evans & Kelly, 2004).
In a similar vein, Parkes (1985) found that student nurses felt as though some staff nurses did not honor the experience that students had and were chastised. Student nurses reported that staff nurses did not give much attention to the reports given to them about the patients. Parkes’s also found students were chastised by staff nurses when they wanted to complete patient care in a fashion that was aberrant to the regular routine of how things are done. The findings of the above studies show that staff nurses chastised student nurses for their inexperience as well as their experience.

The participants in my study spoke of wanting instructors who were supportive of their inexperience, who would not hurry them when they performed skills, and who would provide validation of the assessments they performed on the patient. They said if the instructor had a laid back attitude they felt more confident. Similarly, Mahat (1998) found that student nurses felt that clinical instructors did not support them, were insensitive, overly critical, and made them feel as though they lacked the skills for providing care to patients.

Situated cognition theory, in a practical sense, places the learner in the environment where the learning occurs (Hanks, 1999). The engagement of learners in authentic tasks in authentic contexts contributes to their personal understanding and helps them make meaning of the environment (Choi & Hannafin, 1995; Seel, 2001).

Two tenets of situated cognition are legitimate peripheral participation and community of practice. When a learner is new to a particular setting, he or she participates peripherally (Barab & Plucker, 2002; Brown & Duguid, 1993) and engages in the process of legitimate peripheral participation (Lave & Wenger, 1999). Legitimate peripherality permits learners to gradually absorb and be absorbed by the culture, and
provides opportunities for learners to make the culture their own (Lave, 1991). Persons who belong to a community of practice have a common sense of purpose (Hansman, 2001). An integral part of the reproduction of communities of practice is to transform the newcomers into old-timers (Lave & Wenger, 1999). Communities of practice are themselves regimes of competence. They have guidelines that define a member as competent, as an outsider, or somewhere within the range of competent and outsider (Wenger, 2001).

The student nurses in my research study belong to a community of practice of professionals whose purpose is to provide patient care. This community of practice includes staff nurses, instructors, physicians, peers, patients, and themselves as student nurses. The student nurses were newcomers to the community of practice and were engaged in legitimate peripheral participation. They experienced anxiety as a result of being a part of the community of practice and their legitimate peripheral participation. They knew they were inexperienced in providing patient care and felt that others in the community of practice wanted their location and participation to be, for the most part, on the periphery instead of more centrally located.

Encountering inexperienced faculty and peers. The student nurses in the current study felt anxious when they encountered inexperienced instructors and peers in the clinical setting. Instructors who were inexperienced with patient care, equipment, and grading policy made the students feel anxious. Participants wanted an instructor who was experienced in the area in which the clinical experience was occurring. For example, one participant said she had an instructor for pediatrics whose background was mainly women’s health. They said that instructors who were inexperienced in the clinical setting
were unable to answer their questions or guide them. They were looking for instructors who could act as a model and not having this created anxiety. Likewise, other researchers found that student nurses were stressed if they perceived the instructor to be incompetent (Shipton, 2002) and that learning was facilitated by knowledgeable and skillful instructors (Oermann, 1998). This current research study adds new information to the literature about student nurses experiencing anxiety as a result of an instructor’s inexperienece with grading policy in the clinical setting.

The participants felt anxious when working with inexperienced peers. They wanted to work with peers who were as competent as or more so than them. They were anxious that inexperienced peers would not be able to support them in the clinical setting. These results of my research study bring forth new findings about peers and anxiety in the clinical setting.

*Being Demeaned*

As previously discussed, legitimate peripheral participation and community of practice are two main tenants of situated cognition. Legitimate peripheral participation and communities of practice are complex concepts that are implicated in social structures and have relations of power intertwined in their realities (Lave & Wenger, 1999). When learning and knowing are viewed as a cultural phenomenon, they become enmeshed in the social and political aspects of the environment (Merriam & Caffarella, 1999). Legitimate peripheral participation can be empowering and/or disempowering. The process of legitimate peripheral participation involves moving from the periphery to a more central location of the community of practice. When a person moves centrally, they may feel empowered. However, if they are denied the opportunity to become centrally
located in the community of practice and perhaps are denied legitimacy, they may become powerless within the community of practice (Lave & Wenger, 1999).

