DISSERTATION

CARING BEHAVIORS OF PRECEPTORS AS PERCEIVED BY NEW NURSING GRADUATE ORIENTEES

Submitted by

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WE HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER OUR SUPERVISION BY DONNA LUCAS SCHUMACHER ENTITLED CARING BEHAVIORS OF PRECEPTORS AS PERCEIVED BY NEW NURSING GRADUATE ORIENTEES AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

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ABSTRACT OF DISSERTATION

CARING BEHAVIORS OF PRECEPTORS AS PERCEIVED BY NEW NURSING GRADUATE ORIENTEES

Caring has been purported to be the core essence in nursing however, a review of the literature yields no studies examining if caring behaviors and interactions occur between new nursing orientees and their preceptors. This phenomenological study explored the orientee and preceptor relationship and asked the questions; do caring interactions occur between preceptors and orientees and if so, what does this mean to the orientee.

A purposeful sample of 10 new graduate nursing orientees attending a 10-week orientation period at a large medical center in the Midwestern part of the United States, participated in this study by journaling their thoughts, and feelings about preceptor caring and not so caring interactions that occurred. Journal entries were coded for themes and sub themes. Participant's journals demonstrating specific and rich examples about caring and not so caring behaviors from their preceptors were asked to partake in an in-depth interview. Interviews were analyzed using the Colaizzi methodology. Comparisons of the journal themes and sub themes were compared with the themes extracted from the interviews. Caring and not so caring preceptor behaviors and the powerful meanings and outcomes for the orientees were expressed. Trustworthiness was maintained using reflexive bracketing, peer review and member checking.

Six themes of caring preceptor behaviors emerged; advocating, welcoming, including, autonomy with appropriate preceptor presence, making human connections,

and authentic, specific, and non-punitive feedback. Four themes of not so caring preceptor behaviors also emerged, were antithesis to the caring preceptor behaviors, and included; unwelcoming, autonomy with over or under preceptor presence, unclear, non-genuine feedback. None of the orientees felt comfortable discussing their concerns and feelings with uncaring preceptors. This was due in part to their strong desire to fit into the nursing culture of the unit.

This study provides actual preceptor caring and not so caring behaviors and demonstrates the resultant powerful outcomes. This study can be used in preceptor education to increase the awareness of caring interactions. Caring interactions help new orientees to become independent, safe and accountable nurses, and these positive outcomes can increase retention of nurses at a time when the nursing shortage is critical.

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CHAPTER I

Introduction

Background

The marriage of nursing and caring have stood the test of time because the concept of caring has remained a key component in nursing for over 142 years. Caring is a concept that is frequently discussed in the nursing literature. Most nursing theorists readily espouse the importance of caring in nursing and distinguish the concept of caring as the quintessence of nursing. Leininger (1988) distinguishes caring as both the cardinal and integrative infrastructure for the standards of nursing theory and practice. Roberts (1990) pinpoints caring as a concept inherent to how nurses practice the art of nursing. Leininger (1988) recognizes that caring in nursing can be a powerful agent for healing and motivation of healthier life styles. Nursing theorist Jean Watson (1988) perceives caring as the ethical and moral nucleus of nursing. Watson depicts her theory of nursing as the art and science of human caring. Watson's (1985) ten Carative Factors (Appendix A) reflect the humanistic and scientific principles that are involved in nursing practice based on her theory of human caring. Watson's theory provided the framework for the Denver Nursing Project in Human Caring begun in 1988. This project was a nurse-managed center for people living with HIV/AIDS (Schroeder, 1992). The biggest asset of the center according to Schroeder was the ability of the nurses to implement caring behaviors. The caring behaviors were described as flexibility, acceptance, unconditional support, listening, competence, friendship, and making human connections. The Denver Nursing Project in Human Caring is now closed as a clinical entity. Dr. Watson states, "The next evolution is a series of projects that are involved in caring

theory guided practice" and implementing what she calls the "Nightingale Units of Caring-Healing excellence, along with a professional practice model: Attending Caring Nurse Professional Practice Model" (J. Watson, personal communication, January 19, 2004).

Florence Nightingale has often been described as the founder of nursing and the first nursing theorist. Nightingale defined caring in 1859 as nursing's most important work. Articles about nurse caring continue to appear in the nursing literature each year. In fact, in the March 2001 issue of the Journal of Nursing Education, Dr. Beck wrote an article describing a metasynthesis of caring research within nursing education. The article analyzes several qualitative studies on caring in nursing education and includes: caring among faculty, faculty student caring, caring among nursing students, and nursing student-patient caring.

Since caring is such a central phenomenon to nursing, one would expect caring to be important in nursing education. In 1990 the National League for Nursing passed a resolution on nursing education calling for a curriculum revolution delineating caring as the core value in schools of nursing. Nurse educators were called upon to make certain that caring become an integral part of the nursing curricula. Teaching caring to nursing students is paramount to all nursing instructors and should be a major factor that motivates curriculum planning, drives faculty development, and governs all student-teacher interactions. Nursing instructors need to be responsible for studying, understanding, and practicing theories of caring.

This curriculum revolution was led by nursing theorists such as Jean Watson. Watson declared in 1988, that since caring was the moral ideal of nursing, it should be

central in the educational programs of nurses. A curriculum change from control to caring was espoused by Em Bevis (1994) during her conference in Rochester, Minnesota. Bevis articulated that the primary purpose of such a curricular change was to liberate human beings and their communities through caring, critical thinking and action.

Jean Watson (1989) declared the ultimate importance of teaching caring in nursing education and stated, "Caring is concerned with the human center of self and other. In this sense, caring is linked to healing; thus as caring educators, we are all healers as we provide alternative pathways and enable others to find their own voice and meaning" (p.53). Watson goes on to postulate that when nursing educators allow their students to find their own voice and meaning, emancipation of these students occurs. No longer are nursing students afraid to ask questions; thus, they are able to explore new ways of thinking and doing in nursing. This emancipation in nursing education allows for future nurses to employ their critical thinking and ask questions that may be out of the realm of the usual way of practicing nursing. A curricular paradigm that boasts an educative-caring curriculum allows nursing student emancipation and therefore supports true education. The educated nurse has much more to give to life, clients, and the world.

Caring must be made "visible" to nursing students through the use of modeling, dialogue, practice, and confirmation. Nursing instructors need to nurture and confirm caring responses in order for the student to understand the concept and the importance of caring. Student and teacher interactions in which instructors utilize behaviors denoted as caring are at the heart of a visible caring model. Studies have shown the importance of teaching caring to nursing students in order for them to begin to incorporate caring into

their practice after graduation (Beck, 1991, 2001; Leininger, 1988; Noddings, 1986; Roach, 1984).

Being able to incorporate caring into one's nursing practice after graduation is, of course, the central objective of teaching caring in nursing school. Studies have shown the importance of teaching and modeling caring in nursing school; therefore, it would seem that this thread of caring should continue to be taught and modeled after the student graduates in order to help the new graduate strengthen and improve upon incorporation of a caring practice. It is important that new graduate nurses continue to gain exposure and visibility of caring from preceptors and mentors when beginning their careers in nursing. Fostering and shoring up these caring interactions need to be a central objective of nursing orientation programs and espoused by preceptors of new graduates as well.

Studies show that the first three months of transformation from nursing student to nurse to be the most stressful time in a nurse's career and that the attrition rate of new graduates ranged from 55%-61% during their first year of employment (Hamilton, Murray, Lindholm, & Myers, 1989). A new nurse may decide to leave nursing altogether if this orientation period to nursing proves to be too stressful and uncaring of an experience. The estimated cost of replacing the nurse who decides to leave a health care facility has been cited to be between $30-$50 thousand dollars (Birkenstock, 1991; Messmer, Abelleria, & Erb, 1995). Relationships have been cited as the most important reason why nurses stay in the hospital facility in which they are oriented; a new nurse who does not feel a part of his or her nursing unit because he or she does not feel cared about or has been unable to establish positive relationships with coworkers has been cited as the number one reason for leaving the facility where oriented (Nursing Executive

Center Destination Nursing Survey, 2001). New nurses identified such positive relationships as ones in which co-workers were perceived as caring, friendly, supportive people who took time to get to know them and were flexible and helpful with schedule needs (Nursing Executive Center Destination Nursing Survey, 2001). These comments mirror statements in studies where researchers looked at caring behaviors between students and nursing instructors and indicated that students who experience caring behaviors from faculty also have a higher retention rate and are more likely to be successful in their endeavors than students who experience non-caring (Schumacher, 1995; Viverais-Dressler, 2001). It is obvious that the effects of a caring environment are important throughout nursing school and after graduation. It is imperative that promotion of caring interactions between the new nursing orientee and his or her preceptor should be supported and given utmost attention in order for such positive objectives to continue.

When new graduate nurses leave a more controlled and safe setting, such as nursing school, and enter into the actual nursing environment where they are expected to become active participants, "reality shock" can ensue (Kramer, 1974). Toffler (1970) describes this same type of phenomenon and has labeled it as "future shock." The basis of these two experiences is that the new graduate nurse finds that there is a discrepancy between the two cultures of nursing: the one he or she has been trained for and the actuality of the job. The symptoms that occur when new nurses are not equipped to deal with this discrepancy can be anger, self pity, fear, hate for their new career, and eventually withdrawal from nursing altogether (Kramer, 1974). Kramer's seminal work on the difficulty of transition from nursing student to nurse continues to be investigated and continues to exist. In one study by Goh & Watt (2003) new nurses felt unprepared to

practice nursing, felt the staff had unrealistic expectations of them and felt they were not able to give the quality of care they should due to heavy workloads. Goh and Watt (2003) noted three stumbling blocks to transition from graduate nurse to staff nurse. The first is assimilation anxiety, new nurses felt stressed to fit in and be part of the team as well as a need to prove to themselves and others that they were worthy of the title of good nurse. The second stressor is role stress which includes management of their time and personal accountability. The third stumbling block identified by Goh and Watt (2003) is that of personal stress and fear of making a mistake, power relationships, asking questions, and negativity of colleagues.

The importance of preceptor support was identified as a significant factor for assisting in the transition from student nurse to the RN role and preceptors who were encouraging, supporting, clinically competent, gave feedback, and acted as resources for the new nurses helped to decrease anxiety, fear, and stress (Ellerton & Gregor, 2003; Gerrish, 2000; Godinez, Gruver, Ryan, & Schweiger, 1999; Goh & Watt, 2003). Decreasing anxiety, fear, and stress, and providing a supportive environment are crucial benefits for new nursing orientees and encourages learning. The ability to learn goes hand in hand with the ability to be successful and reach goals. Meeting this basic need of feeling safe in an environment is identified by Maslow's (1954) theory of motivation as one of the basic psychological needs. Having this basic need met, allows orientees to continue up the hierarchical scale to meet needs of self-esteem and finally self-actualization (Bulach & Brown,1998; Schultz, 1992).

Statement of the Research Purpose

The background of this study shows the importance and benefits of teaching caring in nursing. The literature shows that nurses who learn about and incorporate caring into their practice are nurses who are adaptable, independent critical thinkers, and learners. They are able to problem-solve, are tolerant of uncertainty, and are capable of constructing knowledge in their daily practice (Evans, 2000; Watson, 1989). Studies have further demonstrated that nurses who incorporate caring in their practice, are nurses who are able to assess patient's more holistically, and can help improve patient's quality of life (Erci, Sayan, & Tortumluoglu, 2003). Nurses who implement caring behaviors found there was an increase in patient satisfaction (Maljanian, Bohannon. & Columbe, 2003).

Principles of adult learning demonstrate that adults continue to learn about concepts that are important to them and have intrinsic meaning (Knowles, 1984). In order for new nursing graduates to continue to develop and incorporate caring into their nursing practice, the positive, life changing results of nurse caring behaviors must continue to be studied, discussed, confirmed, modeled, and practiced to help new nursing graduates understand caring as an intrinsic motivating factor. Preceptors must recognize the importance of caring in nursing and continue to make caring a central focus during orientation through dialogue, confirmation, and modeling of caring behaviors and interactions. Nursing orientation programs must support the preceptors in this endeavor by making sure that caring is a major cornerstone in the orientation process. The purpose of this study is to better understand if caring interactions are occurring between the preceptor and the orientee during the orientation period and if so, to identify what the actual behaviors, actions, and interactions mean to the orientee regarding caring.

The difficulty lies in the concept of what caring means and how it is perceived. Caring is complex and has a personal and individualized significance based upon each person's life experiences, as well as social and cultural norms (Norris, 1989). The capacity to respond in a caring manner is not an automatic way of relating to others. Nursing preceptors need to understand how orientees perceive caring from their preceptors in order to build a common orientation infrastructure with caring as the core value. Caring concepts, interactions, and behaviors that are clearly understood by both preceptor and orientee will serve to assist the preceptor to model, dialogue, confirm, and practice caring in order to continue to promote caring as an important intrinsic motivating factor in the new nursing graduate's practice.

Research Questions

The purpose of this phenomenological study will be to discover new nursing orientees lived experiences of caring behaviors from their preceptors during a 10-week orientation period at a large medical center in the Midwestern portion of the United States.

1. Are caring interactions occurring between the orientee and preceptors during the 10-week orientation period at the medical center environment.
2. If the orientees do perceive caring interactions from their preceptors what does this mean to them?

Significance of the Study

The literature illustrates that caring is important to teach in nursing school in order for the student to learn to practice caring interactions with patients in the clinical arena, therefore, it is important to know if this caring continues to be a foundational core in the orientation process. This study will provide information regarding an orientation

process in which orientees delineate whether caring from preceptors is perceived or is not perceived. This study will also look at the perceived outcomes from caring interactions identified between orientees and their preceptors. Specific behaviors denoting caring will be synthesized from this study and will give specific direction for implementing and fostering caring into the current orientation process at this medical center as well as other nursing orientation programs. If the study shows that caring is perceived then this study can give information that will help other nursing orientation programs incorporate caring into their orientation process.

The literature also develops the important outcomes of a safe, caring learning-teaching environment in order for nurses to be able to become adaptable, independent critical thinkers, and learners. This study can serve to clarify for nursing preceptors how caring is perceived by nursing orientees. Actual caring experiences will be delineated that will give nursing preceptors more clear-cut examples of how orientees perceive caring. This information could prove useful to preceptors in health care to develop an orientation model that has caring as it's core concept. A caring based orientation model may prove to be useful in the retention of new nurses.

