7-15-2011

Non-Traditional Nursing Students' Perceived Ability to Form Caring Relationships

JoAnn Evanko Thistlethwaite
Indiana University of Pennsylvania

NON-TRADITIONAL NURSING STUDENTS' PERCEIVED ABILITY TO FORM CARING RELATIONSHIPS

A Dissertation

Submitted to the School of Graduate Studies and Research

in Partial Fulfillment of the

Requirements for the Degree

Doctor of Education

JoAnn Evanko Thistlethwaite

Indiana University of Pennsylvania

August 2011

Indiana University of Pennsylvania
The School of Graduate Studies and Research
Department of Professional Studies in Education

We hereby approve the dissertation of

JoAnn Evanko Thistlethwaite

Candidate for the degree of Doctor of Education

_____ _____
Frank Corbett, Jr., Ed.D.
Professor of Education, Advisor

_____ _____
Kelli R, Paquette, Ed.D.
Associate Professor of Education

_____ _____
James D. Hooks, Ph.D.
Professor of Library Science, Retired

_____ _____
Mary E. Williams, Ph.D.
Professor of Nursing and Allied Health

_____ _____
Timothy P. Mack, Ph.D.
Dean
The School of Graduate Studies and Research

Title: Non-Traditional Nursing Students' Perceived Ability to Form Caring Relationships

Author: JoAnn Evanko Thistlethwaite

Dissertation Chair: Dr. Frank Corbett, Jr.

Dissertation Committee Members: Dr. Kelli R. Paquette
Dr. James D. Hooks
Dr. Mary E. Williams

The problem of this study was to examine Associate Degree non-traditional students' perceptions of their ability to form caring relationships upon entry to the nursing program and, to determine if those perceptions change as the student progresses through the nursing curriculum. Measures of association, such as participants' former career and perceived ability to form a caring relationship were completed.

The Caring Ability Inventory (CAI) developed by Nkongho (1990) was administered to a cross-section sample of non-traditional nursing students (N = 24) in two Associate Degree Nursing Programs. Face-to-face interviews followed with the same participants using open-ended questions derived from the questions and results of the CAI. Data were divided into Level I, those students just entering the nursing program and Level II, those students who were finishing the program or had just graduated.

The findings of this study provide evidence that students' caring ability as measured by the total CAI scores, although not statistically different from Nkongho's (1990) original study, decreased from Level I to Level II. For the subscales of Knowing and Patience there were no statistical differences. However, scores for the subscale of Courage decreased. This suggests that the individual subscales be considered as a focus for faculty to provide appropriate educational intervention that facilitates caring ability.

Analysis of qualitative data derived from interviews and a brief written paragraph revealed strong overall perceptions of caring ability existed in this sample of non-traditional students. There was a difference for three students between the CAI and qualitative data.

Learning how non-traditional students perceive their ability to form caring relationships can help nursing educators address pedagogy and provide opportunities for students to practice the development of caring relationships throughout the nursing program. The findings from this study have implications for nursing educators to help all students as well as practicing nurses reach an efficacious level of caring with patients.

ACKNOWLEDGMENTS

A cherished quote by Douglas MacArthur seems an appropriate way to begin my acknowledgements.

> People grow old only by deserting their ideals. Years may wrinkle the skin, but to give up interest wrinkles the soul. You are as young as your faith, as old as your doubt; as young as your self-confidence, as old as your fear; as young as your hope as old as your despair. In the central place of every heart there is a recording chamber. So long as it receives messages of beauty, hope, cheer and courage, so long are you young. When your heart is covered with the snows of pessimism and the ice of cynicism, then, and then only, are you grown old. And then, indeed as the ballad says, you just fade away.

A heartfelt thank you is given to the members of my dissertation committee for keeping me filled with messages of beauty, hope, cheer, and encouragement. I extend a special thank you to my advisor and committee chairperson, Dr. Frank Corbett, Jr. for his direction, support, sense of humor, and ability to keep me motivated. To Dr. James Hooks, for his kind and gentle edits and sharing his library expertise to help with resources, I thank you. Thank you Dr. Paquette for your always smiling face and cheerful approach to my need for your help. Dr. Williams, my nursing expert and long term colleague, your honesty and faithful approach to helping me throughout this journey are sincerely appreciated. You all kept my soul motivated and interested so as to prevent wrinkles and made this academic journey a memorable experience.

There are so many to thank. The relationships with many generous and inspiring people I have met since beginning my graduate work are priceless; and I, will cherish them always. I have been blessed with many family and friends who have both encouraged and listened throughout my experiences in preparing this dissertation. Just like “it takes a community to raise a child,” it

took a community of loving, understanding, and supportive family and friends to help me make this academic journey. I thank you, for without your support and tolerance, I would have never been able to complete this journey.

Thanks to my husband Gary who has toiled and burned the midnight oil right at my side, always supporting me during the ups and downs of graduate studies and dissertation preparation.

To my respondents, thank you for taking the time to help me collect data so that I could support my research to enhance understanding the non-traditional nursing student. I recognize the value of your time; and, I am pleased about your sharing it with me.

Dr. Nkongho, I appreciate your communication with me and permission to use the Caring Ability Inventory. I would also like to acknowledge the Springer Publishing Company for their support and willingness to share materials with graduate students.

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CHAPTER I

INTRODUCTION

A global, sociological, and economic paradox is occurring that has the potential to alter healthcare outcomes, job satisfaction, patient satisfaction, and even hasten death (Anderson, 2007; Herbst, 2007b). This paradox relates to the supply and demand for registered nurses in the healthcare arena. The American Association of Colleges of Nursing (2008) predicts the need for professional registered nurses (RNs) to reach as high as one million by 2016. At the same time, the U. S. Department of Labor, Bureau of Labor Statistics (2009, 2011a), reports a consistent monthly increase of layoffs over the last several years. The current economic slowdown has created a pool of displaced workers from a variety of careers seeking retraining for employment. The nursing shortage, specifically, and the workers displaced by the economic slowdown will be discussed as they relate to this study.

The nursing shortage has caused healthcare providers, business analysts, and government agencies to be concerned as the law of supply and demand for RNs becomes more unbalanced. A report on the RN workforce projects, without targeted interventions, the demand for RNs in the workforce will reach a deficit of 29% by 2020 (U.S. Department of Health and Human Services, 2002). This predicted shortage represents Full-Time Equivalents (FTEs), the measurement for assessing numbers of full-time hours worked. The U.S. Department of Health and Human Services FTE calculations for 2020 predicts a supply of 2,001,998 and a demand of 2,810,414 for full-time registered nurses. More recent reports of the shortage continue, Buerhaus, et al., (2009) found the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025. Buerhaus stated,

> Over the next 20 years, the average age of the RN will increase and the size of the workforce will plateau as large numbers of RNs retire. Because demand for RNs is

expected to increase during this time, a large and prolonged shortage of nurses is expected to hit the U. S. in the latter half of the next decade (American Association of Colleges of Nursing, 2011).

In April of 2011 the U.S. Bureau of Labor Statistics (BLS) reported that the healthcare sector of the economy continues to grow. The BLS confirmed that there are 283,000 jobs added in the healthcare sector within the last year.

The current prediction of shortages may appear contradictory. Reports about the RN workforce illustrate an increase in employment of nurses. Buerhaus, Staiger, and Auerbach (2003) report, in the past, economic slowdowns have forced nurses to return to the workplace. The current slowdown has produced a similar situation. FTEs have increased at a rate of approximately 4.5% for hospital-based RNs aged 35 to 49. Families' efforts to boost their income during periods of economic slowdown have created this situation (Buerhaus, et al., 2003). Although this increase has given some short-term relief to the nursing shortage, long-term projections for the future nursing shortage still remain (American Association of Colleges of Nursing, 2011).

A number of factors contribute to the nursing shortage making resolution a complex issue. First, nursing is a profession that requires arduous work conditions, decisions that are critical to life and death, unattractive activities, weekend and holiday work schedules, and challenging academic preparation (Herbst, 2007a). Yet, in comparison to professions with comparable educational requirements, nursing is considered a low paying occupation (Herbst). Second, approximately 1,190,000 or 25.2% of the national RN workforce is nearing retirement age (U.S. Department of Health and Human Services, 2005). The retirement of these RNs coincides with the increased health care needs of an aging population whose life expectancy has increased because of advances in treating chronic and terminal diseases. Third, technological

advances in genetics have created ethical and moral challenges contributing to the stress level of nurses. Fourth, cost containment trends in healthcare financing are creating an environment where employers seek increased productivity from fewer professional staff and employ more non-professionals at lower hourly wages. Fifth, the importation and use of non-U.S. nurses to fill a gap in supply results in employers using this as a strategy to pay less for nurses (Buerhaus, et al., 2003). Sixth, to add to the complexity of the shortage, numbers of qualified faculty, classroom space, and clinical placement sites are insufficient to support increasing admissions of eligible applicants (American Association of Colleges of Nursing, 2011).

The employment shortage problem is not just about a lack of available resources. Once students enter programs of nursing in universities or community colleges, the attrition rate for students is high. Attrition rates for community college nursing programs are not reported to a central database making statistical analysis and comparison difficult or impossible. According to the U. S. Department of Educational Institute of Education Sciences National Center for Education Statistics (2008), only those institutions that prepare students for transfer to other programs report transfer rates. In addition, the National Center for Education Statistics calculates attrition rates for first time degree-seeking undergraduates only; therefore, governmental databases that report attrition and retention rates in Associate Degree Programs inaccurately reflect total retention rates for the non-traditional student population. The National League for Nursing (2009) reports one-year attrition rate for full-time nursing students enrolled in Associate Degree Programs as 20%. Fraher, Belsky, Carpenter, and Gaul, (2008), using internal estimates reports that only 58% of students in nursing programs actually graduate.

Attrition of nursing students is not easily fixed. Once students progress to the nursing curriculum, a replacement student cannot fill a seat that becomes available by a student who leaves the program. This occurs because credits between programs of nursing are not

interchangeable or transferrable. Therefore, faculty-student ratios decrease, program costs increase, and the number of graduates decreases. To compensate for the attrition of students who lack adequate preparation for academic challenges, admission departments are seeking applicants who are more mature and more likely to be successful in completing the nursing program. A logical source for the mature applicant is the pool of displaced workers looking for retraining and a quick return into a secure workplace market (Kohn &Truglio-Londrigan, 2007; Korvick, Wisener, Loftis, & Williamson, 2008).

The picture of displaced workers remains dismal. According to the U. S. Bureau of Labor Statistics (2009), job losses from April to June of 2009 averaged 436,000 per month while losses from November 2008 to March 2009 averaged 670,000 per month. The latest annual data reports the percent of civilian labor force in noninstitutional population unemployment continues to increase. In 2008 unemployment was 5.8%, in 2009 unemployment increased to 9.3 %, and in 2010 unemployment increased to 9.6%. The Bureau of Labor Statistics also reports a consistent monthly increase of layoffs across different industries over the last several years. These workers are being encouraged to consider nursing as a career since a poor economy has less influence on the healthcare job market (Shatkin, 2009; Smith, 2008). Recruitment and retraining this pool of displaced workers into nursing offers a possible solution to the nursing shortage (Cangelosi & Whitt, 2005; Kohn & Truglio-Londrigan, 2007; Korvick & Williamson, 2006; Shiber, 2003). As a result, nursing schools are accelerating recruitment efforts and designing publicity campaigns to enroll displaced workers as non-traditional students into nursing programs.

As an incentive to improve the goal of retraining a portion of the workforce, state governments are providing free tuition at community colleges for displaced workers who wish to enroll in Associate Degree Nursing Programs. For example, Michigan Governor Jennifer Granholm made an offer to provide displaced workers with tuition-free community college

education for high-demand jobs, one of which was nursing (Eby, 2007, Fierce Healthcare, 2007). According to the *Community College Times* (2009), community colleges across the nation are offering free or discounted tuition to displaced workers. The American Council on Education (2009) publishes a list of state policies that support adult learners in the United States. The list shows that a total of 37 states have policies that range from free tuition to income tax credit for adult workers who are engaged in education and training for high demand professions such as nursing.

Displaced workers are seeking retraining that can return them to the job market as economically and quickly as possible. Without a prior degree, a baccalaureate program in nursing requires four to five years to complete, while Associate Degree Programs require as little as 12 to 18 months. The length of the program of study and free tuition packages offered at community colleges makes this educational opportunity very appealing. Efforts to recruit displaced workers into nursing appear to be a win-win situation for the displaced worker, community colleges, the healthcare industry, and society in general. However, is the problem of a nursing shortage so easily resolved?

Is an Associate Degree Program the best way to prepare the non-traditional student for a professional nursing role? A number of concerns need to be addressed in educating this population of students for nursing. First, Associate Degree Programs may not offer a strong liberal studies curriculum. The American Association of Colleges of Nursing Document (2008) calls for a strong liberal education as prerequisite to the nursing curriculum. Caring for the ill requires unique qualities that include empathy, tolerance, altruism, respect for human dignity, and the ability to deliver services that are often intimate and intrusive. A broad liberal education offers a foundation for understanding the human experience and universal needs. This component of curriculum is lacking in an Associate Degree Program. Comparison of a generic

Associate Degree Nursing Curriculum sequence with a generic Baccalaureate Degree Nursing Curriculum sequence demonstrates the difference in liberal studies requirements (see Appendix A). The concern about displaced workers is whether they possess the necessary dispositional characteristics for this type of work. Potential students without a broad liberal education or students who have not been involved in human service occupations may not have developed the qualities necessary for forming caring relationships with total strangers. It is important to detect this deficit early and intervene if students are not suited for professional nurse roles.

Without the ability to form caring relationships, nurses may not be equipped to meet the needs of patients and families to the degree that promotes an environment conducive for healing. For example, non-traditional students are more likely to enter nursing programs without needed attitudes, values, and skills. Folbre (2003) described caring labor as work that involves connecting to other people. Jobs such as the manufacture of physical products, assembly work in a factory, or service work such as carpentry or plumbing are jobs that do not require caring relationships to be successful. Utley-Smith, Phillips, and Turner (2007) also suggest that students who come from fields characterized by purely scientific backgrounds including disciplines such as mathematics and engineering are less apt to have the needed skills for the humanistic part of nursing. These students may not be able to develop the complex, intimate, caring relationships required of nurses. When this is the case, dissonance exists between the perceived expectation of the profession and the ability of the student to initiate and exemplify caring relationships. Without an understanding of this dissonance, students may become increasingly frustrated, experience moral distress, develop a barrier to learning, and ultimately leave the program (Folbre, 2003; Utley-Smith, et al., 2007).

Although faculties are expert in teaching the scientific practice of nursing, they are less adept at socializing a diverse group of second career students to the caring aspects of nursing

(Utley-Smith, et al., 2007). This study aims to offer insights about how non-traditional students perceive their ability to form caring relationships. The findings may alert nursing faculty to any unique needs identified by the population in this study. All students need a learning environment where time, nurturing, and interaction with faculty assist in developing their realization of the meaning of caring (Raines, 2007). Raines found evidence that students' caring abilities, as measured by the Caring Abilities Inventory, increased when students perceived themselves to be in a caring learning environment. Learning how non-traditional students perceive their ability to form caring relationships can help educators address pedagogy and provide opportunities for students to practice the development of caring relationships throughout the nursing program. The findings from this study have implications for educators to help all students reach an efficacious level of caring with patients.

Understanding the needs and challenges of the non-traditional population may influence retention by providing faculty with the means for assessing an individual's capacity for caring behaviors. This in turn can actualize the degree of modeling and practice necessary for development and enhancement of caring skills. Educational strategies for teaching caring behaviors are necessary for student success and, therefore, retention. In addition, understanding non-traditional students' perception of their ability to form caring relationships prevents or minimizes the detrimental effects of burnout caused by the stress of enhancing, faking, or suppressing emotions in order to behave in a way that is expected but not internalized as part of the personality (Grandey, 2000; Hochschild, 2003).

While aggressive recruitment efforts target displaced workers, there are insufficient studies and evidence about the academic needs of this population. This study proposed to fill this gap in the literature by focusing on non-traditional Associate Degree Nursing Students who do not have a background in healthcare.

Caring relationships are essential to the work of professional nurses. The influence that caring behaviors have on the patient's return to an optimal level of health is significant. Because of studies by Duffy (2005) and Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2002), the ability of nurses to form caring relationships has become a measurable outcome related to functional status of patients and financial benefits of the institution. Practicing the art of nursing, which manifests in the caring relationship among the nurse, patient, and family, has become a major component of the educational experience for nursing students.

The American Association of Colleges of Nursing (AACN) Essentials Document (2008) requires baccalaureate programs in nursing teach appropriate caring skills as part of an accredited nursing program. This requirement for nursing education in the United States is founded on the premise that nurses should be prepared as generalists able to practice the science and art of nursing from a holistic, caring framework. In this document, the curriculum elements and framework are provided for nursing education and accreditation of the program. It is mandated by the AACN that the nursing educational program provide graduates who "promote factors that create a culture of safety and caring." This mandate makes it clear that caring behaviors are integral to nursing and will continue to be a significant focus in the triad of education, practice, and research.

Given that caring skills are an essential component of nursing practice, the issue to be explored is whether individuals who enter nursing programs from fields outside the healthcare or human service arena perceive that they have the ability to form caring relationships necessary to the role of professional registered nurse. The background of this problem gives rise to the following questions addressed in this study.

Problem Statement

The problem of this study was to identify whether non-traditional nursing students who have no experience in a healthcare or related field perceive they have the ability to form caring relationships with patients. Measurement of perceptions of the ability to form caring relationships occurred at two points--before entry into the first semester of nursing courses and at the completion of the program. This study also sought to identify if there is a relationship between students' prior careers and the degree of perceived ability to form caring relationships.

Research Questions

The study addressed the following questions:

1. What are non-traditional nursing students' perceptions of their ability to form caring relationships prior to entry into the nursing program?
2. In what ways do the prior experiences of non-traditional nursing students influence their ability to establish/maintain caring relationships during the nursing program?
3. To what degree do non-traditional nursing students perceive that their ability to form caring relationships has changed from entry to exit of the nursing program?

Definition of Terms

Caring--A complex interaction of factors and processes that enhance the development of a special kind of relationship between the nurse and the patient (Watson 1985, 2002, 2008).

Non-Traditional Student--One who has any one of the following characteristics: (a) delays enrollment or does not enter a post-secondary education in the same calendar year he/she finished high school; (b) attends post-secondary school part-time; (c) is financially independent of parents; (d) works full-time; (e) has dependents other than a spouse; (f) is a single parent; or, (g) does not have a high school diploma, though may have a GED or other high school

equivalency (U. S. Department of Educational Institute of Education Sciences National Center for Education Statistics, 2008).

Level I Student--A student just entering the first clinical practice portion of the curriculum.

Level II Student--A student who is in the last semester or has just finished the nursing program.

Limitations

The study was limited by the following:

1. Research sites were limited to two Associate Degree Nursing Programs;
2. Data were collected using samples of convenience;
3. Cross-sectional design does not provide for studying individual changes over time;
4. Subjects were limited to non-traditional students who had no job experience in a healthcare or related field; and,
5. Accessibility of Level I and Level II students.

Summary

The United States is experiencing a critical nursing shortage that is increasing yearly (American Association of Colleges of Nursing, 2009, 2011). In tandem with this shortage, the economic slowdown has displaced thousands of workers who are looking for accelerated re-training into a secure career. In an attempt to quell the nursing shortage, schools target this population for recruitment into nursing programs, and state governments are providing financial aid for displaced workers to attend community college Associate Degree Programs.

It is essential for nurses to possess the ability to facilitate positive patient outcomes by developing caring relationships with patients, family, and colleagues. Some researchers note that non-traditional students who have had careers where intimate interpersonal relationships were

not required may not have the skills necessary to develop complex, intimate caring relationships required of registered nurses (Folbre, 2003; Utley-Smith, et al., 2007). Understanding the complexities involved in developing caring behaviors required of professional nurses may help facilitate teaching these behaviors and may alleviate problems that arise from poor interpersonal relationships among students, patients, families, healthcare staff, and faculty.

Chapter II examines the literature related to the historical evolution of care in nursing, the perceptions and development of caring relationships, nurses' perceptions of the impact of the nursing shortage on care, and the non-traditional nursing student.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Introduction

The problem of this study was to identify whether non-traditional nursing students perceive they have the ability to form caring relationships with patients. A measurement of the perception of this ability at two points in the program, upon entry and at exit of the nursing program, provided data. The study also sought to identify if there is a relationship between students' prior careers and the degree of perceived ability to form caring relationships.

An important component of nursing practice is for nurses to develop caring relationships with patients in order to provide high quality patient care and to generate positive outcomes. Therefore, it is imperative that faculty be cognizant of non-traditional students' perception of their caring abilities. Some scholars (Folbre, 2003; Utley-Smith, et al., 2007) suggest that students who came from fields characterized by purely scientific backgrounds or who previously performed work that did not involve caring relationships, did not have the skills necessary to develop the complex, intimate, caring relationships that are requisite for the professional nurse. Understanding how non-traditional students perceive their ability to form caring relationships as nurses is the first step to removing learning barriers and alleviating the frustration that may lead to role conflict and high attrition rates from nursing programs. A Review of the Related Literature revealed that studies addressing the ability of non-traditional nursing students to form caring relationships are scarce. For this reason, the Review of the Related Literature focuses on the historical evolution of caring in nursing, the perceptions and development of caring relationships, value of the caring relationship, professional nurses' perceptions of the impact of the nursing shortage on caring and the non-traditional student.

Historical Evolution of Caring in Nursing

The word *caring* is rooted in a philosophy of nurturing and healing. Caring for children, elderly, and the sick has been a part of every culture since the beginning of time, and considered a natural occurrence (Kelly & Joel, 2003; Leininger, 2002; Montgomery, 1993; Nightingale, 1859, 1992). In a composite of her thoughts, Nightingale (1859/1992) wrote:

> Every woman, or at least almost every woman, in England has at one time or another in her life been in charge of the personal health of somebody, child or invalid. Or in other words, every woman is a nurse. (p. 8)

Nightingale, referring to the work of caring for the ill and injured, used the word nursing for "want of a better" word (p. 6). From that time on, the act of caring for the sick and injured has been referred to as nursing. Until the feminist movement of the 1980s, nurses were considered subservient to physicians. Kuhse (1997) wrote about the historical shift in the meaning of the word "nurse" from "substitute mother," "obedient soldier," and "subservient handmaiden," to the present view as advocates on behalf of patients' rights and well-being (p. 23). The feminist movement of the 1980s brought about changes in the role of nurses from one of obedience to the physician to advocate for the patient. Views of the role of the professional registered nurse have expanded to include several essential features. The American Nurses Association (2003) identifies these features as:

> (a) provision of a caring relationship that facilitates health and healing; (b) attention to the range of human experience and responses to health and illness within the physical and social environments; (c) integration of objective data with knowledge gained from an appreciation of the patient or group's subjective experience; (d) application of scientific knowledge to the processes of diagnosis and treatment through the use of judgment and

> critical thinking; (e) advancement of professional nursing knowledge through scholarly inquiry; and (f) influence on social and public policy to promote social justice. (p. 5)

Internationally, the role of the nurse is much broader:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in-patient and health systems management, and education are also key nursing roles. (International Council of Nurses, 2009, para. 1)

Although these contemporary views of nursing significantly expanded an understanding of the role and responsibility of the nurse, Watson (2008b) cautioned researchers not to oversimplify when describing the profession of nursing. She added that nursing is a "complex discipline that requires a delicate balance between scientific knowledge and humanistic practice behaviors" (p. 3) and; that, "Caring Science is the essence of nursing and the foundational disciplinary core of the profession" (p. 17).

In the classic philosophical essay, Mayeroff (1971) described the concept of care, its meaning and its addition to the comprehensive meaning and order to life. Mayeroff wrote about caring as "having a way of ordering other values and activities around it" (p. 3). His thoughts emphasized that caring is a mutual and intertwined interaction that benefits both parties in the relationship. He wrote, "The concept of caring and being in place with the world provides us with the ability to understand our own lives better" (p. 30). He explained that when an individual enters into a caring relationship for the purpose of serving the other, the individual lives out the meaning of his/her own life.

Mayeroff called this process "the basic pattern of caring" (p. 11). It has four steps. First, the person encounters an idea, ideal, or person who becomes the object of caring. The caring person takes ownership of the need to care for the idea, ideal, or person. The intention of caring directed toward another person is growth and actualization of potential. Independence and growth are key elements of positive relationships. Second, persons receiving care must be free to grow in their own right. Caregivers must not force their own values or ideas on the care recipients; hence, they foster autonomy. Third, during the caring relationship, caregivers show the receivers that they are valued as unique individuals and are worthy of the caring given by another. In a complementary way, caregivers receive a sense of well-being from helping recipients to mature or grow. Fourth, caregivers communicate to the receivers that they have the right to autonomous decision making. Mayeroff described this concept as responding affirmatively when giving direction and assistance while following at a distance. Mayeroff advised caregivers to be careful not to be so distant as to lose touch with the person. Above all, caregivers must proceed with a sense of devotion and commitment to the other person.

The eight critical elements of caring include "knowing, alternating rhythms, patience, honesty, trust, humility, hope and courage" (Mayeroff, 1971, p. 19-35). A further description of each of these elements appears in Chapter III. The elements of knowing, courage, and patience are discussed further here since they are the subscales used as the framework of this study.

Mayeroff wrote that caring for someone was not a simple matter of "good intentions or warm regards" (1971, p. 19). Caring included all aspects of knowing. First, the caregiver must know and understand the other person. An assessment of the person is required to identify limitations, strengths, and growth needed. Second, in order to respond accordingly to the other's needs, caregivers must know their strengths and limitations. Next, caring involves knowing things explicitly and implicitly. Explicit knowing is being able to put what one knows into

words. Implicit knowing is something that one knows but cannot put into words. Further elements of knowing involve understanding the difference between knowing that something is so and knowing how to do something. A nurse, for example, may know the theory of caring or theories of the discipline but be unable to form a caring relationship. Mayeroff summarized by cautioning to restrict knowledge to not only what can be verbalized, but also to include everything that is known by using intuition, experience, deduction, and induction.

Mayeroff (1971) did not describe the concept of courage in the same detail as he did the other elements of caring. He simply wrote that it takes courage to go into the unknown. This courage is formed by insights based on experience, openness, and sensitivity to the present. No one can predict how the caring relationship will turn out. It takes risk to enter into the relationship, but it requires trust in the other's potential to grow and one's own ability to care when entering the unknown. Mayeroff concluded, "The greater the sense of going into the unknown, the more courage is called for in caring" (p. 35).

Patience was described as "enabling others to grow in their own time and in their own ways. The growth of a significant idea can no more be forced than the growth of a flower or child" (Mayeroff, 1971, p. 23). If we are impatient with others and with ourselves, we may lose sight of various ways to resolve a problem. Impatience and worry are dysfunctional phenomena that result in decreased focus and productivity. People need time to think and reflect in order to develop creative progress with their situations. Mayeroff illustrated the concept of giving the other person space to learn and grow: "A patient man enlarges the other's living room, whereas the impatient man narrows it" (p. 24). He emphasized caring for and being patient with oneself: "Give oneself a chance to learn, to see and to discover both the other and myself" (p. 24).

According to Mayeroff, one of the most important facets of caring was care of the self. He distinguished this caring from egocentricity because there is no preoccupation with

admiration by others. He suggested that those who are unable to care for themselves are unable to care for others. He concluded that when we understand what the role of caring means in our own lives, we realize how essential caring is to the universal human condition. He shared that meaning in life relates directly to the feelings of being needed, being cared for, and being understood.

Mayeroff's essay on caring has been used to develop nursing curriculum (Fusa, Hayama & Misao, 1997), to design models of care delivery (Boykin & Schoenhofer, 2001; Hardin & Kaplow, 2005), and to develop measurement tools for use in contemporary healthcare settings (Cavanaugh & Simmons, 1997; Nkongho, 1990; Simmons & Cavanaugh, 2000).

Nkongho (1990) used Mayeroff's work with a Review of the Related Literature and interviews to develop the Caring Ability Inventory (see Appendix B). The Caring Ability Inventory (CAI) measures a person's ability to form caring relationships with others (Beck, 1999; Strickland & Dilorio, 2003; Watson, 2008). The development of the CAI is discussed in detail in Chapter III. Numerous researchers have utilized the CAI to determine a person's ability to form caring relationships with others (Baird, 1996; Cavanaugh & Simmons, 1997; Davenport, 1999; Higgins, 1993; Nkongho, 1998; Nkongho1990; Simmons & Cavanaugh, 2003; Simmons & Cavanaugh, 2000).

The American Association of Critical-Care Nurses (AACN) utilized Mayeroff's philosophy on caring as a framework to develop the Synergy Model for Patient Care (Hardin & Kaplow, 2005). The model is based on the premise that the care-giving nurse and the person receiving care join in an interactive process that facilitates growth and transforms each person to a higher level of being in the healing process. The nurse, working at the highest level in the Synergy Model, facilitates the nurse-patient relationship with an intentional caring consciousness. Currently, Mayeroff's framework is being used also for an ongoing research

project involving all registered nurses (n = 285) in a 194 bed acute care, for profit, facility. The purpose of this project was to "focus on grounding the entire healthcare system in caring values and implementing and evaluating nursing as caring on all units" (Pross, Boykin, Hilton, & Gabuat, 2010, p. 142).

In 1978, a group of nurse researchers met with Dr. Madeleine Leininger at the University of Utah in Salt Lake City. As a result of that meeting, the group founded the National Caring Research Conference Group to provide nurses with a direction for research on the concept of caring. Annual research conferences focused on the following major goals:

- To identify major philosophical, epistemological and professional dimensions of care and caring to advance the body of knowledge that constitutes nursing and to help other disciplines use care and caring knowledge in human relationships.
- To explicate the nature, scope, and functions of care and caring, and its relationship to nursing.
- To identify the major components, processes and patterns of care and caring in relationship to nursing.
- To stimulate and support nurse scholars worldwide to systematically investigate care and caring and to share findings with colleagues.
- To share knowledge through publications and public forums. (Boykin & Schoenhofer, 2001, p. xiii)

This group of nurse researchers has met annually since 1978 in support of these major organizational goals. In 1989, the National Caring Research Conference became known as the International Association for Human Caring. The core philosophy of this association is the belief that "caring is the essence of nursing and that caring is the unique and unifying focus of the profession" (International Association for Human Caring, 2009, p. 1).

According to Boykin and Schoenhofer (2001), major philosophical, diverse, and transcultural perspectives of caring were developed by researchers in this group. Later research by members of the group involved analysis of concepts of care and caring as they related to caring practices. This work reflected the perceptions of nurse behaviors by nurses and patients. From this research, a model for caring as a norm for practice, the concept of organizational caring, and methods of inquiry evolved (Leininger, 2002;Watson, 2008b). The group's founder, Dr. Madeleine Leininger, initiated one of the major research efforts on caring. Leininger's contributions to the cultural meaning of healing and health have significantly influenced the profession over the past several decades. The goal of Leininger's (2002) theory was for nurses to recognize, understand, and provide culturally sensitive care to diverse populations of patients. The AACN (2008) strongly supported Leininger's work by stating that "caring is a concept central to professional nursing practice where the nurse and patient work together toward an understanding of a wide variety of physical, psychosocial, cultural and spiritual needs, health-illness decisions, and life challenges" (p. 27).

Another prominent member of the Caring Research Conference Group was Dr. Jean Watson (1985) who developed one of the most comprehensive, relevant, and timely nursing theories on caring. Watson (2008b), a nursing theorist and philosopher, researched and published work about caring in nursing over a 30-year span. Like Mayeroff (1971), Watson agreed that nurses must care for themselves before being able to care for others. She wrote that caring begins with being present, open to compassion, mercy, gentleness, loving-kindness, and equanimity toward and with self before one can offer compassionate caring to others (2008). Her basic premise was that caring potentiates healing. Not only has her work on the concept of caring continued, but the basic premise has remained unchanged.

The combination of the humanistic aspects of nursing coupled with the scientific knowledge needed to provide professional and competent nursing care offer a challenging curriculum to learn and internalize. Watson's theory consistently emphasized nursing's challenge of providing humanistic care while knowing and practicing scientific knowledge. Her concern was that nurses needed to create ways to maintain human context while they allowed for the advancement of knowledge, technology, and the changing healthcare system. She contended that nurses need a broad educational background to develop a repertoire of strategies to create a nurse-patient relationship that facilitates healing.

Watson (2008b) viewed nursing as "a human science and an art that cannot be measured quantitatively with traditional, reductionistic, scientific methodology" (p. 2). Watson also clarified the difference between the caring of nursing and the curing of medicine. To elaborate on the difference, she wrote that while curing is the endorsement of the physician's identity, caring is the identity of the professional nurse. She concurred with Nightingale's philosophy that nursing is a "calling with values essential to sustaining compassion, commitment, and caring in instances where people and society are threatened" (Nightingale, 1859/1992, p. 82). As a result, the carative factors became "the core of nursing philosophy and science and provided a framework to hold the profession of nursing to a deeper vision and ethical commitment to the human dimension of caring in nursing" (Watson, 2008b, p. 30) (see Appendix C). Since then, the concept of the carative factors has evolved into 10 basic concepts Watson refers to as caritas processes (see Appendix D). *Caritas* is Latin for charity or altruistic love. Watson defines caritas nursing as interactions with patients who are humane, significant and caring. These include directions to "practice loving kindness," "develop helping-trusting-caring relationships," "use creative scientific problem-solving methods for caring decision making," and to be "open to mystery and allow miracles to enter" (Watson, 2008b).