The participants of this research study talked about feeling anxious during encounters in which they were demeaned. In speaking about these encounters, the participants made the connection of being demeaned with the authority held by those who made them feel this way, namely physicians, staff nurses, and instructors. As discussed here, the comments made by the participants clearly indicated how they felt they were made to feel on the periphery of the community of practice and were essentially powerless in their position as a student nurse in relationships with physicians, staff nurses and instructors.

Being demeaned by physicians was expressed by the majority of the participants in this study. The participants said they were ignored by physicians when trying to relay important patient information to them, they felt “invisible” to physicians, they wanted to avoid interacting with physicians, and that physicians treated them rudely. Some participants said that the knowledge level and accomplishments of physicians made them feel inferior to physicians. The participants felt that historically physicians have always been superior to nurses and that is the way the power structure of this community of practice remains at present. They felt that nurses and student nurses need to know their place in the hierarchy of the community of practice. My research study has generated new knowledge about the relationship between student nurses and physicians and the power structure of the relationship in relation to anxiety in student nurses in the clinical setting.
The participants in this research study felt anxious when being demeaned by staff nurses and even by a nurse aide. The participants sensed the authority of the staff with whom they were working. They felt as though staff gave them a hard time because that is how the staff nurses themselves were broken into the profession. The participants felt that they could not talk to their instructor about some of the issues because of the genial relationship that existed between the staff and the instructor. The student nurses in this current study were also anxious about working with staff nurses with whom they had developed a contentious relationship and this person would then be giving them a grade. Similarly, participants in other studies reported stressful relationships resulted when students were demeaned, belittled, and humiliated by staff nurses (Parkes, 1985; Shipton, 2002). While both of these studies discuss how student nurses were treated by staff nurses neither study overtly discusses the relations of power that exist between student nurses and staff nurses. This current study generated new information about relationships and the power structure of those relationships between staff nurses and student nurses.

The student nurses in my study expressed that they felt anxious when demeaned by instructors. The participants said that they were called names by instructors and were told that they lacked the knowledge and skill to work as a nurse. The participants did not want to react to the instructor’s insulting behavior because they wanted to be respectful and because the instructor was grading them. They worried that their reactions could have negative repercussions. The behaviors of the instructors made it difficult for them to approach the instructor when they had questions. The participants in Mahat’s (1998) study similarly said that clinical instructors made them feel inadequate to provide patient
care. This current study yielded new information about relationships and the power structure of those relationships between student nurses and their clinical instructors.

**Being Exposed**

The participants shared stories in which they felt anxious when their failures or lack of knowledge would be exposed and made known to other people in the clinical setting such as peers, instructors, physicians, and patients. Several participants felt anxious when needing to answer the instructor’s questions. They worried about failing the clinical day because of this. The participants stated that some instructors were willing to help students answer questions while some were unwilling to do so. Similar findings were found in the review of the literature. Student nurses reported that being questioned by clinical instructors was particularly stressful for students (Kim, 2003). Student nurses also said that clinical instructors who facilitated learning were able to guide students to relate theoretical concepts to the actual care of patients in the clinical setting. Clinical instructors who inhibited learning did not possess this attribute (Oermann, 1998).

The participants in this current study felt anxious when needing to answer physician’s questions. They were anxious about irritating the physician and that the physician would not think well of them. These results of my research study introduce a new finding about student nurses’ anxiety about answering physicians’ questions.

The participants in this research study felt anxious when exposed by staff nurses with whom they were working. They were anxious about what the staff thought of their knowledge level. They said they were discredited by staff nurses in front of patients, staff, and visitors. Participants were reprimanded by staff nurses in hallways and these incidents were witnessed by professional as well as public onlookers. As a result of these
episodes, the participants were afraid to show their knowledge for fear of being criticized and even wanted to quit nursing school. They wanted to work with staff nurses of whom they could ask questions and not feel anxious doing so. These findings are analogous to those of other research studies that found student nurses reported troubled relationships with staff nurses (Lindop, 1989; Parkes, 1985). In addition, a dominant finding in one research study in the review reported that the majority of single reasons for students to leave nursing education were related to troubled relationships with staff nurses (Lindop, 1989).