This study may help to assist nursing preceptors to better comprehend powerful effects that may be cited from orientees regarding caring and non-caring preceptor-orientee interactions. The powerful effects that may be cited would then encourage preceptors to be diligent in the implementation of caring behaviors denoted in the study.

Researcher's Perspectives

I have been involved in nursing education for the past 16 years. During this time I have read and participated in research regarding caring in nursing education. I have seen first hand the powerful effects that a moment of caring or non-caring from nursing faculty or a preceptor can have on nursing students and new nursing graduates. A student or orientee who experiences open communication, acknowledgement and validation from a respected and admired instructor or preceptor is enriched and empowered by the interaction and is able to grow in his or her understanding of nursing. A student or orientee who experiences a brutal non-caring interaction from a nursing instructor or preceptor can be devastated, and may decide to leave nursing altogether. This is a time of extreme nursing shortages, and nurses currently working are getting older and will be looking to retire in the near future thus compounding the shortage (American Association of Colleges in Nursing 2001). With these extreme shortages apparent, it is even more vital that nursing instructors and preceptors realize the impact of caring and uncaring interactions.

I do not believe that all interactions need to be ones in which the instructor or preceptor tells the student or orientee what they did well; often times caring means instructing the student or orientee regarding ways to improve on a procedure or nursing care. However, I do believe that nursing faculty and preceptors and their students or orientees should work towards establishing an equal professional collegial base and a trusting relationship in which open communication and dialogue can take place without fear of retaliation. The role of the instructor and preceptor should be one of facilitator and expert life-long learner. The teacher should instruct the student or orientee on how to

also become an expert life-long learner. I believe that caring interactions are essential for establishing an environment where nursing students and orientees are able to grow and develop as outlined in Chickering and Reisser's (1993) seven major vectors, (Appendix B). I believe that caring should be the infrastructure to assist nursing students and orientees to develop within the five major epistemological categories as outlined by Belinkey, Clinchy, Goldberger, and Tarule, (1986).

I believe that research on teaching caring in nursing education is an area that will continue to need further exploration. However, I do feel that nursing researchers have looked at and addressed the concept of caring in nursing education quite well over the years. A literature search on the teaching of caring in nursing education will yield research with rich qualitative and quantitative results. A literature search regarding orientation programs that continue to foster education regarding incorporating caring practices during nursing orientation has not been detected in the literature.

I fear that the research that has been done on teaching caring in the schools of nursing may not be a core focus once the new nursing graduate goes out into the field and begins his or her nursing practice. My own personal experiences with my nursing orientation after graduation were dreadful. There were many times during that first year that I thought my choice of nursing as a career was a terrible mistake. I endured a very non-caring and regimental orientation in which I had to constantly prove myself worthy to be a nurse. Working as a staff nurse for 14 years, I saw this type of sink or swim orientation happen over and over again. I continue to see this type of non-caring displayed to new nurses who do not seem to "fit-in" with the culture of the units they are hired for.

It is my hope that research such as this study will assist in keeping the heart of caring in nursing after graduation. Caring should be taught in nursing school and should continue to be taught and practiced throughout orientation in order for the new nursing graduate to build a caring foundation for practice. I believe that caring must first be modeled and practiced between all nurses in order provide an environment that is inclusive of all nurses. I believe that caring should become an intrinsic motivational factor which will encourage a nurse to seek continuous improvement of his or her caring nursing practice.

CHAPTER II

Review of the Literature

Caring has been purported to be the core nucleus of nursing by nursing experts. (Beck, 1991, 1992, 2001; Bevis,1994; Leininger, 1988; Nightingale, 1859; Noddings, 1986; Norris, 1989; Roberts, 1990; Watson, 1988, 2001). Teaching the concept of caring in nursing by modeling, dialogue, confirmation, and practice is the first step in assisting the nursing student in understanding the importance of caring in nursing and helping the student to begin developing a framework of nursing practice that incorporates caring. Considerable research has been done that explores how nursing students perceive caring and non-caring behaviors during their nursing education. The literature review yields no studies examining if caring continues to be taught, supported, and fortified by preceptors. This study will explore if this developing, friable framework of caring continues to be fortified by preceptors during the orientation period.

Chapter II will be divided up into five sections. The first section of this chapter will focus on a review of current, popular literature describing general perceptions of caring from outside the discipline of nursing. The second section of this chapter will explore the nursing literature that describes the basic corner stones of nursing practice. Understanding these basic foundational concepts of nursing will help the reader to better understand the idea of nursing as a whole. The third section of chapter II will explore the nursing literature that examines the perceptions of how patients' perceive caring from nurses. The fourth section of this chapter will explore literature regarding how nurses perceive caring nurse behaviors. The fifth section of this chapter will examine how student nurses perceive caring nurse behaviors from nursing instructors, from other

nursing students and while caring for their assigned clinical patients while in nursing school. Exploring these myriad perceptions of caring will provide a deeper understanding of the concept of caring.

Section I: General Perceptions of Caring Portrayed in the General, Popular Non-Nursing Literature

The first section of this chapter will focus on a review of current, popular literature describing general perceptions of caring outside of the discipline of nursing. This review will focus on the general perceptions of caring as noted in magazines, web sites, and books written by psychologists, sociologists, philosophers, and experts in the field of management and leadership. This review will provide the reader with a backdrop of the perceptions of caring as noted by persons without nursing expertise.

The background of caring perceptions outside of the discipline of nursing will provide the reader with information that will be helpful in comparing and contrasting sections two through five of this chapter which will focus on literature regarding descriptions of caring as noted in the literature by experts in the discipline of nursing.

For each section, the literature will be reviewed, analyzed and synthesized. This analysis and synthesis of the literature on caring will help to generate a framework that can support an understanding of the research findings regarding caring encounters.

An analysis and synthesis of the general, popular, non-nursing literature describing caring will be reviewed in this section. Categories and any supporting themes that delineate caring will first be outlined. Examples of behaviors noted in the literature will also be presented to assist the reader to better understand the designated categories and themes.

Category #1 Effective Communication: Supporting Themes Include Attentive Listening, and Open, Honest Dialogue and Feedback.

The ability to communicate effectively was noted in the non nursing literature on caring and will be the first category to be discussed in this section. Supporting themes of effective communication were attentive listening to another and open, honest dialogue and feedback.

To be able to communicate effectively and caringly, people must pay attention and listen to what others are saying. Listening without judging or feeling the need to mold or take responsibility for another are important concepts in attentive listening (Rogers, 1977; Rosenberg, 2003). The results of attentive listening can assist another to re-perceive his or her world and can often assist the person to see ways of dealing with problems that seemed at first insurmountable (Rogers, 1977). The idea of fully attending with another, being present or presencing with another are terms noted in the literature that also reflect the idea of attentive listening (James, 1994; Keen, 1997; Rogers, 1977; Rosenberg, 2003). Attentive listening, presencing and fully attending to another are all described as emptying the mind and listening with total concentration to another. The following story from Rosenberg (2003) highlights the need that human beings have for others to attentively listen to them. A busy grade school principle was running late for a very important meeting. As she came down the hall to her office she saw a small girl named Millie sitting on the bench by her office waiting to speak with her. As the principle came closer and said hello to the child, Millie, began telling the principle that she had experienced a very had a bad week where nothing seemed to go right for her. The principle sat down next to Millie and told her that she too had experienced this kind of

week. The principle then asked Millie what she could do for her. The small child reached up to the principle and took hold of both of her shoulders, looked straight into her eyes and told the principle that she did not need her to do anything; she just wanted her to listen. The principle exclaimed this experience was one of her most significant moments of learning in regards to the importance of attentive listening.

Attentively listening to another invites the other person to participate in open, honest, dialogue, and feedback. Open, honest, dialogue, and feedback that allows people to share their joys, and problems was noted to be an imperative factor in building caring, meaningful relationships (James, 2004; Johnson,1992; Randall, 1992). Keen (1997) declares dialogue and communion as elements of love and states that love unlocks the tongue and allows people to talk about anything, thus creating a wholesome dialogue. Open, honest, dialogue, and disclosure regarding deepest feelings should be spoken between persons who care about each other unconditionally for healthy relationships to grow (James, 2004; Keen, 1997). Open, honest, communication is not easy and there is often confrontation between ideas, beliefs, and opinions before a synthesis can be reached (Keen, 1997). The theme of open, honest, dialogue has been an important concept in the development and continuance of interpersonal relationships for many years. A quote by Charles Dickens, 1812-1870, "Never close your lips to those whom you have opened your heart" reflects the importance of open, honest, dialogue, and feedback. These themes of effective communication are also important outside the realm of interpersonal relationships

These themes of effective communication; attentive listening, and open, honest, dialogue, and feedback are of great importance to the business industry, companies and

schools. Attentive listening to honest, open, dialogue, and feedback from customers should be valued as a gift to help companies improve service, and make positive changes (Barlow & Mollor, 1996; Perkins, 2003). Soliciting honest, open, dialogue, and feedback regarding products through personal phone calls and written or online surveys and giving careful attentive listening during the phone calls or reading of surveys in order to address concerns and make positive changes shows customers that companies care about them (Coleman, Inc 1992; London Underground, 2004; Papa John's Pizza Company, 2004). Schools demonstrating an environment of a caring community listed the ability to work together through ongoing honest dialogue and problem solving, as being of utmost importance in supporting the school's caring community culture (Boutillier, & Sutherland, 2004).

Appropriate feedback is imperative in problem solving and making positive changes. Perkins (2003) describes three types of feedback; negative, conciliatory, and communicative feedback. Conciliatory feedback while pleasant, gives no real information or knowledge. Negative feedback gives direct information about what is wrong and can be useful however, negative feedback does not usually clarify the idea or behavior being criticized nor does it communicate positive features that should be preserved. Perkins (2003) identifies communicative feedback as requiring directness which helps to clarify all behaviors or ideas under consideration. Communicative feedback identifies and preserves positive features, and communicates concerns and suggestions for future improvement. The one negative feature noted regarding communicative feedback is this process takes more time and requires more thought and effort (Perkins, 2003). Foster and Hicks (2000) discuss how truthfulness can be one of the nine choices to attaining a happy

life. The authors discuss how an art critic named Leticia gives honest feedback to budding artists. Leticia is well known among the artists in her community as a person who really cares about others because she is not afraid to give honest advice and feedback in order to help artists grow and improve their artistic abilities. Leticia like many others noted in the non nursing literature has many of the attributes of caring persons. The next category describes these attributes of caring people in more detail.

Category #2: Attributes of Caring People: Supporting Themes Include Concern, Empathy, and Courage to Commit to Action.

The non-nursing literature discusses the category of attributes of caring people. The three supporting themes noted are concern, empathy, and courage to commit to action. It is noted in the non-nursing literature that caring people first become concerned regarding the person or persons needing help. Caring people take this concern a step further by taking the time to really understand, and empathize with the person or persons before deciding a plan for taking action. The last step often calls for courage in order to commit to action to do something to help another person or persons. This section of chapter one will look at each of these themes separately in order to give the reader a better understanding of each theme. The end of this section will give an example of a person whose concern and empathy leads her to commit to action. Her story will give the reader an overall example of the three themes in unison.

The first attribute a caring person has been described of possessing is the ability to have concern for what is happening. Concern is depicted as more than just being cognizant of what is going on in another's surroundings. Concern is described as being thoughtful or having feelings regarding what is happening in the environment or to

another person. Sally Helgesen (1995) interviewed four successful female executives and found that each one made a deliberate effort to be available to their immediate subordinates on an unscheduled basis. All four of the female executives made it clear to their employees they were concerned and available to listen to ideas or issues the staff wanted to discuss. These female executives focused on keeping the relationships in their respective organizations in good repair. Francis Hesselbein, chief executive of the Girl Scouts and one of the female executives that Helgesen interviewed informed Helgesen that she encourages and considers all suggestions from her employees. Hesselbein proposes that by being available and showing concern for all of her employees, she is demonstrating that she truly cares about them (Helgesen, 1995).

Caring people not only note the concerns, but then try to further understand what is going on by being empathetic. Empathy is expressed as trying to understand what kinds of things another person is experiencing, or trying to see the situation from another's point of view. In order to understand what another person is experiencing, it is first important to get to know the person, to ask questions regarding who they are and what they are feeling. Covey (1989) describes this as empathetic communication. He goes on to postulate that by using empathetic communication a person can better diagnose the problem and thus better prescribe the action to take to be most helpful to the person in need. Covey (1989) describes empathetic listening as the first step in empathetic communication. This form of listening is done with the intent to better understand the other person; to get inside his or her frame of reference and see the world from his or her point of view. Rosenberg (2003) concurs with these concepts and terms this type of listening "empathetic receiving". Covey gives the example of a busy, doctor

who is on call. A mother with a sick child calls the doctor to explain how her child is acting. The distracted doctor cuts short their conversation, prescribes medication for the child and tells the mother to pick the medication up at a designated drug store. After the rushed conversation with the doctor, the mother becomes upset because she was not allowed to explain all of her concerns regarding her sick child. The father called the doctor back and gave the doctor more information, informing the doctor that the child was only a newborn. The doctor was very surprised by this fact and quickly changed the medication prescribed. The result of not listening to truly understand the other person's dilemma could have proven to have been disastrous in this case. When the person trying to help does not have all of the information needed to diagnosis the problem, the helping person cannot best prescribe the interventions that would be most helpful. Covey coins this first part of empathetic communication as "seek first to understand." (p. 239).

The second phase of empathetic communication described by Covey (1989) is to seek to be understood. This is the point in which a person clearly explains his or her ideas in a context that is based upon a deep understanding of the other person's paradigms and concerns. Mayeroff (1971) also discusses this idea of getting to know the other person, who they are, what they need, what their powers and limitations are, as well as knowing what you are capable of, and how you can best respond to help the other person as an important aspect of caring. Noddings (1984) discusses the importance of trying to understand the perceived need of others and states; "For if I take on the other's reality as possibility and begin to feel its reality, I feel, also, that I must act accordingly." (p.16).