In development and evolution of these concepts, Watson accomplished the goal of separating the curative aspects of medicine from the carative aspects of nursing. These caritas processes provide a framework used extensively in theory-based practice models and research. Along with copious metaphysical, human behavioral, phenomenological, existential and spiritual research, and an orientation to Eastern philosophy, Watson (2008b) based her theory on five major concepts:

> (a) Relational Caring as ethical-moral-philosophical values-guided foundation (b) Caring core: Ten Carative Factors/Caritas Processes, (c) Transpersonal Caring Moment-Caring Field, (d) caring as consciousness-energy-intentionality-human presence, and (e) Caring-Healing modalities. (p. 30)

Watson (2007) quoted Warburton Goodrich to introduce nursing as a human science and to clarify that nurses must be caring in order to fulfill their role:

> To effectively interpret the truly great role that has been assigned her, neither a liberal education nor a high degree of technical skill will suffice. The nurse must be a master of two tongues, the tongue of science and that of the people. (p. 13)

In spite of the plethora of research about caring, nurses and nurse researchers have not agreed on a common description of caring. Barnum (1998) wrote that nurses have three discrete meanings for care or caring. First, the physical activity of caring for or taking care of someone is demonstrated when the nurse meets the patient's physical needs. Second, caring is the attitude or emotional investment required of the nurse in facilitating a patient's well-being. Third, caring is expressed in the competency of the nurse in being judicious and behaving in a way that keeps the patient safe from injury. Nurses, in fulfilling their professional responsibility to patients, consistently practice all three ways of caring simultaneously. However, it is possible to fragment care by, for example, being careful and competent with the patient while not being emotionally

engaged. The interrelationships of these meanings of caring in nursing make the debate about the definition of caring fragmented and limited (Barnum, 1998).

Finfgeld-Connett (2008) agreed that the concept of caring has not yet been clearly conceptualized. Using an inductive meta-analysis approach to determine how caring is understood in nursing, an extensive Review of the Nursing Literature from 1988 to 2006 was completed. The researcher found 534 qualitative studies and concept analyses on the concept of caring (Finfgeld-Connett, 2008). These findings revealed caring in nursing as "an interpersonal process characterized by expert nursing, interpersonal sensitivity and intimate relationships" (p. 198). The findings suggested, in order for the caring relationship to enhance well-being for the patient, the nurse must have feelings that the patient is in need of care and the patient must have openness to and desire that care. With regard to the nurse, findings revealed that professional maturity, moral underpinnings, and a work environment conducive to caring are preconditions to internalizing caring behaviors.

The AACN describes caring in nursing as, "empathy for, connection to, and being with the patient, as well as the ability to translate these affective characteristics into compassionate, sensitive, and patient-centered care" (AACN, 2009, p. 8). Historically, nurses have provided a type of intimate care for patients not afforded to any other profession. It is in this situation that nurses and patients create unique nurse-patient relationships. Through this relationship, the nurse and patient work toward an understanding of a wide variety of physical, psychosocial, cultural and spiritual needs, health-illness decisions, and life challenges. "Professional nursing requires a balance between evidence-based knowledge, skills, and attitudes and professional confidence, maturity, caring, and compassion."

Dimensions of Caring

Examining the concept of caring is a complex task. Part of the difficulty in describing care and caring is that factors such as professional setting, culture, gender, professional role, and personal experiences influence the dimensions of caring behaviors. Caring dimensions are also specific to the various roles of the nurse such as caring for, caring about, or providing care. Professional nursing has a long tradition of high public respect according to the most recent Gallup Poll (American Association of Colleges of Nursing, 2009; Saad, 2006). Caring is what Hudacek (2008) reported as the basis for why nurses garner public trust and support. Hudacek (2008) completed a qualitative, phenomenological study of 200 international nurses' stories to identify and describe the dimensions of caring in nursing. Each nurse was asked, "Describe one caring practice that made a difference in your life and in the life process of a patient that you have cared for in your nursing career" (p. 125). Using the assumption that caring is the core of nursing; Hudacek's work verified that those caring behaviors by nurses that helped patients regain and improve their health are the "heart of nursing" (p. 126). The findings revealed seven dimensions of caring unique to nursing. The seven dimensions included "caring, compassion, spirituality, community outreach, providing comfort, crisis intervention, and going the extra distance" (p. 128). The following is a brief summary of each of the seven dimensions of caring that are unique to nursing.

The first dimension Hudacek (2008) described is caring as "a gift and talent" (p. 126). According to nurses in Hudacek's study, caring is the core of nursing. Stories about how nurses developed relationships with patients and families during end of life care, how nursing changed them as persons, and how dealing with the ethical issues of birth, life, and death broadened their personal perspectives about what nurses do every day to care for their patients. From a

conceptual perspective, the author fails to explain how *caring* is identified as a dimension of the construct of caring.

Compassion, as described by Hudacek (2008), included nurses using empathetic concern that went beyond skills and techniques to relieve suffering and pain. International nurses' detailed examples of compassionate concern led to accepting the international aspect of compassion in Hudacek's results. Many examples were about the compassion required of nurses in caring for women and children in serious healthcare situations. For example, Roberta was a 19 year old single mother whose baby did not survive delivery. The nurse describes how the funeral for this baby touched her personally and professionally.

According to Hudacek (2008), when patients are in crisis, religion and spirituality become a central need. Nurses recognized and developed specific plans to manage spiritual needs. There were stories also of nurses relying on guidance by a higher power to do their work. Findings revealed the spirituality of both the nurses and their patients. Patients asked nurses to pray with them, bring them a Bible, or to pray for their survival through labor and for a healthy baby. The nurses discussed health promotion and teaching in the community when they described their stories. Examples often chronicled nurses caring for the disadvantaged or those in unsafe situations or neighborhoods. They intervened when patients had no help or advocate. For example, a 21-year-old Vietnamese man had an uncorrected cleft lip and palate, and because of this defect, he had never left his home. The nurse arranged for healthcare and corrective surgery; hence, he became an accepted, productive person in his community.

Nurses who comforted dying patients and helped them to maintain dignity at the end of life shared stories of deep and profound conversations with the patient and the family, oftentimes, helping the patient to maintain life until a special person came to say goodbye or a

family issue was resolved. They also reported interacting with dying patients as they heard the voice of or saw a deceased loved one, angels, or experienced premonitions of impending death.

Another dimension frequently reported by the nurses in Hudacek's study was crisis intervention. This dimension dealt with nurses' behaviors in unexpected life and death circumstances that required quick thinking and broad-based, current scientific knowledge that resulted in a positive outcome. The narratives of nurses who saved lives and helped people to return home to normal functioning posited this dimension of caring.

The final dimension dealt with "going the extra distance" (Hudacek, 2008, p.128). The narratives detailed how nurses gave extra time, personal resources, and accommodations in order to make someone else's life better. The nurses described the way that respect for a patient's uniqueness and specialness gave purpose to their work. One nurse told of a young mother and her newborn discharged from the hospital with only 30 cents in the mother's wallet. After sharing this situation with other members on the unit, within minutes the staff offered their lunch money and sent this young woman and her infant home with $60.00.

Hudacek suggests that the research findings offer insight into the dimensions of caring. The findings of Hudacek's study revealed nurses as "unique caregivers that make a difference in patient's lives" (2008, p. 125) as part of routine nursing practice.

Caring Behaviors

Watson (1985, 2002, 2008b) defined caring as a complex interaction of factors and processes that enhance the development of a special kind of relationship between the nurse and the patient and family. Based on this definition Watson's life-long work evolved into what she identified as Clinical Caritas Processes (see Appendix D). These processes illuminated the science of human caring from the perceptions of nurses, patients, and families and identified perceptions of caring behaviors. In order to understand the nurse-patient relationship an

awareness of these perceptions is beneficial. Rafael (2000) suggested, "Establishing a helping-trusting nurse-patient relationship is pivotal" (p. 36) to Watson's theory of caring and can serve as a framework for nurses in the community as well as the hospital.

In 1984, Larson developed the first quantitative tool to measure caring behaviors by surveying nurses and patients on their perceptions of caring behaviors. The Caring Assessment Report Evaluation Q-sort (CARE-Q) comprised 50 items identified by patients as caring behaviors of nurses (see Appendix E). The behaviors were ordered into six subscales: is access; offers comforts; anticipates needs; establishes a trusting relationship; monitors and follows through; and, is spiritual, subsequently added to the tool. Using Q-Sort methods, nurses and patients ranked 50 behaviors in response to the question, "In order for you to feel cared for, how important is it for the staff . . . ?" (Watson, 2009, p. 41). The tool has been adapted for use by Chinese and Swiss populations. Larson, joined by Ferketich, redesigned the CARE-Q into a caring satisfaction instrument (CARE-SAT) that measured patient satisfaction with nursing care (as cited in Watson, 2009, p. 28).

Caring is in the eyes of the beholder. Khademian and Vizeshfar (2008) wrote, "Care is a difficult entity to explain," and "care is a prime example of emotion, thought, and action coming together to provide physical and emotional comfort" (p. 456). They investigated nursing students' perceptions of the importance of caring behaviors about cultural aspects. The participants (n = 120) were recruited from a university-based nursing program in Iran. They were administered the CARE-Q and asked the question, "In order to make patients feel cared for, how important is it that staff . . . ?" (p. 458).

According to Khademian and Vizeshfar's (2008) findings, students perceived practical and cognitive caring behaviors as the most important and emotional behaviors as the least important. The findings are in contrast to other studies of caring and may be due to cultural

differences. They confirmed that their findings were consistent with the premise of Leininger's (2002) theory that care is unique and diverse within one's culture. These findings have implications for nursing programs who serve diverse populations where the expression of caring may be culturally biased.

Karaoz (2005) studied Turkish students (n = 39) in their last year of an undergraduate nursing program. Students discussed incidents where they observed nursing behaviors conducted in caring and non-caring ways. Follow-up interviews explored and validated the behaviors written about in the incidents. Two major groups of behaviors emerged from the data: professional helping relationships and technical competency. Respect, concern, compassion, communication, and comfort characterized professional helping relationships. Caring viewed within the area of technical competency encompassed activities related to technical procedures. Seven students reported that they did not observe any caring behaviors. The authors suggested that nurse educators become aware of such perceptions and actively seek experiences where the student can learn the process of developing a caring nurse-patient relationship (Karaoz, 2005).

Caring Efficacy

Bandura (1977), a social psychologist, first described self-efficacy during the development of his self-efficacy theory. He described self-efficacy as people's belief about their capabilities to produce designated levels of performance that exercise influence over events that influence their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves, behave and are developed through four major processes; cognitive, motivational, affective, and selection (Bandura, 1998). Coates (1997) used Bandura's self-efficacy work and Watson's (1985) theory of transpersonal human caring as a conceptual basis for developing the Caring Efficacy Scale (CES) that measures one's beliefs about the capability of caring. Coates (1997) described caring efficacy as, "The belief that one has the underlying cognition and

attitudes as well as the behavioral and motivational repertoire to produce results in a desired direction" (p. 53). The instrument was first used to assess caring efficacy as an outcome of the nursing curriculum at the University Of Colorado School Of Nursing (Watson, 2009).

Using a cross-sectional sample of baccalaureate nursing students (*n* = 193) that ranged from pre-nursing to graduating seniors, Sadler (2003) measured caring efficacy using the CES. After completion of the CES, the participants were asked to respond to the questions, "To what do you attribute the greatest contribution to your development of caring?" and "What event, person and/or situation shaped your development of caring?" (p. 297). There were no statistical differences in mean scores among the groups. A Pearson correlation revealed no statically significant relationship between score and class. The CES can be given in two formats, Form A and Form B. The difference in the two forms is the number of negatively and positively worded items. Out of 30 items, Form A has 23 positively worded items and seven negatively worded items. Form B consists of 30 items of comparable content that are balanced between positively and negatively worded items. The senior students (*n* = 28) were given the CES twice using both forms of the CES. The scores between the two forms were highly correlated (r = 0.937, p = .000), and there was no statistically significant difference between the two (p = 0.063). Sadler reported that findings supported the concept that something other than the curriculum helps students develop caring efficacy, and, that even before they enter a nursing program, their caring efficacy was high. The majority of the senior students (*n* = 18) when interviewed, reported the role modeling of their parents and family as contributing to their development of caring. Two students reported negative experiences within their families that required intentional effort to develop caring behaviors. Five students reported that work or personal experiences also helped them and four reported that the nursing curriculum contributed to their caring ability.

Variability for the first-semester sophomore class was the lowest. Sadler suggests that this related to students' response to their ideal or didactic information. Analysis of data from the subjects in the second semester, where Sadler reports that the variability was the greatest, suggested that "students were beginning to question and test their definitions while integrating caring within their conceptualization of nursing and self. In the group of senior students, variability decreased to near the levels of first semester students" (Sadler, 2003, p. 298). There was no explanation or reason reported for this decrease. Findings from the survey and written responses support the data that students accredit the influence of their families as the primary factor in their development of the ability to form caring relationships.

Perceptions of Caring Relationships

The caring nurse-patient relationship is a complex, dynamic concept that relates to the role of the person describing it. Nursing scholars describe the processes involved in what a caring relationship should entail (Gámez, 2009; Halldórsdóttir, 2008; Peplau, 1952, 1992). Researchers such as Disley and McCormack (2002); Dowling (2004); and Warelow, Edward, and Vinek (2008) studied patients' perception of the caring relationship and found there were differences in perceptions between patients and nurses. Patients tended to be attracted to nurses with pleasant personalities, positive attitudes, and the ability to listen and maintain confidentiality. On the other hand, nurses believed that the caring relationship should entail competency, getting work done on time, and listening.

Berg, Skott, and Danielson (2007) and O'Connell (2008) investigated professional nurses' and patients' perception of the caring nurse-patient relationship. Patients' perceptions of caring nurses included those who maintain their dignity, know what to do, project a pleasant personality, keep patients from feeling exposed, exude confidence, works as part of a team, and encourage participation in the plan of care. Nurses in these studies described caring as using

one's own competence, being aware of their own limitations, forming caring relationships in strained situations and being aware of what is needed. Wilkes and Wallis (1998) stated that, "research into caring from the perspective of nursing students was poorly documented" (p. 582). From the findings of their study, they reported they could develop a model of professional nurse caring from the perspective of the nursing student. Additionally, Khademian and Vizeshfar (2008) used a longitudinal design to explore student nurses' perceptions of the importance of caring relationships. Ninety nursing students in Iran responded to 55 items on the Caring Assessment Questionnaire. Caring behaviors fell into seven subscales, comforts, anticipates, trusting relationship, and spiritual care. These students perceived practical and cognitive caring behaviors such as, monitoring and following through, plus, giving patient treatments and medications on time, as the most important caring behaviors. Emotional behaviors such as development of a trusting relationship and voluntarily doing little things for their patient were perceived as the least important caring behaviors. Two factors, explains and facilitates, correlated with age of the respondent and year in the program. The researchers reported data might suggest a cultural preference. The data reported on the emotional and trusting relationship requires further research.

Theoretical Perceptions of Caring Relationships

Peplau (1952, 1992) was the first nursing theorist to introduce a theoretical framework for what she initially called the nurse-client relationship. This terminology became known in contemporary nursing as the nurse-patient relationship. Peplau's (1952) framework identified the nurse-patient relationship as key to the nursing process. The nurse assumes the roles of resource person, counselor/teacher, surrogate and technical expert. Peplau (1952) wrote that this relationship developed through the phases of orientation, identification, exploitation, and resolution. The process begins when a patient becomes ill and seeks medical assistance. Patient

and nurse get to know each other during the orientation phase. This phase requires the nurse to possess an in-depth knowledge about the cultural, ethical, and personal values of the nurse and the patient. Identification is the phase where patients begin to develop trust and identify their role in the healing process. The medical team identifies the patient problem and begins to develop a plan for resolution. When patients find nurses who understand their problem, and with whom they can identify, they begin the exploitation phase. They view the nurse as someone who can help them obtain the necessary resources to facilitate the healing process. During resolution, patients put aside old needs that have been resolved and develop new goals for their life situation. These phases are overlapping, dynamic, and essential during the process of the nurse-patient relationship. Peplau (1952) stated, "The behavior of the nurse-as-a-person interacting with the patient-as-a-person has a significant impact on the patient's well-being and the quality and outcome of nursing care" (p. 14).

Gámez (2009) completed a Review of the Literature to explore how nurse-patient relationships as caring relationships were described. Gámez reported finding only a few studies regarding healthcare professionals and patient relationships and even fewer studies that analyzed the role of the nurse in nurse-patient relationships. The focus of these studies was primarily limited to the communication and ethical aspects of the nurse-patient relationship. Gámez's suggested that the nurse-patient relationship and its importance and value in nursing need to be clarified and expanded. Gámez proposed a theoretical description of the nurse-patient relationship by synthesizing the elements identified by other nursing scholars. According the study completed by Gámez, "Nursing is the integral care of patients while in continual interaction with their environments" (p. 127). The relationship develops while helping patients with activities of daily living; with group, family, or individual therapy; and in a variety of settings including the home, hospital, outpatient care, or community. "The activity of caring is

carried out through the nurse-patient relationship and is concentrated on the needs, limitations, and potentials of the patient" (p. 127).

Halldórsdóttir's (2008) theory on the dynamics of the nurse-patient relationship is one of the most comprehensive descriptions of the need for and the development of caring relationships between nurses and patients. The theory builds on the premise that the functional tasks of nursing take place within the context of the nurse-patient relationship, which depending on the quality of the relationship, can hinder or help patients in healing and overall health.

Halldórsdóttir's (1991) earlier research identified five modes of nurse-patient relationships on a continuum of uncaring to caring. At one end of the continuum, the first mode, biocidic, is life destroying where care is depersonalized leading to loss of joy, anger, despair, and increased patient vulnerability. The stress, fear, and anxiety caused by this mode of interaction can be detrimental to health, such as having a negative impact on the patient's immune response. The second mode, biostatic, is life restraining and described as a cold relationship where care is insensitive or indifferent to the patient. This mode can lead to discouragement, uneasiness, and have a negative effect on one's life and wellness. A third mode, biopassive, was labeled life neutral or an apathetic or detached relationship. In this mode, the nurse has little impact, positive or negative, on the life of the patient. The fourth mode, bioactive or life sustaining, is a positive mode in which a kind and benevolent relationship is developed. Although this is a positive relationship, the patient does not benefit, nor does the relationship have an impact on the patient. Loving benevolence characterizes the fifth mode, which is the biogenic or life-giving relationship and which is the most positive and beneficial relationship. The mode of care is supportive of the patient's healing potential and manifests itself by the nurse being open, receptive, and respectful; there is an almost tangible connection between the nurse and patient. Patients responded positively to nurses described as life-giving.

From research spanning a 20-year period and drawing from psychoneuroimmunology research and the dynamics of human relationships, a comprehensive theory of the dynamics of the nurse-patient relationship was developed (Halldórsdóttir, 2008). Halldórsdóttir found several factors about the need for a caring nurse-patient relationship:

(a) a basic need of the human being is to be in a relationship with others,

(b) a physical and emotional need exists for the personal connection in the nurse-patient relationship,

(c) nurses must know themselves, care for themselves, and reflect upon how they regard and interact with other people. (p. 646)

Major concepts that emerged from Halldórsdóttir's research include the bridge, empowerment, health, the wall, disempowerment, and vulnerability.

> The bridge: perceived openness in communication and the connectedness experienced by the recipient of nursing care
>
> Empowerment: sense of well-being and health
>
> Health: contextual multifaceted lived reality involving a physical, mental, emotional, spiritual, social and societal dimension. Perception can be increased or decreased by actions of the individual or others.
>
> The wall: perceived disconnect between the nurse and the patient. Results from a perceived incompetence and uncaring the patient does not trust the nurse and there develops a mutual avoidance. The wall has discouraging or disempowering effects on the patient.
>
> Disempowerment: decreased sense of well –being and health - sense of being broken down in some way.

> Vulnerability: The patient's sense of self. Being easily hurt and easily set off balance, as well as easily encourage or supported, i.e. easily empowered or disempowered. (p. 645)

According to Halldórsdóttir, these concepts all affect the patient's ability to connect with the nurse in a life-giving way that influences the patient positively.

Patient Perceptions of the Caring Relationship

Peplau (1952) referred to patient expectations when she described the phases in the development of a nurse-patient relationship. According to Peplau, the nurse symbolizes acceptance and assistance to patients in times of stress. Patients expect nurses to demonstrate behaviors that manifest caring, and they selectively respond to nurses who seem to offer the help needed. Patients whose nurses were cheerful, optimistic, and helpful identified with these attitudes and took them on themselves. In this type of environment patients reported that their feelings of helplessness, powerlessness, and dependence were minimized.

Halldórsdóttir (2008) also recognized the patient's perspective in the development of the dynamics of the nurse-patient relationship theory. Patients reported that the nurse-patient relationship was of great importance to their feelings of well-being and progress toward healing. Excerpts from dialogues with former patients described a caring relationship:

> I am not sure how to put it other than personal relationship; the sense is somehow that your and my spirits have met in the experience, and the whole idea that there is somebody in that hospital who is with me, rather than working on me. You know, there is that kind of bonding, that kind of feeling . . . of not intimacy but at least connection, there has been a connection, which I could then, follow-up on; you know would feel free to do so. (p. 643)

The most empowering relationship with health care providers is the life-giving nurse-patient relationship. Quotes of patients that describe the life-giving nurse include, "They seem to be illuminated with the consciousness of spiritual knowledge and filled with genuine caring. Their thoughts seem to be full of loving-kindness, compassion and love for their fellow beings" (p. 650). Halldórsdóttir added:

> The results of the study demonstrate that the core characteristic of the nurse-patient relationship, from the patient's perspective, is that it is a dynamic lived reality characterized by a sense of spiritual connection, which is experienced as a bond made of energy that some former patients have described as a bond of light. (p. 645)

Halldórsdóttir's (2008) findings from patient data revealed prerequisite characteristics of the nurse that exist to enhance the development of a positive nurse-patient relationship. Patients described characteristics of the nurse that would facilitate the development of the nurse-patient relationship as: genuinely caring for them as people and as patients; being competent in skills and connecting with patients; and, having professional wisdom, described as having a combination of knowledge and experience. Patients believed that the nurse-patient relationship involved two opposite processes: closeness and connectedness; and, the distance needed to maintain respect and compassion. To describe this concept of closeness as well as distance, Halldórsdóttir used the metaphor of a bridge. Patients described caring, competent, and wise nurses who created a sense of trust that facilitated the nurse-patient relationship. When patients perceived nurses as uncaring, incompetent, or unwise, patients were less likely to develop the trust needed for a quality interaction between nurses and patients. In such instances, patients withdrew from communication or tried to avoid uncaring nurses, perhaps at the cost of meeting their own healthcare needs.

Disley and McCormack (2002) explored the continuum of caring and uncaring using a guided reflection narrative written from personal experience as patients. Using Halldórsdóttir's (2008) theoretical framework to guide analysis, key elements of caring and uncaring identified in the content analysis were consistent with the categories posited by Halldórsdóttir (2008). Disley and McCormack wrote that encounters with caring nurses gave patients, "a sense of fulfillment, companionship, being in control, peace and feeling valued" (p. 33). These encounters gave a feeling of warmth inside, offering hope and a sense of well-being. On the other hand, uncaring encounters lead to fear, distrust, and a sense of uneasiness about the motives of the staff. Disley and McCormack described these experiences as feeling unheard, being treated as an object, or as a burden to the nurses. These experiences conjured up feelings of aloneness, fright, discouragement, and brokenness, "like one without hope" (p. 34). Further description of these encounters included that the "nurses' heart was not in caring; there was no engagement or connection" (p. 34). Disley and McCormack concluded that when the patient percieved being undervalued, a loss of hope, or disrespected, these feelings might be as detrimental to the patients' health status as the physical illness. Disley and McCormack's results were consistent with Halldórsdóttir's findings. Patients need to feel cared for, safe, and secure in knowing their nurses are competent.

Warelow, Edward, and Vinek, (2008) conducted an in-depth synthesis of contemporary nurse theorists' descriptions about caring nurse-patient relationships as it relates to practice. When taking into consideration the economical and financial constraints of healthcare in Canada and Australia, the results revealed that a paradox exists for nurses. The nurses in the Warelow, et al. study reported caring relationships that set up the conditions of trust where the patient can accept and benefit from the nurses caring take time. In the current healthcare environment where there is a shortage of nurses and the institution is assigning a higher nurse patient ratios, nurses in

this same study discussed feeling as though they are unable to take the time needed to establish the nurse patient relationship. Increased demands for professional staff to accomplish work sets the stage for the frustration expressed by participants in Warlow, et al. The Canadian Nurses Association and the Australian Nursing Federation recognize that current patient care workloads are, at times, so heavy that nurses are unable to develop therapeutic relationships, complete necessary patient assessments, or seek necessary expertise or additional resources (Warelow, et al., 2008).

The researchers consider caring as the basis of the nurse-patient relationship. A caring nurse-patient relationship gives patients a sense of stability, resulting in openness and accessibility, a sense of belonging, and a feeling of comfort in knowing that nurses are there to help them. A caring relationship establishes the trust that enables patients to accept the help offered by nurses. For this trust to occur, patients must sense that nurses accept them without judgment regarding their lifestyle, sexual preferences, employment, diagnosis, and risk factors (Warelow, et al., 2008). When patients in this synthesis reported feeling safe, they shared their problems, thus facilitating the work of nurses to develop a plan for resolution and wellness.

In describing nurse-patient relationships, Warlow, et al. (2008) reports that patients viewed the relationship as providing a connectedness that enabled them to discern problems, recognize possible solutions, and implement a plan for resolution. Given the personal, private, and intimate closeness that often occurs during the nurse-patient care activities, patients deemed themselves especially vulnerable and expected respect and the preservation of their dignity and worth as human beings during any such encounter. This vulnerability requires a level of trust that the nurse will serve their best interest. Because of the complexity of human behavior shaped, in part, by family, culture, past experiences, and education, it is difficult to describe, define, measure, or standardize the relationship without considering the influence these variables

have on human-to-human interactions. Although data reported by Warlow, et al. (2008) supported the premise that caring was essential to nursing and to the nurse-patient relationship, concern was expressed that with the current environment in healthcare, nurses may be forced to become more involved with the tasks of their job rather than focusing on the more complex care needs of individual patients. Others report that nurses continue to strive to establish trusting nurse-patient relationships out of moral duty in spite of time constraints and increased patient workloads (Berg, Skott, & Danielson, 2006; Dowling, 2004).

In a study that used interview methods, Berg and Danielson (2007) asked patients to relate their experiences of caring relationships. They asked, "Please tell me about your experiences of being a patient and receiving nursing care" (p. 501). Additional questions such as, "Could you give me an example?" or "Could you elaborate on that?" elicited specific details from participants (p. 501). Using the values that patients espouse, themes that emerged were maintenance of dignity and trust, and feeling cared for by enthusiastic, welcoming personnel who had the ability to listen. In a strained situation, patients wanted to be in the care of nurses who were available, smiled, and were thoughtful. In uncaring encounters, their findings concur with other nurse scholars, who found that patients who were not able to establish a positive nurse-patient relationship, reported they experienced powerlessness, that their needs were unmet, and that they were not engaged with nurses (Disley & McCormack, 2002; Halldórsdóttir, 2008).

Berg and Danielson (2007) found that patients and nurses both strive for trust in the nurse-patient relationship; but that nurses in Berg and Danielson reported having limited time to form nurse-patient relationships because of acuity of the patients and increased nurse-patient ratios. When this occurs, nurses prioritize care with technical aspects of care considered first. Milton (2002) agrees that, "nurses appear to emphasize and value the completion of technical

tasks and procedures as their primary obligation" (p. 22). When the focus is on getting the job done and getting it done on time, nurse-patient contact is limited and not focused on patient relationships.

Professional Nurses' Perceptions of Caring Relationships

Investigations to determine professional nurses' perception of the caring nurse-patient relationship are rare. However, Pross, Boykin, Hilton, and Gabuat (2010) used Mayeroff's philosophy to describe practicing nurses' caring values of Knowing, Patience, and Courage. The Caring Ability Inventory (CAI) was completed by 187 registered nurses on an organization that had chosen caring values to guide their practice. The primary level of education for this group was the Associate Degree (57%)

When analyzing data, 39% scored high for Knowing, 20% scored high for Patience, 98.6% scored low for Courage, while none scored high in the Courage subscale. Pross, et al. (2010) state, "The process of living and growing in caring takes time, knowledge, patience, courage and ongoing commitment. Before nurses come to know patients or others as caring in nursing situations, they must first know themselves as caring persons." As a result of Pross, et al. results, administrators have chosen to support and provide nurses with the processes that facilitate knowing of self and others as caring by focusing on Knowing, Patience, and Courage.

A phenomenological study of nurses (n = 6) explored the meaning of the caring relationship in daily practice (Berg, et al., 2007). Similar to the results found with patient populations, the sample of nurses in Berg, et al. study were aware of the need to develop trust as a component of the caring relationship. Other themes identified were being compassionate, providing care in strained situations, and anticipating patient needs. In establishing trusting relationships, nurses expressed the importance of clinical competence in developing caring relationships in hectic environments. Berg, et al., also suggested that when nurses became

familiar with patients situations without being judgmental, they were able to accomplish active listening while performing routine tasks, to form caring relationships even during short contacts with patients. Awareness of the elements and limitations of developing trusting relationships with patients was important. Nurse participants wished for a private place where they could hold meetings with patients and families in order to have a deeper understanding of patients and their situations. Data from nurses in Berg, et al. affirmed that shortened lengths of stay and staff shortages affected their priorities and resulted in task-oriented care. Nurses reported being pleased when the patient or family recognized and affirmed their caring (Berg & Danielson, 2006).

Warlow, et al. (2008), also found that caring exists in the nurse-patient relationship even when patients did not always label it as such. Findings from Warlow, et al. data validated the concept that nurses are task orientated when their environment is not ideal. For example, when nurses had large patient assignments and numerous new admissions without a full complement of staff, this created a scenario where tasks, not relationships, became the priorities. A work environment where nurses have the time to focus on the complex care needs is necessary for entering into caring patient-relationships where patients' emotional and psychological needs are as important as tests and procedures. When this was not the case, patients perceived that their relationship or emotional needs went unmet.

O'Connell (2008) using a skilled companionship framework, studied the emotional intelligence required of a critical care nurse in forming therapeutic nurse-patient relationships. In this case, study, the nurse and patients' family used reflection and dialogue to examine the concepts of particularity, reciprocity, mutuality, and graceful care. O'Connell, the nurse reflected on her thoughts about her care for Sam, an 11-year old boy admitted with severe head injuries following a bike accident. The significant use of technology in the intensive care unit

facilitates assessment and getting to know the patient's response to treatment and physiological well-being. The fact that the patient was admitted to an intensive care unit, where staff-patient ratios tend to be 1:1 or 1:2, allowed Sam's nurse the time to get to know the patient and family, including their beliefs, values, and cultural norms related to health and illness. The nurse allowed the mother the opportunity to participate in Sam's care allowing mother and nurse to develop a bond and work together for the benefit of Sam. This action by the nurse facilitated leveling of the power structure in the nurse-patient relationship while validating the mother's ability to provide comfort and care for her son.

In developing care for Sam, O'Connell described using affective, cognitive, emotional, and activities to provide for his needs. For example, as the nurse and Sam's mother gave him a bath, they talked about his soccer team, school friends, and favorite activities. Because O'Connell had sons of her own, she shared personal experiences that helped Sam's mother open to her caring. This self-disclosure allowed the relationship to develop in a positive manner for Sam's mother but also open emotional vulnerability for the nurse when Sam died. O'Connell eluded that she did not know herself and her boundaries well enough to protect herself from excessive emotional vulnerability when Sam died. O'Connell concluded that the therapeutic nurse-patient relationship is central to the delivery of patient-focused care. O'Connell's study demonstrated that nurses who do not set boundaries in nurse-patient relationships could suffer emotional pain. O'Connell (2008) recommends, "Nurses focus on developing relationships that are mutually beneficial to both the nurse and the patient" (p. 142).

To describe professional nurses' perceptions of the trust necessary to develop caring nurse-patient relationships, Belcher and Jones (2009) using phenomenological methodology with beginning graduates ($N = 7$) in Australia explored their perceptions of the nurse-patient relationship. Based on the assumption that trust is a crucial element in establishing an effective

nurse-patient relationship, first year graduate nurses described their knowledge, understanding, and experience of trust in the nurse-patient relationship. The findings identified the components of trust that this population ascribe to the nurse-patient relationship. The nurses reported that trust was essential to initiate the relationship, and trust was having a commitment to provide the best care and in the process to be honest with patients and to maintain strict confidentiality. Themes that foster trust from a nurse perspective include building rapport, communicating effectively, having a good bedside manner, demonstrating competence, and taking time to develop a relationship.

In reporting about the communication process, Belcher and Jones (2009) found that nurses reported listening as an important component of the nurse-patient relationship and it applied to both nurses and patients. Participants in the study agreed that communication takes time, but is crucial to development of the caring relationship. Difficulty in establishing trust occurred when patients spoke different languages than the nurses as well as when nurses used medical terminology that the patient did not understand. Different cultural and health beliefs had an impact on establishing trust in caring nurse-patient relationships.

Personality of the nurse emerged as a theme reported by Belcher and Jones as "either hindering or enhancing the development of the nurse-patient relationship" (Belcher & Jones, 2009, p. 146). The findings suggest that a caring nurse-patient relationship is dependent on the unique personalities of nurses and patients. These findings are consistent with others who identified personality as a factor in such relationships (Dowling, 2004; Halldórsdóttir, 2008). Patients and nurses being comfortable with one other was a theme identified as important to the development of trust in the nurse-patient relationship. Being comfortable was defined as being honest, feeling confident, and having the ability to develop a relationship. Belcher and Jones (2009) reported that the emotional state of the nurse and level of fatigue as having an effect on

the nurse-patient relationship. This supports findings that when work demands were increased and nurses became fatigued and frustrated, they did not promote the nurse-patient relationship (Warelow, et al. (2008).