Situated cognition theory considers the cultural and social aspects of learning. When learning is considered within the context in which it occurs, it becomes a cultural and social phenomenon (Merriam & Caffarella, 1999). Learning is essentially of a social nature (Hansman, 2001). Learning that takes place in actual life-settings, with real individuals is open to social influences (Fuhrer, 1993). While learners are exposed to social groups they undergo the process of enculturation. They copy behaviors, learn the language, and gradually act accordingly with the norms of the group (Brown, Collins, & Duguid, 1989). Legitimate peripheral participation unveils the relations between newcomers and old-timers, and it unveils the activities and developed identities of communities of practice (Lave & Wenger, 1999).

The stories told by the participants in the current study about staff nurses reveal the anxiety that is felt by the students as newcomers with the staff as old-timers. Also revealed are the type of behaviors demonstrated by staff nurses that student nurses could potentially copy and consider normal behavior of the group. Eventually, student nurses become staff nurses who develop an identity within the community of practice. The
behavior of the staff nurses, as told by these participants, reinforces the status quo of how some staff nurses treat student nurses. This perpetuates the likelihood that staff nurses will continue to make student nurses feel anxious when working with them in the clinical setting.

Unrealistic Expectations

The participants interpreted their anxiety in relation to unrealistic expectations that that staff nurses and instructors had of them. The participants wanted staff nurses to have realistic expectations of them in terms of their level of experience. They said that staff forgot what it was like to be a student and not know everything about patient care. The participants said that staff nurses expected them to do things that were clearly the responsibility of the staff nurse and when those things were not done they were berated. In these situations, they became anxious because they were confused as to whether or not they did something wrong.

Staff nurses had unrealistic expectations of students when the staff nurses were having a very busy day and expected students to do things beyond their ability. Students were also expected to proficiently perform tasks if they had done them with a staff member in the recent past. Sometime the staff nurses were disgusted if the students were unable to perform all the care that the patient required because of their level of experience. However, those participants of my research study who were senior student nurses, reported that they were welcomed by the staff when they arrived on the patient care unit.

The review of the literature shows similar findings about stressful relationships between staff nurses and student nurses. Student nurses were made to feel incompetent
by staff nurses (Davitz, 1972; Evans & Kelly, 2004) and that they were a nuisance to staff
nurses (Shipton, 2002). Students felt they were being mistreated by staff nurses when
they demanded that student nurses help them with patient care (Shipton, 2002). Student
nurses also reported that staff nurses developed a loathsome attitude toward them as soon
as they met (Davitz, 1972).

In this current study, the senior level students felt they were moving more
centrally in the community of practice because the staff nurses welcomed them to the
patient care unit due to their higher level of experience. This result validates situated
cognition theory and its tenets of legitimate peripheral participation in the community of
practice. Because of their acceptance by staff nurses, the students felt they were
positioned more centrally in the community as senior level student nurses and felt less
anxious.

Participants in this research study felt anxious when instructors had unrealistic
expectations of them. They talked about “prep” for the clinical experience and said there
were times when they thought they prepped as thoroughly as possible and the instructor
would ask them something that they had not investigated. They said the instructor
expected their prep to be “seamless.” They also spoke of the long hours that prep
required and how they got little sleep the night before clinical experiences. They said
there were times when they prepared as much as much as possible but high levels of
anxiety caused them to forget things.

The student nurses in this research study validated the Yerkes-Dodson Law and
the Inverted-U Hypothesis which is a theory that addresses anxiety and performance.
Yerkes and Dodson performed an experiment to show that the relationship between
arousal and ability to learn tasks was an inverted-U shape. They found when arousal levels were low, performance levels were low. When arousal levels were high, performance levels were also low. Optimum performance was achieved when arousal levels were at a moderate level (Fisher, 1996; Yerkes & Dodson, 1908). The student nurses in this research study said that they forgot things when they experienced high levels of anxiety.

The participants had clinical instructors who expected them to be able to perform in the clinical setting without having any previous theory in the classroom. Participants also spoke of instructors who expected them to think like an expert nurse and expected them to help peers with tasks that the peers did not want to do. They perceived instructors to have the unrealistic expectation that they needed to constantly be doing something during the clinical experience so the instructor would not think less of them. The findings of my research study in regard to students’ thoughts about clinical prep, having clinical experience prior to having theory in the classroom, and the expectation of clinical instructors expecting student nurses to think like an expert nurse are contributing new information to the literature about anxiety in student nurses in the clinical setting.