The last attribute imperative for a caring person is having the courage to become committed to action. It takes courage to go into the unknown, and commit to action to

help another especially with no guarantees about what the outcomes may be. Mayeroff (1971) postulates that this is not a blind courage but an informed type of courage, a courage that is based on insight from past experiences and courage that is also sensitive and open to the present. The more that is unknown about the outcomes, the more courage is needed to commit to action. An example of having the courage to commit to action without knowing the outcome is noted in a CNN interactive news story that discussed a time when Mother Teresa discovered that a group of 37 innocent children were trapped in a hospital between the battles line of the Israeli army and Palestinian guerillas. Mother Teresa was somehow able to convince both groups to stop their fighting long enough to give her time to rescue these children from harms way.

The supporting themes describing the attributes of a caring person were each presented separately to clarify to the reader the intricacies of each. However, the literature on attributes of caring people illustrates that each component must be present and active in order for the caring to person to truly act in a caring fashion. The following story illuminates the intertwining of the three themes of a caring person in action. This story will allow the reader to see how these themes act in unison. Betty Tisdale dubbed the "Angel of Saigon" received the 2003 Caring Person Award from The Caring Institute and the following information is a synopsis of her biography as displayed on The Caring Institute's web site. Ms Tisdale first became interested and concerned in the plight of the sick and homeless in Southeast Asia after reading a book by physician and humanitarian Dr. Dooley. Ms Tisdale developed a sincere concern and desire to find out more about these people, to be able to empathize with them and see life from their point of view. Soon after reading Dr. Dooley's book, she learned that he was going to be in her

hometown of New York to have surgery for cancer. She called him on his phone, at the hospital and he allowed her to come and visit him during his hospital stay. She began a job moonlighting as his secretary and typing for him. For two years she was able to learn more about the people he worked with and their predicaments. In learning more about all of the various aspects of their situations, she was able to begin to empathize with the people Dr. Dooley described. By the time Dr. Dooley died, she had developed a deep interest in visiting the places he had talked about and carrying out the work he had started. She saved her money and in the 1970's Ms Tisdale traveled to the An Lac orphanage in Laos Vietnam that Dr. Dooley had established. While at the An Lac orphanage, she saw babies lying in rusty cribs with rags strung between them. The babies were wet and had multiple sores on their skin. This sight haunted her and gave her the courage to take action by working with Senator Jacob K. Javits and enlisting American soldiers to help make the orphanage more suitable for these children. Later, at the end of the Vietnam War, hours before the fall of Saigon in 1975, she once again acquired the courage to commit to action and was responsible for organizing and managing the airlift of 3,500 children out of the country. The story of Ms Tisdale shows her concern which stimulated her to want to learn more about the people Dr. Dooley administered to. She then developed empathy as she took time to really get to know and understand the plight of the people via stories from Dr. Dooley as well as from her trips to Vietnam. Her courage to commitment to action is evident, in her ability to make changes for these orphans living in dire conditions and later as she helped thousands of orphans escape to safety in America.

Category #3: Helping Others to Grow

Readings in the non nursing literature discuss caring as helping another person to grow. Helping people to grow can include helping them to become responsible for their lives, helping them to be responsible for someone other than themselves, and learning to the degree that one is able (Mayeroff, 1971). This act of helping another to grow or to become self-actualized is an unselfish act and the person helping does not expect to dominate the other person, but to help the other person accomplish his or her own personal best. The person supporting and helping sees the other person as being an independent person with thoughts and visions of his or her own (Mayeroff, 1971). Erikson (1963) describes this aspect of helping another person to grow as they go through the many stages of the life cycle. Erikson gives an example of a mother holding her infant, and realizing the baby, although dependent on her for survival is still an individual human being. The mother will provide the baby with food, warmth and comfort in order for the baby to develop trust. Maslow (1976) discusses the idea of self-actualization in his hierarchy of needs in which he places self-actualization at the top of the hierarchy. He defines self actualization as being the best you can be. This level of functioning does not involve balance or homeostasis and was also called growth motivation. Rogers (1977) indicates there is a natural tendency toward self-actualization in all man. He echoes this idea of helping another to grow and be responsible for himself or herself in his theory of person-centered counseling and psychotherapy. Rogers (1977) postulates that therapy is not intended to solve one particular problem but instead to assist the person to grow and become an independent, self-directed person by learning and applying more independent,

responsible, and better organized problem solving techniques to use for current and future problems. Foster and Hicks (2000) declare that when a person cares enough to give something to another in order to help the person live more independently, this is the highest level of giving. The ability to acknowledge and validate another's present abilities consonant to reality yet recognizing that the person has the potential to grow in their role to be the best they can be is a basic principle of caring persons (Connellan, 2003; Foster & Hicks, 2000; Noddings, 1986).

The first part of section one discussed findings in the non nursing literature regarding caring. Three categories evolved from this exploration of the literature. The first category discussed was communication. Supportive themes listed under the category of communication included attentive listening and open, honest, dialogue and feedback. Examples of the importance of these themes were first discussed in connection to the establishment and longevity of interpersonal relationships. The importance of these themes was also discussed in association with schools and in the corporate business world.

Attributes of caring people was the second category noted in the non nursing literature. Supporting themes of this category included concern, empathy, and the courage to commit to action. This section discussed each of these three supporting themes separately and gave examples for clarification of each theme. At the end of this section, an example of the caring work accomplished by Betty Tisdale was conveyed to show the reader how these three themes of caring were intertwined in caring acts.

The third and final theme noted in the non-nursing literature on caring is the idea of helping others to grow to be their best or to become self-actualized. An example of this

unselfish act was given to help the reader better understand this concept of helping another individual to grow.

This section will assist the reader to have an understanding of how caring is perceived outside the discipline of nursing. The following sections will help the reader to compare the non-nursing literature on caring with the nursing literature that has been written on caring. The next section will give the reader a basic understanding of the two cornerstones of nursing practice and will assist the reader to get an overall picture of how these concepts intertwine into a complex and intricate tapestry that is called nursing.

Section II: Overview of the Basic Elements of Nursing Practice

The second section of this chapter will explore the nursing literature that describes the basic elements of nursing practice. Two categories emerge from this literature review. These categories include both science ideation as well as humanistic art as the cornerstones that lead nurses in their assessment and implementation of nursing interventions. Understanding these basic foundational concepts of nursing will help the reader to better understand the idea of nursing as a whole and assist the reader in obtaining a clearer perception of the how both of these concepts are intricately woven into nursing practice.

Categories of Science and Humanistic Art

Two foundational concepts that appear in the nursing literature describing nursing is the idea that nursing is based on both scientific concepts as well as more humanistic concepts. Nightingale (1859) was the first nursing theorist to address the technical or scientific side of nursing when she discussed tasks that the nurse must tend to. However, Nightingale also wrote about the importance of treating the patient in a humanistic

fashion when she discussed attending to patient's psychological, social, and emotional well being. Interestingly, Nightingale also discussed the need for nurses to care for themselves by taking the time to reflect upon their work and grow in their nursing profession. Bishop and Scudder (1996) support the idea of that nursing has two foundational aspects; the impersonal aspect of nursing, deemed as the technological and professional and the personal side of nursing (Bishop & Scudder, 1996). The technological and professional side of nursing is evident when the nurse is attentive to what is happening with the patient's health and reacts in a way that is efficient and effective. The personal aspect of nursing is defined by Bishop and Scudder (1996) as having compassion for another and supporting and empowering another so he or she can recover and live more healthy. Bishop and Scudder (1996) imply it detrimental to nursing when there is a separation of these two integral aspects of nursing, and that both of these aspects are needed for excellence in nursing practice. Watson (1997) refers to the word "trim" to discuss the tasks associated with nursing and associates this term to the more scientific side of nursing such as procedures, clinical focus of disease process and the technological aspects of nursing. Watson (1997) goes on to state that the trim is not dispensable, but it should not be considered to be the core of nursing which is the transpersonal caring relationships and authentic presencing. The two concepts are not uncommunicative but instead should flow and become the whole of nursing practice (Watson, 1997). Boykin and Schoenhofer (2001) profess that nursing is both a discipline and profession. These authors describe discipline as a more humanistic concept and describe it as a way of knowing in a personal, ethical, aesthetic, and empirical way all at the same time. The concept of profession leans more toward the scientific aspects as

Boykin and Schoenhofer (2001) delineate profession as a way of dealing with a specific problem or dilemma though the use of tested knowledge. These authors are also adamant that the ideas of profession and discipline are inseparably bound together and interwoven aspects of nursing. Asp and Fagerberg (2002) describes the idea of science and humanism in nursing as being structured into two integrated dimensions; content and relational in order to help another survive, maintain health, and grow. The content aspect is described as the intention of nursing care and is described from the theoretical to the practical level (Asp & Fagerberg, 2002). The relational aspect is further defined as the nurse-patient relationship and is described from the philosophical level to the practical level. These two aspects are defined as a woven fabric and include multiple dimensions such as life span, transcultural, gender, and research methods.

These examples help to clarify the complex, multidimensional characteristics of nursing as both a science and humanistic art. Nurses practice the more technical and scientific details of nursing as they tend to medication administration, work with complex, intravenous pumps and other technologies. Nurses also practice the art of nursing through compassion, support, building nurse-patient relationships, caring touch, and presence. These two concepts have been described as an intricate interwoven fabric. Separating these concepts of nursing practice helps to more clearly understand the complexity of nursing, however, much like snipping the threads of a complex, elaborately woven fabric, separating these concepts in nursing practice, would serve to weaken and dilute the strong, sinewy threads of nursing.

Section III: Patients' Perceptions of Caring

The third section of chapter II will explore the nursing literature that examines the perceptions of how patients' perceive caring nurse behaviors. Most of the research performed in identifying patient's perceptions of caring nurse behaviors uses research tools that are based on Jean Watson's (1979, 1985, 1999) theory of caring and her Carative Factors. The Carative Factors will serve as categories in the organization of nurse behaviors considered to be most important to patients in establishing caring nurse-patient relationships. A brief overview of Watson's Carative Factors will first be discussed in order for the reader to better understand the studies on how patients perceive caring nurse behaviors from nurses.

Jean Watson's Theory and the Carative Factors

Watson's ideas and theory of human caring is not a new concept to the nursing world but instead gives a way for nurses to understand the act of caring in the fullest sense and to give language to the idea and acts of caring in nursing (Watson, 1994). The theory of human caring gives guidelines to nurses to help them develop trusting, caring-healing relationships that allows for health and well-being, symptom management, pain control, physical comfort as well as encouraging growth, meaning, and a harmonic relationship between the nurse and his or her patient. Watson has outlined 10 Carative Factors that manifest and ground her caring philosophy and theory (Watson, 1988, 1994). These 10 Carative Factors developed by Watson (1988) continue to be used today to evaluate caring in various situations, provide consistent language for discussing nursing actions and evaluating patient care decisions and outcomes. Before discussing the many research studies that have used the Carative Factors as a foundation for research tools

developed, it is important for the reader to have a basic understanding of these Carative Factors.

The first Carative Factor is a humanistic-altruistic system of values. This Carative Factor is further described as a way of practicing nursing in an unselfish and humanitarianism manner as well as providing nursing actions that come from values that are associated with peace, compassion, an intent to do no harm, and loving-kindness (Alligood & Marriner, 2002; Houghton, 2001; Sitzman, 2002).

The second Carative Factor is enabling and sustaining faith and hope. Nursing actions that would best provide for this Carative Factor would be to assist patients to not give up hope and to help them to not view their illness in a negative manner (Houghton, 2001). Sitzman (2002) states that nurses must actively live their own life with faith and hope for the common good in order to implement this Carative Factor. Watson (2001) clarifies the core of this Carative Factor is being authentically present in order to sustain and enable the deep belief system of self and other.

The third Carative Factor is sensitivity to self and others. Houghton (2001) declares that the nurse must look inward to discover his or her own weaker personality and character traits, and then consider how these weaker traits affect patient care. Sitzman (2002) declares that knowing ones self is just as important as knowing others.

The fourth Carative Factor is developing a more helping-trusting human care relationship. Houghton (2001) gives the example of keeping promises to patients; if the nurse tells the patient he or she will do something at a certain time, it is imperative for the nurse to follow through with this promise in order to help develop trusting relationships. Watson (1979) clarifies that the use of effective verbal and nonverbal communication that

are characterized by congruence, empathy, and warmth are nursing behaviors that are essential for establishing a helping trusting relationship. Effective communication and development of a trusting-helping relationship may allow the patient to more fully discuss his or her concerns with the nurse who is gathering assessment data. The result would be a more complete nursing assessment and the nurse could more expertly guide the patient's care (Iglesias, 2000).

The fifth Carative Factor is promoting and accepting expression of positive and negative feelings. Allowing patients to express positive and negative feelings is good for the patient and is imperative in helping them to return to wellness (Houghton, 2001). Sitzman (2002) explains that the nurse must embrace all feelings that patients express because all feelings are needed to make up the whole person. Watson (2001) clarifies this Carative Factor by stating that nurses need to be present to and supportive of the patient as they express positive and negative feelings in order to form a connection between themselves and the one being cared for.

The sixth Carative Factor is engaging in creative, individualized, problem-solving caring process. This calls for nurses who can think outside of the box and are lateral thinkers (Houghton, 2001). Sitzman (2002) states the importance of acknowledging that person is an individual and has various ways of thinking about the world. The author stresses that it is important for the nurse to be open to the many ways of thinking and problem solving based on each individual's needs (Sitzman, 2002). Watson (2001) redefines and clarifies this Carative Factor by stating that nurses must implement the creative use of self, all the ways of knowing and practice the artistry of caring-healing practices.

The seventh Carative Factor is promoting transpersonal teaching and learning. Sitzman (2002) helps to explain this Carative Factor as she discusses nurses engaging in teaching and learning wherever transpersonal connection is acknowledged. Watson (2001) redefines and explicates this Carative Factor as she explains that nurses must become involved in teaching-learning experiences that take into account the unity of being and meaning to others, and attempt to stay within the other person's frame of reference.

The eighth Carative Factor is attending to supportive, protective and/or corrective, mental, physical, social, and spiritual environment. Houghton (2001) discusses as a parent would support and nurture a child, a nurse would want to support, protect, and correct their patients holistically at all these levels. Watson (2001) illuminates the holistic idea of creating a healing environment at the physical, as well as nonphysical level in order for wholeness, comfort, dignity and peace to become possible.