Experience as a nurse or previous healthcare experience was identified as another major factor important to ability to form caring relationships. Participants reported patients were more comfortable if they knew the nurse had some clinical experience. Norman, Rutledge, Keefer-Lynch, and Albeg (2008) in their exploratory study of nurse-written clinical narratives, also write that experience of the nurse is reflected in how nurses narrate clinical situations. Using Watson's Theory of Caring nurses described clinical events and their experiences in terms of caring. Their data suggested that the narratives of less experienced nurses (clinical nurse I) differed from the more experienced nurses (clinical nurse II) in that the more recent graduate described use of more caritas. In addition the clinical nurse III/IV also utilized more caritas in their descriptions. The researchers had expected to see a progression of use of caratis as described by Benner (2001) where behaviors are based on the five-stage model of adult skill acquisition (Dryfus, 1981).

Using a caring and holistic approach to bedside patient care and involving patients in their care were key findings (Belcher & Jones, 2009). Both approaches served to form a positive and caring nurse-patient relationship. All seven study participants reported this approach was not as well developed for them since they were new graduates and not very skilled. Belcher and Jones concluded that there is no doubt that new graduate nurses found the development of a trusting nurse-patient relationship a difficult aspect to achieve and recommended nursing educators facilitate learning in this area.

Participants reported that job satisfaction was a personal reward for being able to establish caring relationships with their patients. In addition, nurses cited feeling a sense of

clinical competence and confidence in the realm of patient care delivery as a benefit. When nurses did not have the knowledge or confidence to perform some procedures or answer some patient questions, they suffered nervousness, frustration, and decreased confidence. These negative feelings often resulted in actions that created distance between themselves and their patients. They reported feelings of providing inadequate care, which made them question their ability to be nurses. Caring nurse-patient relationships do not just benefit patients; the study findings identified job satisfaction as a positive outcome of nurse-patient relationships (Belcher & Jones, 2009).

Dowling (2004) completed a Review of the Literature to learn more about studies that examine the relationship between love, identity, and caring in the nurse-patient relationship. Love was found to be both essential to caring and simultaneously distinct from it. The term love suggests that nurses sometimes develop special relationships with certain patients. Caring, on the other hand, suggests an ethical and moral duty equally due to all patients. In reality, nurses may develop special relationships with certain patients because of special needs or length of stay, but this is different from the level of caring that all patients should expect to receive. Dowling's Literature Review indicated that the patients' personality, needs, and vulnerability draws the nurse toward or pushes the nurse away from the individual nurse-patient relationship.

Nursing Students' Perceptions of Caring Relationships

Several scholars who have examined the nursing student's perceptions of student-patient relationship report that students are able to form caring nurse-patient relationships only after they refute stereotyping and have mastery of technical skills (Suikkala & Leino-Kilpi, 2005; Suikkala, Leino-Kilpi, & Katajisto, 2008; Wolf, 2003). In a Literature Review from 1984 through 1998, Suikkala and Leino-Kilpi (2001) found little empirical research about student nurses' ability to form caring relationships. They reported findings that the relationship between student nurses

and patients was very complex and improved as students gained confidence and knowledge. The findings also illuminated the importance the student-patient relationship had on the student's professional growth. The Literature Review consistently showed that students reported that the nurse-patient relationship was important, but students reported feeling anxious and tense about how to establish such relationships. While working on required technical skills, students found it difficult to establish a caring nurse-patient relationship. Students reported that a lack of knowledge and skills created a barrier to the rapport needed to develop the caring nurse-patient relationship. As students experienced the day-to-day situations in nursing, they learned how to deal with circumstances that focused on the person instead of the skills, and developed increasing levels of confidence and self-esteem. Examples of the many factors reported in the literature that were associated with the development of the student-patient relationship included "the student's previous personal, educational, and clinical experiences, the characteristics of the patient, and the quality of the interaction between the student and the patient" (p. 48).

Suikkala and Leino-Kilpi (2005) interviewed students and patients in Finland (n = 60) to learn about the student-patient relationship. Content analysis revealed three types of relationships: mechanical; authoritative; and, facilitative. The mechanical type focuses on students' own learning needs, knowledge, and technical skill. Interactions were task related and directed by the supervisor or faculty. Students neither made a personal connection with the patient nor developed a student-patient relationship; patients were a means to learn the practice of nursing and to refine technical skills. The authoritative relationship focused on what students thought was best for the patient, not considering patient wishes or needs in plans of care. Students did not know patients well enough to act in a patient-orientated way. The facilitative relationship, on the other hand, was based on common good for both students and patients. The relationship focused on what patients needed from students; knowing each other well enough to

make a connection similar to that described by other researchers (Halldosdottir,2008; Leininger, 2002; Nightingale, 1992; Watson, 1985, 2008).

Suikkala and Leino-Kilpi (2005) identified various factors that were associated with promoting a positive student-patient relationship:

> (a) student-related factors such as personality characteristics, positive expectations and attitudes, intellect and interpersonal competence.
>
> (b) patient-related factors, such as personality characterized by positive frame of mind, favorable demographic and diagnostic characteristics, and positive expectations and attitudes.
>
> (c) length of time spent together for instance, patients' long length of stays, students' long clinical placements and primary care nursing systems.
>
> (d) atmosphere during the activity for example, good role models offered by staff nurses, supportive supervision relationship and positive and encouraging feedback from staff nurses. (p. 150)

Conversely, students who demonstrated the characteristics of shyness, negativity, low self-esteem and inability to deal with feelings and stress, or had negative or stereotyped attitudes about patients tended to focus on task-oriented learning; therefore, development of the relationship created a challenge. Students reported not being knowledgeable added another barrier to relationship development.

As a follow up, a study was conducted with nursing students (n = 310) to learn more about mechanistic, authoritative, and facilitative types of student-patient relationships (Suikkala, Leino-Kilpi, & Katajisto, 2008). "The purpose of this research was to describe students' perceptions of factors related to mechanistic, authoritative, and facilitative relationships between the nursing student and patient" (p. 546). Factors perceived by nursing students that related to

their ability to form caring student-patient relationships were age, current year of studies, support received from others, perception of patient's attributes, and the clinical environment (Table 1). The only student background variables that significantly predicted a facilitative relationship with patients were age and education. Students who were older and those in the final stages of their education were more likely to establish the student-patient relationship. These students were also more likely to have a positive perception of the atmosphere as one of collaboration. Although patients in Suikkala, et al. reported benefits from the facilitative relationships with students more than the mechanistic or authoritative, students seemed to benefit regardless of the type of relationship.

Idczak (2007) utilized hermeneutic (interpretive) phenomenology (descriptive) as the methodology to describe meanings of behaviors students experience when learning how to be with their patients. To gather data on the experiences of sophomore entry-level nursing students, they recorded their thoughts, feelings, and emotions related to patient interactions. Researchers provided subjects with six open-ended questions to describe their interactions and feelings about the student-patient interaction. Five themes emerged from analysis of the data: fear of interacting with patients; developing confidence; becoming self-aware; connecting with knowledge; and, connecting with the patient.

In describing fear, students reported feeling nervous, scared, afraid, intimidated, frightened, anxious, worried, concerned, and timid. Students shared their fear by describing hesitating at the patient's door, and in approaching the patient, rehearsing what they were going to say, and/or feeling embarrassed at being so inept. Fear was the strongest theme to emerge from the data.

Table 1

Summary of Factors Related to the Nursing Student-Patient Relationship

Type of Student Patient Relationship N = 192	Perceived Student Factors Predicting the Type of Relationship	Consequences Related to the Type of Relationship
Mechanistic (Focuses on the Students' Learning Needs) N = 14	• Less positive perceptions of patient's attributes	• Less positive for personal and professional growth • Less positive for self esteem and confidence • Less positive for patient's improved health and commitment to self care
Authoritative (Focuses on What the Student Assumes is Best for the Patient) N = 70	• Positive perceptions of patient's attributes • More positive perceptions of the atmosphere • More likely to be fourth year students • More likely to have Received support from a person other than supervisor or teacher	• Positive for personal and professional growth • Positive for self esteem and confidence • Positive for patient's improved health and commitment to self care

Table 1 (continued)

Summary of Factors Related to the Nursing Student-Patient Relationship

Type of Student Patient Relationship N = 192	Perceived Student Factors Predicting the Type of Relationship	Consequences Related to the Type of Relationship
Facilitative (Focuses on the Common Good of Both Student and Patient N = 108	• Positive perceptions of patient's attributes • More positive perceptions of the atmosphere • More likely to be older	• Positive for personal and professional growth • Positive for self esteem and confidence • Positive for patient's improved health and commitment to self care

Note. Adapted from "Factors Related to the Nursing Student-Patient Relationship: The Students' Perspective" by Suikkala, Leino-Kilpi, and Katajisto, 2008, *Education Today, 28*, p. 539-549.

Developing confidence was associated with competent performance of skills. When students were able to complete tasks related to patient care, they described an increased confidence in the ability to provide care and be competent. Gaining confidence was more difficult when the student cared for a patient who could not communicate. During such situations, students even questioned their ability to be nurses. Students reflected on situations where the interaction with patients made them more self-aware. Four types of reflection helped students: "reflection on their thoughts; reflecting on an interaction; comparing their thoughts to the actions of another nurse; or seeing inner role conflict" (p. 69). Idczak (2007) described two subthemes that related to connecting with knowledge. These subthemes were connecting with classroom knowledge and connecting with the performance of nursing skills. When students

were able to connect knowledge learned in the classroom with the knowledge they needed to perform nursing skills, they had positive feelings about their ability.

Student journals disclosed connecting with patients in a variety of ways. "One of the most dramatic examples was of a student who could not communicate with her patient because the patient had a stroke" (p. 70). The student wrote that her patient was upset about something but she could not express it verbally. Using patience and willingness to spend time with the patient, the student was able to determine that the patient wanted thorough mouth care. The student expressed that she was able to identify needs and make a difference for this patient. Based on this research, Idczak agrees with Watson (2007) that nurse educators emphasize the importance of maintaining a balance between the art and science of nursing. Learning the art helped students to achieve authentic interactions with their patients. Learning the science was practicing the application of scientific knowledge. In addition, Idczak (2007) wrote, "faculty needs to keep in mind that the traditional nursing student is developing identity simultaneously as a nurse and as a person" (p. 71).

A qualitative study using a questionnaire and semi-structured interview explored the meaning of professional nurse caring with a sample of student nurses (Wilkes & Wallis, 1998). The findings illuminated patterns of growth and development in the description of caring in nursing students as they developed over a three-year period. The first-year students responded to two open-ended questions that required describing what caring meant to them as well as reporting on a situation that demonstrated caring behaviors toward another person. Graduating students responded to the same initial question, but the second question asked them to describe a situation from their most recent clinical practicum that demonstrated caring behaviors toward a patient. Nine themes related to caring emerged from the data: compassion; communication; comfort; concern; competence; commitment; confidence; conscience; and, courage. Wilkes' and

Wallis' (1998) findings suggest that compassion was present in students from the beginning of the program of study, but evolved into a respect and love for others, where student nurses were able to form special relationships with patients. Based on the findings of the study, the researchers developed a model of professional nurse caring from a student perspective wherein compassion is central to the core. "Compassion is the quality that bound students to their patients through communication, providing comfort, being competent, being committed, having conscience, being confident, and being courageous" (p. 587). Leininger's (2002) findings that caring by nurses directed toward the health and well-being of patients were consistent with the results of Wilkes and Wallis.

As part of a larger study, Watson, Deary, and Lea (1999) conducted a longitudinal investigation of perceptions of caring among a cohort of student nurses. The study was designed to determine the change in caring as students progressed through the program. The Nursing Dimensions Inventory (NDI) and the Caring Dimensions Inventory (CDI) were the instruments used to collect this data (Watson, Deary, & Lea 1999). Developed and tested by the researchers, the purpose was to measure professional nurses' perceptions of what constituted caring. Content validity and reliability of the CDI reported a Cronbach's alpha of .91. A commonly accepted rule of thumb is that α of 0.6-0.7 indicates acceptable reliability, and 0.8 or higher indicates good reliability (Creswell, 2007). The purpose of the NDI was to measure the importance nurses attributed to items related to nursing practice. Content validity verified the major conceptualizations of caring and a wide range of nursing interventions related to caring (Watson & Lea, 1997).

Data for Watson, et al. were collected upon initial entry into a nurse education program and again after students were in the program for 12 months. Findings revealed increased scores 12 months into a nursing education program. The researchers found that "nurses identified most

of the nursing actions on the CDI as constituting caring" (Watson, et al., 1999, p. 670). Four dimensions to caring in nursing evolved from the data: psychosocial; professional; technical; and, altruism or personal disposition. The findings show that the perception of professional and technical aspects of caring did increase over time with differences in perception of caring based on age. This perception could have implications for programs who recruit more mature students. A limitation of the Watson, et al. study was that the differences related to age were not described. Watson, et al., (1999) suggests that students enter nursing education programs with high ideals that need fostered throughout the program. Data suggest that students lose some of their idealism about nursing after 12 months in nurse education. According to Watson, et al., "Nursing and caring would appear to become more synonymous to the student nurses in their study after 12 months in nurse education." Since the sample in the study reported lower levels of ideals as they progressed through the program, this issue merits further investigation as it could provide important knowledge for educators.

Kapborg and Bertero (2003) conducted a qualitative study in order to identify, describe, and discuss the nature of caring from the novice student nurses' perspectives. They wrote, "When a nurse and a patient meet in a caring situation, they have to interact with each other and this interaction includes both doing and being" (p. 185). The students surveyed (n = 127) were beginners in their first semester of nursing courses. Questionnaires with an essay that asked "What is your image of caring?" were administered. Content analysis was used to analyze the textual data. Analysis of students' descriptions of caring resulted in three main categories and eleven subcategories of caring. Table 2 is a schematic illustration of the main categories and the subcategories.

Table 2

Describing and Identifying Caring

Caring			
Doing	Being		Professionalism
	Being There	Being With	
Care for			Knowledge
Assist	Facilitate	Reception	Rules and Regulations
Treatment	Do the Right Thing	Empathy	Ethics
			Prevention

Note. Adapted from "The Phenomenon of Caring from the Novice Student Nurse's Perspective: A Qualitative Content Analysis," by I. Kapborg & C. Bertero, 2003, *International Nursing Review, 30,* p. 187.

Caring involved the categories of *doing*, *being,* and *professionalism*. *Doing* was described as performing activities to help the patient. The three subcategories of doing that emerged included being cared for, assisting with care, and providing treatment. *Care for* was described as either a physical response or as taking responsibility for the physical care of someone. To assist with care was to provide help with daily living or other activities. Treatment refers to the medical-technical aspect of the nurses' work and encompasses the competencies of the nurse in administering medications and treatments. The second category was *being*. "*Being* is that care that supports the patient as a human being" (p. 188). *Being* was characterized by behaviors such as listening, communicating concern and is divided into two subcategories--*being there* and *being with*. *Being there* was described as showing concern, making patients feel protected and included patients feeling that the nurse would do what was needed for healing. Providing this kind of security for the patient was *doing the right thing*. To *facilitate* was being aware of emotional and psychological aspects of patient care. *Being with* was described as

making patients feel that they are secure and treated with human kindness, empathy, and concern. *Empathy* was patients feeling that the nurse cares about their problems. The participants defined *reception* as accepting each person as an individual with different needs and the nurse showing respect for those needs. *Professionalism* described the nurses' level of competency. Findings suggest that nurses should be knowledgeable and know the rules and regulations, grounded in ethics, and know the measures related to prevention. The researchers concluded that caring involves care of the entire human being, physically, emotionally, and intellectually. Their findings suggest that student nurses were aware of the critical aspects of caring and were capable of developing the ability for reflection in becoming caring professionals.

Solvoll and Heggen's (2009) research originated from their concern that nursing was a deteriorating profession. They wrote that this deterioration was occurring because the practice arena was under increasing pressure for profitability, efficiency, and effectiveness. The challenge for nurses to be researchers as well as caregivers were based on evidenced-based outcomes. Martinsen (as cited by Solvoll & Heggen's, 2009) wrote that the concept of care includes a practical, a relational, and a moral phenomenon. "These phenomena are interwoven into situations where people need to be cared for" (Solvoll & Heggen, 2009, p. 2). Documented student dialogues with patients during their fieldwork in hospitals, nursing homes, and laboratory practice settings provided data. The findings revealed that students' caring behaviors had characteristic and repetitive features such as sensitivity and empathy for patient's feelings. Students allowed themselves to experience the situation and demonstrated receptivity to the needs of their patients. Students had firsthand opportunities to interact with patients and gained experience with caring. These experiences allowed them to be present in their encounters with patients and to demonstrate empathy and sensitivity to the patients' feelings.

Solvoll and Heggen (2009) found students in their study were moved emotionally in their encounters with suffering people. They also found that students described difficulty in entering into a nurse-patient relationship with strangers. The researchers recommended that, "nurse educators need to be open-minded to students' experiences and find new constructive ways to link reflection and nursing theory with students' experiences in caring." (p. 4)

The results of Sovoll and Heggen (2009) are in contrast with Rognstad, Nortvedt, and Aasland (2004) who found a high degree of self-centeredness in the students they studied. Rognstad, et al., completed a longitudinal survey of Norwegian nursing students that were at least two and one-half years into a three-year program. Factor analysis revealed two factors, altruism, and acknowledgement from the patient. The students in Rognstad, et al., reported that they wanted to be altruistic; but described positive and negative motivational responses to patients' feedback from patients. Analysis of the 18 interviews revealed all 18 students expressed a wish for acknowledgement and positive feedback from their patients. One student stated:

When I do not get positive feedback or thanks for the work I do, then I do not put my heart and soul into it. I do what I have to do, but I do not do anything extra for the patient. It means a lot to me to get positive feedback from the patient. (p. 233)

Development of the Caring Relationship

"The art of caring is professionally embodied in a therapeutic alliance that develops between the nurse and the patient and is referred to as the nurse-patient relationship" (Hill, 2005, p. 158). The foundation for the development of the caring relationship, as it relates to clinical nursing, evolved from scientific nursing theory and concepts from humanistic psychology (Pohlmann, 2006). Nurses hold a key position in the health and recovery of patients by having

the ability to form caring relationships that promote healing outcomes. Being in this position creates a challenge for nurses to avoid uncaring relationships with patients because such relationships are detrimental to the patient, the nurse, and nursing profession (Buerhaus, Donelan, Ulrich, Norman, DesRoches, & Dittus, 2007; Quinn, Smith, Ritenbaugh, Swanson, & Watson, 2003).

Perhaps the most well-known nursing theorist who described the process of development of the nurse-patient relationship is Peplau (1952, 1992). Her theory was initiated from her experience as a psychiatric nurse and resulted in describing a framework for the development of all nurse-patient relationships. She considered the nurse-patient relationship as central to the nursing process. Peplau (1992) described the development of the nurse-patient relationship as "an interactive phenomena where the nurse and patient identify problems and their variations, appreciating, applying and testing remedial measures in order to produce beneficial outcomes for patients" (p. 13). Peplau commented that professional nurses must know, recall, and apply a considerable body of knowledge during the nurse-patient relationship. In addition, the nurses' interaction with patients has a significant impact on patient well-being as well as the quality and outcome of nursing care. There are four components to the nurse-patient relationship: two persons; the nurse and the patient; professional expertise; and, patient need. Peplau described the nurse-patient relationship as having phases through which the relationship progresses. These therapeutic phases included the orientation phase, the working phase and the resolution phase. These phases are similar to the nursing process of assessment, nursing diagnosis, planning, implementation, evaluation, and reassessment. Peplau (1952), similar to Watson (2007), and Mayeroff (1971) wrote that the nurse-patient relationship assisted nurses in their personal growth and helped them better understand themselves.

Halldórsdóttir (2008) outlined six main stages in the process of developing the nurse-patient relationship. These stages were developed from patient perspectives and were described as interactive between patients and nurses. The first stage was reaching out; either the patient or the nurse must reach out and respond in this stage for connectedness to occur. The next was removing the masks of anonymity, meaning removing the stereotypes of both the nurse and the patient, and acknowledging the other as a person. This connection and bond leads to the third stage described as acknowledgement of the connection. Acknowledgement may come in the form of non-verbal communication, eye contact, or warmth in the voice. Halldórsdóttir affirms that the strongest indicator of acknowledgement is when the nurse responds to patients in a way that makes them feel special. When this occurs, the relationship can advance to a level of truthfulness. It is at this point where patients feel safe with the nurse and they are willing to share their feelings and information that is crucial to their care. The nurse calls the patient by name, respects the patient as a person, and allows the relationship to reach a level of solidarity. Patients feel that they are not alone; they have someone on their side to help them through the illness. The last stage is the negotiation of care. By getting to know patients and understanding their needs and wishes, the nurse can then increase patients' well-being by being supportive in helping them attain wellness and efficacy to where nursing care is no longer needed.

Using reflective journaling, a non-traditional baccalaureate-nursing student used the metaphor of the process of making a quilt to describe development of the student-patient relationship (Wolf, 2003). The student described development of the student-patient relationship as similar to making a quilt in that both provide warmth, comfort, and expression. The main element in the quilt was the home because it was a key element for this particular patient caring relationship. There are 10 houses on the quilt representing Watson's (1994) caritive factors and the role Watson's theory played in the development of the caring relationship. The student

wrote, “there was a period of dreaming about my first clinical experience, who I would meet, what will it be like, will it smell, and who will be there” (Wolf, 2003, p. 82). Dreaming about the first experience created apprehension and anxiety much like the plans for the quilt. She discussed looking for a patient and perhaps finding a woman who would like to quilt, giving the student and patient a safe common ground.

Upon arrival to adult day care center, the student met E.M., an 89-year-old man with advanced Alzheimer’s disease. This patient became one of the student’s first learning experiences as she discovered that even persons with advanced Alzheimer’s could participate in a caring relationship. After spending time with E.M., the student found they could have short conversations about fragments of his childhood. Her goal was to develop a positive student-patient relationship with him. The goal was accomplished by using reflection and caring theory. She reported her relationship had moved from that of a doing student-patient relationship to that of being for the patient. She wrote that she applied many of Watson’s (1994) carative factors. Just as with making the quilt, she spent time researching concepts, using trial and error, and considering different techniques and processes. When working on the quilt, she decided to limit the use of quilting tools. In the student-patient relationship, she also left behind the tools of nursing and only brought herself to the interaction. Conversation was patchy and irregular just like the pieces in the quilt, but a connection and mutual purpose were established. Eventually the student became comfortable using knowledge and theory to solve dilemmas.

Relating the caring relationship to color theory, Wolf (2003) used the word complement to describe the balance required to meet the patients’ needs and create wholeness that leads to healing. Even though the semester ended, Wolf reflected that the artistic creation of the quilt and the building of the nurse patient relationship had many similarities.

Value of Forming Caring Relationships

Forming a caring relationship with patients and families is essential to high-quality nursing practice and positive patient outcomes. Outcomes are the endpoints of the health care process, and they are the driving force behind the power of the healthcare dollar. As a result, outcomes have become a high priority among insurers, health care institutions, accreditors, and providers (Duffy, 2003). These outcomes include such foci as health status, patient safety, patient satisfaction, comfort, increased knowledge, and quality of life. Data collected using empirical evidence based on these outcomes demonstrated that supporting linkages exist between nurse caring and patient outcomes. This is especially true for the outcome of patient satisfaction related to the nurse-patient relationship.

Press Ganey Associates Incorporated (as cited by Guadagnino, 2003) is one of the nation's leading independent vendors that conduct patient satisfaction surveys. A confidential list of all patients discharged from the hospital is sent to Press Ganey. They then randomly select individuals from the list to receive a patient satisfaction survey. These data analyses benchmarks for best practices, quality monitoring, and improvement efforts. According to Press Ganey research, the nurse-patient relationship sets the tone of the care experience and has a powerful impact on patient satisfaction (Guadagnino, 2003). Guadagnino wrote that when patients are satisfied they are more likely to encourage other patients to use the facility, the overall image of the services are improved, and patients are alerted that healthcare workers are being held accountable for their services. Patients who report experiencing a positive nurse-patient relationship are more likely to report satisfaction with their care. Duffy (2003) reported that an increase in nurse caring was correlated with an increase in patient satisfaction, indicating that the caring relationship nature of nursing may be directly connected to positive health outcomes.

A study that reviewed 700 hospitals in 11 states also reported that increased amounts of care delivered by registered nurses was associated with improved outcomes in hospitalized patients (Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). They concluded that a higher portion of hours of care provided by registered nurses was associated with better care and improved outcomes for hospitalized patients including a decrease in mortality rate.

Similar results of a comprehensive meta-analysis concurred that higher registered nurse staffing was associated with lower rates of hospital-related mortality, mortality following a complication (failure to rescue), cardiac arrest, hospital acquired pneumonia, and other adverse events (Anderson, 2007; Kane, Samliyan, Mueller, Duvall, & Wilt, 2007). These events were described as nursing-sensitive outcomes meaning that the outcome depends on registered nurses' nursing processes and interventions, the foundation of which is the nurse-patient relationship. The International Council of Nurses (2002) has identified some of these same outcomes as nursing sensitive outcomes.

> The four most commonly used nursing sensitive outcome indicators include: 1) patient complications such as urinary tract infections, skin pressure ulcers, hospital acquired pneumonia and deep vein thrombosis/pulmonary embolism; 2) a group of exploratory measures, comprising upper gastrointestinal bleeding, central nervous system complications, sepsis and shock/cardiac arrest; 3) complications among surgical patients such as would infection, pulmonary failure and metabolic derangement; 4) patient length of stay, and failure to respond to patients' urgent conditions such as shock, cardiac arrest and deep vein thrombosis, potentially resulting in increased morbidity and/or mortality. (p. 1)

Duffy (2003) reported that interactions with patients involving features or characteristics of caring by nurses have led to improved healthcare outcomes. The specific factors that

accounted for this relationship between better outcomes and nursing care are unknown. One aspect of nursing practice identified by Duffy as having a significant impact on quality patient outcomes is the associated affective behaviors that support caring. Despite the fact that the measurement of these affective behaviors, such as caring behaviors and the nurse-patient relationship, might be masked behind quantitative assessments of patient ratios and directly measurable outcomes, the affective behaviors of nurses have an impact on patients' return to an optimal level of health. According to Duffy's findings, caring was a key aspect of the professional nurses' work.

Anderson (2007), in a policy brief from the National Foundation for American Policy reported that for every extra patient added to the nurses' workload, the mortality rate increases by 7%. Therefore, if a nurse's workload increased from four to eight patients, the mortality rate would theoretically escalate to 31%. The same brief also described a Health and Human Services report completed in 2007 that found "increased registered nurse staffing equated to less hospital-related mortality, failure to rescue, cardiac arrest, hospital acquired pneumonia and other adverse events. Greater registered nurse hours spent on direct patient care were associated with decreased risk of hospital-related death and shorter length of stay" (p. 1).

Suikkala and Leino-Kilpi (2001, 2005) found that when patients experienced positive student-patient relationships, patients benefited from a more rapid recovery. Students also benefited by the positive student-patient relationship with increased self-esteem and confidence. Watson (2008) described a transpersonal caring-healing relationship as having benefit to the nurse as well as the patient. She wrote, "Caring and love beget caring and love. Caring and compassionate acts of love beget healing for self and the other" (p. 87). If students were viewed as vulnerable during their educational process, they needed a caring, nurturing environment where they could safely benefit from caring relationships (Noddings, 2005). When the

relationship between student and patient was negative, students expressed feelings of failure in technical or interpersonal skills.

When nurses were perceived as uncaring, a negative environment was created for patients and families; thus, the opportunity for positive outcomes was diminished. Some researchers (Duffy, 2003; Duffy & Hoskins, 2003), called attention to the fact that if patients do not feel cared for, they experience thoughts of helplessness, discomfort, anxiety, insecurity, and even fright, consequently decreasing positive outcomes. Halldórsdóttir (2008) also reported that when either negative or positive situations exist in the nurse-patient relationship, the physiological responses had important effects on health outcomes. Halldórsdóttir added that the findings demonstrated a relationship between immune function and caring nurse-patient relationships.

Warelow, et al., (2008) wrote that health systems are forcing nurses to care for larger numbers of patients with the same numbers of staff making positive outcomes difficult or impossible to achieve.

> A healthcare system grounded in corporate ideology with a financial bottom line, based on technology and self-interest, is the result of a society organized around economics rather than around those things that contribute to better lives and health outcomes for its citizens. Corporate principles force nurses to adjust their work to maximize the kind of efficiency that is valued and forces nursing, in our view, toward professional mediocrity. This not the nature of nursing and it comes at huge personal cost to nurses and appears at odds with quality nursing care and accepts sameness or status quo as a benchmark. (p. 150)

Warelow, et al. (2008), suggested that this mentality has a direct bearing on recruitment and retention of nurses. These researchers called for a restructuring of nursing practice to improve conditions for nursing, thus improving health care outcomes for patients. They also

believed that if environmental concerns for nurses were addressed, there would be financial rewards such as reduced sick leave and overtime, improved nurse satisfaction, improved staff recruitment and retention rate, increased patient satisfaction, better patient outcomes, and better bed utilizations. In turn, all of this would decrease facility costs allowing an increase in professional staff.

Another financial dimension to the importance of forming a caring nurse-patient relationship, the enactment of the *Deficit Reduction Act of 2005*, has provided the seed for financial incentive to link to patient satisfaction. The Centers for Medicare & Medicaid Services have worked with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Project Team to develop a credible survey tool that measures patient satisfaction. Hospitals that benefit from the Inpatient Prospective Payment System are now required to report publicly the HCAHPS survey results. If they do not, their annual payment may be reduced 2.0 percentage points. More recently, the enacted *Patient Protection and Affordable Care Act of 2010* includes HCAHPS as one of the measures to calculate incentive payments. The United Stated Department of Health and Human Services Centers for Medicare and Medicaid Services (2011) issued a proposal to:

> establish a hospital value-based purchasing program for acute care hospitals that are paid under the Medicare Inpatient Prospective Payment System (IPPS) for inpatient services furnished to Medicare beneficiaries. The new program, which was required by the Affordable Care Act of 2010, would provide value-based incentive payments to hospitals beginning in FY 2013, based on their achievement or improvement on a set of clinical and patient experience of care quality measures. (p. 1)

The patient experiences of care quality measures include eight items from the HCAHPS survey. Of these eight measures, five of them relate directly to the nurse-patient relationship.

These include communication with the nurse, responsiveness of hospital staff, pain management, communication about medication, and discharge information (U.S Department of Health and Human Services, Center for Medicare & Medicaid Services, 2011).

During this time of economic challenge and healthcare reform, a reflection from Guadagnino (2003), "The nurse-patient relationship sets the tone of the caring experience and has a powerful impact on patient satisfaction" illuminates the physical, emotional, spiritual and financial importance of the caring nurse-patient relationship.

Professional Nurses' Perceptions of the Impact of the Nursing Shortage on Care

Buerhaus, Donelan, Ulrich, Norman, DesRoches, and Dittus (2007) surveyed registered nurses (n = 657) to determine their perceptions of the impact of nursing shortages on patient care. Nurses responded to two questions.

> In the past year, have you observed any of the following as a result of nursing shortages in the hospital? and From what you know, how much of a problem do you think the shortage of nurses has been for: quality of patient care, time for collaboration with teams, ability of nurses to maintain patient safety, early detection of complications, nurses' time for patients, and quality of nurses' work life. (p. 585)

Table 3 illustrates the results of that survey's data.

Table 3

Impact of Nurse Shortage on Process of Care and Hospital Capacity and Nurses' Ability to Provide Care

In the past year, have you observed any of the following as a result of nursing shortages in the hospital?	RNs N = 657
Impact on care delivery processes	
Delayed nurse responses to pages or calls	82%
Increased patients' complaints about nursing care	84%
Increased staff communication problems	85%
Increased physician workload	50%
Impact on hospital capacity	
Reduced number of available beds	78%
Delayed discharges	69%
Increased patient wait time for surgery or tests	68%
Discontinued/closed patient care programs	44%
From what you know, how much of a problem do you think the shortage of nurses has been for the following?	
Quality of patient care	78%
Time for collaboration with teams	55%
Ability of nurses to maintain patient safety	69%
Early detection of complications	65%
Nurses' time for patients	91%
Quality of nurses' work life	82%

Note. Adapted from "Impact of the Nurse Shortage on Hospital Patient Care: Comparative Perspectives," by P. Buerhaus, K. Donelan, B. Ulrich, L. Norman, C. DesRoches, & R. Dittus, 2007, *Health Affairs, 26*(3), p. 835-862.

These data suggest nurses are concerned about not being able to fulfill their caring role in meeting patient needs. Of interest was the nurses' perception of the effects of the shortage on nursing's future; 90% responded it will lower quality care for patients, and 91% perceived an increase in nurses leaving for non-nursing jobs. Findings correlate with those of Warelow, et al.

(2008) that nurses are concerned about their ability to perform competent caring nursing. Although in Buerhaus, et al., study 91% of the nurses reported that they expect the shortage will influence the amount of time the nurse will be available for patients, only 78% reported that quality of patient care will be affected.

Non-Traditional Students

Over the last 25 years, the numbers of non-traditional students dramatically increased. The National Center for Education Special Analysis (2002) revealed almost three-quarters of undergraduate students are in some way non-traditional. Since that time, "adult students have been a growing presence on college campuses and these students constitute a significant proportion of the undergraduate population" (Ross-Gordon, 2011, p. 1). Not only has the number of non-traditional students increased rapidly, the age range of the non-traditional learner has increased. More adults aged 55 to 79 are entering the third age of life. "The majority of these adults plan to stay engaged in some form of work, community service or learning activity" (Lakin, Mullane, & Robinson, 2007, p. 3).