Being Abandoned

The participants perceived anxiety in relation to clinical experiences in which they were abandoned when the instructor was occupied or inaccessible. They said that instructors did not share time equally with the students. They were anxious while waiting for the instructor because they were missing learning opportunities such as seeing procedures performed on the unit or they could have spent the time providing patient care instead of waiting for the instructor. While some participants said that the problem was
that the instructor did not share her/his time equally, others said that their peers “monopolized” the instructor’s time. This finding is similar to Shipton (2002) who found that students were stressed if they had to wait for the instructor to be available.

When students were abandoned by instructors they felt they were caught in the middle between the instructor and staff nurses. The participants said that not all staff nurses wanted to help students and the staff would tell them to ask the instructor. This made them afraid to approach the staff again and impaired relationships between student nurses and staff nurses. They said that if they tried to track down the instructor then the instructor was mad at them. If the staff nurse was willing to help the student, the student felt as though she was being a nuisance to the staff and she was also uncertain whether or not the instructor would approve of the staff helping her. Similarly in other research studies, participants reported they were made to feel they were a nuisance to staff nurses (Shipton, 2002) and that students were offended when staff nurses did not want to share their knowledge with them (Evans & Kelly, 2004).

A surprising finding in this current research study is that the student nurses who said they were relatively competent in the clinical setting felt anxious when abandoned by the clinical instructor. This finding was new to the field.

*Sensing Difference*

The participants made meaning of their anxiety when they discussed differences between themselves and their peers. There were two dimensions in this theme. The first dimension entailed the participants’ discussion of how their clinical experiences differed from those of their peers in a way that they felt created anxiety about their learning. The second dimension refers to sensing difference because of competition among peers.
Differing clinical experiences. The participants spoke of differing clinical experiences with instructors, with the clinical evaluation process, and with clinical sites. They said that one clinical group seemed to always get the lead instructor (lead instructors were viewed as good clinical instructors). The student nurses in this study said that some of their clinical experiences with an instructor were poor as compared to the experiences of their peers in other clinical groups with different instructors. As a result, they said they did not learn what they were supposed to learn.

The participants felt anxious when they were not evaluated by instructors as often as their peers in other clinical groups. They said their peers were evaluated weekly while they had to wait until the end of the semester to find out how they were performing. Not being evaluated by the clinical instructor until the end of the semester made them feel anxious because they did not know what they needed to improve upon and were left to wonder whether or not they were passing or would receive a passing grade for the clinical experience. Student nurses’ anxiety about differing clinical experiences in regard to the evaluation process and their learning in the clinical setting with a particular instructor brings forth new information to the literature.

The student nurses in this current study felt that instructors in other clinical groups pushed and challenged students more and gave them more responsibility than the instructors they had. They also noted that there was a difference between clinical instructors. For example, some instructors gave the students two patients to provide care to while other instructors gave students only one patient. This finding affirms that found in another research study in which student nurses said learning was facilitated by clinical
instructors who had the ability to simultaneously direct students while supporting their independence (Oermann, 1998).

The participants said their peers were getting better experiences on other units and at other hospitals and even said their peers within their own clinical group were getting better experiences than they. When the participants sensed these differences it led not only to anxiety, but also tension, jealousy, and anger within the participant’s clinical group and between other clinical groups. These emotions affected their mood as well as that of their peers in the clinical group and this made it difficult to focus on patient care. This is a new finding in relation to anxiety in student nurses in the clinical setting.

*Competition among peers.* The participants in this research study sensed competition among peers in the clinical setting. The competition was made evident by fighting among peers as well as by non-verbal behaviors when students asked questions and peers looked at them as if to say ‘what are you asking that question for?’ The participants felt that peers were competitive when other students readily showed their knowledge and made them look as though they knew nothing. When working with competitive peers they felt “doomed” and that they had to try harder because competitive students “shine in the eyes of the instructor,” thus making them look average. The participants even feared they would not receive a passing grade from the instructor when there were competitive students in the group. This constitutes a new contribution to the literature.