The ninth Carative Factor is assisting with gratification of basic human needs, while preserving human dignity and wholeness. Houghton (2001) clarifies this Carative Factor by discussing how nurses assist with human needs such as assisting patients with feeding, drinking, and toileting and to do so while preserving dignity for the patients. The author goes on to discuss how sometimes it is more difficult for the nurse to cope with family needs or patient needs outside of the care facility rules such as having a pet be at the patients side. Sitzman (2002) states that nurses must acknowledge that suffering and joy are both inevitable and nurses must help patients meet these needs while preserving their dignity and wholeness.

The final and tenth Carative Factor is allowing for being open to existential-phenomenological and spiritual dimensions of healing. Watson (2001) gives an example of what nurses should reflect upon when attempting to implement this Carative Factor. Nurses should consider how the patient views the future for himself or herself and for their significant others. Nurses then must ask themselves how they can enable the patient to find meaning in these experiences and assist the patient to make informed decisions about his or her life and/or death. Nurses should consider what life lessons are to be discovered for both themselves and the patient.

An understanding of Watson's Carative Factors will assist the reader to better comprehend the research that has been completed on caring using the Carative Factors. Section III will now examine caring nursing behaviors that are considered important to patients in the development of caring nurse patient relationships.

A search of the literature gleaned over fifteen research articles describing patients' perceptions of nurse caring behaviors using tools based on Watson's Carative Factors. The top four most important Carative Factors identified by patients in these studies will be discussed. The most important nursing behaviors delineated will be listed and will be categorized according to their fit within Watson's Carative Factors.

Category I: Watson's carative factor #9:assisting with basic human needs with an intentional caring conscious. The results of ten studies examining patients' perceptions of nurse caring behavior indicates shows that nursing behaviors that demonstrate the nurse is competent in what he or she is doing is number one. Nurse behaviors indicating that the nurse knows how to give shots, IVs etc., knows how to handle equipment/monitors and knows when to call the doctor were listed as the top caring nurse behaviors identified

by patients. These behaviors were categorized under Watson's Carative Factor number nine which addresses nurses assisting with basic human needs with an intentional caring conscious (Watson, 2001). The following studies list the premise of nurse competence as the number one nurse-patient caring behavior.

Patients hospitalized in a transitional care unit who had experienced a myocardial infarction indicated technological nurse behaviors were deemed as the most fundamental features of caring nurse behaviors (Cronin & Harrison, 1988). Walsh (1992) had similar findings in her study also exploring critically ill patients' perceptions of caring. Walsh found that nursing actions focusing in on the patients' physical condition were considered by the patients to be most indicative of caring. Cronin and Harrison (1988) postulate that patients who are critically or seriously ill need the reassurance that the nurse will be close by and will be competent in his or her nursing skills. These authors also state that cares given in a calm and expert manner by a nurse in control of the situation is very important in heightening the patient's sense of security and well-being.

Studies looking at patients needing care in the emergency room also indicated that these nurse behaviors demonstrating competence were perceived as most important by patients (Baldursdottir & Jonsdottir, 2002; Huggins, Gandy, & Kohut, 1993; Walsh,1999). Baldursdottir and Jonsdottir (2002) postulate that caring is not something a nurse does after finishing basic, competent nursing cares but that caring and competence must coexist in quality nursing practice. This idea of the interweaving of competent, scientific nursing care with caring humanistic skills is once again discussed.

Patistea and Siamanta (1999) reviewed 13 studies comparing patient and nurse perceptions of caring elements and behaviors spanning the timeframe from 1972-1994.

Patients perceived nurse behaviors such as dealing with physical care needs, clinical expertise (monitoring), technical skills, manual skills, cognitive aspects of care and practice focused care to be the most important caring elements and behaviors (Gooding, 1993; Larson, 1984, 1987; Mayer, 1987; Rosenthal, 1992; Scharf & Caley, 1993; Swanson, 1993; von Essen & Sjoeden, 1991a, 1991b). These caring nurse behaviors are in concordance with Watson's (1979) Carative Factor number 9 of assistance with the gratification of human needs

Iglesias (2000) interviewed patients receiving care in an adult outpatient urgent care center and discovered the results of her study correlated with the previously mentioned studies. The patients she interviewed also stated that nurses who knew how to handle equipment, give shots, IV's and knew when to call the doctor were number one in establishing a caring nurse patient relationship. Iglesias (2000) states that the majority of patients receiving care in the urgent care center were very concerned about their health problems and were seeking basic survival needs. Iglesias (2000) gives an example of a patient who came to the urgent care center after experiencing vomiting and diarrhea for several days resulting in dehydration. Not surprisingly, this patient was most concerned about the nurses competence in starting an IV and providing medical interventions to assist with ending the dehydration which is life threatening (Iglesias, 2000). The studies thus far have explored patients in emergent and urgent health care settings. The following study explores elderly patients with possibly more chronic health care factors.

Elderly patients residing in long term care institutions listed the most important nurse caring behaviors as those behaviors indicating nurse competence (Marini, 1999). Marini (1999) stresses the need for educational efforts that promote excellent technical

skills that elderly patients declare as vital in nurse caring relationships. Employing advanced practice nurses with gerontological skills to provide staff education to geriatric care givers is vital as the patient population in long term care facilities increase (Marini, 1999).

The idea of caring for and caring about patients is an idea that is expressed in many of the studies on patients' perceptions of nurse caring behaviors. Lemmer (1991) explored parental perceptions of caring following perinatal loss, or stillbirth and the consequent parental bereavement. Women and their significant others receiving nursing care while experiencing a third trimester stillbirth or neonatal death described nurse caring in two categories: taking care of them and caring for or about them (Lemmer, 1991). Taking care of the patients meant that the nurses took care of the physiological and safety needs of the mother and/or baby. Within this category of taking care of the mother, baby and significant other, the subcategory of providing expert care ranked first (Lemmer, 1991). Caring for and about the mother, baby and significant other ranked a close second and will be further elaborated upon when discussing sensitivity to others. However, the idea of taking care of basic safety and physiological needs is shown to be of utmost importance in this study and was viewed by the mothers, and significant others to be the number one caring nurse behavior (Lemmer, 1991).

The results of Lemmer's (1991) study are similar to a study by Lugenbiehl (1986) because the idea of caring for and caring about is once again discussed. Caring for the safety and physiological needs of women during the labor and delivery emerges as the most important nurse caring behavior in order to assist the mother and baby in a safe and uneventful delivery (Lugenbiehl, 1986). Caring about the patient was perceived from

nurse behaviors in which the nurse asked questions rather than assuming, was present and routinely checking in with the couple but also was respectful of the couple's personal space.

Caring about patients as individuals ranked number one in a study where patients were receiving care for their diagnosis of HIV/AIDS (Mullins, 1996). Caring for the patients was represented by such nurse behaviors as, knowing what they were doing such as giving shots, IVs etc. and knowing when to call the doctor.

Women receiving care for a diagnosis of breast cancer noted that the number one essential characteristic of an excellent nurse was competence in what they were doing (Jensen, Back-Pettersson & Segesten, 1996). Competence was described as not only knowledge of practical nursing skills but knowledge of human beings, communication skills and the ability to use self as a tool in interaction. The authors give examples of statements made by participants that clearly elucidate the idea of competence blended with humanistic skills such as, explaining procedure first, supporting, noticing things like anxiety and discussing with the patient as well as the use of appropriate humor (Jensen, Back-Pettersson & Segesten, 1996).

In a study by Parsons, Kee and Gray (1993) patients receiving nursing care during outpatient surgeries listed the idea of nurse competence or nurses knowing what they are doing as the number one nurse caring behavior. The authors stated that patients in their study clearly indicated that the nurses' attention to their physical and emotional well-being was of greatest importance. This study was in concordance to a study by Lenihan, (1995) who studied patients' perceptions of nurse caring on a medical surgical unit.

These patients' stated that the most important nurse caring act was that of meeting their human needs with vigilance, competency, and knowledge.

The idea of nurses competently caring for patients who cannot care for themselves due to basic physiological needs such as pain, bleeding, need for oxygen, need for food and water, a safe environment, fear of unknown diagnosis and or prognosis, and fear of their future is apparent in all of these studies. Needing nursing assistance with these basic physiological human needs ranks high in such situations and is in concordance with Maslow's Hierarchy of needs which was adapted by Watson (1979) in her philosophy of caring. Thus the need for nurses who can competently administer to these essential human care needs is of utmost importance in order to assist patients toward a trajectory of homeostasis.

Caring for patients with basic physiological needs has been clearly illustrated in these studies as being of great importance to the patients. However, the way in which nurses care for patients' basic physiological needs and the way the nurse cares about the patient is also of importance as indicated by further review of other studies as well as further review of the studies mentioned above.

Category II: Watson's carative factor: sensitivity to self and others. The idea of treating others with sensitivity has been briefly mentioned in many of the studies previously mentioned and as Watson has discussed, the Carative Factors are not meant to be treated as separate entities or based on a hierarchy of importance but instead are listed to assist nurses to see the interventions to be used in a caring nursing practice (Alligood & Marriner, 2002). As stated above, in the two studies where patients visited the emergency room for emergent care, the number one caring nurse behaviors listed were

those demonstrating competent nurse behaviors, however, the second most important caring behaviors cited in these two studies centered around those nurse caring behaviors in which the nurse was sensitive to the patients needs and treated patients as individuals, with kindness and respect, and in a calm manner (Baldursdottir & Jonsdottir, 2002; Huggins, Gandy, & Kohut, 1993).

In a case study of a man with AIDS, the provision of dignity, respect and sensitivity without judgment of another person's lifestyle was of utmost importance and was listed as the most important nurse caring behavior (Beauchamp, 1993). Similar results were obtained in a study of 46 adults with a diagnosis of AIDS or HIV(Mullins, 1996). The author found that participants described caring nurse behaviors to be: acceptance of the patient and significant other, their special feelings, ideas, and views without judgment listed in as the third most important caring nurse behavior.

The idea of caring about another was discussed in a study by Lemmer (1991). She states that to provide sensitivity to and an empathetic awareness of the emotional pain of bereavement of the loss of an unborn child or fetus was noted as the second most important nurse caring behavior. Parents in the study, further described nurse caring behaviors as understanding, kindness, had a sense of awareness of what we were going through, compassionate, sympathetic, and personal. The following is an example that illuminates this idea of the nurse being sensitive to the uniqueness of the family who has lost a baby. The nurse dressed up the baby in a little red dress and kept the baby in a warmer so that when the siblings came to hold the expired baby and say goodbye, the baby was warm, soft, and dressed nicely. This allowed the siblings to say goodbye and have good memories of the baby who had died (Lemmers, 1991).

To be treated as an individual with respect and dignity was reported as the second most important nurse caring behavior by residents of a long-term care facility (Marini, 1999). This study indicated that for older adults, being treated with respect and dignity is a crucial component to nursing and demonstrated the significance of delivering competent care with interpersonal processes that enhance individuality and human dignity (Marini, 1999). Being kind, considerate and treating persons as individuals was listed as second in importance to a group of 19 adult patients who had outpatient surgery (Parsons, Kee, & Gray, 1993). These themes are similar to a study by Smith (1977) who found that participants stated that understanding the uniqueness and wholeness of the person-family was rated as the number one caring nurse behavior.

Demonstrating respect, dignity, and acknowledgement of others as unique human beings, are nursing behaviors that illustrate the Carative Factor of providing sensitivity to others. The Carative Factors of providing human needs assistance and providing sensitivity to others are closely intertwined in importance. These studies have shown that patients perceive that a caring nurse patient relationship first occurs when nurses know what they are doing and are competent in caring for the patients' immediate needs. However, there is more to just knowing what to do and when to do it in order for the interaction to be deemed a truly caring interaction. This part of the literature review demonstrates the importance of the need for nurses to be sensitive while performing these basic human needs. Nurse behaviors that illustrate sensitivity to another person and demonstrate that the nurse cares about the patient include nursing interventions such as providing care with respect and dignity while realizing that each patient has unique and individual needs.

Category IV: Watson's carative factor transpersonal teaching-learning. Seeking knowledge about health problems or gaining more knowledge about health problems for oneself or loved ones was sited as the third most important Carative Factor by many patients. Transpersonal teaching-learning has been described by Watson (1985) as an interactive process that assists patients to understand their healthcare concerns and should serve to help patients maximize their health potential. The studies show that nurses who are able to update families on the progress of loved ones, share new information regarding external resources, assist patients and families to discover internal strengths and resources, and answer questions clearly and succinctly are nurses who demonstrated this Carative Factor.

Cronin and Harrison (1998) stressed the importance of allowing the patient to become an intellectual partner in his or her treatment after experiencing a myocardial infarction. It is important for nurses to be cognizant of the patient's need for information regarding what has happened to them and how to assimilate their physical and emotional needs into a comprehensible and manageable condition. Cronin and Harrison (1988) suggested that nurses need to assess patient learning needs, explore patients' perceptions and knowledge of their health status and answer questions to clarify any misconceptions that patients may have regarding their health problems. These nursing interventions can be of great assistance in the process of transpersonal learning and teaching.

Other examples of knowledge being a top priority are demonstrated in studies involving patients seeking care in the emergency room. The need to have questions answered clearly and efficiently is cited to be an important caring nurse behavior (Baldursdottir & Jonsdottir, 2002; Huggins, Gandy, & Kohut, 1993). These behaviors are

defined as nurses giving written and verbal home care instructions to the patient. The idea of patient knowledge assessment as discussed by Cronin and Harrison (1988) was also listed as important nurse caring behaviors and was cited as; ask you what you know about your injury, and ask questions to make sure you understand (Baldursdottir & Jonsdottir, 2002; Huggins, Gandy, & Kohut, 1993).

Seeking of knowledge through loved ones, nursing staff, and others was listed as a top nurse caring behavior in the study of six spouses of persons with grave incurable cancer (Andershed & Ternestedt, 1999). In this study three categories emerged, to know, to be and to do. In the category to know, relatives of dying patients found it imperative to know and understand their loved one's situation. Knowing basic information such as how ill the patient was, and what assistance he or she needed was prerequisite to becoming involved in their cares. Relatives asked questions of the nurses and needed to know information such as symptoms, diagnosis, prognosis and the plan of care the nurses had instituted (Andershed & Ternestedt, 1999). It was imperative that the relatives of these terminally ill patients were able to have ongoing visits with staff in order to ask questions and have a better understanding of what to expect.