> In spite of the increasing numbers of non-traditional students, Wilson (2009) writes:
>
> It is evident that this population has been greatly ignored in both professional and non-professional examination. While there may be tremendous information on adults in the workplace, or college students as a whole, there is little information on non-traditionally aged college students. (p. 4)

Research about this population of students was plentiful in the late 1970s and early 1980s when the non-traditional student presented a unique situation. The research done at that time focused on the facts that the adult learner (non-traditional student) was "highly motivated, relatively independent with special needs dependent on their schedules and developmental level" (Wilson, 2009. p. 3). Because of this influx of non-traditional students with their different

challenges and unique barriers to completion of a degree, scholarly works that investigate and support the learning style, and contemporary challenges of this population are beginning to surface (Korvick & Williamson; 2006; Montgomery, Tansey, & Roe, 2009; Strage, 2008; Taniguchi & Kaufman, 2005; Tatum, 2010; Wilson 2009). Institutions of higher education are seeking information that would provide in-depth understanding of this group enhancing recruitment, retention, and degree completion.

Findings from a study done at a community college in Texas (Tatum, 2010) summarize some of the challenges the contemporary non-traditional Associate Degree Nursing Program student faces. The researcher identified three major themes that emerged from the anecdotal responses of the participants. The themes were precollege factors, situational factors, and institutional factors. Within the precollege factors were items such as lack of direction, early marriage, and work-related injury. The situational factors were family responsibility, career change, and being older. Institutional factors were academic advising, new student orientation, schedules of services and childcare assistance.

There is a small body of literature in the professional nursing journals about the non-traditional nursing students in the Associate Degree Nursing Program. Prior research has focused on the importance of second-career nursing programs as a solution to the nursing shortage (Korvick & Williamson, 2006; Shiber, 2003) and as a strategy for increasing enrollment in nursing programs. Schools of nursing discovered that this particular pool of applicants was attractive because of their previous successes, resourcefulness, maturity, and life experiences; all qualities associated with academic success and goal achievement (Montgomery, Tansey, & Roe, 2009; Vinal & Whitman, 1994; Wassem & Sheil, 1994).

Montgomery, et al. (2009), identified a number of reasons that non-traditional students were highly desirable as potential students of nursing. Montgomery, et al. reported, 58% of the

non-traditional students had previous experience working in the healthcare field, and 62% of the participants stated that they had dependents. Montgomery, et al. interpreted these findings as meaning that these students were more likely to have a better grasp of the caring role. Non-traditional students acknowledged that they had developed time management skills, the ability for multitasking, and refined interpersonal skills. The findings suggested that non-traditional students believed their life experiences promoted formation of positive relationships with patients; and, they were motivated and committed to learn. In addition, the findings reported that non-traditional students tend to perform better academically. Montgomery, et al. (2009) recommended that encouraging the recruitment, retention, and support of non-traditional students would be of value to the government, healthcare, and the university.

Scholarly works about non-traditional students in other professions were reviewed in order to obtain a more in-depth view of this student. In a study of social work students (Zosky, Unger, White, & ills, 2003), the faculty rated non-traditional and traditional students who were in their senior capstone field experience. The researchers found that "non-traditional social work students were rated as more competent in maintenance of professional boundaries, promotion of self-determination, confidentiality, dignity of the individual, respect for diversity, honesty, and integrity than their traditional counterparts were" (p. 194).

In one of the first studies (Walker, Martin, Haynie, Norwood, White, & Grant, 2007) done to identify preferences of teaching methods for second degree students, non-traditional students gave themselves scores that were significantly higher than traditional students in self-directedness and motivation to learn and study. These ratings supported findings in the literature related to self-directedness and motivation.

These investigations highlight the positive aspects of recruitment of non-traditional students into nursing: academic success; goal achievement; and, retention. However, research

of non-traditional students in general illuminates some of the challenges these students face as they enter higher education. For the non-traditional student, "learning entails the undoing of earlier learning as they enter a new environment with different subjects, learning approaches and teaching styles" (Christie, Tett, Cree, Hounsell, & McCune, 2008, p. 567). In this longitudinal study, researchers investigated the teaching and learning experiences of non-traditional students using data obtained from interviews. During analysis of data, the emotional aspects of learning emerged as an important theme. The researchers found that many non-traditional students working toward becoming competent learners also had the desire to participate in the social environment of the university. They expressed "ambivalence and dislocation" (p. 576) when they were never able to fully participate in student life. According to Wilson (2009), how to meet the needs of the non-traditional student fitting into the social group of the academic community was not clearly understood. An awareness of the non-traditional students' need to fit into their new role could be beneficial to faculty and advisors who interact with this population.

Although these same variables, such as prior life experience, marital status, parenting status, spouse/partner support, and age of the student that kept them from full participation in student life were significant in increasing student competence (Zosky, Unger, White, & Mills, 2003). These researchers wrote that prior life experience was the variable that determined successful preparation for the senior capstone experience. When analyzing this variable the "mean for non-traditional students was 8.31 and traditional students 7.37 ($p = .015$), demonstrating that the non-traditional students were significantly more competent than the traditional student" (p. 196).

Another challenge for non-traditional students, which emerged from the data, was how students dealt with the "experience of loss of prior identities and displacement within the university environment" (Christie, et al., 2008, p. 579). Non-traditional students often have to

manage multiple role demands including student, parent, partner, and worker creating role strain as students enter college (Zosky, et al., 2003). The emotional adjustment in learning the new role of student adds to the frustration. Christie, et al. (2008) calls this "learning shock" and students commented that their first semester was "a total write off" (p. 570). The fact that non-traditional students maintain these numerous roles adds a more complex challenge to students' finishing their degree. Often studying is not the priority and is the first to suffer when the student is not able to maintain the discipline of higher education (Croix, 2009).

Contemporary non-traditional students are at most risk of leaving during their first year, regardless of their degree objective (U. S. Department of Educational Institute of Education Sciences National Center for Education Statistics, 2002). Compared with their traditional counterparts, non-traditional students seeking bachelor's and associate's degrees are less likely to attain their degree goal within five years and more likely to leave post-secondary education. Schools that recognize these issues and offering services such as childcare, more flexible class schedules, more access to libraries, tutorial support, and placement services are finding more success in helping non-traditional students finish their degrees (Croix, 2009).

Christie, et al., (2008) recommends that faculty be careful not to oversimplify students' ability to transfer learning skills from one setting to another. For example, if students were parents, they may not necessarily have the skills to form a caring nurse-patient relationship. Findings reported by Croix suggest when students move into a new learning environment a new set of risks are presented where students must learn how to negotiate and where to find support in this new setting. This becomes difficult when self-perceptions of mastery orientation exist in the non-traditional student (Strage, 2008). Again, this added burden sets the non-traditional student up for more emotional stress and less learning in the higher education environment.

Non-traditional students have forced changing trends in higher education (Croix, 2009). Croix's findings suggest that non-traditional students have changed the focus of higher education from a broad based, liberal study education that includes arts, sciences, and humanities to a more career focused training program. Another finding reported by Croix includes the shortening of online curriculum and lengthening for traditional programs. The online degree is popular for non-traditional students because they can fit it in with other demands for their time, and an online degree takes less time to complete. Fast track courses are also increasing in popularity, enhancing the ability for the non-traditional student to return to the workplace in a shorter period. This impetus is particularly telling for nursing.

Croix (2009) found that at least 58% of students in higher education were non-traditional students, with 40% attending two-year degree programs. This evidence suggests that scholarly works and a commitment to recruit, retain, and facilitate degree completion for this dynamic emerging population of non-traditional students are needed. This research about non-traditional students' perceived ability to form caring relationships is an effort to add to the understanding of and commitment to the non-traditional nursing student.

Summary

The central task of nursing education must be to help students and faculty learn how to form caring, healing relationships with patients, families, their communities, each other, and with themselves (Watson, 2008b). Although described as essential, this task creates a complex challenge for nursing educators and students. With the projected nursing shortage looming (American Association of Colleges of Nursing, 2008), workers displaced from a variety of careers are being recruited into nursing (Cangelosi & Whitt, 2005; Kohn & Truglio-Lodrigan 2007; Korvick & Williamson, 2006; Shiber, 2003). The challenge is to identify and educate students who may not be adept at developing caring relationships with patients. Some

researchers (England & Folbre, 1999; Folbre, 2003; Utley-Smith, et al., 2007) found that non-traditional students who have not worked in the caring professions might need modifications in pedagogy and educational interventions to facilitate teaching and learning of behaviors that lead to forming caring relationships. Chapter III of this study describes the methodology used to study the perceptions non-traditional students have of their ability to form caring relationships, the changes that occur from entry into the program to graduation, and the influence of prior experiences on their perception of caring ability.

CHAPTER III

PROCEDURES

Introduction

A Related Literature Review indicated that non-traditional students encounter numerous challenges in order to become successful registered nurses. Wilson (2009) validated that studies about the needs of the contemporary non-traditional student have been ignored. Therefore, the researcher committed to increase understanding that would facilitate success for non-traditional students enrolled in the Associate Degree Nursing Program.

The problem of this study was to identify non-traditional nursing students' perception of their ability to form caring relationships with patients. Perceptions of the non-traditional students' ability to form caring relationships were measured at the beginning and the end of their nursing curriculum to identify if changes occurred. The effect of prior experiences on perceptions of caring ability during the nursing program was also investigated.

A descriptive, cross-sectional, mixed-method design was utilized. It included a comprehensive Related Literature Review, participants' response to an online survey, content analysis of a brief paragraph written by the participants, and a sequential, semi-structured, one-on-one interview to answer the following research questions:

1. What are non-traditional nursing students' perceptions of their ability to form caring relationships prior to entry into the nursing program?
2. In what ways do the prior experiences of non-traditional nursing students influence their ability to establish caring relationships during the nursing program?
3. To what degree do non-traditional nursing students perceive that their ability to develop caring relationships has increased from nursing program entry to exit?

Chapter III describes the design and methodology of the study, including the setting of the study, participants, procedures for data collection, instruments, and methods of data analysis.

Setting of the Study

This study was conducted with non-traditional students of two community college Associate Degree Programs of Nursing. Similarity of curriculum and number of non-traditional students in the programs served as the basis for the choice of programs. Site selection enabled the researcher to be available for on-site personal contacts with program representatives and to conduct one-on-one interviews with participants. The researcher had no academic contact with or authority over the students. One study site was located in a suburban community in Western Pennsylvania and one was located in a rural community in Central Pennsylvania. Although neither college program is designated specifically as non-traditional, both sites had an appropriate number of non-traditional students to meet the projected requirements for 15 participants at Level I and 15 participants at Level II. A Level I student is defined for purposes of this study as a student just entering the first clinical practice portion of the nursing curriculum. A Level II student is defined as one who is in the last semester of or has just finished the nursing program. Each location provided a secluded, quiet area where the interviews could be completed ensuring privacy and confidentiality.

Using Associate Degree Programs for this study was based on several socio-economic factors revealed in the Related Literature Review. Numbers of non-traditional students entering nursing through the community college are increasing (American Council on Education, 2009; U. S. Department of Educational Institute of Education Sciences National Center for Education Statistics, 2008). From data reported by the National League of Nursing (2010) it was determined that 54% of nursing students graduated from an Associate Degree Program, 42% graduated from a Bachelor of Science degree program, and 4% graduated from a diploma

program. It is anticipated that the number of non-traditional students graduating from Associate Degree Programs will continue to increase resulting in the need to facilitate learning and decrease attrition rates for these students (National League of Nursing, 2010; U. S. Department of Educational Institute of Education Sciences National Center for Education Statistics, 2008).

Also contributing to increased enrollment in the Associate Degree Programs is the fact that displaced workers attend Associate Degree Programs because they want to transition into a new career as quickly as possible (U. S. Department of Educational Institute of Education Sciences National Center for Education Statistics, 2011), and a poor economy has less influence on the healthcare job market than on non-healthcare job markets (Shatkin, 2009; Smith, 2008). The turn-around time for returning to the workforce as an Associate Degree Nurse can be as little as 12 to 18 months.

Next, recruitment and retraining of displaced workers into nursing is regarded as a possible solution to the nursing shortage (Cangelosi & Whitt, 2005; Kohn & Truglio-Londrigan, 2007; Korvick & Williamson, 2006; Shiber, 2003). The offer of free tuition to attend an Associate Degree Nursing Program for displaced workers results in an increase in the non-traditional population (Eby, 2007, Fierce Healthcare, 2007). This combination of factors has contributed to the increased enrollment of non-traditional students in Associate Degree Programs.

Another reason Associate Degree Nursing Programs were chosen was because of the higher representation of non-traditional graduates and the lower exposure to liberal studies courses. Liberal studies courses are recognized as a source for understanding concepts embedded in caring. It is believed a broad liberal education offers a foundation for understanding the human experience, universal needs, and serves as a prerequisite to the ability to deliver services that are often intimate and intrusive (American Association of Colleges of

Nursing Standards, 2008). A review of the Associate Degree curriculum verifies a dearth of liberal studies courses (see Appendix A). This factor highlights the need to evaluate the perceptions of non-traditional Associate Degree students regarding their ability to develop caring relationships during the course of their program.

After obtaining approval from the Institution Review Board (IRB) at Indiana University of Pennsylvania (IUP), two Associate Degree schools of nursing were contacted for site approval. One site granted approval using their Expedited IRB Review process. The other college did not have a formal IRB process. The college president and chairperson of the nursing department were the gatekeepers at this site. Upon their review of the approved IRB from IUP, the approval was granted.

Participants

Participants consisted of a cross-sectional sample of non-traditional nursing students. A total of 95 students met all criteria for being a non-traditional student. The criteria for this study included, being a non-traditional student as defined by the National Center for Education (2008), a student just entering the first clinical practice portion of the curriculum (Level I), or a student who is in the last semester or just graduated (Level II), and a novice to the healthcare field.

U. S. Department of Educational Institute of Education Sciences National Center for Education Statistics (2008) defines the non-traditional student as one who has any one of the following characteristics:

> (a) delays enrollment or does not enter a post-secondary education in the same calendar year he/she finished high school; (b) attends post-secondary school part-time; (c) is financially independent of parents; (d) works full-time; (e) has dependent other than a spouse; (f) is a single parent; or, (g) does not have a high school diploma, though may have a GED or other high school equivalency. (p. 1)

In a study completed by Sadler (2003), students reported that their work experiences in nursing homes and hospitals contributed to their perceptions of caring. Belcher and Jones (2009) also reported that previous healthcare experience was identified as a major factor important to the ability to form caring relationships. Spohn (2011) reported that 68% (n = 304) of her total sample (N = 439) of student nurses had prior healthcare experience. Therefore, to remove this bias, students with prior experience in a healthcare field were not included in the sample for this study.

The researcher presented a verbal explanation of the criteria during the initial personal contact with students. Students who thought they met these criteria completed an invitation and consent form for participation and contact information.

A total of 95 students from two Associate Degree Nursing Programs in Central and Western Pennsylvania consented to participate. Of this number, 64 students responded to the Caring Ability Inventory (CAI) on Qualtrics, online survey software, making a response rate of 67%. For this study, the original CAI was modified to include demographics of the group including, identification of level in the nursing program, age, gender, former career, first degree, and contact information. If respondents answered yes to the default question, "Were you previously employed in healthcare?" they were forwarded to the end of the survey and were unable to complete the CAI. Of the 64 respondents who completed the survey, 26 met all the criteria including not having prior healthcare experience. Two Level I surveys were eliminated because of missing data. The remaining 24 respondents consisted of 12 Level I and 12 Level II students.

Procedures for Data Collection

After IRB approval, the original study design entailed establishment of contact with the chairpersons of the appropriate college department to review the study and recruit their

assistance in obtaining participants. Chairpersons received letters according to approved IRB procedures (see Appendix F). Due to extenuating circumstances, a significant amount of time passed before contact between the researcher and College A chairperson was established. Once it was, the chairperson was not able to identify the non-traditional students because the site did not categorize students as traditional and non-traditional. In addition, the incoming Level I students had no e-mail accounts, and the Level II students had graduated by the time contact was established.

To address these issues, the chairperson offered time for the researcher to attend the Level I orientation session and the Level II National Council Licensure Examination (NCLEX) preparation class to recruit participants. An addendum to the original IRB, addressing the revised procedure, was approved. The researcher provided a personal presentation, including a description and purpose of the study to Level I students at orientation, and Level II students at their NCLEX review program. The presentation included an explanation of the definition of non-traditional student from the National Center for Education (2008) as well as a description of exclusion criteria for those who had prior healthcare experience. Students who met the criteria accepted invitations to participate in the study via consent forms. Signing the consent form and supplying their contact information on the form ensured that participants entered the research of their free will. It was explained that the participants could withdraw at any time without consequence. Qualtrics was used to e-mail a description of the study with the link to the CAI. After participants responded to the CAI on Qualtrics, telephone contacts were made and appointments were scheduled for one-on-one interviews.

The chairperson at College B responded in a timely manner and agreed to provide contact information for all Level I and Level II students. This college also did not identify traditional from non-traditional students. The department secretary from College B provided e-mail and

home addresses for all 282 students who were about to enter, or had just graduated, from the program. The e-mail addresses were loaded into Qualtrics as a College B panel, and the students were e-mailed a letter of explanation (see Appendix **G**) with a link to the survey. After one week, there were no responses to the survey. E-mailing the survey was repeated. After another week, there were still no responses. A contact to the department secretary revealed an error in the e-mail addresses. After correction of the error, the addresses were reloaded into Qualtrics and the letter of explanation resent.

Another week passed; and, there were no responses. The survey was e-mailed again. Still there were no responses. A contact was made to the staff at the Information Technology (IT) department at IUP to determine if they might identify the problem. They had no resolution. Staff at the IT department at College B was contacted. It was determined that Qualtrics was identified as spam in their e-mail system; and, the students did not receive the e-mail. The IT department of College B contacted the e-mail management system to determine if there could be an override for the survey, but such an override could not be done. To address this issue, individual letters on IUP letterhead were mailed to 55 randomly selected students from the original 282-person e-mail list. Seven letters were returned as undeliverable. There were no responses received from any of the 55 letters. A final attempt to contact potential participants was made through flyers posted on the department Level I and Level II bulletin boards (see Appendix H). Three students responded to the flyers and completed the survey and the interview.

In order to identify if there was a change in perceptions of caring ability over the time from the entry level (Level I) to graduation (Level II) a cross-sectional sample of non-traditional students was administered the CAI. The chronological time frame for this period was two years. Data were collected at two points in time, the orientation session for students who were entering

Level I nursing courses; and at the end of the spring semester for Level II graduating seniors. After the CAI was completed contact information on the survey provided means to schedule the one-on-one interviews. The final number who consented to participate from the two Associate Degree Programs was 95. The CAI was attempted by 64 of the respondents on Qualtrics. Of that number, only 26 respondents met all the criteria and were included in the data analysis. Two respondents had missing data, leaving 24 subjects in the study. The projected requirements of 15 Level I participants and 15 Level II were not met.

After the CAI was completed, contact information on the survey provided a means to schedule the interviews.

Polit and Beck (2008) write that incentives can reduce the risk of no-shows for interviews. Therefore, each participant who finished both the survey and the interview received a monetary incentive of $25 per person.

Instruments

Triangulation of the Related Literature Review, content analysis of a text response on the survey, interview protocol, and data collected from the CAI were completed. All sources provided data for investigation of the phenomenon of non-traditional nursing students' perceptions of their ability to form caring relationships. Amalgamation of Mayeroff (1971) and Nkongho's (1990) concepts of caring provided a unique design to analyze quantitative and qualitative data.

To determine current knowledge about the problem, a comprehensive Review of the Related Literature was completed. There is little empirical research about displaced workers entering nursing. Therefore, to build a foundation, topics in the Related Literature Review examined the historical evolution of caring in nursing, the perceptions and development of caring

relationships, nurses' perceptions of the impact of the nursing shortage on care, and the non-traditional nursing student.

This review validated that the definition and research on caring is a broad topic with little consensus. Therefore, the researcher chose to use text topology based on Nkongho's research and design of the CAI to manage the abundant amount of data in the literature and data collected for this study. Hatch's (2002) typological model was applied to complete a content Review of the Related Literature. This was done in order to develop a matrix for analyzing the written and interview data. Using Hatch's (2002) steps in typological analysis, qualitative data were divided into categories on the basis of Knowing, Patience, and Courage as described by Mayeroff. The steps in Hatch's typological analysis include:

1. Identify the typologies to be analyzed.
2. Read the data, marking entries related to the typologies.
3. Read entries by typology, recording the main ideas in entries on a summary sheet.
4. Look for patterns, relationships, themes within typologies.
5. Read data, coding entries according to patterns identified and keeping a record of what entries go with each elements of the patterns.
6. Decide if patterns are supported by the data and search the data for non-examples of the pattern.
7. Look for relationships among the patterns identified.
8. Write the patterns as one sentence generalizations.
9. Select data excerpts that support the generalizations. (p. 153)

Caring Ability Inventory

"The purpose of the CAI is to quantify a person's degree of caring ability relative to others. Specifically the purpose is to measure the degree of a person's ability to care for others" (Strickland, 2003). The CAI was chosen as a data gathering tool since the problem of this study was to identify if non-traditional nursing students perceive they have the ability to form caring relationships with patients; and, if this perception changes as the student progresses through the program. It is reliable and valid (Nkongho, 2003) and has been used in prior research to predict nurses perceptions of their ability to form caring relationships (see Appendix I). Permission to use the CAI for this study was obtained from Springer Publishing Company (see Appendix J) and Dr. Nkongho (see Appendix K).

Mayeroff's (1971) work provides the one overarching philosophy that serves as the foundation for caring. Nkongho (1990) chose Mayeroff's (1971) essay on caring to use as the theoretical framework for developing the CAI. Elements of Mayeroff's philosophy used in the development of the instrument included what he describes as the eight critical elements that comprise caring. The eight elements consist of knowing, alternating rhythm, patience, honesty, trust, humility, hope, and courage. Nkongho interpreted the elements and utilized them along with data from interviews to formulate the statements on the CAI. Table 4 demonstrates Mayeroff's and Nkongho's descriptions of the critical elements of caring. The descriptions of Knowing, Patience, and Courage were the basis for analysis of content from the Related Literature Review, the student's answer to an open-ended question on the survey, and interviews for this study.

Table 4

Mayeroff and Nkongho's Description of the Critical Elements of Caring

Critical Elements of Caring	Mayeroff (1971)	Nkongho (2003)
Knowing	Knowledge is explicit and implicit, knowing that and knowing how, direct and indirect knowledge, all related in various ways to helping the other grow (p. 21).	Awareness of the other as separate with unique needs. Understanding who the person cared for is. Includes general and specific knowedge of the person cared for. Important to knowing is knowing one's own strengths and limitations (p. 185).
Alternating Rhythms	There are two rhythms in caring. The first involves acting with certain expectations, undergoing or suffering the results of actions and then linking these two phases to determine if what was expected was in fact achieved. between a narrower and wider framework Considering events as isolated or as the expression of a general pattern (p. 22-23).	Refers to the fluctuations in the scope of caring. At times doing for the person being cared for, at times doing nothing. This provides a basis for identification of patterns of caring. Patterns help one to learn from past experience what was helpful or not and that the actions may need to be modified to facilitate growth (p. 185).

Table 4 (continued)

Mayeroff and Nkongho's Description of the Critical Elements of Caring

Critical Elements of Caring	Mayeroff (1971)	Nkongho (2003)
Patience	Patience allows the other to grow in their own time and own way. The growth of a significant idea or change can no more be forced that the growth of a flower or child (p. 23).	Patience allows time and room for self-expression and exploration. It allows time for confusion and disorganization which is a characterization of growth (p. 185).
Honesty	Honesty is something positive. "To be honest with one's self." See the other as it is and not as I would like it to be or feel it must be (p. 25). It involves being present for the other person. There should be no significant gap between what I feel and what I say I feel. I cannot be really present for the other person if I am more concerned about how I appear to other people than I am with seeing and responding to their needs (p. 26).	Honesty involves seeing the care receiver as they are instead of as the caregiver wants them to be. Includes being genuine or real to oneself. When honesty is present the caregiver is available and open to the other. Time is not wasted on pretending to be what one is not (p. 185).

Table 4 (continued)

Mayeroff and Nkongho's Description of the Critical Elements of Caring

Critical Elements of Caring	Mayeroff (1971)	Nkongho (2003)
Trust	Trusting is allowing the other to grow in its own time and in its own way. Letting go; includes an element of risk and leap into the unknown. This takes courage (p. 27). Domination, forcing the other into a mold, requiring guarantees, or caring too much is lack of trust (p. 27). Trust is not indiscriminate. It is grounded in actively promoting and safeguarding those conditions that warrant trust (p. 28). Trust also involves trusting my own capacity to care. Not trusting self makes for further indifference to the needs of the other (p. 29).	Trust allows the care receiver to grow in their own way and their own time. It involves having trust in both persons' abilities and encourages and fosters independence (p. 185).

Table 4 (continued)

Mayeroff and Nkongho's Description of the Critical Elements of Caring

Critical Elements of Caring	Mayeroff (1971)	Nkongho (2003)
Humility	Since caring is responsive to the growth of the other, caring involves continuous learning about the other. This involves learning from the one cared for. Thinking there is not any more to learn is incompatible with caring. Humility is also the realization that my caring is not in any way privileged, overcoming arrogance, and pretentiousness. Recognize that others have integrity of their own. Vindictive triumph over another person is not pride in a job well done (p. 32).	This involves continuous learning about the other and is never completed. One kind or other persons caring is not more or less important than another. There is genuineness without the need to pretend what one is not or to conceal aspects of oneself. One can be seen truly as a person with both strengths and weaknesses (p. 185).
Hope	It is an expression of the plenitude of the present, a present alive with a sense of the possible. This rallies energies and activates our powers. Also requires courage, standing with the other in trying circumstances and taking risks. Lack of hope eats away any sense of worthiness (p. 33).	Hope is associated with the anticipation of growth and caring. The present becomes alive and significant as the possibilities to be realized in the future are recognized (p. 185).

Table 4 (continued)

Mayeroff and Nkongho's Description of the Critical Elements of Caring

Critical Elements of Caring	Mayeroff (1971)	Nkongho (2003)
Courage	Courage is willingness and ability to take risks; to go into the unknown (p. 35). It is interlinked with hope and trust.	Present when the direction of growth and its outcome are largely unknown. Courage to care is gained from past experience and by being sensitive and open to the needs of the present (p. 185).

Note. Adapted from Mayeroff, M. (1971). *On caring*. New York: Harper Collins Publishers. and Nkongho, N. (2003). *Measurement of nursing outcomes: Self care and coping.* O. Strickland & C. Dilorio (Ed.). New York, NY: Springer Publishing Company.

During Nkongho's (1990) development of the CAI, a review of the caring literature provided 61 of the original 80 items on the CAI. Nkongho also completed 15 interviews with adult subjects that included 10 open-ended questions about their thoughts on the characteristics of caring. These open-ended questions yielded 19 additional items to arrive at the 80 original items. There were 34 positive statements and 46 negative statements (Nkongho, 2003). A 7-point Likert scale was used with 1 representing strongly disagree and 7 representing strongly agree. This original version of the CAI was tested using 543 participants with a factor analysis of the items. Nkongho (2003) writes that a principle-axis factor analysis was done with the responses to the original CAI (n = 543).

Based on the screen test, as well as interpretability of factors, it was decided that a 3-factor analysis was appropriate. Results of the orthogonal solution revealed that items loaded on factor 1 related to Mayeroff's description of Knowing. Items loaded on factor 2 related to dealing with his description of Courage. Factor 3 items related to toleration

and persistence and named Patience. Items were included only if they loaded above .30 and did not load at the .30 level on the other factors. (p. 184)

After analysis using these criteria, the subscales Knowing, Patience, and Courage emerged as determinates of one's ability to care when involved in a relationship with others. The current version of the CAI has 37 items that represent these three subscales of caring: 14 items of Knowing; 13 items of Courage; and, 10 items of Patience. "The instrument is designed in a psychological trait manner so that the intent of each item in regard to construct of caring ability is not apparent" (Simmons & Cavanaugh, 2000, p. 79). Each subscale yields a possible range of scores. The range for Knowing is 14 to 98. The range for Courage is 13 to 91, and the range for Patience is 10 to 70 (Nkongho, 2003). Higher scores indicate greater degrees of caring if the score is positively phrased. If the item was negatively worded, it was reverse scored. The survey includes 13 negative items, which were reverse scored.

"Various reliability and validity tests indicate the CAI is both reliable and valid for measuring caring elements of knowing, courage, and patience" (Nkongho, 2008, p. 118). Nkongho (1990) reported an internal consistency of the total CAI = .84. Subscales of Knowing = .79, Courage =.75, and Patience = .71. A test re-test conducted on two different occurrences revealed the total CAI = .75. The subscales reported were Knowing = .80, Courage = .64, and Patience = .73. In this same study, a content validity index of .80 was reported from ratings of two experts (Strickland, 2003). Other studies completed that support the reliability and validity of the CAI can be reviewed in Appendix I.

Use of the CAI as a predictor of nurses caring ability after three years of practice was tested in a longitudinal study. Simmons and Cavanaugh (2000) completed a longitudinal study that involved administration of the CAI to senior nursing students with a follow-up survey three years after they were in practice. The Simmons and Cavanaugh reported the CAI scores of

students were the strongest predictor of perceptions of caring ability after three years of entry into practice.

For this study, the original survey was modified to include demographics of the group including, identification of level in the nursing program, age, gender, former career, first degree, date of last educational experience, and contact information. A question that asked participants to write a brief statement about why they chose nursing as a career was also included. Qualtrics data were reviewed, and analysis completed using the statistical software, Statistical Package for the Social Sciences (SPSS). The descriptions of Knowing, Patience, and Courage were the basis for analysis of content from the Related Literature Review, the student's answer to an open-ended question on the survey, and interviews.

Gathering Data through Interviews

The researcher chose sequential, semi-structured interviews as a follow-up to the CAI. The interviews were considered sequential since the data were collected from participants in two sequential steps. First, participants were asked to complete the CAI using Qualtrics. Next, after a preliminary review of the data, interview questions emerged to provide clarification of the survey data. For example, all survey participants scored below the normed mean on the subscale of courage; therefore, the researcher encouraged participants to tell their stories in the interviews about situations where participants perceived they demonstrated courage. To add the participant's voice during the interview, a semi-structured interview approach was used. This approach was chosen because it allowed flexibility and encouraged new questions and information during the interview process. Participants answered all of the questions as well as added explanation and details about their personal stories. Advanced preparation of the interview questions to be explored included an informal group discussion with peers to determine clarity and understanding of the questions. Revisions were made and a practice

interview with a volunteer colleague who was not part of the peer evaluation followed. To examine final interview questions see Appendix L.

Participants had the opportunity to respond in their own words, providing as much detail as they wished, with illustrations and explanations as recommended by Polit & Beck (2008). To establish rapport and trust, prior to the beginning of the interview, the researcher presented herself in person to participants as a former non-traditional student, a nurse, and a learner. A brief review of the purpose of the study was offered in a conversational manner to relax and prepare the participant for each interview. The researcher reminded participants there were no right or wrong answers, that they could stop the interview at anytime, and they did not have to answer any question that made them uncomfortable. They were assured of the confidentiality of their responses. Sensitive questions such as, "How would you describe your ability to establish a caring relationship with patients?" were included at the end of the interview after rapport was established.

Interviews with participants were conducted at a time and place convenient to the participants. When the participant was not available to meet in person to complete the interview, a telephone or online Skype interview was conducted. The flexibility of interview options was advantageous for the Level II participants since they were starting new employment, working different shifts, and preparing to take the National Council Licensure Exam for Registered Nurses (NCLEX-RN) during this time.

Just before the interview portion began, participants were reminded that they would be recorded and asked permission to record the interview verifying consent. Prior written consent forms had been signed and collected when the interviewer first met the participants. Interviews were then recorded using a high quality digital recorder. Upon completion of the interviews, participants were asked if they needed any clarification or had any questions. They were encouraged to call or e-mail the

researcher if they had additional information or questions. Data collection occurred over a four-month period, May through August, in order to capture a cross-section sample.

After listening to the audio files for clarification and recording problems, files were copied to a transportable drive and given to a professional transcriptionist for transcribing. Once the data were in word format, for purposes of data analysis and reporting, the participants were identified with a pseudonym to ensure confidentiality. In compliance with federal regulations, after analysis was completed, the data were locked in the researcher's safe where it will remain for a three-year period after which it will be destroyed.

Methods of Data Analysis

Data from the CAI using the Qualtrics Statistical program were entered into and analyzed using the SPSS. Demographic data were summarized by computing the total mean CAI score, as well as, the total mean scores for each subcategory of Knowing, Courage, and Patience. These total mean scores were then compared with the total mean scores for college students, practicing registered nurses, and student nurses in previous studies (Nkongho, 2003). Charts and histograms demonstrate comparison of perceptions of caring ability for participants at each level in this sample, as well as for the total sample. Frequency distributions for each subcategory were conducted. Of particular interest were the subcategory scores for courage in Level I and Level II participants. All participants scored below the mean. Because the interviews were sequential, questions were added to illicit a response requiring the participant to articulate courageous behavior in the response. For example, "Describe how you would handle a situation where the physician was doing something you knew was harmful for your patient?"

Descriptive statistics and nonparametric tests were employed for the sample data. Because of the use of convenience sampling and a small sample size ($N = 24$) nonparametric measures were appropriate for data analysis. Frequency distributions, measures of central

tendency, and measures of variability were completed. Level I and Level II data were compared using the Mann Whitney U to determine the differences in perceived levels of ability to form caring relationships. The effect size was measured using data from previous studies.

Qualitative data were analyzed using Hatch's (2002) steps in typological analysis. The steps in Hatch's typological analysis include: (1) *Identification of the typologies to be analyzed.* According to Hatch (2002) predetermined typologies can be used to initiate the data analysis process. Therefore, Mayeroff and Nkongho's (1990) research on caring framed the management of qualitative data analysis. Knowing, Patience, Courage, and Other were selected as the topologies. Other was added because there were words in the literature that did not fit into one of the three typologies.