*Being Uncertain of Ability*

The participants understood their anxiety in relation to performing a variety of skills on patients in the clinical setting. The participants said that they were nervous the
first time when performing a skill, especially if there was little time to review the skill or they had little time to prepare emotionally to perform the skill. The students said that the more often they performed a skill, the less anxious they felt. They experienced anxiety when there was a lapse of time from when they last performed a skill, but once they began to perform the skill they felt better. Comparably in other research studies, students were concerned about their ability to perform nursing procedures (Elfert, 1976; Kim, 2003; Kleehammer, et. al., 1990, Parkes, 1985). Overwhelmingly, “all” (p. 53) students in one study felt they lacked practical skills (Hamill, 1995).

The participants in the current research study said they learned how to perform skills in the campus lab but there was a difference between performing them in the lab on mannequins versus performing them on a real patient in the clinical setting. Related findings show that a significant source of stress for some students was the ability to transfer theoretical knowledge to the clinical setting when providing care for patients (Brown & Edlemann, 2000).

Participants worried about performing the skill correctly and they made sure that the staff nurse checked if they did it correctly. Similarly, the results of other research found that students felt they lacked clinical knowledge to accomplish patient care (Beck & Srivastava, 1991; Elfert, 1976; Mahat, 1998; Oermann, 1998). The student nurses in the current study were also worried about not knowing what to do in certain situations. This finding was analogous to that of Parkes’ (1985) study in which student nurses wondered if they would be able to respond and react appropriately in an emergent situation.
The participants in my study said that they spent a lot of time observing nurses performing skills and worried that they would be inadequate when they actually had to do the skill. They questioned whether or not they would be able to perform the skill when the time came. Data from several studies indicated that student nurses felt they were inadequately prepared for clinical experience and this was a source of stress for them (Dye, 1974; Mahat, 1998; Shipton, 2002).

The participants in my research study were concerned about causing pain to the patient when performing certain skills. They worried about their assessment skills, in particular doing them properly and knowing which assessments to perform in order to accurately monitor the patient’s clinical condition. Being uncertain of ability in administering medications was mentioned by several of the participants in my research study. They were anxious about administering medications in general, administering medications to pediatric patients, and administering intramuscular injections. Comparably, students in another research study said they were worried about causing paralysis to a patient if an injection is administered incorrectly (Parkes, 1985).

Participants in my research study were uncertain of their ability to perform skills on patients during their Community Health experience when they visited patients’ homes and a registered nurse was not with them. Similarly, student nurses in another research study found their Community Health experience to be stressful because they were unsure of their role in that particular setting (Elfert, 1976).

The student nurses in this current research study experienced sweating and their faces getting red when performing skills on patients. Likewise, student nurses in other research studies used the words “stressful,” “scary,” “nervous and stupid,” and causing
‘butterflies and flutters’” when relaying their thoughts about performing nursing procedures (Elfert, 1976; Shipton, 2002). When a person feels threatened, an anxiety state is aroused. An anxiety state is an unpleasant emotional reaction and is comprised of unpleasant feelings and thoughts. The person who is experiencing an anxiety state may feel apprehensive, tense, frightened, and nervous. A person often worries about the specific circumstances that provoked the anxiety state (Spielberger, 1979).

An anxiety reaction involves the feelings as described above, as well as a physiologic process that results in certain behaviors. Some of the behaviors associated with an anxiety reaction are restlessness, trembling, shortness of breath, muscle tension, heart palpitations and dizziness (Spielberger, 1979). These behaviors are a result of stimulation of the autonomic nervous system. The autonomic nervous system is the means by which the body endures emotional changes (May, 1996).