Informing and updating patients and family members was also noted in a study by Marini (1999). The participants in her study noted the importance of keeping families informed of patient's progress as the second most important nurse caring behavior listed by older adult family members living in an institution (Marini, 1999).

Providing information to bereaved parents experiencing the death of a newborn or fetus was deemed as the second most important nurse caring behavior in a study by Lemmer (1991). Supplying information to help parents and their families anticipate what

to expect at each step as well as what could be expected during the bereavement period was noted to be extremely helpful by all participants. Fathers stated the need to know what was happening to their baby and/or their wife was of utmost importance in helping them understand the diagnosis, prognosis, and treatment plan (Lemmer, 1991).

Patients who had received outpatient surgery declared that knowledge about what was going to happen to them before the surgery as well as what was happening during and after the surgery to be very reassuring (Parsons, Kee, & Gray, 1993). Patients found that nurses who could answer their questions clearly made them feel less anxious and this behavior was listed as the third most important nurse caring behavior (Parsons, Kee, & Gray, 1993).

It is imperative that nurses teach about procedures, and give explanations to patients during procedures in order to allay fear and anxiety of the unknown. As patients recover and their basic homeostatic needs become met, patients need to better understand what has happened to them. They need to learn about the health care interference as well as learn about ways to maximize their current health. A transpersonal teaching/learning experience is an interactive process in which the nurse engages the patient as an intellectual colleague.

Category III: Watson's carative factor of enabling and sustaining faith and hope. This Carative Factor ranks in fourth place in most of the studies reviewed. Within this Carative Factor, Watson discusses the idea of being authentically present with another human being. The idea of being authentically present to another person and helping them to sustain faith and hope ranked as number one in the five themes discovered in a study of women diagnosed with depression (Mullaney, 2000). Women in Mullaney's (2000)

study noted the need to feel understood, feel hopeful that there was a way out of the depression they were experiencing, and feel hopeful in gaining an empathetic perspective towards themselves and others.

This idea of finding hope with a diagnosis that interferes with a person's life is discussed in an article by Nyman and Lutzen (1999). In this study of 6 women diagnosed with rheumatoid arthritis, each one had to begin to seek help and begin searching for meaning and sources of faith and hope in order to effectively deal with their diagnoses (Nyman & Lutzen, 1999).

This Carative Factor was included in one of the three themes listed in a study of persons with grave incurable cancer and their caregivers (Andershed & Ternestedt 1999). The three themes gleaned from this study are; knowing, being with and doing. The theme of being is the theme that best fits with the Carative Factor of enabling and sustaining faith and hope. Examples of this theme were noted from the caregivers point of view as being with a loved one dying of incurable cancer and to be in the other's world (Andershed & Ternestedt 1999). These episodes included just being with the patient in the hospital or institution, and by lying in the patient's bed and holding them and/or reminiscing about past experiences. Nurses need to know the importance of relatives being present and empathetic with their loved ones in order to encourage these interactions.

Jensen, Back-Petterson, and Segesten (1996) performed a study looking at caring nurse behaviors as perceived by women with breast cancer. Three themes emerged from this study: compassion, courage and concordance. Participants stated that nurses who took the time to understand their situation and who caught their wavelength were nurses

whose behaviors were most caring. These nurses were described to be like a friend who infuses hope and meaning which illuminates the darkness of their cancer.

A listening presence and a verbal sharing presence were identified by couples who had experienced perinatal death to be very meaningful (Lemmer, 1991). Caregivers who demonstrated a listening presence did not avoid the parents but instead checked on the parents more often that was expected, hugged the parents, wiped away tears, squeezed the mom's shoulder and let the parents know that what had happened to them was important and moving to them as well as the parents. The nurses listened to what the parents had to say and at times cried with the parents (Lemmer, 1991). A verbal sharing presence from nurses and doctors who shared about the personal loss of their own babies was identified by the parents who had lost a baby as very meaningful and these conversations were highly regarded by the parents. Facilitating the creation of memories was of great significance to these parents and helped to instill faith and hope for the future. Nurse behaviors listed as helping to preserve memories included taking pictures of the baby, clipping a lock of the baby's hair for the parents to keep and letting parents hold the baby and say goodbye.

The idea of a reassuring presence by the nurse was indicated to be of top importance to patients waiting to have surgical procedures (Parsons, Kee, & Gray, 1993). Nurse behaviors indicating this theme included giving verbal reassurance and expressions of concern to the patient as well as attention to the patient's physical comfort.

Studies show that being present with another can be demonstrated by attentively listening to the patient, squeezing a patient's shoulder and wiping away tears, verbally presencing with the patient, reminiscing with the patient and facilitating the creation of

memories. Being present with the patient and or family can be instrumental in enabling and sustaining faith and hope.

This third section of Chapter II reviewed the literature regarding how patients perceive nurse caring behaviors. This section first reviewed the Carative Factors set forth by Jean Watson in order to help the reader better understand the results of the studies on patient perceptions of caring behaviors that used the Carative Factors as the basis for the research tool used. The top four most important Carative Factors delineated in these studies were outlined along with caring nursing behaviors indicative of the Carative Factors outlined. The next section will look at nurses' perceptions of caring in order to view caring from yet another perspective and to help the reader to gather information to better understand caring in nursing.

Section IV: Nurses' Perceptions of Caring

Category #1: Making Human to Human Connections: Presencing

A category that is noted numerous times in the literature on nurses' perceptions of caring is that of making a connection with another human being. Walsh and Dolan (1999) state that if the nurse behaves in the role of the a detached, cold clinician, retreating into a clinical role and see the patient only as a head injury or other condition, and expects the patient to play the part of a passive patient then there can not be a meeting of people, only a meeting of roles. If it is only roles that meet, then there is simply role playing that occurs. It is people who need to meet, not roles in order for true human to human connectedness to occur and for relationships to be meaningful (Walsh & Dolan 1999). The caring behavior of presence is a foundational step in the establishment of a human to human connection and a resulting meaningful, caring nurse patient relationship (Benner

& Wruble, 1989; Sadler, 1997). The following paragraphs describe this idea of presencing with another and help to explain why nurses perceive it to be one of the most important nurse caring behaviors in making connections with patients.

Boykin and Schoenhofer (1990) suggest that caring in nursing begins with knowing oneself as caring, and being cared for, then progresses to knowing others as caring individuals and worthy of care. Boykin and Schoenhofer (2003) declare that the nursing situation contains both nursing knowledge and the framework for knowing nursing. The nursing situation is a shared lived experience in which caring between the nurse and the one being cared for helps to enrich both individuals. Boykin and Schoenhofer (2003) offer the following steps for establishing a nursing situation. The first step in establishing a nursing situation begins when the nurse comes forth and offers nursing service, the person seeking and wanting this nursing service then accepts it. The nurse then intentionally enters into the situation with the distinct purpose of getting to know the patient better, to make a human to human connection in order to understand the patient's needs. The use of authentic presence, an inherent human ability which can be sharpened with intention and practice comes into play. It is through this developed ability to be present with another that the nurse begins to understand the patient more fully and deeply. It is through this understanding of the patient, that the call for nursing becomes known as a specific situated expression of caring and a call for explicit caring response (Boykin & Schoenhofer, 2003). These authors postulate that nursing another is therefore a service of caring, which has been communicated through authentic presence.

Watson (1999) explains that caring in nursing summons forth from the practitioner an authentic presencing of being in the caring moment, carrying an

intentional caring –healing consciousness. Watson (1999) contends that the idea of transpersonal conveys a human to human connection in which both persons are influenced through the relationship or connection and the being together in the moment. Watson (2001) goes on to describe the importance of being authentically present in her Carative Factors in order to support patients.

The idea of attentive presence and being with the patient in the moment can be made more understandable by an example that McGraw (2002) gives that helps to clarify Watson's (1999) and Boyken and Shoenhofer's (2003) concept about the idea of the nurse caring behavior of presence in a case study called Debbie. Debbie is a 29 year old woman admitted with Class V cervical cancer and who undergoes a radical hysterectomy and bilateral salpingoopherectomy. Debbie has two small children, and a husband who does not support her financially or emotionally and at times is abusive. Debbie, her husband and their two small children live with Debbie's mother. The nurse hears Debbie sobbing, and although feeling very uncomfortable about what to do, makes an intention to be caring and walks into the room and offers her service by asking in a gentle voice if she can be of any help. Debbie looks up and apologizes for crying, the nurse lets her know it is OK to cry, in Debbie's face the nurse sees vulnerability. As Debbie tries to set up in the bed, she winces in pain and the nurse notes she has not eaten her breakfast and looking once more into Debbie's face the nurse sees pain, despair and fear. The nurse helps Debbie to sit up and as she touches Debbie she touches an embodied spirit. The nurse asks her if would like something for pain, again offering nursing service and Debbie accepts this service by accepting the offer for pain medication so she can be strong when her two children come to visit. Debbie then picks up and touches a picture of

herself with her two children during a much happier time, the picture is a touchstone for Debbie. In this touchstone the nurse sees a mother's love and the face of hope. The nurse looks back in the room before getting the medication and sees Debbie holding the picture and looking off into space, obviously alone once more with her own thoughts. The nurse admires Debbie's strength and personhood. As she gathers the medication, she begins wondering what Debbie's hopes and dreams are and commits to care for Debbie in whatever way she can, to be there for her. The nurse feels a connection with Debbie and will continue to listen and learn more of Debbie's story. The nurse reflects that by working on the oncology unit, and that by being with others, she has learned so much about her own life, a sort of reciprocal enrichment. It is through this reciprocal enrichment that both patient and nurse grow towards self-actualization (Boykin & Shoenhofer, 2002; Green-Hernandez, 1992; Mayeroff, 1971; Watkins, 1999).

This case study demonstrates the nurse assessing the patient with competent nursing knowledge, and providing needed pain medication, an important function of nursing. However, this case study also gives the reader a much deeper example regarding the whole picture of what nurses do, and shows that assessing for pain and providing pain medication is only one piece of the big puzzle of nursing. The nurse has taken the steps to intentionally care for Debbie, to be in the moment with her and try to understand what she is experiencing. The nurse has made the intention to further care for Debbie by returning later once Debbie's pain has subsided and get to know more of Debbie's story.

The importance of presence in caring is well presented in the nursing literature, and is not a new concept to nurse caring. Patistea and Siamanta (1999) reviewed 13 studies comparing patient and nurse perceptions of caring elements and behaviors

spanning the time frame from 1972-1994. The idea of presencing and connecting with patients was cited as the most important nurse caring behavior from the nurse's perception and was displayed in such behaviors as employment of interpersonal therapeutic communication skills, being present and attentively listening to the patient in order to understand and empathize with what the patient is experiencing (Gooding, 1993; Larson, 1984, 1987; Mayer, 1987; Rosenthal, 1992; Scharf & Caley, 1993; Swanson, 1993; von Essen & Sjoeden 1991a, 1991b). In other studies examining nurses' perceptions of caring the idea of attentively listening to the patient, and being with the patient, were all stated as top important nurse caring behaviors (Ford, 1981; Larson, 1986; Lugenbiehl, 1986; McNamara, 1995). Jensen, Back-Pettersson and Segesten (1996) studied nurses who were identified by their nurse managers to be top notch or "green thumb" nurses. These green thumb nurses were noted to often be involved in caring situations; these caring situations were noted to include mutual attention between caregiver and receiver, harmony, trust and taking time with each other or time stopping. Benner and Wruble's (1989) seminal work on the primacy of caring indicate that it is through a caring presence with another that allows the human to human connections to be formed. Green-Hernandez (1992) declares that if one is not present with another, caring cannot occur. Presence is essential to the caring process and defines the caring moment. Green-Hernandez (1992) states, "being there to give caring to another is a powerful metaphor for standing witness to one's own humanity." (p.38)

A closer look at the concept of presence in the literature reveals that the phrase attentive presence means to be with another person in such a way that acknowledges or actually takes part in the person's experience. The idea of attentive presencing is not new

and was used by the German philosopher and writer Martin Heidegger in the late 1890's. The phrase came from the German words "Anwesenheit" and "Zugengensein" which were later translated to "To presence oneself" (Benner, 1990).

The powerfulness of the phenomenon of attentive presencing was noted in the work of two psychiatric mental health nursing theorists, Patterson and Zderad (1988). The work published by Patterson and Zderad describing presence and caring in the 1970's proliferated and heightened the awareness of presence as an important infrastructure of the caring process (Gilje, 1992). Presence has been defined as closeness in time, space, resemblance or amount (Gilje, 1992). Presence in nursing has been divided into the idea of being there physically and being with psychologically (Patterson & Zderad, 1988; Von Essen & Sjoden, 2003). Von Essen and Sjoden (2003) postulate that the psychological component is much more complex to understand and involves the nurses' ability to intuitively know or sense another's experience.

Bulechek and McCloskey (1992) declare presence as an actual nursing intervention in their book describing all nursing interventions. In 2000, this book's third edition continued to declare presence as a powerful nursing intervention (Bulechek & McCloskey, 2000). The definition of the nursing intervention of presence is defined as "Being with another, both physically and psychologically, during times of need." (Bulechek & McCloskey, 2000 p. 532). To be attentively present means that the person is available and accessible to spend time with another in such a way that the other person feels that he or she is understood and supported (Benner, 1990). Simons (1987) further clarifies attentive presence as not only just spending time with another person but actually paying attention, understanding and empathizing with the other person's needs.

These themes of being there physically and being with psychologically, with another are very strong themes seen in the literature on nurses' perceptions of caring.

Category#2: Recognition of Patient's Human Dignity and Uniqueness

Human dignity includes the freedom and ability to make decisions that can shape a person's life (Eriksson, 1995). The right to be considered a unique human being with unique thoughts, feelings and desires is defined by Eriksson (2000) as absolute human dignity. Respect for a patient's absolute human dignity should be at the heart of the ethical motive for caring (von Post & Eriksson, 2000).