(2) *Reading the data, marking entries related to the typologies.* The Review of the Related Literature was revisited and coded listing words in each research study that referred to caring. A total of 78 different words were identified. Using these words, the Related Literature Review was divided into two categories; studies where the participants were practicing registered nurses and those where the participants were student nurses. Then the Related Literature Review was read again to identify which words came from studies where the participants were student nurses. A grid was made to guide the tally (see Appendix M). The total number of words describing caring in studies of the practicing registered nurses was 70. A total of 28 words describing caring were identified in the research where student nurses were participants. This step helped capture the perspective of the student nurse versus the practicing registered nurse. For example, in the studies where registered nurses described caring, 10 references to knowing the patient as a part of caring were made; while, the studies where student nurses were the participants included only four. This grid served as the framework for the next steps in the analysis.

(3) *Reading entries by typology, recording the main ideas in entries on a summary sheet;* and (4) *Look for patterns, relationships, themes within typologies.* A summary sheet was developed that included all 78 words describing caring. The researcher categorized each word under the typology of Knowing, Patience, Courage and Other using Mayeroff (1971) and Nkongho's(1990) research as detailed in Table 4. In order to validate the categorization of data, two content experts, a masters prepared hospice nurse and a doctoral prepared nurse educator repeated this step. This analysis served as a matrix to review the qualitative data (see Appendix N).

(5) *Reading data, coding entries according to patterns identified and keeping a record of what entries go with each element of the* patterns. Written data from the participants' answers to an open-ended survey question and the one-on-one interviews were then read and color coded using the matrix developed from the Related Literature Review and Mayeroff and Nkongho's description of the critical elements of caring as presented in Table 4. Using the matrix, data were re-read completely and color coded keeping only one typology in mind at a time.

(6) *Deciding if patterns are supported by the data and search the data for nonexamples of the pattern;* and (7) *Looking for relationships among the patterns* identified. Since the relationships of the typologies have been validated through the prior research of Nkongho, a comparison of the survey answers and qualitative data were made to detect and report any discrepancies between the data sources. This comparison was done for the sample as a whole, and then, separately for Level I and Level II.

(8) *Writing the patterns as one sentence generalizations*. Descriptions of caring typologies as described by Mayeroff and Nkongho were written listing words and statements aligned with related quotes from participants

(9) *Selecting data excerpts that support the generalizations.* An excerpt from the chart is presented in Table 5 as an example of how the student text was related to the defined topologies. Color-coding was used to identify the themes in each of the four subcategories of Knowing, Courage, Patience, and Other. After re-reading and coding all the student self-reported data, patterns, relationships, and themes from the text were entered on a chart grouping them into Knowing, Patience, Courage, and Other.

Table 5

Description and Examples of Knowing, Patience, and Courage with Corresponding Quotes from Non-Traditional Student Interviews

Definitions		Quotes by Mayeroff & Nkongho Describing the Ingredients of Knowing, Courage, and Patience	Quotes Extrapolated from Student Interviews and Open-Ended Survey Questions
Knowing	Explicit and implicit knowledge, knowing that and knowing how, direct and indirect knowledge, all relate in various ways to helping the other grow.	"In order to care I must understand the other's needs. I must be able to respond properly to them and clearly good intentions do not guarantee this. I must know who he is, what his powers and limitations are, what his needs are and what is conducive to his growth. I must know How to respond to his needs; and what my own powers are" (Mayeroff, 1971, p. 19). "Awareness of the other as separate with unique needs. Understanding who the person cared for is. Includes general and specific knowledge of the person cared for. Important to knowing is knowing one's own strengths and limitations" (Nkongho, 2003, p. 185).	"I think it helps if you get a chance to look at a patient's history so you know where they are coming from and you can make reference to even the name of a family member." "I want to know everything I am supposed to know, so I can truly help someone."

Table 5 (continued)

Description and Examples of Knowing, Patience, and Courage with Corresponding Quotes from Non-Traditional Student Interviews

Definitions		Quotes by Mayeroff & Nkongho Describing the Ingredients of Knowing, Courage, and Patience	Quotes Extrapolated from Student Interviews and Open-Ended Survey Questions
Patience	Enabling the other to grow in its own time and in its own way.	"The growth of an idea can no more be forced than the growth of a flower or a child. By being present for the distraught man, we give him space to think and feel. The patient man gives the other room to live; he enlarges the other's living room while the impatient man narrows it. Besides being patient with the other, I must be patient with myself. I must give myself a chance to care" (Mayeroff, p. 23-24). "Patience allows time and room for self-expression and exploration. It allows time for confusion and disorganization which is a characterization of growth" (Nkongho, p. 185).	"I don't just want to talk to the patients. I want to wait for a response. To hear and know what they say." "I knelt down to be eye to eye with the patient and talked to her." "I am patient with everyone but my husband." "I want to give the patient a chance to talk. Just sit and talk."

Table 5 (continued)

Description and Examples of Knowing, Patience, and Courage with Corresponding Quotes from Non-Traditional Student Interviews

Definitions		Quotes by Mayeroff & Nkongho Describing the Ingredients of Knowing, Courage, and Patience	Quotes Extrapolated from Student Interviews and Open-Ended Survey Questions
Courage	Willingness and ability to take risks; to go into the unknown.	"I have no guarantee where it will end or in what unfamiliar situations I will find myself. I cannot anticipate fully who or what the other will become or who I will become. This is the courage of the artist who leaves the fashions of the day to go his own way, and in doing so comes to find himself. Trust in the other to grow and in my own ability to care gives me courage to go into the unknown. The greater the sense of going into the unknown, the more courage is called for in caring" (Mayeroff, p. 34-35). "Present when the direction of growing and its outcome are largely unknown. Courage to care is gained from past experience and by being sensitive and open to the needs of the present" (Nkongho, p. 185).	"I was pregnant, single, and a family member committed suicide all during the same year. It was tough especially being single, I raised him on my own, went through the pregnancy alone." "If I knew a colleague was taking drugs while on the job, I would confront them and report them. It's because I care about them as well as their patient's safety."

Summary

This chapter presented the design of a mixed-method study to determine whether non-traditional nursing students, who do not have prior healthcare experience, perceive they have the ability to form caring relationships with patients and if the perception changes during the course of an Associate Degree Nursing Program. The effect of prior experiences on perceptions of caring ability during the nursing program was also investigated. A description, rationale for choice of the study sites, and choice of the population were included. Recruitment procedures, along with

challenges met along the way, were detailed. A description of the quantitative instrument, the CAI, its development, reliability, and validity were presented. An explanation of gathering data through interviews was given and the process for analysis of the mixed-method provided. The design of this study provided in Chapter III offers a framework for the data obtained in order to answer the research questions. Chapter IV presents the data analysis of the study.

CHAPTER IV

DATA ANALYSIS

Introduction

Non-traditional students seeking a career in nursing at a community college can add significant numbers toward decreasing the nursing shortage (Cangelosi & Whitt, 2005; Kohn & Truglio-Londrigan, 2007; Korvick & Williamson, 2006; Shiber, 2003). In fact, state governments such as Michigan are offering displaced workers tuition-free community college education for high-demand jobs, one of which is nursing (Eby, 2007, Fierce Healthcare, 2007). However, little research is offered that investigates the perceptions of students' ability to form and maintain the caring nurse-patient relationship. If students perceive that they do not have the ability to form caring relationships, they are ill equipped to meet their own needs for satisfying jobs or to meet the needs of patients to the degree that promotes an environment conducive for healing. If students are transitioning from a job that does not require caring relationships to be successful, they may suffer from burn out, job dissatisfaction, negative attitude, or early attrition rates. An example of such jobs as cited by Folbre (2003) described jobs such as those on the assembly line, plumbers, or bookkeepers. It has also been suggested that students who come from fields characterized by purely scientific backgrounds, such as mathematics and engineering, are less adaptable to the humanistic part of nursing (Utley-Smith, Phillips, & Turner, 2007).

The problem of this study was to identify whether non-traditional nursing students who have no work experience in a healthcare or related field perceive they have the ability to form caring relationships with patients. Cross section measurement of perceptions of the ability to form caring relationships occurred at two points--before entry into the first semester of nursing courses and at the completion of their program. This study also sought to identify if there was a

relationship between students' prior careers/experiences and the degree of perceived ability to form these relationships.

In this chapter, the findings of the study designed to answer the following research questions are discussed.

1. What are non-traditional nursing students' perceptions of their ability to form caring relationships prior to entry into the nursing program?
2. In what ways do the prior experiences of non-traditional nursing students influence their ability to establish/maintain caring relationships during the nursing program?
3. To what degree do non-traditional nursing students perceive that their ability to form caring relationships has changed from entry to exit of the nursing program?

Descriptive Analysis

Response Rates

The total number (N = 95) from two Associate Degree Nursing Programs in Central and Eastern Pennsylvania consented to participate. Of this number, 64 non-traditional students responded to the CAI on Qualtrics, an online research software program, making the response rate 67% (64 of 95). For this study, the original CAI was modified to include participant demographics such as, identification of level in the nursing program, age, gender, former career, first degree, and contact information. When respondents answered yes to the default question, "Were you previously employed in healthcare?" they were forwarded to the end of the survey and were unable to complete the CAI. Of the 64 respondents who attempted the survey, 26 did not have prior healthcare experience. Two Level I surveys were eliminated because of missing data, leaving a total of 24 respondents who met all the criteria. The remaining 24 respondents consisted of 12 students just entering the first clinical practice portion of the curriculum (Level I) and 12 students who were in the last semester or had just finished the nursing program (Level II).

Demographic Data

The participants ranged in age from 22-54 years. The mean age of the students who participated in the study (N = 24) was 37.4 years. Figure 1 provides a visual demonstration of participants' distribution of age.

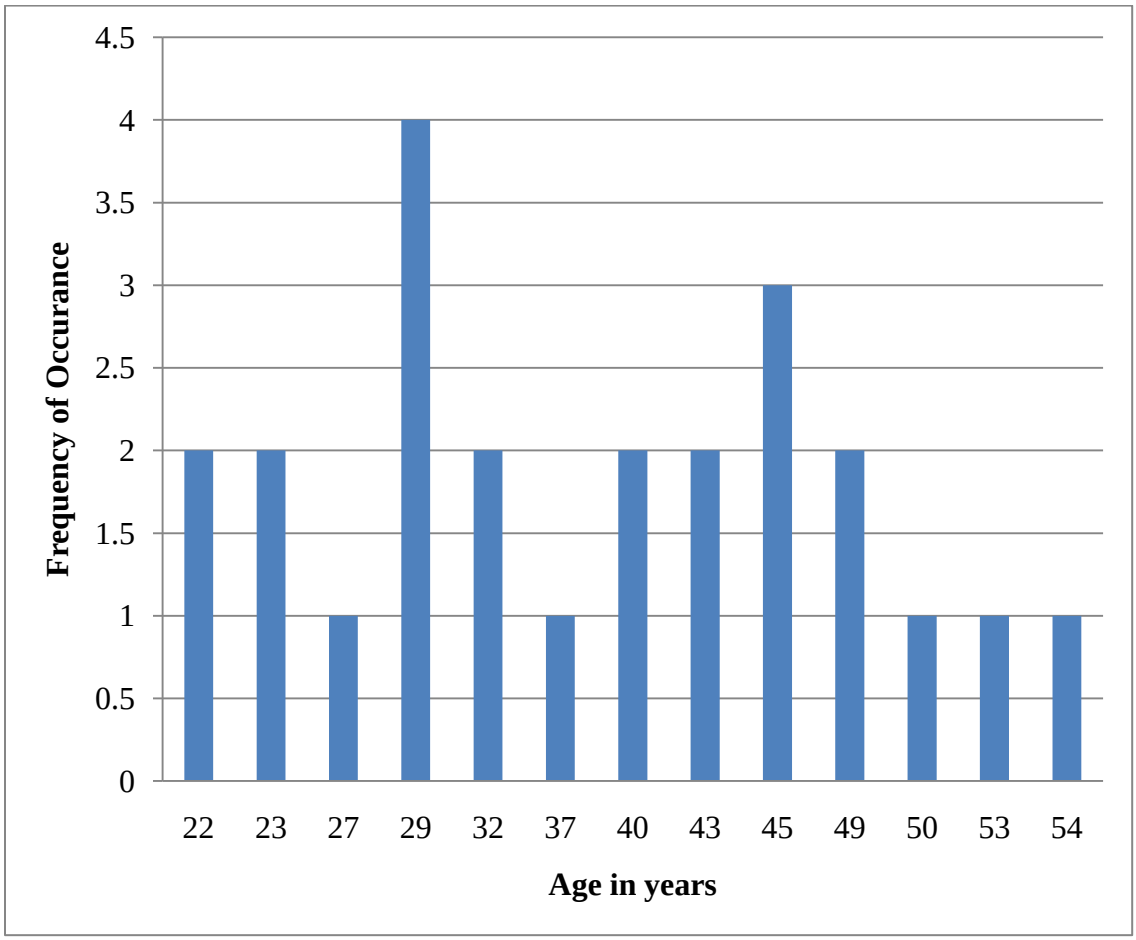

Figure 1. Age distribution of participants.

Analysis of the distribution showed that the data were evenly distributed with 12 respondents above the mean of 37.4 years and 12 below the mean of 37.4 years.

The population consisted of 19 females and 5 males. Former careers included managerial and clerical roles, service occupations, and other. The highest number of those with former

careers (n = 11) were in managerial roles such as club manager, management consultant, sales manager, employee manager, insurance case manager, customer advocate, and manager of restaurant design. The next greatest numbers of occurrence were those who reported being in clerical roles, such as administrative assistant, secretary, and bookkeeper (n = 6). Four reported they were in service occupations such as waitress, bartender, day care worker, and massage therapist. One respondent reported having a position as a cashier in a large superstore. Additionally, one reported being a research administrator for a local university, and one was an interior designer.

Seven students reported having a prior degree; thus, 29% (7 of 24) of the sample were second degree students. These degrees included Bachelor of Science in Business Management/Marketing, Associate Degree in Specialized Business - Executive Secretary, Associate Degree in Interior Design, Bachelor of Science in Health Sciences, Bachelor of Science in Psychology, Bachelor of Science in Legal Studies, and Bachelor of Science in Accounting. The participant who earned a Bachelor of Science in Health Sciences met the criteria as she did not have experience in the clinical area during the program or while working as a research administrator reviewing and negotiating research contracts for a local university.

In this study, data gathered from interviews and personal choice writings were reviewed in order to understand the perception non-traditional students have of their ability to form caring relationships. Therefore, data analysis to answer the research questions included many direct quotes from the participants. The chapter also includes personal stories of respondents describing individual perceptions of their experiences and ability to form caring relationships.

Research Question 1: What are Non-Traditional Nursing Students' Perceptions of Their Ability to Form Caring Relationships Prior to Entry into the Nursing Program?

This question was answered through analysis of quantitative scores from the CAI as well as qualitative data gathered from the brief paragraph and interviews.

All participants (N = 24) completed the CAI on Qualtrics, an online research software program. The CAI was used to measure perceptions of their ability to form caring relationships prior to entry into the nursing program. Level I and Level II data were divided and analyzed separately to measure non-traditional students' perceptions prior to entering the nursing program. To measure the perceptions of Level I non-traditional students in this sample (n = 12) had of their ability to form caring relationships prior to entry into the nursing program, the means of the Level I responses were compared to Nkhongho's (1990) data using SPSS. Each respondent was scored on each of the subscales, Knowing, Patience, and Courage as well as the total CAI. Respondents may have had one high, a low or medium score for one or more of the subscales but still received a high score on the total CAI. For example, a respondent whose score for Knowing was in the medium range (81), high range for Courage (84), and low range for Patience (57) when added together received a total score of 222 placing her in the high range. Analysis of the data from the CAI for Level I (those prior to entering the nursing program) non-traditional students revealed the following subscale means: Knowing, (74.6); Courage (73.9); and, Patience (60.7). Range for total CAI was < 200.8 to > 219.8. The norming procedure determined by Nkongho (1990) was used to determine the ranges for low-, medium- and high-norm scores. A 0.5 standard deviation on either side of the mean was considered to be in the middle range of scores. Scores above this range were considered high, and scores below this range were considered low (Nkongho, 2003). These scores are compared with the participants' scores for the CAI for nurses in the studies completed by Nkongho (2003) and Raines (2007) and discussed

in Chapter V. Table 6 illustrates the low, medium, and high scores of perceptions of ability to form caring relationships as compared to the maximum obtainable score for the Level I participants.

Table 6

Low, Medium, and High Norms for Caring Ability Inventory and Subscales for Level I Non-Traditional Students (n = 12)

Subscale	Low*	Medium	High
Knowing	Below 72.2 (*n* = 7)	72.2-79.6 (*n* = 5)	Above 79.6 (*n* = 0)
Courage	Below 69.42 (*n* = 0)	69.42-75.58 (*n* = 7)	Above 75.58 (*n* = 5)
Patience	Below 59.2 (*n* = 3)	59.2-64.8 (*n* = 6)	Above 64.8 (*n* = 3)
Total CAI for Level I	Below 200.82	213.42	Above 219.98
Total CAI	Below 203.7	203.7-217.1**	Above 217.1

Note. *For ranges for low, medium, and high norm scores, 0.5 standard deviation on either side of the mean was considered to be in the middle range of each score. Scores above this were considered high and those below were considered low (Nkongho, 2003). The Caring Ability Inventory. In O. Strickland & C. Dilorio (Eds.), *Measurement of Nursing Outcomes* (pp. 184-196). New York: Springer Publishing Co. **Total possible scores for the CAI range from 37-259. Mean CAI score $\pm$ standard deviation was 213.42 $\pm$ 3.68.

Analysis of scores on the CAI for Level I resulted in 41.6% (*n* = 5) of the sample with a caring score of 72.2 or better for Knowing. For Courage, 100% (*n* = 12) of the sample had a caring score of 69.42 or better. For Patience, 75% (*n* = 9) of the sample had a caring score of 59.2 or better. Although there were 10 scores in the low range for Knowing and Patience, when looking at the total CAI scores, which predict perceptions of caring ability, a total of two respondents had a score less than the mean of 203.7, 7 scored in the medium range, and three in the high range. This is illustrated in Table 6.

In addition, participants were asked focused interview questions related to their perceptions of their ability to form caring relationships (see Appendix L). For example, one question asked students to describe their perception of ability to establish a caring relationship with patients they cared for using a scale of 1 to 10 (with 1 being the weakest ability and 10 being the strongest ability). The Level I students scored themselves in a range from 8 to 10, with a mean of 8.67. Comments from this group included: "I will probably never be a 10 because you can always learn something. I enjoy talking to people. I enjoy learning about things;" "I would say a 9 because I know I care about people, but I have never actually done it yet;" "I think I am an 8 for now since I am not experienced yet;" and "I think I am a 9. I have always been a caring person." All of Level I respondents except two reported their scores as higher than that of other nurses they have observed. One respondent discussed wanting to score the nurses on a range of 3 to 10, adding that she had seen some "really poor and some really good" caring nurses. Another gave herself and others the same score of 8. Other students' perceptions of nurses' ability to form caring relationships ranged from 2 to 10. Figure 2 depicts the perceptions Level I students had of their ability to form caring relationships compared with nurses they have observed. The scale is 1 to 10 with 1 being students' perception of weakest caring ability and 10 being students' perception of strongest caring ability.

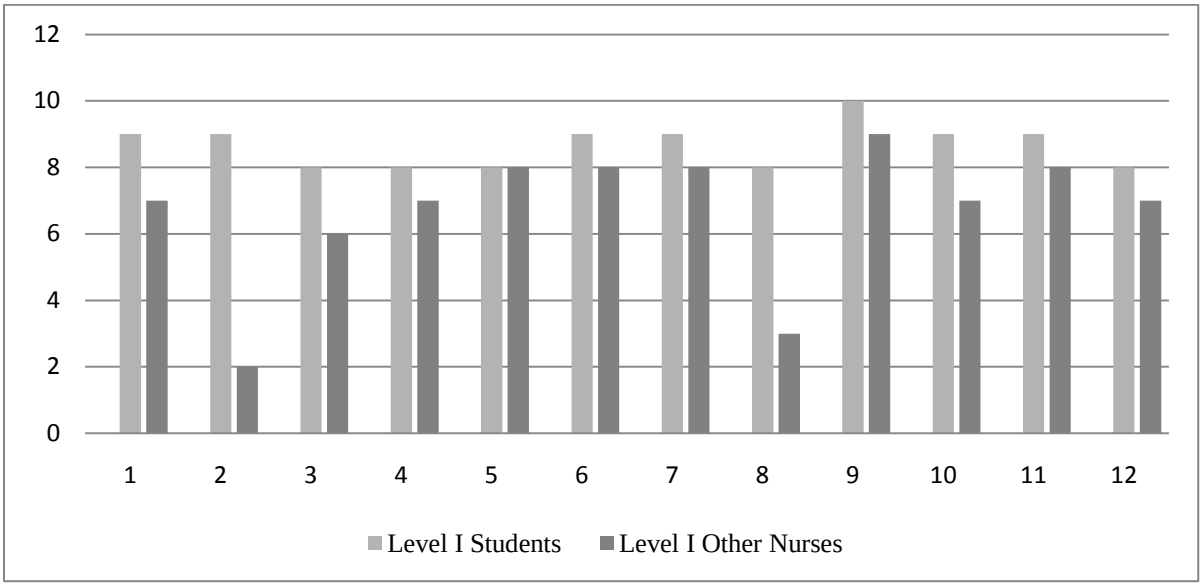

Figure 2. Level I non-traditional students' self-reported perceptions of caring ability compared with observations of other nurses. Level I participants scored perceptions of their own ability to form caring relationships compared to nurses they have observed in practice based on a score of 1 to 10 with 1 being the weakest and 10 being the strongest.

In order to obtain a more in-depth analysis of the students' personal and prior experiences from the survey, an open-ended question, "Write a brief paragraph about why you chose nursing as a career," was included. The responses identified three common themes that motivated these student nurses to choose nursing as a career. The first theme that evolved was that students had long-term desires to become nurses. Next, the desire to become a nurse was based on personal experience within the healthcare system. For some, this personal experience was positive. For others, it was a negative experience; and respondents wanted to prevent such negative experiences from happening to someone else. Third, all 24 students wrote they had a caring or nurturing personality that would be valuable to them as a nurse, and they wanted to help others. The following excerpts from the interview and brief paragraph relate to each of these themes.

Nine students always wanted to be a nurse, but life circumstances diverted their attempts. All nine students shared this lifelong desire during the interviews or brief essay. Dorothy's story was representative of participants who reported they always had the ability and desire to become a nurse. For Dorothy, becoming a nurse had been a lifelong desire.

I've been interested in nursing since my teens, but was encouraged by well-meaning family members to pursue other educational and occupational opportunities. While my degree and additional academic work along with professional advancements provided enjoyable challenges and adequate rewards, my interest in nursing remained. Pursuing that interest however, was further delayed in recent years as I had the fulfilling opportunity to stay at home with my children during their pre-school years. Because I was at home raising my children, I also had the opportunity and honor to care for my mother-in-law in the last weeks of her life during her battle with cancer. This experience both confirmed my desire and resolve to enter a vocation in nursing.

The following table illustrates Dorothy's scores on the CAI. Her total score was 214 which placed her perception of her ability to form caring relationships in the medium score range. However, on her individual subscale she scored high in patience.

Table 7

Individual and Total Caring Ability Inventory Scores for Dorothy (Long Term Desire to Become a Nurse)

	Caring Ability Inventory Scores for this Group by Participants (N = 24)			
Subscales	Low	Medium	High	Dorothy
Knowing	<72.2	72.2 – 79.6	>79.6	76
Courage	<69.42	69.42 – 75.58	>75.58	72
Patience	<59.2	59.2 – 64.8	>64.8	66
Total Caring Ability Inventory Scores	<203.7	203.7 – 217.1	>217.1	214

Others (n = 6) had intense personal experiences within the healthcare arena as patients or as family members of a patient who was critically ill or died. They either wanted to model the positive care given to them and their family or to ensure others were not treated as negatively they had been. For Maria the decision to become a nurse was sealed after her fifth miscarriage. She described her experience as having a negative and positive influence on her decision to become a nurse.

> The main reason I want to be a nurse is so that nothing ever happens to another person like it happened to me. About two months after my last miscarriage, I started to have severe abdominal pains. They really hurt and wouldn't stop. It felt like I was in labor. I went to the emergency room where I stayed most of the day. They could not determine why I was having the severe pain. It just wouldn't let up. They thought I just wanted drugs. I felt they were rude and unkind. Finally, they discharged me and told me to go see my medical doctor. I left the ER and went over to his office to see if I could make an

> appointment. I was still in a lot of pain. When I was standing at the receptionist desk, I delivered another miscarriage right there. Since my OB/Gyn was in the same building, the receptionist walked me over to their office. A nurse came out and took me into a small private room. She hugged me and all I could do was cry. It must have been 30 minutes or so but she did not leave me. She just left me cry and she held me. She didn't feel like she had to run off . . . she just held me until I was done. That was the first time anyone had been so caring and kind. That is the kind of nurse I want to be. I want to help people like that.

Amy talked about her father who passed away many years ago from acute myelogenous leukemia and how the care given to him and their family was an event that left a lasting positive impression.

> I found myself very intrigued with nursing from that point forward, and felt this was a career path that would be of interest to me. . . . I want to treat patients like I would want to be treated or would want my family members to be treated. It could be my grandmother, or that could be my mother and I want them to be treated like my family.

Maria's and Amy's CAI scores are illustrated in Table 8.

Maria's scores on the CAI indicated that her perception of being able to form caring relationships correlated with the verbal and written data. Her total CAI score fell in the high range for Knowing and in the medium range for Courage for this group of participants. Her score for Patience was in the high range. Amy had high subscale scores for Knowing, Courage, and medium scores for Patience. Her overall CAI score fell in the medium range.

Table 8

Individual and Total Caring Ability Inventory Scores for Maria (Negative Personal Experience with Healthcare) and Amy (Positive Personal Experience with Healthcare)

	Caring Ability Inventory Scores for this Group by Participants				
Subscales	Low	Medium	High	Maria (Negative)	Amy (Positive)
Knowing	<72.2	72.2 – 79.6	>79.6	76	80
Courage	<69.42	69.42 – 75.58	>75.58	75	76
Patience	<59.2	59.2 – 64.8	>64.8	67	61
Total Caring Ability Inventory Scores	<203.7	203.7 – 217.1	>217.1	218	217

It is evident in the open-ended responses in the brief paragraph that all 24 students perceived they possessed the caring ability necessary to form the relationships required of nurses. "I've always enjoyed helping people because I love people in general and I love helping people," "I've always enjoyed helping people get through difficult times in their lives," "I chose to pursue a career in nursing so that I can help others and make a difference in their lives," and "I have always had a knowledge and love for the career. I want to be part of the healthcare field that is loving and compassionate."

Chloe Ann's comments reflected her feelings of being nurturing and wanting to help others. She had always viewed herself as a caregiver. After perusing a career in interior design, she reported her work was not personally fulfilling. She had family members who were in the medical field and thought helping others as a nurse would give her the fulfillment she was seeking.

I wanted to do something where I could make a difference and actually help people. I have always, and continue to be, a natural caregiver, and now is the right time for me to pursue my dream of being a Registered Nurse. I just think I have what it takes to be a great nurse and cannot wait to get started.

Chloe Ann's individual scores on the CAI were: Knowing 80; Courage 73; and, Patience 64. Her score for Knowing was within the high range. Chloe Ann's total CAI score was 217, placing her overall perception of ability to form caring relationships in the medium range. Her scores are presented in Table 9.

Table 9

Individual and Total Caring Ability Inventory Scores for Chloe Ann (Caring or Nurturing Personality)

	Caring Ability Inventory Scores for this Group by Participants			
Subscales	Low	Medium	High	Chloe Ann
Knowing	<72.2	72.2 – 79.6	>79.6	80
Courage	<69.42	69.42 – 75.58	>75.58	73
Patience	<59.2	59.2 – 64.8	>64.8	64
Total Caring Ability Inventory Scores	<203.7	203.7 – 217.1	>217.1	217

Although financial security was not one of the major themes, when mentioned by respondents as a motivation for pursuing a career in nursing, those respondents' statements included a description of strong perceptions of caring as the primary reason for choosing nursing. These responses were similar to Yong's.

Clearly my love of people and caring for them is the main motivator in choosing this career; however, I also find the flexible hours (working anytime around the clock) and the ability to adequately provide financial support to my family to be the icing on the cake.

Yong's survey response shown in Table 10 in total scores was 222 and represented a high overall score. Her only low score was in the subscale of patience.

Table 10

Individual and Total Caring Ability Inventory Scores for Yong (Financial Security)

	Caring Ability Inventory Scores for this Group by Participants			
Subscales	Low	Medium	High	Yong
Knowing	<72.2	72.2 – 79.6	>79.6	81
Courage	<69.42	69.42 – 75.58	>75.58	84
Patience	<59.2	59.2 – 64.8	>64.8	57
Total Caring Ability Inventory Scores	<203.7	203.7 – 217.1	>217.1	222

In analyzing the interview transcriptions, the matrix for evaluation of qualitative data developed from Mayeroff and Nkongho's framework, as well as, the content Review of the Related Literature were used to identify concepts shared by interviewed students as described through Knowing, Patience, and Courage (see Appendix N). For example, Chloe Ann's statement reflected her perceptions of caring through Knowing (competence, efficiency) and Courage (integrity and empathy).

> I believe that as a nurse, some of the virtues I can offer my patients and their family is empathy and adaptability; and to my medical superiors, I can offer competence, efficiency and integrity.

Dorothy added concepts of Knowing (knowledge and compassion), Courage (commitment and love), and Patience:

> I love people. It is loving another person, another that you are looking out for. It is not just a feeling but as a commitment. You are going to do your job each day. I think first of all, to go into nursing you are going to have to be a compassionate person to be a good nurse. You have to love people. Otherwise, I don't think you are going to be a good nurse. It is a choice. You go into work every day. It doesn't mean you feel the best. But you are going to go in and you have a responsibility to those people that you are in charge of. So, caring there is still that compassion, that love, and that commitment. It is a sincere interest in the client, full attention, taking time with the patient, okay, not rushing through. The other thing is knowledge and willingness to spend the time to give that knowledge and to truly help.

Tara added that she was able to form caring relationships by Knowing:

> I like to talk to people and I like to listen, somebody needs, you know, food, shelter and clothing, but they need somebody to listen to them, somebody to deal with their problems, their fears, make sure everything is understood. That if there is anything extra that I can do to make it a little more comfortable.

All Level I non-traditional students during the interview and in the brief paragraph perceived they had strong abilities to form caring relationships prior to entering the nursing program.

When CAI scores of these participants were compared with the norms established by Nkongho (1990), the total CAI scores demonstrated no significant difference. However, calculation of independent sample t-tests in comparison with prior studies revealed that there is a significant difference in the subscales of Knowing, Courage, and Patience. Of particular interest, the scores for Courage for this study were significantly higher than the norms in Nkongho's study. The scores for Knowing and Patience were significantly lower than the norms in Nkongho's study. Because of the variation in each of the three areas Knowing, Courage, and Patience, the total CAI scores demonstrate no significant difference. Table 11 displays this data. When facilitating students in the growth of caring behaviors this information may serve to alert educators where individualized focus is needed.

Research Question 2: In What Ways do the Prior Experiences of Non-Traditional Nursing Students Influence Their Ability to Establish/Maintain Caring Relationships During the Nursing Program?

Respondents (N = 24) came to the nursing programs from a variety of other careers. No matter what their prior career, all respondents were motivated to enter nursing based on prior personal or family experiences with healthcare, a long term desire to become a nurse, and the perceptions that they had personalities and caring abilities that would be beneficial as a nurse.

Table 11

Comparison of Mean Caring Ability Inventory Scores for Participants in this Study with Those in Nkongho's Study

Subscale	Mean for this Study (N = 24)	Mean for Nkongho's Study (N = 75)	t test
Knowing	76 (SD = 7.3)	80.2 (SD = 7.6)	t = 6.65
Courage	72.4 (SD = 6.2)	68.3 (SD = 8.25)	t = 5.4
Patience	62 (SD = 5.7)	63.1 (SD = 4.2)	t = 2.28
Total CAI	210.4 (SD = 13.4)	211.7 (SD = 17.2)	t = 1.24

Note. Critical level = 1.98.

One respondent in particular made an interesting analogy for transferring skills from a prior career to the caring required as a nurse. When Gary talked about having a level of comfort in developing a caring relationship with his patients, he reported self-confidence developed as a retail sales manager was helpful. His perception that he had already acquired the ability to establish a relationship while helping people purchase items of clothing was easily transferred to helping people with healthcare. When he was asked "How did you develop that level of comfort?" he responded:

> I have been actually helping to serve the public for a very long time; and it is something that I enjoyed. I can't say that selling something was the enjoyable part. I think that the relationship you did have with your customers and, in this case, with patients where you make them feel as ease and make them feel that you are there for them. So for me it was easy to use the strong customer skills I developed in my former career. For me to

> approach a person and fire questions about what they needed, it was just me. Because I used to sell shirts, ties, suits, and shoes before I was the manager there. I just apply everything that I learned there into developing those assessment questions. All it is a matter of tweaking things. I ask you your shoe size. I ask you if you went to the bathroom last night. Did you sleep well last night? Oh, you were up at 2 am? What happened at 2:00 o'clock to wake you up?

Gary used his communication and sales skills to give him confidence in establishing a relationship with and assessment of his patients. As a result, he could focus on the other learning required of the profession.