Implications for Practice

The implications for practice of this research study are many. The findings of this research study can inform those who teach in nursing education and those who teach in adult education in either the classroom or clinical setting. Among the findings there are some instances of anxiety that would be expected in any new or complex learning environment. In the case of student nurses learning in the clinical setting, anxiety about performing skills or procedures on patients, anxiety about the patient sensing the student’s lack of knowledge, and anxiety about competition among peers are examples of some instances in which anxiety would be expected. There were other instances however, that one would not expect to find in a learning situation. It is these that we need to pay particular attention to in practice and which are addressed here.
The student nurses in this study experienced anxiety when staff nurses, physicians, and instructors were inconsiderate of their inexperience when they were unsupportive and angered by their inexperience. Because of their inexperience the students felt as though they did not belong to the community of practice of which they were an integral part. Nursing instructors, staff nurses, and physicians need to recognize that student nurses are learning and they need to be aware of their behaviors toward students. They need to have unwavering patience and not become angered or irritated toward the student because of inexperience. Student nurses need to be recognized for the experience that they do indeed have. This will help them feel as though they belong to and are an integral part of the community of practice and will help to decrease their anxiety in the clinical setting.

The participants in this research study felt anxious when they encountered instructors and peers in the clinical setting who they perceived to be inexperienced. It is imperative that student nurses know the background of their nursing instructors. Nursing instructors can share their experiences and background with the students. Knowing this will clarify their perceptions of the qualifications of the instructor and in turn they will feel more confident and less anxious when working with the instructor. It is also imperative that members of faculty search committees try to attract faculty who have the background in the clinical areas in which they are working with students. In regard to working with peers who the students perceive as inexperienced, nursing instructors could pair/group students according to the students’ strengths and weakness. For example, students who perform well in the clinical setting could be paired or placed in groups of students who have less confidence and skill in the clinical setting. The stronger students
can provide support and perhaps build confidence in the students who do not perform as strongly in the clinical setting. This has the added potential to build confidence in the stronger students in a positive way. This strategy may decrease anxiety of student nurses in the clinical setting.

The participants of this research study talked about feeling anxious during encounters in which they were demeaned. In speaking about these encounters, the participants made the connection of being demeaned with the authority held by those who made them feel this way, namely physicians, staff nurses, and instructors. When being demeaned they were disempowered and felt their location in the community of practice to be on the periphery. Nursing instructors, staff nurses, and physicians need to be aware of their privileged position within the community of practice and how they use their position within the community. Student nurses view these persons as authoritative figures and perceive them to have power and influence. As persons with privileged positions, nursing instructors, staff nurses, and physicians need to be aware of and respectful to those persons whose status is on the periphery of the community of practice. A respectful, accepting attitude of student nurses could help the students feel more centrally located in the community of practice and could alleviate their anxiety in the clinical setting.

The participants shared stories in which they felt anxious when their failures or lack of knowledge would be exposed and made known to other people in the clinical setting such as peers, instructors, physicians, and patients. Answering the instructor’s questions was particularly anxiety provoking for the participants. Nursing instructors need to be sensitive to the anxiety experienced by student nurses when they are required
to answer questions. Nursing instructors can provide guidance to students by directing them toward correct answers either by providing hints or have students use available resources such as textbooks or the internet. This guidance will demonstrate support of the student in their learning and aid in mitigating anxiety. The student nurses in this research study also felt anxious when needing to answer physician’s questions. They were anxious about irritating the physician and that the physician would not think well of them. Again, physicians need to demonstrate unwavering patience and respect when working with student nurses. This display of patience will help allay student nurses’ anxiety when physicians ask them questions.

The student nurses in this research study felt anxious when staff reprimanded and discredited them in front of patients and other health care professionals. As a result of these episodes, the participants were afraid to show their knowledge for fear of being criticized and even wanted to quit nursing school. Staff nurses need to be aware of their behavior when interacting with student nurses. They need to be open and approachable when students have questions. This will help lessen anxiety in student nurses in the clinical setting.

A rather troubling implication for practice, as evidenced in this study, is that the offensive behaviors of staff nurses toward student nurses has become manifest as normal behavior for this group. The student nurses who are mistreated by staff nurses have the potential to treat student nurses in the same fashion once they become staff nurses. This reinforces staff nurses’ behavior of mistreating student nurses for generations to come.

This study has shown that participants wanted to quit nursing school as a result of being
mistreated by staff nurses. This has far reaching implications for a profession that is already experiencing a shortage of registered nurses.

Participants in this research study wanted staff nurses as well as instructors to have realistic expectations of them in the clinical setting. Staff nurses need to recognize and have an accepting approach to the level of experience and responsibility of student nurses. Staff nurses should not expect students to perform duties that are beyond their capability or outside their scope of practice. Feeling accepted for their ability and responsibility will make student nurses feel more centrally located in the community of practice and ease their anxiety in the clinical setting.