Caring behaviors that were noted in the literature illustrated nurses having genuine concern for patients and through this concern, the nurses developed a need to get to know the patients as individuals to understand their uniqueness (Christopher, 2000; Essen and Sjoden, 1991a ; Ford, 1981; Larson, 1986). Green-Hernandez (1992) indicates that every individual is a unique human being communicating and interfacing as one with his or her environment. Green-Hernandez (1992) and Fanslow (1987) stress the need to value each person's uniqueness, and accept them as they are without attempting to influence or change them. Treating others with respect and equality and not judging them or treating them differently because of socioeconomic levels, moral standards, mental or physical conditions indicates that nurses truly value others uniqueness (Christopher, 2000; Fanslow, 1987; Green-Hernandez, 1992).

Respecting the patient's autonomy is a part of valuing each person as a unique human being and one valued by nursing. Nurses, because of their education and expertise sometimes know when it is best to promote a patients recovery. An example of respecting patient autonomy and yet encouraging and helping patient's to overcome depression and

fear is given in this case study example by Hawley (2000). Irene, a piano teacher had suffered a small stroke and had lost some functionality in her right hand. When the nurse approached her to take her to physiotherapy for exercise, the patient refused. The nurse sat and talked with her and went over each day of her hospitalization reminding her of how much she had improved since being admitted to the hospital, and how the exercises had been responsible for much of the improvement. The nurse discussed only the positive aspects of Irene's hospitalization this day because the nurse felt Irene could only focus on the negative and think about how much she had lost due to the stroke. The nurse stated that after they had talked, the patient decided to go to physiotherapy. Hawley (2000) postulates that part of the nurse's role is to help patients to overcome uncertainties, and fears, and learn ways to recoup lost skills and abilities or learn new ones in order to reach their maximum health care potential.

Another example of how nurses demonstrate concern for a patient's human dignity is through the act of being an advocate for the patient. This often takes courage to intervene and prevent patient's human dignity from being violated (von Post & Eriksson, 2000). When nurses lack the courage and confidence to stand up for patients' wishes the outcome for the nurse can lead to an ethical moral dilemma. In the following exemplar by Fanslow (1987) a nurse discusses her story of caring for a patient who was dying. The dying patient and her family decided to stop all further medical treatment. The patient and her family had come terms with her impending death. Her blood counts continued to drop due to blood loss but the patient was in no pain and edged in and out of consciousness as the nurse cared for her and took care of her bodily needs in order to preserve her dignity. As her blood count became incompatible with life, and the patient

began peacefully slipping away, the physician decided to give her transfusions and hydration and try to save her. The nurse was devastated as she watched the patient writhe in pain while dealing with agonizing and futile treatments ordered by the physician which resulted in 7 more days of life that were full of agony instead of peacefulness. The nurse stated that thinking about the experience continues to leave her feeling guilty and responsible for the pain and suffering the patient endured because she was too afraid to speak up for the patient.

The idea of being a patient advocate is valued and respected by nurses. A study by Bar and Bush (1998) explored factors of nurse caring in an ICU. Four factors were revealed, one of the factors was that of nurses who acted as role models to other nurses. These nurses were deemed as role modelers of caring practice and were admired by other nurses on the unit. One characteristic that the nurses listed that stood out as especially caring from the designated role models, was that of speaking up for the patients and making suggestions to the doctors instead of hanging back and waiting for the doctors to make up their minds. Green-Hernandez (1992) state that the role of nurse advocate is one way that nurses demonstrate support for patients. The idea of supporting patients' emotional and psychosocial needs has been demonstrated through the categories and examples listed above. Another important way that nurses support patients is by assisting patients with their physical needs.

Category #3: Supporting Patients' Physical Needs

In section three of this chapter, the nurse behaviors most highly regarded by patients as caring were the more physical kinds of tasks, such as professional knowledge and competence, providing physical cares, possessing good manual skills, good clinical

and technical skills, giving medication on time, and monitoring and assessing patients' needs competently. Studies examining nurses' perceptions of caring nurse behaviors do not deny the importance of the top ranked caring nurse behaviors indicated by patients. In fact, nurses are taught the importance of doing for patients what they would do for themselves if they were able. The literature acknowledges that nurses are keenly aware of the importance of assisting the patient with basic needs and giving good physical cares (Henderson, 1966; Larson, 1986; Mangold, 1991; Orem, 1980; Swanson, 1993). This theme has been cited in the literature as doing for, caring for, or instrumental caring and includes the psychomotor tasks that are identified by patients such as shots, IV therapy, monitoring, and competent nursing knowledge. This theme of caring however was not recognized in the literature review of nurses perceptions of caring to be the most highly ranked caring theme. Studies of nurses' perceptions of caring in the literature viewed another realm or theme of caring that nurses' rated as most important. This theme was the affective, emotional or expressive theme of caring about another and includes the categories previously discussed (Gardener & Wheeler, 1979), Benner and Ruble (1986) state that it is caring that makes the nurse take notice when nursing interventions are helping or not helping and it is this concern that further guides subsequent care. The authors also conclude caring causes the nurse to vigilantly assess for any subtle signs of improvement or deterioration in the patients.

The literature on patients' perceptions of caring does not rank psychosocial nurse caring behaviors as the most highly regarded. The literature does indicate however, that patients perceive these psychosocial nurse caring behaviors as important. The literature shows that patients simply do not value these psychosocial caring behaviors as highly as

the nurses do. The literature on patients' perceptions of nurse caring identified sensitivity, empathy, presencing, therapeutic communication that includes listening as important nurse caring behaviors, they just did not list them as the *most* important caring behaviors in the majority of the studies. Another example that indicates that patients do value the more psychosocial aspects of nurse caring is demonstrated in a study by Riemen (1986).

Riemen interviewed patients to collect information on what they thought were uncaring behaviors of nurses and three patterns emerged as nursing behaviors that indicated uncaring: physical presence but emotional absence, belittling and inhumane conduct, and devaluation of the patient as a unique individual. These types of uncaring behaviors caused the patient fear, depression, frustration, anger, and increased anxiety. The literature indicates that the incongruence between patients' and nurses' perceptions of caring lies in the rank order of importance that the behaviors are ranked.

Caring in nursing is an interwoven fabric that consists of threads bearing the patients' more highly regarded technical perspectives of caring as well as the nurses' more highly valued affective aspects of caring. Understanding both patients' and nurses' perspective of caring can assist nurses to build a deeper, more holistic caring practice resulting in nursing actions that are in agreement with both nurse and patient and are interactions agreed upon by both (Christopher, 2000; von Essen & Sjoden, 2003; Walsh, 1992).

An understanding of both paradigms of caring may prove to be invaluable in the mentoring of nursing students. Section V will look at the nursing literature that explores how nursing students perceive caring in nursing. Nursing students are the future of nursing and must learn about and share with the body of nursing knowledge their

perceptions' of caring. Nursing students must also be cognizant of how nurses' and patients' perceive and rank various caring interactions. Green-Hernandez (1992) states that professional caring encompasses the concept of natural caring, and professional nurse caring can only be taught to nurses following and/or concurrent with their living the experience of natural caring. Thus, it is imperative that nursing students experience caring in nurturing environments in order to discuss, understand, and incorporate caring into the core of their nursing practice (Roach, 1984).

Section V Nursing Students Perceptions of Caring

In this section, I will analyze and synthesize nursing literature that explores nursing student's perceptions of caring. This section will include studies that examine how nursing students perceive caring from faculty, from other nursing students, and their lived experiences and caring interactions between themselves and their patients. An analysis and synthesis of categories that denote caring from each study will be outlined. Supporting themes and nursing behaviors indicated that further define these categories will then be presented.

Category #1 Attentive or Authentic Presence: Three Themes Noted: Attending, Empathizing, and Sensing

Attentive presencing is a category that shows up frequently in the nursing literature regarding nursing student's perceptions of caring. This category is predominate in studies where nursing students are asked to describe caring interactions from nursing faculty (Beck, 1991; Hansen, 1992; Hansen & Smith, 1996; Hugh, 1992; Schumacher, 1995). Attentive presencing is also the predominate category in a study exploring student nurses' perceptions of caring among other nursing students (Beck, 1992). Attentive

presence is delineated as the main category when student nurses were asked to describe caring clinical encounters between themselves and their clients (Beck,1992 & 1993).

Attending is the first theme of authentic/ attentive presence and is defined by behaviors of actively listening, spending time, and being with another person. Students felt they were cared about when their teachers stopped what they were doing, looked at them and gave the students their undivided attention and really listened to what they had to say (Beck, 1991; Dillon & Stines, 1996; Hansen, 1992; Hansen & Smith, 1996; Juethong, 1998; Schumacher, 1995). Students felt the teachers who showed caring gave them all the time they needed to discuss issues, and or concerns and did not make them feel rushed or unimportant (Beck, 1991; Hansen, 1992; Hansen & Smith, 1996; Juethong, 1998; Schumacher, 1995). The ability to discuss concerns, issues, and ask questions of nursing instructors made the students in Juethong's (1998) study of Thai nursing students feel less anxious while practicing nursing during their clinical experiences. The students felt the clinical learning environment was safe and "home like" because their clinical instructors were available both physically and psychologically as companions to assist the students to succeed. When the students felt the learning environment was a safe and protected environment, the students were encouraged to continue asking questions and therefore to continue to learn (Juethong, 1998). Beck (1991) found that students felt respected and valued as individuals when teachers gave the students their time and allowed the students the opportunity to discuss issues, concerns and questions. Caring instructors were also perceived to not only share the students' emotional experiences but to also share with the student their own experiences. These caring interactions where both faculty and student share of themselves is necessary in order for a caring connection to

ensue. An important outcome of this caring connection is that it teaches the students and enables them to reach out to others through caring (Beck, 2001; Grams, Kowsowski, & Wilson, 1997; Gregsby & Megel, 1997).

Students describing their lived experiences of caring between themselves and their patients discussed similar behaviors of attending. Students discussed the importance of spending time with their patients and listening to them while putting all else aside in order to really listen and try to experience what their patients were experiencing (Beck, 1992 & 1993). Wilkes (1998) described a professional model of nurse caring through nursing student's experiences. In the core center of her model is compassion which is actualized in the students' practice of nursing by listening and being there for the patient. This is a key concept that is stated as important from first year to fourth year nursing students.

In studies where nursing students discussed their perceptions of caring among other nursing students the theme of attending was strong. Students felt it was caring when another student took the time to listen to and really focus on another student as he/she expressed thoughts and feelings. Beck's (1992) study gives an example of a student who was having a particularly rough time during her nursing education. The student confided in another student about the demands of school and her life. The other student did not judge her, but took time to really listen to her as she discussed her complaints. This fellow student then went the extra step to help her with her studies and gave her the encouragement she needed to stick with the nursing program (Beck, 1992). This idea of attending or focusing on another human being while putting all other thoughts aside is a form of full presence as outlined by Osterman and Schwartz-Barcott

(1996). It is during this time that the nurse begins to truly understand and empathize with the client.

Understanding or empathizing with another is the second theme in the category of attentive or authentic presencing and is also described as full presence (Osterman & Schwartz-Barcott, 1996). In studies that looked at nursing students' perceptions of caring from nursing faculty, students declared that caring nursing instructors viewed them as a whole person, not just a student nurse. Students stated that instructors who really tried to understand the student's point of view and showed the students empathy were faculty who really cared about them (Beck, 1991; Hansen, 1992; Hansen & Smith, 1996; Schumacher, 1995). In a phenomenological study by Miller, Haber and Byrne (1990) the idea of developing a supportive environment between students and instructors began when nursing instructors reached out to students in an empathetic manner with holistic concern for the student both academically and personally. The outcomes of such student-teacher interactions resulted in students experiencing an increase in self-worth and self-confidence.

In studies that explored student perceptions of caring experiences between themselves and their patients in the clinical arena, empathy and consequent understanding was again noted. One student stated that by visualizing herself as unable to do anything for herself and lying helpless in a bed she was able to empathize with her patient and thus understand and anticipate the clients needs (Beck, 1992 & 1993). Understanding and or empathizing with another person helps to anticipate or sense needs that another person may have.

Sensing is the third theme of authentic presence. In studies that looked at nursing students' perceptions of caring from their nursing teachers, behaviors that were associated with sensing, included the following example. The teacher noticed that after a test, the student was acting downcast, and was fearful she had failed the test; the teacher sensed the student's distress, approached the student, touched her arm, smiled and helped her put the experience into context by talking with her for a few minutes (Schumacher, 1995). Teachers who look for and are aware of student's expressions and nonverbal reactions signifying distress and anxiety are thought of as caring by the students (Beck, 1991; Hansen, 1992; Hansen & Smith, 1996; Schumacher, 1995). This idea of being anchored in the present reality and interactive communication is also indicative of full presence (Osterman & Schwartz-Barcott,1996). However, in order to assist in solving a human problem, to give relief of a here and now distress, the person involved in authentic presencing must first recognize a problem exists and then respond by giving fortifying emotional and or physical support. Recognition is the second category of caring noted in this section and giving fortifying emotional and or physical support to the person in distress is the third category of caring noted in this section. Giving fortifying physical and emotional support will be discussed later in this section. Giving physical or emotional support in a competent manner is discussed last in this section.

Category #2 Recognition of Another Themes Include: Inquiring and Responding

Recognition of another person is the second category of caring synthesized from the literature on nursing student's perceptions of caring. There are two themes synthesized under this category, Inquiring or initiating and responding.

In the studies that examined nursing student's perceptions of caring from their nursing teachers, inquiring about the student or initiating a conversation with the student were highly regarded as caring behaviors. Students felt cared about when teachers called them by their names and inquired about how they were doing or asked about their families (Beck, 1991; Dillon & Stines, 1996; Hansen, 1992; Hansen & Smith, 1996; Schumacher, 1995). Recognition by faculty of students' needs leads to a genuine connection between faculty and student. This connection is not a power-based connection, but instead one of equal power such as colleague to colleague or friend to friend (Hansen & Smith, 1996).