Amy submitted her resignation to her employer 29 years ago when she planned to attend a local vocational school to become a Licensed Practical Nurse. Her employer offered her a substantial raise and persuaded her to stay with the company. She was a loyal employee during her career and had many opportunities for professional growth as a Customer Advocate for men's tailored clothing. She lost this job when the company closed. Amy was then able to revisit her interest and passion for nursing. Amy said that her role as a Customer Advocate gave her skill in social interactions with patients and families:

> As a customer advocate you basically were the advocate for the customer within the company. I met with them very often, at least a couple times a monthly, even though they were in like Dallas and Florida. And it gave me a good background with social interaction with people. . . . Because I have that background and, I can focus on learning the technical things, the tasks I need to practice on. I feel I do have the ability to form caring relationships. I really feel I can do that.

Amy's comments validated that her perception of the ability to form the nurse-patient relationship was enhanced by the skills learned in her prior career.

A summary of the types of prior experience is illustrated in Table 12.

Table 12

Prior Employment and Education Experience

Experience	Frequency (N)	Percent %
Response Rate	64	67
Prior Experience in Health Care	38	59
Gender		
Female	19	79
Male	5	21
Prior Degree	7	29
Degree Type: Bachelors of Science	5	20
Business Management/Marketing	1	04
Health Sciences	1	04
Psychology	1	04
Legal Studies	1	04
Accounting	1	04
Degree Type: Associate Degree	2	08
Specialized Business	1	04
Interior Design	1	04
Experience Type		
Managerial	11	46
Clerical	6	25
Service	4	17
Other	3	12

The total group of non-traditional students (N = 24) was sorted into former careers and subcategories established for the CAI. The median of the scores for all participants fell into the medium range of perceptions of ability to form caring nurse-patient relationships. There were two exceptions. Those in the service group (waitress, bartender, day care worker, and massage therapist) scored in the high range for Knowing; and, those in the Other group (cashier at a large superstore, research administrator, and interior designer) scored high in the subcategory of Patience.

Table 13

Prior Careers and Scores on Caring Ability Inventory for Non-Traditional Students (N = 24)

Former Career	*N*	Knowing	Patience	Courage
Managerial	11	74.60** (*Mdn* = 76.00)	60.70** (*Mdn* = 61.00)	73.90** (*Mdn* = 74.00)
Clerical	6	81.20** (*Mdn* = 81.00)	62.40** (*Mdn* = 63.00)	71.60** (*Mdn* = 66.00)
Service	4	78.50* (*Mdn* = 78.50)	64.75** (*Mdn* = 64.00)	72.50** (*Mdn* = 71.50)
Other	3	80.00* (*Mdn* = 76.00)	67.00** (*Mdn* = 65.50)	75.00* (*Mdn* = 71.50)

Note. The median scores were chosen for analysis of this data as a result of the small sample size. Field, A. (2009). *Discovering statistics using SPSS.* California: Sage Publications, LTD. *High range of total score. **Medium range of total score.

Due to the small sample size non-parametric statistical analysis was completed. To determine if there were differences between the categories of careers, a Kruskal-Wallis test was conducted on the data from the CAI. Critical level of significance was set at .05. The results of the test (Table 14) demonstrated there was no statistically significant difference ($p > 0.05$) between prior career/experience in this study in terms of perception of ability to form caring relationships.

Table 14

Kruskal Wallis Test for Knowing, Courage, and Patience Subscales of Non-Traditional Students in this Study (N = 24) Related to Prior Career

	Knowing	Courage	Patience
Chi-Square	5.5	1.02	3.50
df	3	3	3
p	0.14	0.80	0.32

During the interviews all non-traditional students could verbalize how prior experiences and careers helped their perceptions of their ability to form caring relationships. The following excerpts relate how life and career experiences led to perceptions of abilities to form caring relationships based on Knowing, Courage, and Patience.

Knowing involves, "explicit and implicit, knowing that and knowing how, direct and indirect knowledge, all related in various ways to helping the other grow" (Mayeroff, 1971, p. 21). Additionally, Nkongho (2003) describes Knowing as the "awareness of the other as separate with unique needs, understanding of with general and specific knowledge of the person cared for. Also important, is knowing one's own strengths and limitations" (p. 185).

Roseanne, a former club manager and server, and Bonnie, a former administrative assistant, perceived they had an innate ability to form caring relationships, and for them becoming nurses had been a life-long dream. Roseanne stated that she had wanted to be an RN since she was 16, but her health prevented her from entering college and getting her degree. Now that she was well she could follow her life-long dream:

> I think my attitude would be the most important for my patients. I honestly believe, because I have had so much experience in the hospital, I would have great compassion

for people. And like my doctor told me, he wants to hire me once I'm done with schooling. He said, "Roseanne, your compassion, in everything, your knowledge of what goes on in the hospital and everything, will take you much further than other nurses." He said. "You have an advantage whether you know it or not."

Bonnie spoke about always being a natural caregiver and wanting to become a nurse since she was very young. She perceived that her ability for caring was strong. In the following quote she used words that described Knowing.

> I will put my best foot forward every day to ensure that the patient is comfortable; and that I can do it efficiently and empathetically. Lots of nurses are good at what they do, but there are those some that are just those gold stars and when they come in the room you just feel comfortable and you are at ease and you just know you are in good hands with that nurse. They have that aura about them and they just . . . I don't know they just, appear confident but not harsh. I think I am compassionate. I am empathetic. I think I have somewhat of an intuition into how someone is feeling. It is really that compassion and, you know, the competency that go together, just make me think that I would be a caring nurse. . . . I think since I was little I have always had the caring gene or what it really is exactly. . . . I have always wanted to take care of the person who seemed to need help most.

Table 15

Knowing Subscale Scores on the Caring Ability Inventory for Roseanne and Bonnie

Subscale	Roseanne	Bonnie
Knowing*	70	83

Note. *Norm for this group, Low (< 72.2), Medium (72.2-79.6), High (>79.6).

The scores for Bonnie were high in the subscale of Knowing. Bonnie's score for Courage was 65 and for Patience 64, making her total CAI scores 212, which fell within the high range for this group. Roseanne's score of 70 for Knowing put that score in the low range for that subscale. When calculating her total score including 73 for Courage and 45 for Patience, her total score made her perceptions of her ability to form caring relationships in the low range.

Courage is willingness and ability to take risks; to go into the unknown. It is integrated with hope and trust (Mayeroff, 1971). Nkongho (2003) writes that courage is present when the direction of growth and its outcome are largely unknown. Courage to care is gained from past experience and by being sensitive and open to the needs of the present. Using these descriptions of courage, all non-traditional students in this study demonstrated courage when they decided to enter the unknown of a challenging curriculum and profession. Caring for the dying patient and family was largely an unknown. Dorothy, Joe, and Amy linked courageous personal experiences dealing with the deaths of close loved ones to strengthening their choice to become nurses. For Dorothy taking care of her mother-in-law during her last days proved to be a pivotal period that made her want to pursue a career of nursing. Their conversations during that time demonstrated Dorothy's courage in this situation.

> I took care of my mother-in-law when she was dying with cancer. My husband is a pastor. We have a great faith. My mother-in-law had a great faith, but I found I didn't

> hide things. I remember telling her the day hospice came. I just started crying and I said I want to take this from you. I wish I could take this from you. She said, well, I have to do it myself and I said, well then you better just promise me that when it is my turn you better be right there waiting for me. And she said, I promise.

Joe made a move into an unknown situation when he decided to move home from Los Angeles, California to Pittsburgh, Pennsylvania to care for his terminally ill grandmother. This experience evolved into his choice to pursue nursing as a career.

> My grandmother was suffering from ovarian cancer and she had been in remission for a while. She was in remission and then it relapsed and came back. She had decided this time not to try to fight it anymore, she was getting a little older, she was 84 and she opted for hospice care. I was moving home from LA and decided that instead of getting into school or getting a job, I would take care of her. I got more joy from doing this type of caring than I ever did doing massage.

Amy, Chris, and Gary shared details of feeling intimidated or frustrated by the way they were treated in the clinical area. Included with each quote for these respondents are their age and former career in order to highlight for the reader the courage needed for these professional adult learners to commit to their program of nursing when they experienced intimidation in the learning environment. Yong was included in this section since she was a combat lifesaver who provided battlefield first aide while in the military and scored the highest (84) on the subscale of Courage.

Amy, a 49 year old Level II respondent and prior customer advocate for a man's tailored clothing company, chose nursing after observing the nurse who cared for her family after the death of her father. Her comments about courage reflected on the way students were treated in some facilities. She conferred that some clinical assignments were a challenge because the staff

was just not receptive to nursing students. This situation gave students a fear of going into the unknown producing increased anxiety because the students would go to clinical with the expectation of being treated poorly. It took courage to attend clinical in this hostile learning environment. While job hunting, she specifically talked about looking for a work environment where the staff was caring with patients, each other, and welcomed the novice nurse.

Similar comments were expressed by Chris, a 43 year old Level II participant and former sales manager, when he shared his feelings of intimidation around physicians. Gary, also 43 years old and prior retail sales person, shared some of the same thoughts "from the student nurse point of view" when he talked about being "intimidated so much by everyone, not only from the doctors but from the seasoned nurses and just . . . everybody that you are encountering . . . even the nurse's aide."

The scores for Dorothy, Joe, Amy, Chris, Gary, and Yong for Courage are listed in Table 16.

Table 16

Sample of Scores on the Caring Ability Inventory for Courage

Subscale	Dorothy	Joe	Amy	Chris	Gary	Yong
Courage*	72	70	76	69	75	84

Note. *Norm for this group Low <69.42, Medium 69.42-75, High >75.58.

Dorothy, Joe, and Gary had scores for the subscale Courage that were in the medium range for the group, while Amy and Gary scored in the high range. The score for Chris was in the low subscale. These total CAI scores for Dorothy (214) and Amy (217) Chris (206) fell in the medium range. Joe (219) and Gary's (224) total scores were in the high range.

When given a scenario during the interview that required students to make decisions that would involve courage to perform, all students reported that they would do what was best for their patient. For example, one scenario involved a physician who was not following the standard of care for patients. All students (N = 24) voiced they would talk to their superiors about the situation. When asked what they would do if they knew of a colleague who was using or under the influence of illegal drugs or alcohol on duty, all respondents reported they would either confront the person or report the person to supervisors. These kinds of situations required courage to advocate for the patient which is part of the role of the nurse. The concept of needing/having courage was discussed as a complex phenomenon, especially in the role of a student.

Chris, a Level II respondent, described feelings of intimidation when he answered the interview question "do you think it takes courage to be a patient advocate?"

> Yes. It does. It completely does. Well, at this point in my career I can say that right now I am almost intimidated by most doctors. I do better on the telephone with them than I do in person. . . . Yes, I would definitely say that it does take courage to be a patient's advocate.

In response to the question about confronting a physician who made an error in patient care, he added, "I would say that right now I would probably be a little bit more meager that I would maybe in six months to a year from now," indicating this was an area where he needed some practice and experience to develop. Chris had just finished his nursing program, passed NCLEX, and was practicing as a Registered Nurse.

Chris scored a 69 on the CAI subscale of Courage. This fell within the low range (< 69.42) validating his verbal response with the score on the CAI.

Gary was laid off from his position as a sales manager in a major department store because of downsizing. He described his feeling in the first days of class as "exciting and intimidating."

> It was exciting and intimidating at the same time. I needed confidence. For example use of the computers. When I was in high school there was one computer in the whole school and we were starting college and like close to 3 years ago . . . walking into a classroom with 25 computers in the room and I was like, wow! It took me a while to adjust until finally I got a laptop.

Gary's score for Courage on the CAI was 75 placing him within the medium (69.42-75.58) range for this group.

Yong verbalized a strong sense of courage was needed to be a good nurse. She talked about being in the military where developing a caring relationship in a short period of time was needed to "care for and look out for each other." She expressed this same kind of courage was needed to be a patient advocate. "You know what is right and what should be done. I will do what is right and what should be done." Yong's score for the subscale of courage was 84, far above the high range of 75.58 and the highest score in the group (N = 24). Her total score was 222 (High >217.1) with 57 for Patience (Low < 59.2) and 81 for Knowing (High >79.6).

"Patience allows the other to grow in their own time and in own way. The growth of a significant idea or change can no more be forced that the growth of a flower or child" (Mayeroff, 1971, p. 23). Nkongho (2003) adds that "patience allows time and room for self-expression and exploration. This includes time for confusion and disorganization which is a characterization of growth" (p. 185). When asked how students would include development of caring relationships in their patients' plan of care, Dorothy, Kara, and Patricia said that developing a caring relationship took time and patience.

Dorothy added that because everybody was different with different personalities and different skills, it took patience to get to know your patient.

> I think there is a level of patience there. . . . There is something even beyond that because you have got to be patient, but you have got to understand. I am not going to do that in five minutes. That is going to take a while. But even if I can plan say, 20 to 30 minutes for that person, it still might not complete it all, but I would come back later. And I know myself, I would be back even when my shift was over.

Kara, a Level I student, had not yet started her clinical experience. She related her experience to the patience of her nurse during her own labor and delivery. She detailed how her nurse in labor and delivery was with her "every step of the way" as she stayed with her during the entire shift and was willing to stay beyond just for her.

> I was a little nervous, but I had everything planned out . . . and I wanted to have a traditional birth and my nurse was excellent. She stood by me every step of the way. Her shift was supposed to end like at 3:00 and she said, "I am not leaving you or your side until you have your child" . . . and she was great. She just was there every step and she really helped me with the way I wanted to go. That was the biggest one that really showed caring.

Patricia defined taking time with the patient and family as an example of caring behavior.

> I have watched nurses take time to explain everything, answer questions, hold a hand if they need to and also explaining things to family members that are as scared as the patient. And it takes time . . . you have to have a lot of patience with patients who are not always completely with it. You have to have a nurse with a lot of patience.

In summary, all non-traditional students in this study perceived their prior experiences beneficial as they entered into the nursing program. Those who held managerial positions

expressed strongly that their experience with interpersonal relationships learned in their prior careers were beneficial. Those who related to their own experiences wanted to model the nurses who provided caring experiences or used the negative experience to make them more caring nurses than they had experienced. Respondents who reported they had nurturing and caring personalities believed the experience they had prior to becoming a nurse helped to increase their perceptions of ability to form caring relationships.

Research Question 3: To What Degree do Non-Traditional Nursing Students Perceive that Their Ability to Form Caring Relationships has Changed from Entry to Exit of the Nursing Program?

Results from statistical analysis of CAI data were evaluated to compare if there were any changes from the beginning to the end of the nursing program. Based on non-parametric analysis using the Mann-Whitney U, upon entry into the program, Level I respondents had an overall score on the CAI of 71.14 (SD = 7.90). Scores on the three subscales were Knowing, 76.67 (SD = 3.98), Courage 74.67 (SD = 5.57), and Patience 62.08 (SD = 6.05).

The overall mean scores on the CAI for Level II participants at the end of the program were 69.22, (SD = 6.97). The mean score for each subscale was 75.33 (SD = 9.73) for Knowing, 70.42 (SD = 6.26) for Courage, and 61.91 (SD = 5.93) for Patience. This analysis suggests that perceptions of caring ability decreased slightly as the students progressed through the nursing program. Figure 3 presents a graphic demonstration of these scores.

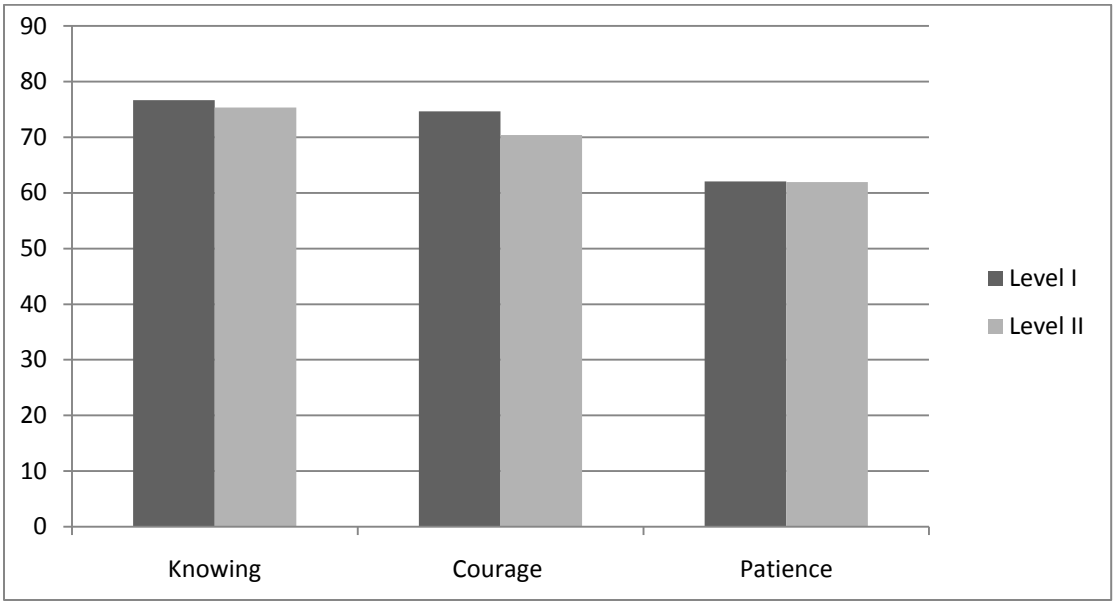

Figure 3. Graphic comparison of Caring Ability Inventory mean rank scores of Level I and Level II respondents in this study.

Because of the small sample, non-parametric tests were completed to determine whether there was significant difference between Level I and Level II perceptions of their caring ability. The Mann-Whitney U Test was conducted to ascertain if there was a statistical level of significance on the CAI subscales of Knowing, Courage, and Patience. Scores were analyzed using the mean rank for each level in each subcategory (Table 16) and then, the median scores from the CAI were compared between the two levels with each subcategory to determine statistical significance (Table 17).

Table 17

Mann-Whitney Rank of Occurrences in Each Subcategory: Level I and Level II

	Level	Number of Participants	Mean Rank
Knowing	I	12	12.33
	II	12	12.67
Courage	I	12	14.88
	II	12	10.13
Patience	I	12	12.79
	II	12	12.21

According to the results of the Mann-Whitney U Test, Level II students demonstrated a slightly higher rank for Knowing (Level II 12.67/Level I 12.33). Scores for Patience (Level I 12.79/Level II 12.21) revealed a slight decrease by the end of the program; however, no significant difference between Level I and Level II students existed for these two subscales. For Courage, the Level I (14.88) students had a greater number of higher ranked scores than Level II (10.13) suggesting a decrease in the subcategory of Courage as students progressed through the program. These statistics are presented in Table 17. Further data from the Mann-Whitney U provided a determination of statistical significance.

Table 18

Mann-Whitney U: Level I and Level II

	Knowing	Courage	Patience
Mann-Whitney U	70.000	43.500	68.500
Wiloxon W	148.000	121.500	146.500
Z	-.116	-1.650	-.203
Sig. (1-tailed)	.90	.04	.83

The Mann Whitney U provided statistics that revealed no statistically significant difference between perception of caring ability scores between the Level I (Md = 76) and Level II students (Md = 80), for Knowing (U = 70.00, z = -1.16, $p > .05$). The same was found for the caring abilities scores between the Level I (Md = 66), and the Level II (Md = 62) group of non-traditional students for the subscales of Patience (U = 68.5, z = -.23, p >.05). However, when analyzing the significance of the two-tailed results of the subscale of Courage, dividing the mean (.099) by 2 resulted in the one-tailed probability level of .045. Therefore, the difference between the Level I (Md = 73.00) and Level II students (Md = 68.50) for the subcategory of Courage, (U = 43.50, z = -1.65, $p < .05$) was statistically significant. The data indicated a statistically significant decrease in students' perceptions of courage from entry into the program to exit.

The effect size of the Mann Whitney U for Courage in this sample is 0.34. Using the guide provided in Field (2009), this effect size represented a medium effect and accounted for 9% of the total variance.

During the interviews respondents ($N = 24$) were asked two questions involving perceptions of caring relationships. First, they were asked to score their perception of their own ability to form caring relationships based on a score of 1 to 10 with 1 being the weakest and 10

being the strongest. Next, they were asked to use the same scale to score their perceptions of caring relationships demonstrated by nurses they had observed in practice or experienced personally. In the Level I group of respondents, all students (n = 11) but one perceived their ability to form a caring relationship as great as, or greater than, the nurses they had observed or experienced. The one respondent scored herself the same (8) as the other nurses. A visual demonstrating this data appears in Figure 4.

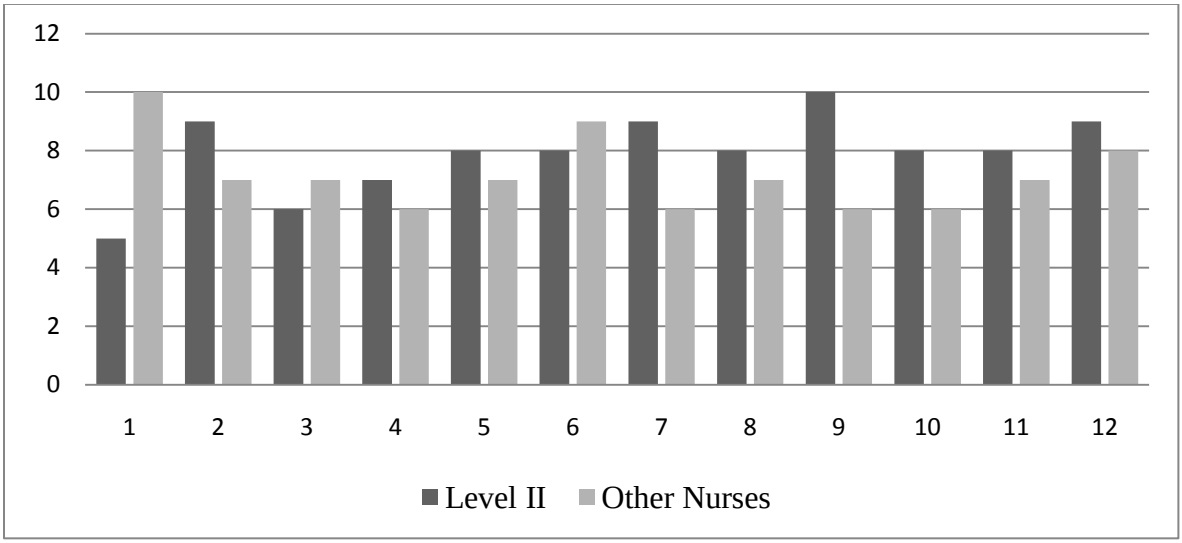

Figure 4. Level II non-traditional students' self-reported perceptions of caring ability compared with observations of other nurses. Participants scored perception of their own ability to form caring relationships in comparison with other nurses based on a score of 1 to 10 with 1 being the weakest and 10 being the strongest.

In the Level II group of respondents, nine students perceived their ability to form a caring relationship as equal to or greater than the nurses they had observed or experienced. When viewing the graphic data it may appear that Level I students have stronger perceptions of their caring ability to form caring relationships. However, there was no significant difference between respondents at the beginning and those at the end of their program.

Although there was no statistically significant differences between the Level I and Level II scores, the following graphic comparison of Level I with Level II self-reported scores suggests

that half of the Level I (n = 6) respondents reported stronger perceptions of their ability to form caring relationships than those of Level II. Two respondents, one from Level I and one from Level II, perceived having a stronger ability to form caring relationships than the others (score = 10).

The CAI total mean scores of participants (N = 24) was 210.4. This score when compared with the total scores 211.7 of the nurses in Nkongho's original study (N = 75) showed no significant difference. When compared with the college students (N = 462) of varied majors in Nkongho's (1990) study, the total mean for participants in this study was higher 210.4 than that reported for a sample of students from varied college majors which was 196.

The following is a graphic representation of the comparison of Level I and Level II student subscale scores as they are compared with practicing nurses and general college students in Nkongho's (1990) original study.

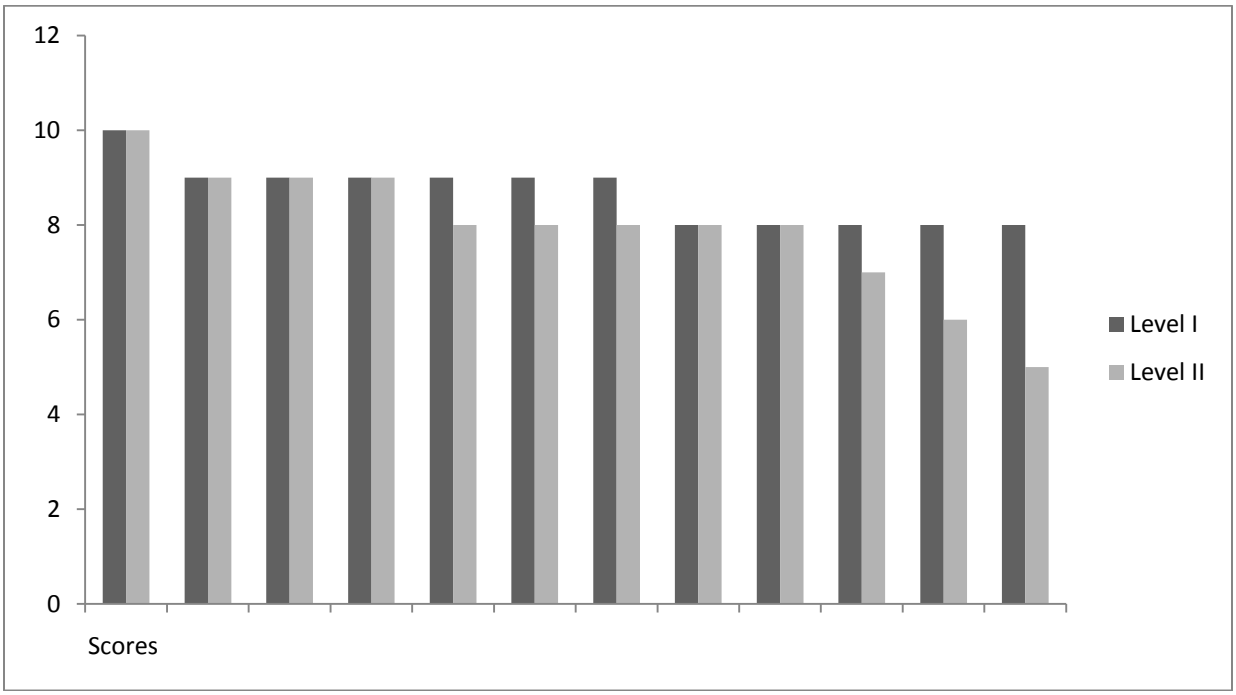

Figure 5. Comparison of Level I and Level II self-reported scores for perception of ability to form caring relationships. Participants' perception of their ability to form caring relationships based on a score of 1 to 10 with 1 being the weakest and 10 being the strongest.

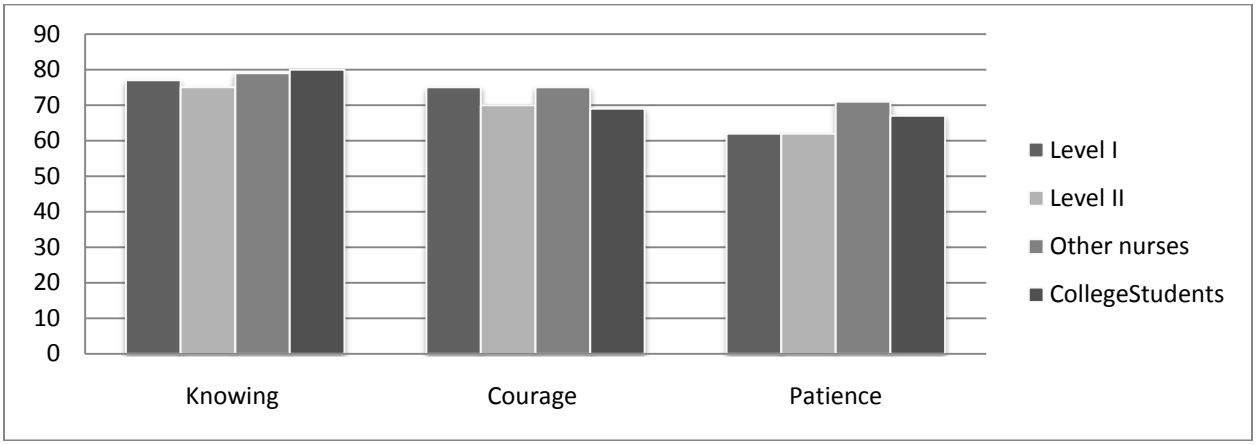

Figure 6. Graphic demonstration of scores from Level I and Level II for this study with other nurses and general college students in Nkongho's (1990) study.

However, a visual of the subscales for each group demonstrates slightly lower scores for the participants in this study for Knowing and Patience. Scores for Courage are equal for Level I and slightly lower for Level II. There is no statistical difference in the scores of the participants in this study versus other nurses or college students.

Narrative Reflections of Two Representative Non-Traditional Students

In order to display insight into the private context of the non-traditional student, two accounts extrapolated from the qualitative data are presented. Each account was chosen by the researcher based on how closely the story related to themes identified in the Related Literature Review. One female and one male participant were chosen based on their discussions of intentional effort used to develop caring behaviors. Mary and Alex shared their stories.

Mary, a Level II participant, was raised in a family where communication and relationship building was not a priority. She recognized this as a weakness and worked very hard with her husband and children to build strong caring relationships. During the 20 year period while she was raising her children she worked as an administrative assistant in a one-person private office secluded from personal contact with clients or anyone except her boss. She

shared that she did not have the interactions with people that would polish relationship building skills. She said that she "probably looked like the deer in the headlights" as she was learning the complex and numerous interactions required of the nurse. She was confident that it would come naturally once she got a little more comfortable and saw how the interactions would work between patients and staff and knew what behavior was permissible, what was encouraged and what was not encouraged. She expressed that communication was really important. Mary talked about when she first walked into clinical, feeling like a fish out of water. "I felt like a fish out of water in clinical during the program. I worked being isolated for 20 years, and I still feel like a fish out of water." As she was coming to the last days of the program, she shared that she was someone who she really did not know.

When asked if she were helped through the anxiety, she shared that she did have a learning problem based on the anxiousness she experienced. The second semester of clinical she had a 12 hour clinical where she had to get up at 3:30 in the morning to get there on time. She shared that this really kind of put her off psychologically. "I wasn't able to be as quick with things, and I am not fast and this is all new to me. The not knowing in a new situation caused me a great deal of anxiety." To top it off Mary took a class over spring break and was not able to get some needed rest or get caught up with assignments. The whole semester her anxiety just built and built, by the end of the semester she was doing so poorly. "That was the worst grade I ever got." She repeated, "This is not happening so . . . that was really . . . that was really tough!" But the next semester she had a different instructor who helped and calmed her so she was able to relax and learn. She said, "It was obvious I can't learn when my anxiety is way up."

When Mary was asked to share what event or person in her life helped her develop her caring attitude, she referred to the person who inspired her to become a nurse. She described that when she hung out with her she saw something she had never seen in her growing up, a different

way of talking to people, offering self, giving, and very kind. And in turn people came to her with questions. She loved that. They came to her. She loved them. She added, "and that was something I wanted. That was something I wanted to grow in me." She reflected, "I was sitting in my office thinking there is a world out there." She used the analogy of the movie *Sleeping with the Enemy* where Julia Roberts was looking out at the ocean. She was a total captive and there was a world out there and she was going to find it.

Mary attributed her learning of how to care to role modeling from the director of the program and the amazing clinical instructor she had in her last semester. They gave her examples of how to build relationships while caring for patients, which she reported was really important because she had not seen how to do that before. At the end of the interview Mary shared that learning to establish a caring nurse-patient relationship had been a real joy. She stated she now had permission to be different. "A way that is different from the way it always was and that is really wonderful!" That was her favorite thing.

Mary's total CAI score was 219 placing her in the overall range of High for perceived ability to form caring relationships. Mary's individual score for the subscale of Knowing was 80 (medium), Patience 67 (high), and Courage 82 (high). The score for Courage was the second highest in the group of 24 well above the high range of >75.58. When asked to score her ability to form caring relationships on a scale of 1 to 10 with one being the weakest and 10 the strongest, she gave herself a score of 5. She rated herself a five because she believed she was not familiar enough with the proper protocols for what she was permitted and not permitted to do and she was still really learning. She ended by saying, "I am willing and I am able, but I am a little unsure of myself." She scored other nurses she had observed as a 10.

Alex defined caring in nursing as "putting the patient's needs first, making the patient's needs a priority without judgment or discrimination." Nursing was not the first career choice for

Alex. His dream was to go to a Naval Academy to study pre-law and then go into law school. He attended a private high school where his curriculum was focused on constitutional law. The semester prior to entering the academy, he was diagnosed with Type I Diabetes that was nearly fatal. He considered nursing but was a little anxious about making a commitment to the program. His experience with nurses during his recovery and the fact that this disease barred admission to the military school, added to advice from family members in healthcare, he chose nursing. Now he believes he probably would not be happy doing anything else. The eldest of six boys, Alex shared that he came from a large caring family. He perceived himself as a good listener and a caring individual that would make him a good nurse. But, when he got into nursing, he learned that he was not able to display his caring in a way that was recognized by his patients and faculty. He recognized that six boys do not necessarily demonstrate the same kind of caring behavior he needed to establish caring nurse-patient relationships. He verbalized this as a challenge for him as he entered the nursing program.

> I had trouble, not so much with the feeling of caring, but with demonstrating caring, so that my patients knew I cared. I am a guy from a family of all boys. I am the oldest of six boys. And displaying caring as a nurse was a little bit difficult for me at first; and, I think I had to work to actively show my patients that I cared. This was an adjustment in and of itself. . . . Men express caring in different ways and my personal experience, you know, usual ways or outlook or world view was to display caring by getting positive results and that is not always enough. I have learned to carefully explain procedures . . . use therapeutic communication to alleviate anxiety . . . and have gotten better about offering a hand to hold or holding the shoulder.