In regard to unrealistic expectations of student nurses, nursing instructors need to realize and recognize the hard work and long hours that students spend on clinical prep. It is also essential that nursing instructors clearly explain the expectations of prep and assure students that their expectations are and will be commensurate with the students’ level of experience. Another unrealistic expectation of student nurses found in this research study is that they were expected, by their clinical instructors, to perform in the clinical setting without having any previous theory in the classroom. Nurse educators need to examine curriculum and scheduling of clinical experiences to ensure efficacy of learning and performance. This will help alleviate anxiety in student nurses in the clinical setting.

The participants perceived anxiety in relation to clinical experiences in which they were abandoned when the instructor was occupied or inaccessible. They felt they were missing learning opportunities or could have spent the time providing patient care instead of waiting for the instructor. Nursing instructors need to be cognizant of the time
spent with individual students in the clinical setting. While this may not be an easy task to accomplish because of the added complexity of providing safe and effective care of the patient, instructors can set a time limit and establish the amount of time that will be spent with the student at the beginning of the encounter.

When students were abandoned by instructors they felt they were caught in the middle between the instructor and staff nurses. The participants said that not all staff nurses wanted to help students and the staff would tell them to ask the instructor. If they tried to track down the instructor then the instructor was mad at them. If the staff nurse was willing to help the student, the student felt as though she was being a nuisance to the staff and she was also uncertain whether or not the instructor would approve of the staff helping her. It is imperative that staff nurses and clinical instructors work together and be available to provide learning experiences for student nurses. While it is not the ultimate responsibility of staff nurses to teach student nurses, they could offer their time and expertise to help the student provide the care for the patient that ultimately would have to be done by either the staff nurse or the student nurse. Nursing instructors also need to realize that students who are deemed competent in the clinical setting also experience anxiety when they feel abandoned. Nursing instructors need to provide assurance of their ability to these students.

The participants spoke of differing clinical experiences with instructors, the clinical evaluation process, and clinical sites. While it is impossible for clinical instructors to teach similarly and to have similar clinical experiences it is possible to ensure that some things are conducted similarly across clinical groups. The students in this research study said that one clinical group seemed to always get the lead instructor
who was considered a good clinical instructor. The assignment of clinical instructors could be fashioned so that one group does not always have the lead instructor.

The participants also felt anxious when they were not evaluated by instructors as often as their peers in other clinical groups. The evaluation process could be made uniform so that students across clinical groups are evaluated at the same intervals.

The participants in this research study sensed competition among peers in the clinical setting and this caused them to feel anxious. First, the competition among peers needs to be recognized by the instructor; however, this could be difficult to recognize if the competition is not blatantly exhibited by students in the presence of the instructor. If the competition does become obvious, the instructor can speak with individual students and ask them to be more respectful of their peers and to think about how their actions, words, and competitive attitude affect others. The students in this research study also felt there was competition when their peers readily showed their knowledge and made them look as though they knew nothing. The instructor could address this by gently placing limits on the students. The instructor could request that students raise their hand to answer questions. This will give each student the opportunity to show their knowledge and decrease the competitive feeling in the group which will then decrease the students’ anxiety.

The participants understood their anxiety in relation to being uncertain of their ability to perform a variety of skills on patients in the clinical setting. They worried about performing them correctly and about causing painful or detrimental outcomes to patients. They said that the more they performed a skill, the less anxious they felt. They also worried about knowing what to do in certain situations. Nursing instructors need to
be sensitive to the students’ feelings about anxiety when performing skills and provide support and encouragement. Instructors also need to reiterate and emphasize to students that confidence will build with repeated performance.

Student nurses in this research study spoke of physiological responses to anxiety. Once again it is important for instructors to be understanding of the physiological responses to anxiety. If the student is directing attention to how their body is feeling when anxious, they will be unable to concentrate on the skill that they are performing. Nursing instructors need to give the student time to recompose during the times they are feeling anxious.