Responding is the second theme analyzed in the category of recognition. In the studies where nursing students described caring from their teachers, this meant that the teachers actually followed up with them. Behaviors that indicated that the teacher remembered the problems that the student had discussed with them and made a special endeavor to find out how things worked out made the student feel cared about. Also noted in these studies are when teachers not only sensed a student's distress but actually responded to them by helping them with information and or feedback (Beck, 1991; Hansen, 1992; Hansen & Smith, 1996; Schumacher, 1995). Schumacher (1995) found that when instructors actively sought out students to find out how they were doing after the student shared personal issues or concerns and offered to give the student an extension on a test or paper if needed, the student decided to not drop out of the nursing program. These behaviors may be considered supportive to some degree but the literature lists a third category of caring that is one in which support given is much stronger and can actually be fortifying in nature.

Category 3: Fortifying Physical and or Emotional Support through Assisting Another

Fortifying physical and or emotional support is listed as the third synthesized category of caring. This category has one theme that has been delineated as assisting.

This category was strongest in the literature on caring among nursing students (Beck, 1992). Students who were perceived of as caring were students who assisted other students without reserve by lending them notes, copying articles, and giving encouragement. Students supporting other students during illnesses and by just being there for each other were perceived as caring individuals. In one of the studies in the literature on students caring among themselves, one student felt the support was so strong that she could almost touch it and felt enclosed in a protective circle (Beck, 1992).

Emotional support in the form of honest, caring feedback was cited often in the literature on caring interactions between the nursing teacher and nursing student. In a study by Juethong (1998) students called this form of feedback "artful dialogue" because they felt it was important for the instructor to give feedback in a way that was encouraging and supportive and not hurtful or demeaning to the student. This study gives many examples where a nursing instructor gave feedback that was helpful instead of hurtful and or demeaning. One example given of "artful dialogue" happened in the clinical arena. A nursing student was asked a multitude of questions regarding numerous IV medications by one of the staff nurses regarding a patient. The student quickly became anxious and was not able to answer the many questions posed to her by the nurse. Knowing this to be the student's first day on the unit, the nursing instructor quickly came to assist the student in answering the questions the staff nurse asked of her. The student directly involved, and the other students nearby who overheard the conversation were

very impressed by this caring instructor (Juethong, 1998). This idea of artful dialogue was the second category uncovered in Schumacher's (1995) study, and was termed confirmation/affirmation. Confirmation is defined by Noddings (1986) as an important segment in the moral education of nurses. Hughs (1992) added the word affirmation to Noddings moral education of caring and describes confirmation/affirmation as an interactional episode in which the teacher acknowledges and validates the student's present abilities consonant to reality yet recognizes that the student has the potential to grow in their role of nurse. Schumacher (1995) found that when students were given feedback that confirmed and affirmed their present knowledge and abilities, they in turn felt good about themselves, and felt validated by their knowledge and nursing judgment. When instructors gave feedback that was non-judgmental, or not downgrading regarding ways the student could improve his or her practice the student felt empowered and felt he or she could learn from their mistakes (Schumacher, 1995). This idea of student empowerment by caring nursing instructors is espoused in Wade's (2002) study. Wade found that when nursing instructor's behaviors were perceived of as caring by students, there was a positive direct effect on the student's perceived clinical competence. Hanson and Smith (1996) also found confirmation/affirmation to be one of the categories gleaned in their study. The outcomes of an interaction in which the student receives affirmation by a nursing instructor are very powerful and motivating. Students have cited that after these experiences, they wanted to work harder in school and do their best (Hanson & Smith, 1996; Schumacher, 1995). A student in Schumacher's (1995) study stated that because the nursing faculty had given her such positive emotional support by giving her encouraging feedback, the student learned a lot about herself and was able to give other

students and patients support. The importance of being able to give honest feedback in a caring and supportive manner to others after graduation from nursing school was noted in a study by Wiles (1995). Wiles found that teaching characteristics such as feedback that encourages students to succeed, ranked high in the facilitation of augmentation of caring attitudes and caring behaviors of nursing students. The idea of honest and immediate feedback has been cited by Hugh (1992) as being an ethical responsibility of the teacher. Teacher's behaviors should be fair and impartial and expectations should be clearly communicated (Hughs, 1992). Honest, open, and timely feedback from nursing instructors that gives the student affirmation and confirmation regarding the things that students do correctly as well as feedback that is neither judgmental or demeaning regarding areas for improvement can empower students, increase their self-confidence, and help them to incorporate caring into their future nursing practice.

Category #4 Competence

Instructors who are competent both in their clinical knowledge as well as in the classroom were designated as caring instructors in many of the studies analyzed (Hanson & Smith, 1996; Halldorsdottir, 1990; Juethong, 1998). Instructors regarded as caring are those instructors who are committed to nursing, and possess professional competence and are able to assist the patient's needs and share and role model their clinical competence with students (Halldorsdottir, 1990; Roach, 1984). A nursing instructor who is competent in both the classroom and clinical arena can assist the students to critically think and problem solve nursing issues (Smith & Hanson, 1996). Students in Halldorsdottir's (1990) study stated that learning about caring without clinical competence was of little significance to them. Hughs (1992) declared the importance of professional credibility in

her study and described professional credibility as mastery of nursing skills, in depth knowledge of nursing practice as well as personal experience with patients. Students in her study were impressed as they watched clinically competent nursing instructors interacting and caring for patients and knowing what to say and do because they had experience and knowledge with patients (Hughs, 1992). Hughs (1992) and Juethong (1998) discuss instructor's role modeling of clinical competence as a positive caring factor in their studies. Not only can a competent clinical instructor role model and share his or her nursing knowledge with students, a competent clinical instructor can help students to feel confident they will be observed closely and will not be allowed to do anything to harm the patient. A competent clinical instructor can be relied upon for his or her technical expertise and clinical knowledge in order to be available to assist the student and patient if the patient should take a turn for the worst (Hughs, 1990; Juethong, 1998).

Being clinically competent was of extreme importance to nursing students caring for patients in their clinical experiences (Beck, 1993). It was viewed as extremely important for nursing students to feel prepared when taking care of patients. The students delineated behaviors such as following up with patients, explaining and providing patient education as behaviors illustrating competence. The idea of clinical competence takes on serious meaning in the third and fourth year in a nursing program according to Wilkes (1998). Wilkes developed a model of professional nurse caring from the nursing students' experience. Competence is defined as the ability to use cognitive, affective and psychomotor characteristics needed for particular patient clinical care situations (Wilkes, 1998).

This section reviewed the literature on nursing student's perceptions of caring from faculty, from each other nursing students and from their own experiences with patients in clinical. Four categories emerged from this analysis and synthesis; attentive or authentic presence, recognition, fortifying physical and emotional support, and competence. There are many threads of similarity seen between nursing students' perceptions of caring, nurses' perceptions of caring, patients' perceptions of caring and perceptions of caring held by persons outside of nursing.

The threads of presencing with another in order to attentively listen are seen as dominate and brightly colored threads in nurses', and student nurses' perceptions of caring. While presencing is not an unimportant thread, it is not one that shines as brightly in the patients' perceptions of caring. Competence is an important thread noted in patients' perceptions of caring as well as in student nurses' perceptions of caring. While competence is certainly not noted as an unimportant thread, it does not stand out so boldly in the nurses' perceptions of caring. Perhaps competence in nursing is a strong sinewy thread of expectance with most nurses and is a sturdy color, while it is a thread that is colored boldly as it is heavily taking on meaning for student nurses, and a thread that can mean life or death, pain or pain free for patients. The tapestry of caring in nursing takes on many colors from many different perceptions, all are important and make the tapestry what it is, beautiful, at times confusing and complex but always continuing forward.

CHAPTER III RESEARCH METHODOLOGY

Research Design and Rationale

First I will explain the research design used, as well as the rationale for choosing this research design. Second, I will describe the setting where the study took place. Third, I will discuss the participants and describe the way in which they were invited to join this study. Fourth I will discuss the sources I used for data collection and the detailed steps used in each. Fifth, I will describe the three processes of reflexive bracketing, peer review, and member checking that I used to ensure trustworthiness within the study. Sixth, I will describe how the data was analyzed from each data source.

The research method used for this study was the phenomenological approach of qualitative research. Phenomenology attempts to understand wholeness of human beings and their lived experiences of the phenomenon under study (Valle & Halling, 1989). Caring in nursing has been deemed to be the ethical and core value of nursing (Watson, 1988). Because caring is such a vital component of nursing practice, the National League for Nursing (NLN) called for a curriculum revolution in 1990 for caring to be incorporated into nursing program curriculums. Studies have shown the importance of teaching caring in nursing programs to be vital for new nurses to learn how to begin incorporating caring into their practice (Beck, 1991, 2001; Leininger, 1980; Noddings, 1986; Roach, 1984). One of the challenges of teaching caring in nursing programs has been to first understand the complexity of the concept of caring to make it visible to nursing students through the use of modeling, dialogue, practice, and confirmation (Noddings, 1986; Roberts, 1990). Phenomenological studies have explored the lived experiences of caring interactions and have helped nursing students, and instructors to

better understand this complex concept (Beck, 1991, 1992, 2001; Hansen & Smith, 1996; Schumacher, 1995).

What happens to those burgeoning, tender buds of caring ideas and concepts once the new nursing graduate leaves the shelter of a nursing program that has a caring curriculum? There are no studies that have explored whether caring continues to be taught, supported, and fortified by orientees' preceptors. This study's research questions help to get to the heart of the orientees' perceived perceptions of caring interactions with their preceptors. The research questions will be repeated here for the reader's convenience:

1. Are caring interactions occurring between the orientee and preceptors during the 10 week orientation period at the medical center environment?
2. If the orientees do perceive caring interactions from their preceptors what does this mean to them?

The questions posed in this research study were fundamental in discovering new nursing orientees' lived experiences of caring from their preceptors during the 10-week orientation period at this large medical center in the Midwestern portion of the United States. Phenomenology is an approach that is used to discover the participant's lived experience (Giorgi, 1985). Phenomenology allowed me to collect and interpret narrative data in order to understand what it was like for the new nursing graduate orientees to experience caring and non-caring interactions and relationships from their preceptors during the 10-week orientation period. Phenomenologists do not stress a definite methodology, but stress the necessity for open disclosure and creativity when performing the task of data collection and exploration of the meaning of their data (Burns & Grove,

1993; Giorgi, 1985; Hanson 1992; Pallikkathayil & Morgan, 1991). The phenomenological approach allowed me entrance into the orientee's world to better understand her point of view. Through the phenomenological approach, I was able to determine that orientees perceived both caring and not so caring interactions with their preceptors during the 10-week orientation period in the medical center environment. I was also able to determine what these behaviors were and what the experiences meant to the orientees.

Setting

The medical center is located in the Midwestern United States and is made up of two large hospitals and a clinic. These three entities form an integrated medical center providing comprehensive care to patients in the surrounding communities as well as patients around the world. The first hospital contained within this medical center has 794 licensed beds and 40 operating rooms. This hospital has acclaimed recognition for treatment in liver, kidney, pancreas, and bone marrow transplants as well as comprehensive cancer treatment, care of women with high-risk pregnancies and a special unit for dermatological problems. The second hospital has 1,157 licensed beds and houses a major trauma unit as well 53 operating rooms. Neurosurgery, heart and lung transplants as well as a rehabilitation unit, ventilator dependent unit and a children's hospital are all unique to this hospital. The clinic sees approximately 3,350 patients daily resulting in about 162 daily hospital admissions. This medical center provides treatment in almost every medical and surgical specialty. In 2002 the medical center declared a total number of staff of approximately 26,209.

The primary philosophy of this medical center is that the needs of the patient come first. Three of the core principles cited within the medical center includes education, practice and research. This medical center's department of nursing has been the recipient of the Magnet Award for excellence in nursing service since 1997. The Magnet Award is the highest credential given by the American Nurses' Credentialing Center. The award is given to health care centers exhibiting excellence in nursing service to patients as well as existence of an environment that promotes and supports professional nursing practice and allows for nurses to grow and develop in their nursing practice. The medical center has approximately 3,000 nurses on staff. The medical center hired approximately 340 new nurses during 2003; these nurses were hired to work in all areas of the medical center. The hiring policy at the medical center states that all nurses hired are required to attend central nursing orientation. These nurses hailed from all over the United States with the largest proportion (approximately 63%) being new nursing graduates seeking their first job in nursing.

Participants

The subjects of this study were a purposeful sample of 10 new graduate nursing orientees who attended the 2004-2005 central nursing orientation. All 10 of the participants were female and had baccalaureate degrees in nursing. Three orientees with associate degrees in nursing originally volunteered for the study but dropped out within the first three weeks of orientation, thereby resulting in a total of 10 participants in this study with baccalaureate degrees in nursing. All of the participants in my study were American Caucasian and ages ranged from age 22-41 with the average age being 23 years. Two of the participants had previous baccalaureate degrees in other fields.

Participants attended schools of nursing in Montana, South Dakota, Illinois, Iowa, and Minnesota.

The orientees that volunteered for this study described their experiences of caring from preceptors at the medical center through the use of brief, daily reflective journaling. Seven of the participants' journals displayed specific examples about caring and not so caring interactions that were detailed and rich in their explanations. These seven orientees participated in an in-depth interview which took place at the end of their orientation period. Orientees who participated in the interview told their story, and explained their feelings about their experiences of caring or not so caring interactions with preceptors during the orientation period.

I met with the first group of new nursing orientees at the end of their central classroom orientation, before they left to complete their clinical orientation. At this time, I invited all of the new nursing graduates in this group to be a part of my research study. I briefly explained my research, in which they would be asked to gather their thoughts, ideas, and feelings about caring interactions they may experience from their preceptors during their 10-week orientation period. At this time, I handed out the letters of invitation (Appendix C) to each new graduate nurse orientee in the room. After an explanation of the study and after the new nursing graduate orientees had time to read the letter of invitation, I asked for a show of hands to determine how many orientees would be willing to participate. Orientees who did not wish to participate, left the room at this time. There were 10 willing new nursing graduate orientees who declared an interest in participating in this study. Each participant read and signed the consent form required of the institution as well as the consent form required by the university. I accepted all 10 participants

because I was allowed up to 20 total participants. Next, I handed out the three by five cards that asked for the following: their name, unit, and home phone number. The participants filled out the demographic form (Appendix D). The participants then turned in all of their forms and as they left I gave each one a spiral ringed notebook for journaling purposes. Instructions for journaling were attached to the front cover of each notebook (Appendix E). Directions were included on the front cover of the journal regarding how they could contact me at work and at home if questions or concerns arose. I approached three different orientation groups using this same process and with attrition from each group, a total of 10 participants completed the study. Transcripts of the interviews were sent to each participant in confidential sealed envelopes via intra clinic mail with instructions to contact me if any statements on the transcript were taken out of context, were of concern to them or if they had any questions about their transcripts. A follow up call was made to touch base with each participant two weeks after they received their transcripts.