Alex shared that at first he had problems not with the feelings of caring but with the demonstration of caring so his patients knew he cared about them. "That was an adjustment in

and of itself." He reflected that he noticed, that follow-through was important in demonstration of caring for patients. "I think this is something my own healthcare experience as a patient has highlighted for me." He elaborated by saying, "When you say you are going to do something for the patient, make sure you do it. Sometimes my nurses would say they were going to get me something or check on me and never returned."

Alex considers his ability to empathize with his patients was a personal strength. "I am good at seeing things from the other person's perspective." He believed being the eldest of six also taught him to be patient and sociable. Talking to patients came easy for Alex and knowing about them gave him the opportunity to talk to them during procedures and while doing assessments.

Of special interest was Alex's progress toward learning how to form caring relationships. When asked to give examples of caring, he used examples his maternity rotation. He described his difficulty being compassionate toward a mother who used illegal drugs during pregnancy and her baby was in the Neonatal Intensive Care Unit suffering through drug withdrawal. He described his feelings about a mother who would do this to her baby. He observed when the mother was crying, her nurse still went over and talked to her and put her arm around her shoulders and let the mother know she was there for her and the baby. He was impressed with this nurse and how she developed a caring relationship with this mother and baby. This nurse provided a role model that helped Alex learn to be non-judgmental in establishing a caring nurse-patient relationship. Alex also mentioned that his observations of a nurse caring for a patient in labor showed him the kinds of behaviors that helped the patient relax and affirm her work through the labor and delivery process. He considers he demonstrated growth and introspection during these experiences. He also indicated that careers in medicine, consisting of three

physicians and at least eight nurses, were prevalent in his family. Since two of his cousins were male nurses, he had a support system to encourage him to continue in the program.

Alex expressed having a difficult challenge at first and needed to repeat one semester. He shared that he had a hard time adjusting to nursing exams that involved critical thinking questions and a negative faculty-student fit. On the repeat semester, he described the faculty as "absolutely fantastic, empathetic, understanding, and caring." The teacher went out of his way to help him understand, learn the material and know how to take NCLEX type exams. This faculty member had what Alex called a "huge impact" on his learning experience. Alex talked about his resilience. "You can knock me down, but I won't stay down."

When asked to score himself on his perception of ability to form caring relationships, Alex gave himself a six. "I am a very caring person, but sometimes especially at first, I do have a hard time showing and establishing that with the patient."

Alex's total CAI score was 197 placing him in the overall range of low for perceived ability to form caring relationships. Alex's individual score for the subscale of Knowing was 84 (medium), Patience 54 (low), and Courage 64 (low). Alex had appropriate perceptions about his ability to form caring relationships. As a result of this introspection and awareness, he was able to identify weaknesses and work toward learning and enhancing his caring behaviors.

Non-traditional students such as Mary and Alex are increasing on college campuses and constitute a significant proportion of the undergraduate population (Ross-Gordon, 2011). Not only have the numbers of non-traditional students increased rapidly, the age range of the non-traditional learner has also increased, Alex 23 and Mary 54 years old. The mean age for this study was 37.7 years with a range of 22 to 54. Although the age range and gender differ for these examples, the challenges they experienced were similar. Both Mary and Alex chose

nursing related to the theme personal experience as identified through the qualitative data from the group.

Information gathered from the qualitative data conflicted with data reported on the CAI for both Mary and Alex. Data collected from the interviews suggested that both participants perception of their caring ability served as an obstacle to their learning. When discussing her perceptions of caring ability in writing and the interview, Mary scored herself low. However, her scores on the total CAI (219) placed her in the high level. Her individual scores for Knowing were in the medium range. Scores for Patience and Courage were in the high range. Alex, on the other hand, verbally and in writing perceived he had a strong ability to form caring relationships, but total score on the CAI (197) placed him in the low level. His individual score for Knowing was medium. His scores for Patience and Courage were both low.

Summary

Statistical analysis of survey data using a comparison of the low, medium, and high norm range for each subcategory for Question 1 revealed for Knowing, seven respondents fell within the low range, five fell within the medium range, and none fell in the high range. For Courage, none fell within the low range, seven fell within the medium range, and five fell within the high range. For Patience, three fell within the low range, six fell within the medium range, and three fell within the high range. This supports the premise that non-traditional students' have a strong positive perception of their ability to form caring relationships prior to entering the nursing program.

Analysis of data comparing prior careers with perceptions of caring ability revealed no significant difference between prior careers and perceptions of ability to form caring relationships. However, during the interviews students described how prior personal experiences within the healthcare system impacted their motivation to enter the nursing program.

Analysis of data related to Question 3 revealed that participants in Level I were significantly stronger in their perceptions of caring in the subcategory of Courage than those of Level II. For Knowing and Patience there were no significant differences. Content in the analysis of the interviews reinforce this finding. In support of these results, when asked to self-report a score and compare themselves with other nurses they have observed, students reported a slight decrease from Level I to Level II.

In Chapter V, a summary of the Findings of the Study are presented. Limitations, Recommendations and Conclusions are also included along with implications for theoretical development and future research.

CHAPTER V

SUMMARY, RECOMMENDATIONS, AND CONCLUSIONS

Introduction

This chapter begins with a brief summary and discussion of the study and findings. Interpretation of the findings for each research question is discussed as they relate to the Review of the Related Literature in Chapter II. Limitations associated with the study, recommendations, implications and conclusions are included.

An essential component in nursing practice is that nurses are able to develop a caring nurse-patient relationship. When nurses have the ability to form a positive nurse-patient relationship, patients report satisfaction with their care (Duffy, 2003), experience lower rates of hospital-related mortality and morbidity (Anderson, 2007; Kane, Samliyan, Mueller, Duvall, & Wilt, 2007), and report an overall improved healthcare outcomes. Outcomes for the institution include financial benefits, such as reimbursement based on positive outcomes and increased scores on patient satisfaction surveys.

The problem of this study was to identify whether non-traditional nursing students, who have no experience in a healthcare or related field, perceive they have the ability to form caring relationships with patients. Measurement of perceptions of the ability to form caring relationships occurred at two points, before entry into the first semester of nursing courses and at the completion of the program to identify changes from entry to exit of the program. This study also sought to identify if there is a relationship between students' prior careers and the degree of perceived ability to form these relationships.

Triangulation of data collected from the Related Literature Review, the Caring Ability Inventory (Nkohngo, 2003), a brief written paragraph by the respondents, and one-on-one interviews were analyzed to answer the following questions:

1. What are non-traditional nursing students' perceptions of their ability to form caring relationships prior to entry into the nursing program?
2. In what ways do the prior experiences of non-traditional nursing students influence their ability to establish/maintain caring relationships during the nursing program?
3. To what degree do non-traditional nursing students perceive that their ability to form caring relationships has changed from entry to exit of the nursing program?

A cross-sectional survey of non-traditional nursing students entering (n =12) or just graduating (n =12) from two Associate Degree Nursing Programs in Central and Western Pennsylvania was conducted. Quantitative data (N = 24) were gathered using a self-administered survey tool, the Caring Ability Inventory (CAI), developed to measure a person's perceived ability to form caring relationships. Internal consistency of the tool was confirmed by Nkongho (1990) in the original study of 537 respondents with an alpha of .84. Subcategories that evolved from Nkongho's data that predicted caring ability included Knowing, Patience, and Courage. Data were analyzed using descriptive statistics, Mann Whitney U, and typological analysis (Hatch, 2002) of a self-reported brief paragraph and one-on-one interviews to answer each research question.

All data sources confirmed Level I students' strong perceptions of ability to form caring relationships. Effects of prior career were measured using the Mann-Whitney U. These results showed no significant difference between the managerial, clerical, service, and other career categories and perceived level of caring ability. Findings suggest there were no differences of perceptions of total caring ability for those students entering the program (Level I) and those

exiting the program (Level II) for the subcategories of Knowing and Patience, although when scores were graphed separately there appeared a slight decrease. For the subscale of Courage, there was a statistical difference (p = .045) between the two groups. The Level I students scored higher than the Level II students, suggesting that during the program scores for this subscale decreased.

When the mean scores were compared using a *t* test between the participants in this study and practicing nurses, total CAI scores demonstrated no statistically significant difference. However, when each subscale was calculated and compared, there were differences between the two groups.

Qualitative data collected via the brief paragraph on the survey and the one-on-one interviews gave student voice about their perceptions of caring. This data added depth and insight to answering the research questions. The self-reported data suggested that respondents expressed in writing or interviews that perceptions of their ability to form caring relationships was strong. In comparison with nurses they have observed in experiences or practice, all (n=12) Level I students perceived their caring ability as greater than other nurses observed. However, for the Level II students (n=12), only nine perceived they had a greater ability to form a caring relationship than other nurses they have observed.

In this chapter, each research question is discussed reviewing the resulting data in relationship to the prior research. Because of the complexity and multiple facets of caring in nursing, and the fact that the concept of caring has still not been clearly conceptualized (Finfgeld-Connett, 2008), the discussion of findings is presented using two related frameworks. First, Mayeroff's (1971) philosophical essay on caring frames this study and serves as the basis for the survey tool. Prior research and findings related to Mayeroff's philosophical description of caring as it relates to Knowing, Courage, and Patience are discussed. Second, Nkongho's four

theoretical assumptions: (1) caring is multidimensional, with cognitive and attitudinal components; (2) the potential to care is present in all individuals; (3) caring can be learned; and, (4) caring is quantifiable will serve as the framework for Recommendations.

Summary of the Findings

To determine the perceptions non-traditional students have of their ability to form caring relationships, respondents completed a self-administered on-line survey with the opportunity to write a response to the request: "Write a brief paragraph about why you chose nursing as a career." In addition, the survey was followed with a one-on-one interview to add richness and depth to the survey questions.

Summary of findings from the CAI, interviews, and a brief paragraph suggest that non-traditional students in this study perceived they had a strong ability to form caring relationships. Raines (2007) who studied second-degree students in a baccalaureate program reported a total CAI score of 196.8 for the respondents entering the nursing program. The scores for this group of non-traditional nursing students who have not had prior healthcare experience are not significantly different from Nkongho's group of practicing nurses. When comparing with the various college majors, scores for the participants in this study were slightly higher. The scores for this group are limited in comparison to the other groups of nurses and students who used the CAI to measure caring ability since the variables of time in practice, mix of traditional and non-traditional students, and prior experience in healthcare may have an effect on the result.

Based on the typological analysis (Hatch, 2002) in the literature describing studies of how caring is perceived, nursing students' perceptions of caring differed from that of the practicing nurses. To mention an example, when registered nurses described caring, ten references to knowledge of the patient were made. In the studies involving students, only four references referred to knowledge of the patient. In the subscale of Courage, practicing nurses

had no references and student nurses had one mention of words that describe courage. For topology that identified Patience, the practicing nurses had eight references while the studies that involved students had none. This supports Normal, et al.'s (2008) data from their exploratory study that narratives of nurses who are less experienced differ in terms of the caring dimensions than do those of more experienced nurses.

The participants (*N*= 24) in this study chose in-depth descriptions using caring typology to describe their perceptions of caring abilities in a variety of ways related to each one's individual life or educational experience. Overall, participants used words categorized from the literature by the experts who sorted them (see Appendix N). For example, advocate, comfort, communication, compassionate, confidence, dignity, knowledge of the patient, physical/social/emotional, and spirituality expressed Knowing and were used during the interviews and the brief paragraph. Follow-through, healing relationships, monitoring, potential of others, time, and tolerance fit into the subscale of Patience. There were fewer descriptive words that fit with Patience. This correlates with Patience having the lowest subscale score for this group when compared with other studies (Nkongho 1990; Raines, 2007). Interesting to note is that in these other studies, the scores for Patience were also the lowest subscale scores. Courage, going the extra mile, loving, safety, make a difference, ethical duty, and trust were used by the participants as the words that related to the subscale of Courage. As the qualitative data were analyzed, non-traditional students discussed the subscales of Knowing and Patience as the words related to their patients. For example, Kara a Level I student stated, "I would make sure I understood everything that was going on with the patient so I could give them the best care possible." Patricia, a Level II student described Patience when she said, "I have watched the nurses take time to explain everything, answer questions, holding a hand, and explaining things

to family members. You need a lot of patience . . . you have to have a nurse with a lot of patience."

When participants discussed courage they talked more about their own need for confidence and how much courage it took for them to care for their patients. For example, when asked if it takes courage to be a patient advocate, Chris responded, "Yes. It does. It completely does. . . . At this point in my career, I can say that right now I am almost intimidated by most doctors." Chris is a Level II participant, just graduated and passed NCLEX to be licensed as an RN. Another Level II participant, Amy shared that it took courage to attend some clinical experiences where the staff was not receptive to students.

The research questions were answered using the data from the CAI, one-on-one interviews, and the brief paragraph written in the survey. The Related Literature Review was used to develop typology for identification of words in the content that referred to Knowing, Patience, and Courage. Quotes from the qualitative data were chosen based on the typology.

Table 19 demonstrates the data source used to answer each research question.

Table 19

Summary of Data Collection

Area to be Measured	Research Questions	Collection Instrument	Collection Procedure	Framework Used
Perceptions of ability to form caring relationships upon entry	#1	Caring Ability Inventory Interviews	Caring Ability Inventory Brief Paragraphs	Mayeroff (1971) Nkhongo (1990) Related Literature Review
Influence of prior careers/ experience	#2	Caring Ability Inventory Survey Brief Paragraphs Interviews	Survey Interviews	Survey Interview Related Literature Review
Change in perceptions from entry to exit of program	#1 #3	Interviews Caring Ability Inventory	Interviews Survey	Nkhongo (1990) Caring Ability Inventory Related Literature Review

Question 1: What are Non-Traditional Nursing Students' Perceptions of Their Ability to Form Caring Relationships Prior to Entry into the Nursing Program?

In order to answer Question 1 mixed-methodology was used. Data from the CAI provided quantitative results which supported that all of the respondents (N = 24) in this study expressed their perceptions of ability to form caring relationships as strong. They expressed personal motivation based on perceptions of their caring ability that emerged into three major themes. First, nine students expressed a long-term desire to become a nurse. Second, personal experiences within the health care arena served as a motivation. Third, all participants (N = 24) perceived they had nurturing personalities that were valuable to nursing and they wanted to help

others. Data are comparable with Mullen's (2005) description of intrinsic attraction for becoming a nurse. Intrinsic attraction is described as interest or enjoyment in being a nurse and comes from a desire within the person. Mullen reported 60% of his total nurses and student nurses (N = 2006) chose intrinsic attraction as the motivational factor to become a nurse. In the current study all participants (N = 24) shared intrinsic desires to become a nurse. Comments such as, "Caring is second nature to me. I have taken care of many of my family members," "My love for people and caring for them is the main motivator in choosing this career," "I want to be a nurse so I can help fill the world with one more compassionate nurse, knowing they are greatly needed," and "I want to help people and feel the importance of my job" demonstrates a sampling of the intrinsic attraction for this group of participants and relates to their perception of caring ability.

The total CAI range of scores for Level I (n = 12) students (those prior to entry into the nursing program) was below 200.82 to above 219.98 with a mean score of 210.40. These scores compared with nurses in Nkongho's original study whose reported range was below 203.1 to above 220.3. Calculation of a t test demonstrated no statistically significant differences between these two groups. This demonstrates that scores for this group of students fell within the ranges of the practicing nurses in the original study. The Level I scores for the second-degree baccalaureate nursing students in Raines (2007) reported a range from below 182.97 to above 209.85 with a mean score of 196.68. When compared with students who were general college students, the total CAI ranged from below 190.29 to above 211.12 with a mean score of 207.1 (Nkongho, 1990). Data based on the total CAI for Level I participants in this study suggest that the perceptions of ability to form caring relationships are slightly higher than the general college student population, slightly higher than the Level I second-degree students in Raines' study, and the same as the practicing nurses in Nkohngo's original study. Due to the small sample size of

the current study a general assumption cannot be made about the value of the total CAI score. However, a comparison of data from other studies done by Nkohongo (N = 537) and Raines (N = 60 matched pairs) suggests that no matter whether the participant is a practicing nurse, second-degree baccalaureate student, or Associate Degree non-traditional nursing student the total mean and range scores were not significantly different.

A comparison of the mean scores of the subscales for each data set was also completed. The practicing nurses and college students (N = 537) in Nkongho's (1990) study had mean scores for the subscales of Knowing 79, Courage 75, and Patience 71. When assessing the subscale mean scores for Level I second-degree baccalaureate students (Raines, 2007), Knowing was 74, Courage 68, and Patience 54. The mean scores for participants in this study were: Knowing 77, Courage 75, and Patience 62. For a visual explanation of this comparison refer to Table 20. The higher subscale scores demonstrate that non-traditional students in this study perceive their ability to form caring relationships defined by the subscales of Knowing, Courage, and Patience as strong. It is also noted that in order to identify strengths and weaknesses in perceptions of caring ability, the subscales must be evaluated in order to individualize educational interventions that would facilitate perceptions of caring ability. For example, nursing students could practice in a clinical performance and simulation laboratory doing scenarios that give them confidence in their skills. This type of activity could enhance Knowledge. To enhance Patience, students may be given information and practice on self-care, relaxation techniques, and test taking strategies. A professional ethics course may facilitate the development of Courage. Most important, is individual interaction between the faculty advisor and the student.

Table 20

Comparison of Level I Participants in Two Studies using the CAI Nkongho's Practicing Nurses and College Students as the Established Norms

Subscale	Nkongho (1990) (*N* = 537)	Raines (2007) Level I (*N* = 60)	Thistlethwaite (2011) Level I (*n* = 12)
Knowing	79	74	77
Courage	75	68	75
Patience	71	54	62
Total CAI	211	194	214

Note. Numbers have been rounded in order to provide consistency.

When reviewing the typology in the qualitative data, Level I students discussed Knowing, as knowing their patients physically, mentally, emotionally, and spiritually. Comments such as, "I would think some people would just consider caring physically, but when I become a nurse I can help them mentally and emotionally as well. That I would be there for support" and "I want to know everything I am supposed to know, so I can truly help someone," "My husband and I have great faith," and "The nurse I was with prayed with her patient and the patient calmed down," are examples that demonstrate Knowing. Level I students described their experiences that dealt with patience by making comments such as: "I like to listen. When we are assigned only one patient, if I sit in a room for 45 minutes and talk to them it is not a big deal," "I think taking time with a patient is important. It goes along with sincere interest, knowledge and willingness to spend the time to give that knowledge to truly help" and "I will take that extra time to put them at ease." While discussing Courage, students made comments such as, "I know what is right and what is wrong, so I am not going to let something go because everybody else does . . . I will do what I know is right and what should be done" and "going into nursing was exciting and intimidating at the same time." Several participants described going back to school

as courageous events that related to technology, the long hours, and lack of confidence. These comments draw a parallel with Mayeroff's description of courage being "willingness and ability to take risks and go into the unknown".

Level I participants, when asked to score their perception of caring ability on a scale of 1 to 10 with 1 being the weakest and 10 being the strongest, scored themselves at a range of 8 to 10. When asked to score other nurses they have observed using the same scale, those scores ranged from 2 to 9. This data suggest that this group of Level I non-traditional students perceive they have stronger overall caring abilities than practicing nurses they have encountered.

To summarize, the Level I population for this study demonstrated strong caring ability in the CAI data as well as the qualitative interviews and written paragraph. They discussed their perceived ability to form caring relationships as positive and were looking forward to entering the actual clinical portion of the program. A weakness identified for this group of Level I students was that they were not able to articulate what they did to care for themselves which is the first step and major concept of being able to form caring relationships (Leininger, 2002; Mayeroff, 1971; Nkongho, 1990; Peplau, 1992; Pross, et al., 2010; Watson, 1983) . This may be related to their high stress levels and lack of time for self-care while maintaining numerous roles with school, family, and community commitments.

Question 2: In What Ways do the Prior Experiences of Non-Traditional Nursing Students Influence Their Ability to Establish/Maintain Caring Relationships During the Nursing Program?

Data to answer this question were gathered using the brief paragraph on the CAI and the one-on-one interviews. No matter what their prior career, three themes emerged from the data: one was that they were motivated based on a prior personal or family experience with healthcare; second was having a long term desire to become a nurse; and third, they perceived that they had

personalities and caring abilities that would be of benefit to a nurse. Those who were in management positions expressed ease in transferring the people skills learned in their prior career to nursing. One in particular expressed that her skills as a customer advocate gave her confidence in establishing patient relationships; as a result she could focus on learning the technical parts of the program.

When the subscale scores were analyzed across careers and medians compared, the managerial and clerical group scored in the medium range for all subcategories. There was no significant difference between types of career and scores on the CAI. When evaluating the subscale scores, those in the service group (waitress, bartender, day care worker, and massage therapist) scored in the high range for Knowing. Those in the other group (cashier at a large superstore, research administrator, and interior designer) scored high in the subcategory of Patience.

When data were compared with the prior careers for indications of perceived difficulty in the ability to develop the complex, intimate, caring relationships that are requisite for the professional nurse (Folbre, 2003; Utley-Smith, et al., 2007), one participant demonstrated these suggested challenges. Mary is discussed in Chapter IV under narrative reflections. Surprisingly, Mary, who reportedly grew up in a family who did not express caring relationships and worked in an isolated office without personal contact with others, scored high in the total CAI as well as in the subscales of Patience and Courage. Her score for Knowing was in the medium range. Mary attributes her improving perceptions of her ability to form caring relationships to the role model of the program director and to a faculty member who mentored her through a challenging semester. In the qualitative portion of her data, she described herself as low on the ability to form caring relationships. She stated this was because she was not familiar enough with the protocols for what she was supposed to do and believes she was still learning. For Mary, this

statement supports the assumption made by Nkongho (2003) that caring can be learned and she perceives she is progressing from novice to expert (Benner, 2001; Dryfus, 1981). This phenomenon remains unexplained as little research has investigated prior career and perceptions of caring ability. Spohn (2011) in her research of all levels of a baccalaureate nursing program (N = 439) found that program level, age, and prior experience did not predict belief in caring ability when compared with characteristics of caring. Perhaps there are other variables related to life experiences of the individuals that may explain these scores and would warrant further research.

Research Question 3: To What Degree do Non-Traditional Nursing Students Perceive that Their Ability to Form Caring Relationships has Changed from Entry to Exit of the Nursing Program?

The expectation of the researcher was that the Level II students would demonstrate higher scores on the CAI since they were at the end of the program. This was not the case. When the scores from the Level I and Level II (Figure 3) were compared graphically, it appears as though the scores for this group of participants decreased slightly from entry into the program to graduation. In order to compare the small sample a nonparametric testing was applied to the data. The Mann-Whitney U was conducted to determine statistical difference. Level II students demonstrated a slightly higher rank in the subcategories of Knowing and Patience. But there was no statistical significance between the two groups for these subcategories. For Courage, the data demonstrated a significant decrease (p = .045) from entry to exit of the program. Perhaps the decrease in score for Courage is related to the Level II students living the real experience in the clinical setting where any preconceived idealism has been dissipated. For the total CAI, data revealed no significant difference.

The mean scores of the subscales for each data set were compared with other research to include Level II students. This comparison is presented in the Table 21.

The Level II students in this study did not increase in perceptions of caring ability in the subscales of Knowing and Patience, but decreased in Courage.

Table 21

Comparison of Mean Scores with Nkongho's Study and Raines' Level I and Level II Students

Subscale	Nkongho (1990) (N = 537)	Raines (2007) Level I (N = 60)	Raines (2007) Level II (N = 60)	Thistlethwaite (2011) Level I (n = 12)	Thistlethwaite (2011) Level II (n = 12)
Knowing	79	74	81	77	75
Courage	75	68	76	75	70
Patience	71	54	62	62	62
Total CAI	211	197	219	214	207

Note. Scores have been rounded for consistency among studies.

Clearly, those students in Raines' (2007) study scored higher as they progressed through the program of nursing. These second degree nursing students were in a program grounded in a philosophy of caring and humanism. Use of the CAI in this study was completed as a measurement of caring as an outcome of the program. This data supports that caring can be learned when it is supported by the curriculum.

When Level II participants reported their perceptions of caring in relationship to other nurses they have observed, they also scored themselves lower than the Level I participants. This data also suggests that the perceptions of caring ability for this group of participants decreased slightly over time in the program. This correlates with Watson, et al. (1999) whose data suggested that students lost some of their idealism about nursing after 12 months in a nurse education program. In a cross-sectional sample of baccalaureate nursing students (N = 193),

Sadler (2003) also reported that the variability using the Caring Efficacy Scale changed as the students progressed through the program. The scores for the group of senior students in Sadlers' study decreased to near the levels of first semester students. Sadler suggested these changes related to "students beginning to question and test their definitions while integrating caring within their conceptualization of nursing and self" (p. 298).

This observation may indicate that professional maturity and time spent in practice has an effect on the nurses perception of caring. Pross, et al. (2010) states that the "process of living and growing in caring takes time, knowledge, patience, courage, and ongoing commitment. Before nurses come to know patients or others as caring in nursing situations, they must first know themselves as caring persons" (p. 143). The living experience of the participants in this study during the clinical experiences and a sign of maturity in knowing and understanding the complexity of the caring student-patient relationship may also have served to change the students' perception. The concept is reinforced by the results of Suikkala and Leino-Kilpi (2001) who reported the importance the student-patient had on students' professional growth. Students who were working on learning technical skills found it difficult to establish the nurse-patient relationship in this study. This signals educators to design curriculum and an environment where students can comfortably share their perceptions of caring ability. In this way, faculty can mentor students to learn caring skills that facilitate quality nurse-patient relationships.

Limitations of the Study

This study was subjected to limitations which were envisioned in Chapter I. However, others were added as the study progressed.

Research sites were limited to two Associate Degree schools in Central and Western Pennsylvania: Limiting the research sites to only two Associate Degree schools did not allow for a heterogeneous mixture of non-traditional students. Only a small number of participants in this group (n = 4) were displaced workers. Only one came from an environment where establishing personal relationships were not part of the job. Although the qualitative data were rich in the descriptions and perceptions of ability to form caring relationships for this participant, no generalizations could be made for other non-traditional students from similar backgrounds. This does not preclude the fact that if a challenge existed for this participant that an analogous challenge may exist for other non-traditional nursing students with a similar career background. Conducting a replication of this study in a geographical area such as Michigan where a larger number of displaced workers are offered free tuition to attend the Associate Degree Nursing Programs would provide a larger sample and stronger evidence.

Data were collected using samples of convenience: The numbers were limited to non-traditional nursing students within a 100 mile radius from the researcher's home and work. This was chosen in order to be able to interview the projected 30 subjects for the sample. Again this geographic distribution was not diverse enough to make generalizations about specific age groups, prior career groups, or gender even though the areas differed by rural versus suburban.

Cross-sectional design does not provide for studying individual changes over time: A cross-sectional was chosen since only one variable, caring was being measured. It was suspected that once the participants were involved in the program the curriculum and faculty would increase caring in the population. This was not the case. Instead, the data suggested that data collection over time with the same participant would yield more meaningful information. No generalizations could be made based on the diversity of complex and numerous life experiences and the fact that they were different individuals. Even when the other scholars (Nkongho, 1990;

Pross, et al., 2010; Raines, 2007) evaluated the total CAI data, information for the group was not specific enough to diagnose challenges for students and provide educational support and intervention.

Subjects were limited to non-traditional students who had no previous job experience in healthcare or related field: In Sphon's (2010) study, a total of 439 students participated. Of those students only 135 did not have prior healthcare experience. In this study, only 24 of the 95 respondents did not have prior healthcare experience. This severely limited the sample size. It was considered that including those participants who had experience in healthcare would bias the study. Therefore, the researcher believes the data would relate more closely with those non-traditional students who were displaced workers or were entering nursing for the financial gain. After reviewing the CAI data and the qualitative data, neither was the case. All participants demonstrated scores within the ranges for other nurses and college students except one. Further research is needed that individualizes the assessment of every student as they learn the caring process.

Accessibility of Level I and Level II students limiting sample size: The sample was limited to non-traditional students who were just entering the nursing program and those who were finishing or just graduated. The original proposal was to capture this sample during the orientation sessions for the entering Level I students and the last weeks of the semester for the graduating Level II students. The first obstacle was that neither school had a mechanism to identify the non-traditional students. Therefore, all students needed an invitation to participate. Initially, the contact was to be made by e-mail describing the study and inviting the students to participate. Numerous technological barriers and excessive time was lost trying to access the students preventing early contact from occurring in a timely manner. Since the college provided home addresses of students, a random selection of 50 students was done and personal letters of

invitation were sent. A flyer was also posted on the bulletin boards of the Level I and Level II students at that particular setting. Some of this work may have been avoided if there was a liaison, in addition to the Chairperson of the Department, to be aware of the research and champion the project. It was also helpful for recruitment to make a personal visit to the student groups.

At the other college, the Level I students were scheduled for an orientation session and the Level II students were scheduled for an NCLEX review session after graduation. A personal contact explaining the research, the criteria for inclusion, invitation, and consent were part of the presentation made at the facility for each of these events. Even though the criteria for inclusion were explained at the presentations, a portion (n = 40) of the respondents who attempted the CAI on Qualtrics did not qualify; two surveys had missing data, leaving only 24 respondents who met the criteria for being a non-traditional student who did not have prior healthcare experience. As a result, the predicted sample number of 30 was not met. Additionally, it was difficult to schedule to schedule the interviews with the Level II participants, since they were studying for NCLEX, the RN licensure exam, moving away from campus, and starting new jobs that required 24/7 shift work.

As the study progressed, other limitations evolved. As the participants provided the self-reported data, the written and verbal reports of their perception of ability to form caring relationships were subjective and may have represented their ideal of what caring should mean rather than their personal perceptions. In order to check for this potential source of bias each participant score on the CAI was compared with matched individual comments in the interview and the brief paragraph. Only two discrepancies were found and discussed in the Narrative Reflections Representative of Two Non-Traditional Students section in Chapter IV.

During the initial analysis of the data from Qualtrics, the CAI data suggested that the scores for the subscale of Courage were low for the group of participants that had responded up to that point. As a result, questions were added to the subsequent interviews to validate that data. When the final data were analyzed using SPSS with all respondents included, the subscale scores for Courage fell within the medium to high range. Although when subscale scores for Courage for Level I were compared with Level II, the data demonstrated a decrease (p = .045) from entry to exit of the program.

Prior research quantifying caring dealt with a mixed population of practicing nurses, baccalaureate nursing students, second-degree nursing students, and Associate Degree students. Students who have experience in healthcare were not eliminated from these studies possibly creating another bias. A limitation for this study was that there were no studies that dealt purely with non-traditional Level I and Level II Associate Degree nursing students. Therefore, the variables that change perceptions of caring ability such as time in clinical practice, liberal studies courses, experience in healthcare, and age could not be compared, making this project more of an exploratory rather than explanatory study.

Recommendations for Future Research

The sample from only two Associate Degree colleges in Pennsylvania limited the diversity of the non-traditional student entering the nursing program. Since only four students from the sample were displaced workers, a clear view of the transition from a position where personal relationships were not required for the job to the intimate complex nurse-patient relationship could not be generalized. In order to capture a larger and more diverse population, an expanded geographic area with a higher concentration of displaced workers should be surveyed.

A longitudinal study where the CAI was administered upon the entry and repeated at exit of the nursing programs would be beneficial to provide data to assess nursing students, especially non-traditional students. In that way educational interventions could be provided to help mentor students and facilitate the process of learning the care involved in the nurse-patient relationship. Evaluation of the scores for the subscales of Knowing, Patience, and Courage would be the most beneficial for the nursing student. When the focus is on one of the subscales on knowing, especially as it is related to Courage, (Pross, et al., 2010) described how encouragement and support in living courage facilitated an increase in Courage for a particular nurse.

Clearly, the results of the non-traditional nursing students in this study indicate that perceptions of caring based on the total CAI did not facilitate a focus on where the participant had strengths and weaknesses. In order to assess the students' needs, the individual subscales should be addressed with a focus on the areas where the students are challenged. In this way faculty can support students to grow in their perceptions of their ability to form caring relationships.

Institutions of higher education are seeking information that would provide in-depth understanding of the non-traditional student in an effort to enhance recruitment, retention, and degree completion. Research specifically targeted toward the non-traditional nursing student is needed. Findings from this study support reports from Raines (2007) that there is a lack of information about the development of caring abilities of nursing students or evaluation of the change in caring behaviors after the learning experience. Raines suggested that it was difficult to study caring abilities since each learner brings a different background and commitment for faculty to develop pedagogy based on the affective domain rather than the technical aspects of nursing. The recommendation is for research to specifically target non-traditional nursing students. Little prior research dealt with how non-traditional Associate Degree students develop

their perceptions of caring ability. Another recommendation for further research is gathering data for development of a model of caring specifically related to non-traditional nursing students.

This research serves as a foundation for further research that would specifically identify nursing students' perceptions of caring ability and help faculty develop methods to assess and intervene for those students who have weaknesses in the areas defined by the subscales of the CAI. For example, if Alex would have had early intervention based on his low CAI score, he may not have had to repeat a semester. Even though the non-traditional and second degree nursing students have historically been an attractive pool of applicants because of their previous successes, resourcefulness, maturity, and life experiences, faculty need to be careful not to oversimplify student's ability to transfer learning skills from one setting to another. Administration of the CAI, assessment of the subscales, and interviews with the students and faculty interventions may increase the likelihood of attainment of degree goals. The benefit to the student would be enhanced learning through support with the emotional aspects of nursing. This is supported in a study on non-traditional students by Christie, et al. (2008) who found that the emotional aspects of the non-traditional student emerged from their data as an important theme. The benefit to the university and college would be an increased retention rate and decreased cost of a high attrition rate. Further research is strongly recommended to understand the stressors and challenges of the non-traditional nursing student.