A paramount thread in the results of this research study is the behaviors and actions of staff nurses, clinical instructors, physicians, and peers that have contributed to anxiety of student nurses in the clinical setting. One of the most important undertakings to promote changes in behaviors and actions is to have people acknowledge them. An approach to accomplish this is to offer in-services in facilities where student nurses have clinical experiences or a presentation in the classroom setting with clinical instructors and the students’ peers. Student nurses, staff nurses, clinical instructors, and physicians can participate in the in-service/presentation. Their participation can occur in a role playing scenario. Student nurses can be creative and develop a role-playing scenario that includes the people and experiences in which they became anxious in the clinical setting including, for example, issues of power relations or situations where the students did not feel respected. An acted out scenario may help impress upon staff nurses, clinical instructors, physicians, and peers how their behaviors and actions result in anxiety in
student nurses in the clinical setting. This will help to increase understanding of this phenomenon which adversely impacts students’ learning.

The role playing scenario has the potential to be beneficial on several levels. First, the students are granted permission to share feelings based on their lived experience of anxiety in the clinical setting in a non-threatening setting and perhaps in a humorous fashion. In addition, the role playing scenario could become a small percentage of the course grade. Changing the behaviors and actions of staff nurses and physicians has the potential to attract student nurses to work in their facility after graduation because of the acceptance and support they found during their educational experience. These former student nurses who become staff nurses can continue to execute behaviors that decrease anxiety in student nurses in the clinical setting. Changing behaviors and actions of instructors and peers has the potential to decrease anxiety in student nurses in the clinical setting and promote learning.

Another approach to using in-services at health care facilities to promote changes in behavior of staff nurses and physicians is to present the students’ suggestions for changes at an in-service. This would need to be conducted when the students are not present because it could be a very uncomfortable scenario for students. The students could complete a survey at mid-semester or at the end of the semester. The purpose of the survey would be to provide students the opportunity to have input in an anonymous fashion. The survey would anonymously give students a voice to those things that went well during the clinical experiences and to those things that need improvement. The information would be shared at an in-service by the person who serves as the liaison between the health care facility and the school of nursing.
In this section I have made several suggestions of implications for practice. One should keep in mind that a main objective of decreasing anxiety in student nurses in the clinical setting is to promote their continuance in nursing education. Meeting this objective will ultimately help to alleviate the nursing shortage and be a benefit to society.

Implications for Further Research

This research study has added to the body of knowledge about anxiety in student nurses in the clinical setting. This phenomenological, qualitative study literally gave voice to the anxiety experienced by student nurses in the clinical setting. Much of the research on this topic has been quantitative in nature; however, even this is relatively scarce. More quantitative and qualitative research needs to be conducted on this topic. Qualitative research will provide rich descriptions of the anxiety that student nurses experience in the clinical setting.

There are few to no published research studies about several points of interest that emerged from this study. Research conducted in these areas will provide nurse educators as well as educators in the field of adult education with an understanding about the anxiety that adult learners experience in their educational endeavors. The results of my research study revealed anxiety provoking relationships between student nurses and staff nurses, instructors, physicians, and peers. Research studies should be conducted that specifically focus on the anxiety that students experience within these relationships. This research study revealed that student nurses experienced anxiety in relation to the power that was held by staff nurses, instructors, and physicians. Further research needs to be conducted that focuses on students’ anxiety in relation to the power relations that exist with these people in the clinical setting.
Further research could be conducted with student nurses who are culturally diverse. The participants of this study were mainly Caucasian and one Hispanic woman. Some of the research studies conducted on this topic have been conducted in countries outside the United States; however, few address whether or not the results are influenced by cultural differences between student nurses and the people they encounter in the clinical setting.

Because students experience anxiety in relationships with staff nurses, instructors, and physicians in the clinical setting, it would be interesting and thought provoking to conduct research with these people. This research could provide their perception and understanding of the anxiety that student nurses experience in the clinical setting. This research could be the beginning of increasing awareness and changing their behaviors toward student nurses which could ultimately decrease anxiety of student nurses in the clinical setting.

A rather remarkable result that warrants further investigation is that even competent student nurses experienced anxiety in the clinical setting. Research needs to be conducted on this topic as the results could provide insight into helping those student nurses who experience anxiety in the clinical setting. The results could also help nurse educators to implement behaviors, strategies, or techniques to decrease anxiety in student nurses in the clinical setting and enhance and promote their learning.
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