Contributions and Implications

This research contributes to the research and education community interested in helping non-traditional nursing students succeed in nursing programs. Included is a demonstration of the use of the CAI as a framework for identification of existing challenges for the student who is struggling to learn the complex dynamics of the caring nurse-patient relationship. Implications for practice will be discussed using Nkongho's (2003) four theoretical assumptions derived from

the literature while developing the CAI. First, caring is multidimensional, with cognitive and attitudinal components. Second, the potential to care is present in all individuals. Third, caring can be learned. Fourth, caring is quantifiable.

Caring is multidimensional with cognitive and attitudinal components: Students in this study commented on the positive effects of having a caring mentor (director of the program, faculty member, or friend who was a nurse), who helped them understand what caring in nursing meant. They also commented on how these role models demonstrated caring behaviors they wanted to emulate. A curriculum component or thread devoted to promoting a caring attitude and behavior included in all nursing curriculum would expand this concept and facilitate learning for students. A rubric that assesses student caring behaviors expected during the nursing program would be helpful for formative assessment of the students. Consideration of the Benner Novice to Expert Model of Skill Acquisition would provide the multidimensional components expected for performance at various levels and students would know the behaviors that were appropriate.

The potential to care is present in all individuals: Administration of the CAI and assessment of the subscales would target areas where students may be challenged prior entry into the program. Faculty should be able to facilitate enhancement of the caring process and repeat the CAI. In this way it could be used as a formative assessment tool throughout the program to monitor enhancement of the caring process.

Caring can be learned: In the cases where students are having difficulty, faculty can provide remediation to enhance learning the caring nurse-patient relationship, such as, engagement with a mentor who is able to create an environment where caring can be learned. This involves knowing our students, listening to them, gaining their trust, and developing a relationship through which they will be able to accept what we need to share with them. As

faculty learns about the individual student, information is gained about how to develop a learning plan for the student. Part of this learning plan involves learning how to care for oneself. Even though these students were non-traditional and had various life experiences, a theme that emerged from the qualitative data was that they were not able to verbalize self-care activities. Scholars on caring unanimously agree that understanding of, growth of, and caring for self was the most important facets of caring (Leininger, 2002; Mayeroff, 1971; Nkongho, 1990; Peplau, 1992; Pross, et al., 2010; Watson, 1983).

Caring is quantifiable: The CAI is a reliable and valid tool that can be used as an assessment mechanism for colleges to measure the curriculum outcome of caring. Administration of the CAI at entry and exit of the program gives the college a means to assess the required curriculum outcome of the nurse educators' obligation to provide students with the ability to form a caring relationship that facilitates health and healing (American Nurses Association, 2009). Administration periodically throughout the program would provide a means for formative evaluation, especially in those students who had challenges.

Conclusions

With the effects of the nursing shortage and increasing numbers of non-traditional students entering nursing as a first or second career, the issue of forming the caring relationship essential to student success, high-quality nursing practice, positive patient outcomes, and financial reimbursement to healthcare facilities is at the forefront of nursing education.

Concern over the emotional effects of nursing students who may have difficulty in transferring skills from a prior career where development of caring relationships were not required served as the motivation for this study. Of equal importance was the concern about poor outcomes for patients who were assigned an uncaring nurse. To determine perceptions of caring ability, a mix-method design was used to study non-traditional nursing students'

perceptions of ability to form caring relationships. The study was designed to gather quantitative data using a reliable and valid tool, the CAI, to survey non-traditional nursing students in two Associate Degree Programs of Nursing. A qualitative portion was added to the survey via a brief paragraph and a one-on-one interview to validate the quantitative data as well as add depth and understanding of each student's living experience.

All students scored in the medium to high range for the total CAI but one. Qualitative data in reference to the one exception expanded on the particular situation and conflicted with the results of the CAI data. This student had remediation and demonstrated Knowing of self and growth toward learning the caring aspects and behaviors required of the nurse. All students expressed their perceptions of a caring or nurturing personality, either in writing or in the interview, in terms that would be valuable to them as a nurse, they wanted to help others, or they have always had a long-term desire to become a nurse.

Prior career had no significant effect on the scores on the CAI. Some students commented that prior careers helped with developing the nurse-patient relationship, leaving them less anxious with patient contact and more able to develop the technical skills of the experience.

Unlike what was expected, the total CAI scores did not increase as the students in the current study progressed to graduation. Total CAI scores remained in the medium to high range of norm. A decrease was noted in the subscale of Courage. This information illuminates to the nurse educator that it is essential to know each student individually and take caution not to oversimplify a non-traditional students' perceptions of caring ability.

The results of this study have solidified a philosophy to be adopted for nursing educators. Frances Peabody, a medical doctor, while giving a lecture to medical students in 1925 about caring for patients said, "The secret of the care of the patient is in caring for the patient" (Elasy,

2006. p. 1). The philosophy based on this quote for nursing educators should read, "The secret of teaching the care of the patient is in caring for the nursing student."

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Appendices

Appendix A

Comparison of Generic Associate Degree to Generic Baccalaureate Curriculum

Associate Degree	Bachelors of Science Degree
General Education Required Courses	**Education Required Courses**
BIO 171 Anatomy and Physiology	**CHEM 101** College Chemistry I
BIO 172 Anatomy and Physiology	**CHEM 102** College Chemistry II
BIO 265 Microbiology	**ENGL 101** College Writing
ENG 164 Advanced Composition	**ENGL 202** Research Writing
ENG 161 College Writing	**ENGL 121** Humanities Literature
PSY 160 General Psychology	**SOC 151** Principles of Sociology
PSY 161 Human Growth and Development	**BIOL105** Cell biology
CPT 150 Microcomputer Concepts	**BIOL150** Human Anatomy
Mathematics Elective	**BIOL 151** Human Physiology
	BIOL 241 General Microbiology
	PSYC 101 General Psychology
	PSYC 310 Developmental Psychology
	Philosophy/Religious Elective
	FDNT 212 Nutrition
	Fine Arts: Art/Music/Theater/Dance
	Health and Wellness
	HIST 195 History of the Modern Era
	MATH 217 Probability and Statistics
	Social Science Elective
	Nursing Curriculum Requirements
Nursing Curriculum Requirements	
NSG 110 Introduction to Nursing & Health Care	**NURS 212** Professional Nursing I
NSG 111 Foundations of Nursing Care	**NURS 211** Nursing Practice
NSG 120 Basic Medical Surgical Nursing Care in Acute Settings	**NURS 236** Foundations of Nursing
	NURS 214 Health Assessment
	NURS 213 Nursing Practice II
NSG 121 Basic Medical Surgical Nursing Care in Selected Settings	**NURS 316** Research Utilization in Nursing
	NURS 336 Adult Health I
NSG 122 Mental Health Concepts	**NURS 337** Adult Health Clinical I
NSG 210 Role of the Associate Degree Nurse	**NURS 338** Maternal-Child Health
NSG 220 Nursing Care of the Childbearing Family	**NURS 339** Maternal-Child Health Clinical
	MURS 312 Professional Nursing II
NSG 230 Nursing Care of the Infant, Child and Family	**NURS 412** Professional Nursing III
NSG 240 Psychiatric/Mental Health Nursing Care	**NURS 436** Adult Health II
	NURS 437 Adult Health Clinical II
	NURS 432 Psychiatric/Mental Health

NSG 260 Advanced Medical Surgical Nursing Care of the Chronically Ill	**NURS 434** Community/Psych/Mental Health Clinical
NSG 270 Advanced Medical Surgical Nursing Care of the Acutely Ill	**LBST 499** Senior Synthesis
NSG 280 Manager of Nursing Care	**NURS 450** A Cognitive Approach to Clinical Problem Solving

Appendix B

Items in the Caring Ability Inventory Survey for This Study

Demographics:

Were you previously employed in healthcare?
Age:
Gender:
Previous Career/Jobs:
Degrees Earned:
List last educational experience:
Write a brief paragraph about why you chose nursing as a career:
Contact information for interview:

Read each of the following statements and decide how well it reflects your thoughts and feelings about other people in general. There is no right or wrong answer. Using the response scale, from 1 to 7, choose the degree to which you agree or disagree with each statement.

1 2 3 4 5 6 7

Strongly Disagree — Strongly Agree

	Strongly Disagree						Strongly Agree
	1	2	3	4	5	6	7
1. I believe that learning takes time.	1	2	3	4	5	6	7
2. Today is filled with opportunities.	1	2	3	4	5	6	7
3. I usually say what I mean to others.	1	2	3	4	5	6	7
4. There is very little I can do for a person who is helpless.	1	2	3	4	5	6	7
5. I can see the need for change in myself.	1	2	3	4	5	6	7
6. I am able to like people even if they do not like me.	1	2	3	4	5	6	7
7. I understand people easily.	1	2	3	4	5	6	7
8. I have seen enough in this world for what I need to know.	1	2	3	4	5	6	7

9. I make time to get to know other people.	1	2	3	4	5	6	7
10. Sometimes I like to be involved and sometimes I do not like being involved.	1	2	3	4	5	6	7
11. There is nothing I can do to make life better.	1	2	3	4	5	6	7
12. I feel uneasy knowing that another person depends on me.	1	2	3	4	5	6	7
13. I do not like to go out of my way to help other people.	1	2	3	4	5	6	7
14. In dealing with people, it is difficult to let my feelings show.	1	2	3	4	5	6	7
15. It does not matter what I say, as long as I do the correct thing.	1	2	3	4	5	6	7
16. I find it difficult to understand how the other person feels if I have not had similar experiences.	1	2	3	4	5	6	7
17. I admire people who are calm, composed, and patient.	1	2	3	4	5	6	7
18. I believe it is important to accept and respect the attitudes and feelings of others.	1	2	3	4	5	6	7
19. People can count on me to do what I say I will.	1	2	3	4	5	6	7
20. I believe there is room for improvement.	1	2	3	4	5	6	7
21. Good friends look after each other.	1	2	3	4	5	6	7
22. I find meaning in every situation.	1	2	3	4	5	6	7
23. I am afraid to “let go” of those I care for because I am afraid of what might happen to them.	1	2	3	4	5	6	7
24. I like to offer encouragement to people.	1	2	3	4	5	6	7
25. I do not like to make commitments beyond the present.	1	2	3	4	5	6	7
26. I really like myself.	1	2	3	4	5	6	7
27. I see strengths and weaknesses (limitations) in each individual.	1	2	3	4	5	6	7
28. New experiences are usually frightening to me.	1	2	3	4	5	6	7
29. I am afraid to be open and let others see who I am.	1	2	3	4	5	6	7
30. I accept people just the way they are.	1	2	3	4	5	6	7
31. When I care for someone else, I do not have to hide my feelings.	1	2	3	4	5	6	7
32. I do not like to be asked for help.	1	2	3	4	5	6	7
33. I can express my feelings to people in a warm and caring way.	1	2	3	4	5	6	7
34. I like talking with people.	1	2	3	4	5	6	7

35. I regard myself as sincere in my relationships with others.	1	2	3	4	5	6	7
36. People need space (room, privacy) to feel and think.	1	2	3	4	5	6	7
37. I can be approached by people any time.	1	2	3	4	5	6	7

Appendix C

Watson's Carative Factors (1979)

1. Formation of a humanistic-altruistic system of values.
2. Instillation/enabling of faith-hope.
3. Cultivation of sensitivity to one's self and others.
4. Development of a helping-trusting human caring relationship.
5. Promotion and acceptance of the expression of positive and negative feelings.
6. Systematic use of a creative problem-solving caring process.
7. Promotion of transpersonal teaching-learning.
8. Provision for supportive, protective, and/or corrective mental, physical, societal, and spiritual environment.
9. Assistance with gratification of human needs.
10. Allowance for existential-phenomenological-spiritual forces.

Source: J. Watson (1979), Nursing: The Philosophy and Science of Caring. Boston: Little Brown.

Appendix D

Watson's Caritas Processes (2002-2007)

1. Practicing loving-kindness and equanimity for self and other.

2. Being authentically present; enabling/sustaining/honoring deep belief system and subjective world of self/other.

3. Cultivating one's own spiritual practices; deepening self awareness, going beyond ego self.

4. Developing and sustaining a helping, trusting, authentic caring relationship.

5. Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one being cared for.

6. Creative use of self and all ways of knowing/being/doing as part of the caring process (engaging in artistry of caring-healing practices).

7. Engaging in genuine teaching-learning experiences within the context of caring relationship-attend to whole person and subjective meaning; attempt to stay within the other's frame of reference (evolve toward "coaching" role versus conventional imparting of information).

8. Creating healing environment at all levels (physical, nonphysical, subtle environment of energy and consciousness whereby wholeness, beauty, comfort, dignity, and peace are potentiated (Being/Becoming the environment).

9. Reverentially and respectfully assisting with basic needs; holding an intentional, caring consciousness of touching and working with the embodied spirit of another, honoring unity of Being; allowing for spirit-filled connection.

10. Opening and attending to spiritual, mysterious, unknown existential dimensions of life-death suffering; “allowing for a miracle.”

Source: J. Watson (2008). *Nursing: The Philosophy and Science of Caring*. Boulder, Colorado: The University Press. p. 31.

Appendix E

CARE-Q English Version Items

SUBSCALES	ITEM
Accessible	1. Frequently approaches the patient first, e.g., offering such things as pain medication, back rub, etc. 2. Volunteers to do "little" things for the patient, e.g., brings a cup of coffee, paper, etc. 3. Gives the patient's treatments and medication on time. 4. Checks on the patient frequently. 5. Gives a quick response to the patient's call. 6. Encourages the patient to call if he/she has problems.
Explains and facilitates	7. Tells the patient of support systems available, such as self-help groups or patients with similar disease. 8. Helps the patient not to feel dumb by giving him/her adequate information. 9. Tells the patient, in understandable language, what is important to know about his/her disease and treatment. 10. Teaches the patient how to care for himself/herself whenever possible. 11. Suggests questions for the patient to ask her/his doctor. 12. Is honest with the patient about his medical condition.
Comforts	13. Provides basic comfort measures, such as appropriate lighting, control of noise, adequate blankets, etc. 14. Provides the patient encouragement by identifying positive elements related to the patient's condition and treatment. 15. Is patient even with "difficult" patients. 16. Is cheerful. 17. Sits down with the patient. 18. Touches the patient when he/she needs comforting. 19. Listens to the patient. 20. Talks to the patient.

	21. Involves the patient's family or significant others in their care.
Anticipates	22. Realizes that the nights are frequently the most difficult time for the patient. 23. Anticipates the patient's and her/his family's shock over her/his diagnosis and plans opportunities for them, individually or as a group, to talk about it. 24. Knows when the patient has "had enough" and acts accordingly, e.g., rearranges an examination, screens visitors, ensures privacy. 25. Is perceptive of the patient's needs and plans and acts accordingly, e.g., gives anti-nausea medication when patient is receiving medication which will probably induce nausea. 26. Anticipates that the "first time" is the hardest and pays special attention to the patient during these times.
Trusting relationship	27. When with a patient, concentrates only on that one patient. 28. Continues to be interested in the patient even though a crisis or critical phase has passed. 29. Offers reasonable alternatives to the patient, such as choice of appointment times, bath times, etc. 30. Helps the patient establish realistic goals. 31. Checks out with the patient the best time to talk with the patient about changes in his/her condition. 32. Checks her/his perceptions of the patient with the patient before initiating any action, e.g., if she/he (the nurse) has the feeling that the patient is upset with the treatment plan, discusses this with the patient before talking about it to the doctor. 33. Helps the patient clarify his thinking in regard to his/her disease and treatments. 34. Realizes that the patient knows himself the best and whenever possible includes the patient in planning and management of his/her care. 35. Encourages the patient to ask her/him any question. 36. Puts the patient first, no matter what else happens. 37. Is pleasant and friendly to the patient's

	family and significant others. 38. Allows the patient to express his feelings about his/her disease and treatment fully, and treats the information confidentially. 39. Asks the patient what name he/she prefers to be called. 40. Has a consistent approach with the patient. 41. Gets to know the patient as an individual person. 42. Introduces himself/herself and tells the patient what she/he does.
Monitors and follows through	43. Is professional in appearance-wears appropriate identifiable clothing and identification. 44. Makes sure that professional appointment scheduling, e.g., x-ray, special procedures, etc., are realistic to the patient's condition and situation. 45. Is well organized. 46. Knows how to give shots, I.V.s, etc., and how to manage the equipment like I.V.s, suction machines, etc. 47. Is calm. 48. Gives good physical care to the patient. 49. Makes sure others know how to care for the patient. 50. Knows when to call the doctor.

Source: Watson, J. (2002, 2009). *Assessing and measuring caring in nursing and health science.* New York: Springer Publishing Co.

Appendix F

Letters to the Chairpersons of Nursing

Date
JoAnn Evanko Thistlethwaite
Principle Investigator
Doctoral Candidate, Curriculum and Instruction
215 Johnson Hall
Indiana University of Pennsylvania
Indiana, PA 15705

Dear [ ]:

Please allow me to introduce myself. I am currently a doctoral candidate in Curriculum and Instruction at Indiana University of Pennsylvania. My dissertation title is "Non-traditional nursing student's perceived ability to form caring relationships". It is my intention to examine whether non-traditional students perceive they have the ability to Form caring relationships with patients and families.

For the purpose of this study, non-traditional nursing students are defined as one who has any one of the following characteristics as identified by the National Center for Education Statistics (2002) : (1) delays enrollment or does not enter a postsecondary education in the same calendar year he/she finished high school; (2) attending part-time; (3) being financially independent of parents; (4) working full-time; (5) having dependents other than a spouse; (6) being a single parent; or (7) not having a high school diploma.

In order to recruit a sample population of non-traditional nursing students to complete the Caring Ability Inventory and a one-on-one interview, I am asking for your help. Would you be able to assist with the recruitment of non-traditional nursing students in your program by providing me with an e-mail list of non-traditional students in your nursing program? A request for report of non-traditional student e-mails has been submitted and a copy is enclosed. Prospective students will then be e-mailed with an invitation to participate in the study. Enclosed is a copy of the e-mail invitation.

A copy of the study proposal that has been submitted to the Institutional Review Board at IUP and your school is also enclosed. I welcome an opportunity to meet with you to answer questions you may have about the study. I look forward to your response to this request. Please e-mail me at jthistle@iup.edu with your consent to participate. Thank you.

Respectfully Yours,

JoAnn Thistlethwaite

Appendix G

Letter of Explanation to Students

Date:

JoAnn Evanko Thistlethwaite
Department of Nursing and Allied Health Professions
Indiana University of Pennsylvania
Indiana, PA 15705

Dear Study Participant:

Please allow me to introduce myself. I have been a member of the faculty at Indiana University of Pennsylvania for 35 years and am currently a doctoral candidate in Curriculum and Instruction at Indiana University of Pennsylvania. My dissertation title is "Non-traditional nursing student's perceived ability to Form caring relationships." It is my intention to examine if non-traditional students perceive they have the ability to Form caring relationships with patients. I currently teach in the undergraduate nursing program at Indiana University of Pennsylvania and have for over 35 years.

The study is designed to measure the perceptions of non-traditional nursing students' ability to Form caring relationships with patients/clients. In addition, the study is designed to provide insight to nursing educators about the challenges non-traditional nursing students may encounter while transitioning into the caring role of the nurse.

You will be asked to complete a survey on line and a follow up face to face interview with the researcher. If you agree to participate, please email your email address to jthistle@iup.edu Complete anonymity is assured since no identifying information will be conveyed to anyone other than the interviewer.

You are welcome to ask questions about the study or participation. Feel free to contact the researcher at 724 238 4811 or email jthistle@iup.edu if you need additional information.

I appreciate your interest and willingness to participate in this research. Results from the study will be forwarded to you upon request.

Sincerely,

JoAnn Thistlethwaite

Appendix H

Flyer

Appendix I

Studies Supporting Reliability and Validity of Caring Ability Inventory

Nkohgho (1990)	Two groups (1) 462 college students from varied majors, and (2) 75 nurses attending a national professional conference. Of the 537 respondents, 20% were male and 80% were female. Most of the sample (61%) was under the age of 35 years.	**Internal consistency:** Total CAI = .84 Subscales : Knowing = .79 Courage = .75 Patience = .71 Test-retest: Conducted with 38 respondents on 2 occasions, two weeks apart. Total CAI = .75 Subscales: Knowing = .80 Courage = .64 Patience = .73	**Content validity:** A priori content validity was supported by the fact that items were developed based on the literature and critical elements of caring identified by Mayeroff (1971). A content validity index of .80 resulted from ratings of two experts. **Construct validity:** Results from *t*-test analysis supported the hypothesis that practicing nurses would score higher on caring than college students for the total CAI ($t = 7.06$; $p < .001$); and each of the subscales, i.e., Knowing ($t = 7.95$; $p < .001$, Courage ($t = 3.43$; $p < .001$), and Patience ($t = 5.16$, $p < .001$). **Factor analysis**: Results indicated the presence of three factors that were compatible with the conceptual basis of the CAI.
Simmons & Cavanaugh (1996)	National sample of 350 female senior US baccalaureate nursing programs randomly selected from the National Student Nurses Association. Median age	**Internal consistency:** Cronbach's alpha for total CAI = .79	**Construct validity:** Supported by the hypothesized relation between the CAI score and perception of caring within nursing school climate as assessed by

	23 years (M= 26.5, SD = 7.0). About 90% were white, 41% reported income levels below $20,000, 14% above $60,000		Part A of the Charles F. Kettering Ltd. School Climate Profile. The correlation between the CAI and CFK Profile was .16 (p<.01).
Cavanaugh & Simmons (1997)	National sample of 495 female students (the 350 senior students in the 1996 study along with 145 juniors from the same group. Median age 24 (M = 27.1, SD = 7.3). About 88% were white, 43% reported income levels below $20,00, 14% above $60,000.	**Internal consistency:** Cronbach's alpha for total CAI = .79.	**Construct validity:** The correlation between total CAI score and overall nursing school climate was .24 (p <.001). The dimensions of school climate that correlated most strongly with the CAI subscales were Caring: r= .17, .22, .17 with Patience, Knowing, and Courage respectively (p < .001. Furhter evidence of construct validity: The total CAI mean of 208 for the nursing students was higher than the mean of 196 reported for 462 college students with varied majors by Nkongho (1990), but lower than the mean of 212 reported for 75 nurses in that study.
Simmons & Cavanaugh (2000)	In the second phase of a longitudinal study, 189 of the 495 nursing students included in the Cavanaugh and Simmons 1997 study, who had obtained their nursing degree and entered nursing practice, responded to a follow-up survey 3 years later. Almost 97% reported passing the national nursing licensing exam with more than 90% passing on the first attempt.	Cronbach's alpha for total CAI = .83 Evidence of the stability of CAI scores was found in the .59 correlation (p < .001) between student and follow-up graduate CAI scores.	**Construct validity:** A paired t-test indicated that, as hypothesized, CAI total scores were higher for graduates than for students (p = .001). This cannot be attributed to maturation, as age was not found to be related to CAI in this group. Additional confirmation of construct validity: the correlation between CAI score and perception of nursing school climate was .17 (p < .05).

Baird (1996)	The sample consisted of 286 nursing students (58 males and 228 females) and 267 dental hygiene students (5 males and 262 females) in Associate Degree Programs at four northeastern community colleges. Mean age of nursing students 30.4 of dental hygiene students 25.8.	**Internal consistency:** Cronbach's alpha for total CAI = .81 for nursing students, = .79 for dental hygiene students.	**Construct validity:** A comparison of nursing and dental hygiene student scores on the CAI provided evidence for construct validity. As hypothesized, the nursing students' mean (209.8) was higher (p <.01) than that of the dental students (205.5). In addition, the CAI scores were correlated with scores on the Inventory of Socially Supportive behaviors, r = .24, p < .001.
Davenport (1990)	The sample consisted of 76 sophomore students at a Texas university. Half were nursing majors and half were non-nursing majors. There were 29 males and 47 females. Median age was 22.	**Internal consistency:** Cronbach's alpha for total CAI = .84.	**Construct validity:** Evidence of construct validity was provided by the results of a t-test comparing non-nursing majors' and nursing majors' total CAI scores. The nursing majors' mean (212.4) was found to be higher than that of the non-nursing majors (198.2), p < .001. Additional support for construct validity was the finding that the total CAI mean of the female nursing students was higher than that of the male nursing students (202.9), p < .05.
Higgins (1993)	Sample of 39 male and 47 female Air Force mental health nurses. About 90% held rank of captain or above. Media age was 36. Median number of experience as a RN was 13.	**Internal consistency:** Cronbach's alpha for total CAI = .87.	**Construct validity:** Total CAI scores were positively related to a number of variables in this study, providing evidence for construct validity. CAI scores were correlated with years of RN experience, (r = .20, p < .05), scores on the Nurses' Attitudes Toward Mental Illness

			Scale (r = .31, p < .01), and scores on the Power in Knowing Participation in Change Tool (r = .55, p < .01).
Nkongho (1998)	Sample of 15 male and 94 female undergraduates attending a large urban university. Median age 25.	**Internal consistency:** Cronbach's alpha for total CAI = .83. Subscales Patience = .67 Knowing = .80 Courage = .69	**Construct validity:** A relationship was found between ego development levels and CAI scores. Spearman correlation coefficients between scores on the Washington University Sentence Completion Tent and the CAI were: Patience = .18 p < .05 Knowing = .17 p < .05 Courage = .29 p < .001 Total CAI = .28 p < .01

Appendix J

Permission to use Caring Ability Inventory from Springer Publishing Company

SPRINGER PUBLISHING COMPANY

www.springerpub.com

5/28/2009

JoAnn E. Thistlethwaite
779 Four Mile Run Road
Ligonier, PA 15658

Dear Ms. Thistlethwaite,

Thank you for your permission request made on 5/21/2009 to make reproductions of the following:

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Jessica Perl
Sales Associate

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Appendix K

Permission to use Caring Ability Iventory from N. Nkohgho, Ph.D., RN, CNE

From: "Nkongho, Ngozi O." <nnkongho@nlnacinc.org>

Subject: RE: permission to use CAI

Date: Fri, 23 Jan 2009 13:10:56 -0500

To: "Joann E Thistlethwaite" <jthistle@iup.edu>

Best wishes!

Ngozi Nkongho, PhD, RN, CNE
Deputy Director

61 Broadway, 33rd Floor
New York, NY 10006
P. 800.669.1656 ext. 465
F. 212.812.0390
www.nlnac.org

-----Original Message-----
From: Joann E Thistlethwaite [mailto:jthistle@iup.edu]
Sent: Friday, January 23, 2009 12:58 PM
To: Nkongho, Ngozi O.
Subject: Re: permission to use CAI

Dr. Nkongho,

Thank you for your speedy response. I am thrilled to have your permission to use the survey. I will keep you posted and send you an electronic and hard copy of the dissertation. JoAnn Thistlethwaite

On Fri, 23 Jan 2009 11:50:57 -0500
"Nkongho, Ngozi O." <nnkongho@nlnacinc.org> wrote:
Ms. Thistlethwaite:

I give you permission to use the Caring Ability Inventory in your work.
I request that you give me copies of publication/s (paper and electronic) in order to continue to refine the Inventory over time.
I appreciate your interest in the tool and wish you the very best in your dissertation and research activities.
Ngozi

Ngozi Nkongho, PhD, RN, CNE
Deputy Director
61 Broadway, 33rd Floor
New York, NY 10006
P. 800.669.1656 ext. 465
F. 212.812.0390
www.nlnac.org
-----Original Message-----
From: Joann E Thistlethwaite [mailto:jthistle@iup.edu]
Sent: Friday, January 23, 2009 10:54 AM
To: Nkongho, Ngozi O.
Subject: permission to use CAI

Dear Dr. Nkongho,
This is a follow up to the message left on your voice mail today. Currently, I am a nurse educator working on my doctoral degree; and I would appreciate your precious time and effort in assisting me with my study: Non-traditional nursing students' perceived ability to form caring relationships. This study is in partial fulfillment of completion of my doctoral dissertation research which I am conducting
through Indiana University of Pennsylvania Department of Education. The data I would like to collect and analyze is the perception non-traditional students have about their ability to form caring relationships with their patients and families. It is my belief that the Caring Ability Inventory would give me the data I am seeking for this study. May I please have permission to use this instrument? I assure you that full credit for the source will be given and the acknowledgment will be in the form that you require.
Please contact me to let me know if you grant permission and any conditions that may apply. If you have any questions about this request, please feel free to contact me at 724 238 4811. The best time to reach me is in the evening. You may also email me at jthistle@iup.edu.
Thank you for Your Consideration,

JoAnn Thistlethwaite, MNEd, RN, ABD
Department of Nursing and Allied Health
Indiana University of PA
217 Johnson Hall
Indiana, PA

Appendix L

Final Interview Questions

When you are answering these questions, think about yourself or behaviors that you have observed in others.

1. How do you ordinarily define caring?
2. Describe what caring in nursing means to you.
3. What are some examples of caring behaviors that you have seen in nursing practice?
4. How do you let your patients know you care about them?
5. How do you include caring as part of the patient plan of care?
6. What abilities for caring do you believe you possess?
7. Do you believe you have the ability to form caring relationships with your patients?
8. What event person and/or situation has shaped your development of caring?
9. Describe a situation where you observed caring behaviors.
10. Describe your understanding of the connection between feeling cared for and wellness?
11. Do you think it takes courage to be a patient advocate?
12. How do you feel about confronting a physician when you identify an error he/she has made?
13. If you find a fellow nurse is using illegal drugs while on duty, what would you do?
14. Describe one thing that has made the biggest impression on your perceptions of caring while you have been in the nursing program.
15. How would you describe your ability to establish a caring relationship with patients you care for using a scale of 0 to 10 (with 0 being the weakest ability and 10 being the strongest ability)? Please explain your rating.
16. How would you describe the ability of nurses that you have observed to establish caring relationships with patients using a scale (with 0 being the weakest ability and 10 being the strongest ability)? Explain your answer.

Appendix M

Word Grid: Typological Review of the Related Literature

Theme	Related Literature	Student Literature	Total
Accessibility	1	0	1
Advocate	1	0	1
Altruism	4	0	4
Care of self	2	1	3
Cared for	5	0	5
Comfort	2	1	3
Commitment	2	1	3
Communication	3	1	4
Companionship	2	0	2
Compassionate	6	1	7
Competence	11	2	13
Complex	0	1	1
Concern	1	0	1
Confidence	1	2	3
Confidence	0	1	1
Confidentiality	2	0	2
Connecting to others	6	0	6
Conscience	0	1	1
Courage	0	1	1
Courage to let go	3	0	3
Crisis intervention	1	0	1
Critical thinking	1	0	1
Culturally Sensitive	2	0	2
Dignity	7	0	7

Empathy	4	2	6
Enthusiastic	1	0	1
Establish SP relationship	0	1	1
Ethical and moral duty	1	1	2
Extra Mile	2	0	2
Fear	0	1	1
Follow through	1	0	1
Fulfillment	1	0	1
Getting work done on time	1	0	1
Growth	1	0	1
Health	2	0	2
Health/healing relationships	1	0	1
Honest	1	0	1
Human experience	4	1	5
Job Satisfaction	2	0	2
Knowledge of patient	10	4	14
Knows self/role	2	2	4
Limitations	2	0	2
Listens	4	0	4
Loving	3	0	3
Make a difference	1	0	1
Master technical skills	0	1	1
Monitor	1	0	1
Mutually beneficial	2	0	2
Non-judgmental	1	0	1
Nurturing	1	0	1
Patient need (vulnerable)	7	0	7
Patient satisfaction	1	0	1

Physical/social/emotional	7	0	7
Positive financial outcomes	1	0	1
Positive Pt outcomes	2	0	2
Potential of Others	1	0	1
Professional Maturity	8	0	8
Public policy	3	0	3
Research	2	0	2
Safety	6	0	6
Scientific knowledge	6	2	8
Sensitivity	1	0	1
Skills	1	2	3
Spirituality	2	0	2
Student growth	0	1	1
Take ownership	1	0	1
Team member	1	0	1
Time	1	0	1
Tolerance	1	0	1
Trust	2	0	2
Unifying	1	0	1
Unique	1	0	1
Universal needs	2	0	2
Welcoming	7	0	7
Well being	1	0	1

Appendix N

Matrix for Evaluation of Qualitative Data

Other	**Knowing**	**Patience**	**Courage**
Well being	Advocate	Care of self	Care of self
Job Satisfaction	Care of self	Compassionate	Commitment
Accessibility	Comfort	Complex	Compassionate
Alturism	Communication	Ethical and moral duty	Complex
Cared for	Compassionate	Follow through	Courage
Welcoming	Competence	Growth	Courage to let go
Comfort	Complex	Health/healing relationships	Empathy
Companionship	Confidence	Monitor	Extra Mile
	Confidence	Make a difference	Ethical and moral duty
Unifying	Crisis intervention	Non-judgmental	Growth
	Critical thinking	Potential of Others	Human experience
Concern	Culturally Sensitive	Time	Loving
Honest	Dignity	Tolerance	Make a difference
	Establish SP relationship Mechanical Authoritative Facilitative		
Confidentiality	Ethical and moral duty		Safety
	Extra Mile		Take ownership
	Growth		Trust
Listens	Knowledge of patient		Establish SP relationship Mechanical

			Authoritative Facilitative
	Knows self/role		
	Limitations		
	Make a difference		
Connecting to others	Master technical skills		
Conscience	Monitor		
Enthusiastic	Mutually beneficial		
Fulfillment	Non-judgmental		
	Patient need (vulnerable)		
Positive Pt outcomes	Physical/social/emotional		
	Positive financial outcomes		
	Professional Maturity		
	Public policy		
Patient satisfaction	Research		
	Scientific knowledge		
Getting work done on time	Sensitivity		
Health	Skills		
	Spirituality		
	Student growth		
	Team member		
	Uniqueness		
Nurturing	Universal needs		