Data Collection Procedure

I collected data from two data sources. The first data source was the participants' daily reflective journal entries, which contained their perceptions, thoughts, feelings, ideas, activities and interventions regarding caring during their orientation. The second data source was an in-depth interview with selected participants. Participants were selected based on journal entries that had specific examples about caring and not so caring preceptor behaviors and interactions and were detailed and rich in their explanations.

I met with all of the participants who agreed to be in my study at the end of their last day of classroom orientation, before they began their orientation to the clinical areas. During this meeting, they filled out the 3X5 cards, the demographic information, (Appendix D) and they signed the consent form from the University and the consent form from the Institution.

I then gave each participant a spiral-ringed notebook to record daily reflective journaling. Each notebook contained information regarding how the participant could contact me at home or at work. Verbal instructions regarding journaling and confidentiality of preceptors were given at this time. Written instructions for journaling (Appendix E) were attached to each journal as a daily reminder. The Participants were instructed to briefly journal at the end of each day for approximately 10 minutes. The participants were instructed to keep their preceptor's names confidential. They were instructed to not write their preceptors names, after describing any caring or not so caring interactions. The participants were directed to use the initials PP for any interactions they had with their primary preceptors and to use the initials OP after describing any interactions they had with their other preceptors. These instructions were also written on the cover page of the journals as a daily reminder to keep the preceptors names anonymous. This allowed data collection of interactions between the primary preceptor and other preceptors to be clearly defined. The participants selected for the in-depth interviews were informed that the journals would be used to help them remember their experiences. The participants were informed that all of their journals would be returned to them after successful defense of the dissertation. They were also told that their 3X5 cards

would be shredded at this time also. The participants were informed they would be given pseudonyms in order to keep their journal and interview entries anonymous.

I collected journals during week 7 of the 10 week orientation period and I read each journal completely looking for core themes and sub themes. I also read each of the journals with the intention of looking for examples about caring or not so caring experiences that were detailed and rich. Participants who had written about the richness of the essence of caring or not so caring episodes were asked to participate in an in-depth interview at the end of their orientation. I photocopied each of the participants' journals to highlight core themes and sub themes first individually then I compared the journal entries of the entire group and looked for similar statements from each of the transcripts as well as similar core themes and sub themes from the journal entries.

The second technique of data collecting was through a taped, open-ended interview with selected participants during the last weeks of their orientation period. These interviews lasted from 30 to 70 minutes. The following are the initial open-ended questions that were asked to stimulate thoughts, feelings, ideas, activities and interventions that occurred during the orientation experience. These initial open-ended questions were followed by questions that were used in order to probe deeper thoughts, feelings, and ideas.

1. Tell me what the overall orientation experience was like for you.
    a. Was it what you expected?
2. Tell me about a time when you felt cared for by one of your preceptors during the 10-week orientation here at the medical center.
    a. What were your thoughts and feelings during this experience?

b. How did you respond to the experience?

c. How do you feel about the experience now?

Transcriptions were made of the taped interviews and the researcher proofread the transcripts while listening to the tapes to assure that no mistakes in transcribing were made which could cause misinterpretation of data.

During the 10-week orientation period, I kept a researcher's journal in which I wrote about my own thoughts and feelings that were triggered after meeting with the participants, and after the interview process. My journal entries were not a source of data collection, but were helpful in enhancing data analysis and as a means of providing trustworthiness as described in the following paragraphs.

Data Analysis

Data was collected and analyzed from two sources. The first data source was the participants' daily reflective journal entries. Each journal was read carefully in order to extract core themes and sub themes. Each core theme and sub theme identified was highlighted a specific color. Journal entries were analyzed for detailed and rich examples of caring or not so caring experiences in order to select participants for the interview process. After examination of each individual journal, the highlighted core themes and sub themes from all of the participants' journals were reviewed collectively in order to extract common core themes and sub themes within the entire group of participants. Each journal was photocopied in order for this highlighting process to be done and to allow for return of the journals without the highlighting or other marks. The journals were returned to the participants after successful defense of the dissertation. The photocopied journals were shredded after successful defense of the dissertation.

This second source was the individual interviews with selected participants whose journal entries were detailed and rich in their explanations of caring or not so caring behaviors and interactions from their preceptors. Participants who were asked to partake in the interview process used their journals during the interview as a resource to refresh the vivid thoughts and feelings they had experienced during the many weeks of orientation. These interviews took place at the end of the 10 week orientation period. The transcripts obtained of each subject's interview were analyzed according to Colaizzi's (1978) technique of analysis of phenomenological data. The primary feature of Colaizzi's method of analysis is an inductive and emergent approach to data analysis (Munhall, 2001). The Colaizzi technique I used to code my data consists of six steps outlined below.

1. Reading all of the subject's descriptions. Each transcript of the interview and written descriptions (called protocols) were read numerous times in order to get the sense of the total content.

2. Extracting significant statements. The protocols were then read to identify and extract significant statements regarding how the orientees perceived caring. Each phrase or sentence directly relating to caring was typed on one column of a two column grid.

3. Creating formulated meanings. This next step was to spell out the meaning of each significant statement. The formulated meaning of each significant statement was typed on the opposite column of the significant statement on the two column grid.

4. Aggregation of the formulated meanings into clusters of themes. I was able to delineate six themes of caring preceptor behaviors; advocating, welcoming, including, autonomy with appropriate preceptor presence, making human connections and clear, non-punitive feedback. I was also able to delineate four themes of not so caring preceptor behaviors; unwelcoming, autonomy with no preceptor presence, no autonomy with preceptor over presence and feedback that was not clear and timely.

5. Writing an exhaustive description. In this step, I integrated the significant statements, the formulated meanings, and the themes into six narrative exhaustive descriptions of caring and four narrative exhaustive descriptions of not caring.

6. Returning to subjects for member checking validation.

After each in-depth interview, transcripts were made of the interviews and copies of the transcripts were sent to each participant via intra clinic mail in confidential sealed envelopes. Instructions were given to the orientees to look over the transcripts and if they had questions, concerns or felt they needed to clarify any of their statements to contact me. My work phone and home phone were included in this note. After giving the participants two weeks to look over their transcripts and not hearing back from any of them, I gave each one a final chance to make changes or ask questions by calling each participant and leaving messages for each one to give me a call to discuss concerns, questions, or to clarify any statements. Five of the participants did return my call and informed me that they did not have any questions and felt the interview transcripts represented their thoughts and feelings.

Trustworthiness

Maintaining rigor within qualitative study is important for qualitative researchers (Ahern, 1999; Creswell, 1998; Hopko, 2002; Munhall, 2001). These authors also give guidelines that can assist the researcher to be as objective as humanly possible. I am in agreement with Creswell (1998) that trustworthiness is a process that needs judicious attention throughout all aspects of the qualitative research study. I used three processes to ensure trustworthiness within my study as I collected the data, analyzed the data and reported my findings. The first process used included reflexive bracketing or decentering. The second process that was used was the technique of peer review and the last process that was used was that of member checking. The following paragraphs will clarify how I used these techniques to lend trustworthiness to my study.

Reaching a state of complete objectivity or unknowing is humanly impossible and not necessarily desirable (Ahern, 1999; Muhall, 2001). However, in order to truly listen and be present with the participant it is necessary for the researcher to put aside preconceived notions and personal feelings. Ahern (1999) suggests that by using the strategy of reflexive bracketing the researcher will be able to identify potential areas of bias and bracket them in order to minimize their influence on the research process. Munhall (2001) describes a process called decentering which is very similar to bracketing and states that decentering must first occur in order for the researcher to understand and become aware of his or her own values, biases and prejudices. Decentering opens the dialogue between the researcher and participant and allows the researcher to actively listen and be present with the participant. Munhall declares that to become phenomenological, there must be less assuming in order to be nonjudgmental,

compassionate, and open for the purpose of truly understanding another person's perspective (Munhall, 1994, 2001).

This idea of decentering is further defined by Munhall as clearing one's vision, and perceptions about prior experiences as much as possible, and she suggests trying ones best to listen with the "third ear" and to the extent possible of any prejudice or bias. I used journaling to help clear my head of thoughts and biases and I found that by journaling my thoughts and biases I was able to decenter and listen more carefully during the interview process. Hopko (2002) declares that by being honest about human qualities and identifying them up front, the researcher is able to bracket them and set them aside so that the resultant data can be better clustered and summarized. Such reflections were made in my researcher's journal throughout the research process to help me understand the effects of my own experiences and perceptions. Reflexive bracketing or decentering helped me to keep my own thoughts and bias's in check so that I did not confuse my story with the participants. After meeting with the participants, I recorded my observations, thoughts, feelings, perceptions and biases. This journaling helped me to identify pertinent personal history, attitudes, and values that I have.

The second trustworthy process that I used was that of peer review. Peer review is a technique for clarification of interpretation of collected data and provided me with an external check on the inquiry process (Polit & Hungler, 1993). Several copies of the transcripts were read by my advisor, and co-advisor to check for concordance in identification and interpretation of data. I asked my advisor and co-advisor to review my data as I performed the coding technique according to Colaizzi's methodology to make

certain that the meanings and interpretations made sense and again to give me that external check.

The third trustworthy process included member checking. This process is described by Creswell (1988) as a process in which the researcher asks the participants for confirmation of the collected findings and interpretations. I sent each of the participants in my study a copy of their transcripts from their interviews in sealed confidential envelopes via intra clinic mail with instructions to please call me at home or at work if they had questions, concerns or would like to clarify any of the data in the transcripts. After two weeks, I attempted to reach each participant by phone in order to make sure they had the opportunity to discuss any questions, concerns or felt a need to clarify any of their statements on the transcripts. The participants declared they felt the transcripts were clear and had expressed their thoughts and feelings very well. No changes were suggested and no questions or concerns were given. Lincoln and Guba (1985) declare member checking to be a particularly important technique for ascertaining the trustworthiness of qualitative data.

CHAPTER IV DATA ANALYSIS

Introduction

I will use Campbell's (1968) three stage hero journey as a comparative framework for the new nursing graduate orientees' professional journey. Campbell's three stages include the departure, the initiation, and the return. These three stages will be presented along with a discussion of the six themes that emerged indicating the orientees' perceptions of preceptor's caring behaviors. Each theme will be examined separately and included in the stage of the hero's journey where it is most predominate. The first three critical themes that emerged were advocating, welcoming, and including. These are discussed during the departure stage at the crossing of the threshold. The fourth theme that implies caring preceptor behaviors was autonomy with varying levels of preceptor presence. This theme was observed predominantly in the second stage delineated as the initiation stage, during the road of trials. The fifth theme indicating caring preceptor behaviors was making caring human connections and was seen predominantly during the initiation stage throughout the mythological meeting of the Goddess. Preceptor feedback that is clear, continuous, specific and non punitive was the sixth vital theme revealed. This theme was noted to prevail in the initiation stage during the time declared as the atonement.

This chapter will be organized to show these six themes of caring behaviors that emerged during the orientees' professional journey. First I will explain why I chose Campbell's hero's journey to be used as a comparative framework with the orientees' professional journey.

Second I will examine the stage of the hero's journey entitled the departure. Campbell (1968) has divided this stage into various elements which include the call to adventure, refusal of the call, supernatural aid from the helpers, the crossing of the threshold, the threshold guardians, and the belly of the whale. An overview of the departure stage as well as each of the elements included will first be presented and then compared with the orientees' journey during their departure stage.

Third I will examine the stage entitled the initiation. The initiation stage includes the elements of the road of trials, the meeting of the goddess, atonement, and the ultimate boon. This stage and it's elements is described and then a compared to the orientees' journey during their initiation stage.

Fourth I will discuss the final stage entitled the return. In this stage I examine the element of bringing home the ultimate boon. This final stage will first be clarified and a summary of the orientees return and the boon or gifts they have received during their journey will be discussed.

The orientees' told their stories in their journals and their interviews taught me the struggles and positive events that occurred during their times of caring interactions. The orientees' stories are not unlike the myths which have been around since the beginning of human existence. Myths and stories taught our ancestors and continue to teach us today. In the next section of this chapter I will further discuss the enlightenment of mythology and explain why I chose to use Campbell's hero journey as a comparative framework.

The Hero's Journey as a Comparative Framework

Reasons for Choosing the Hero's Journey

Through the symbolic nature of myth, people are urged to reflect upon their true selves, consider the unexplainable mysteries of life, open their imagination to life's possibilities, and become energized to grow and change. As the new graduate nursing orientees begin their professional journey, which is not unlike the hero's journey, they are taking stock of who they truly are, and what they have to offer the profession of nursing. They begin to question the mysteries of the nursing profession and look forward to the possibilities nursing can offer them as well as their gifts they can offer the nursing profession. They become excited and energized in their transition to become an expert nurse. They begin contemplating the entry through the threshold of future doors where opportunities await them. These are the thoughts, dreams, and feelings of the orientees that are expressed through their journal entries, their interviews, and my observations. In reading the journals and contemplating the interviews, the symbolic analogies between the orientees' journey and the hero's journey began to take shape in my mind's eye. As I read more about mythology and Campbell's (1968) work, the similarities became stronger and clearer. Campbell, a scholar who studied mythology, found that no matter what the culture or the story line, there was a certain sequence of events that happen to the heroes as they achieve and accomplish something that was above and beyond their ordinary life experiences. The same symbolic sequence of events encountered in the hero's journey continues to be experienced by heroes or heroines of today. Similar patterns of events were clearly delineated in the factual narratives of these participants' professional journeys.

An Overview of the Departure Stage and the Elements

The departure discussion will include an explanation of the stage as well as the elements included within the departure stage. Campbell's (1968) departure stage includes the call to adventure, refusal of the call, supernatural aid, crossing the first threshold, and the belly of the whale. After an explanation of the stage and the elements designated by Campbell, I will discuss the orientees' stages of their professional journey. The significance that the preceptor's caring behaviors had upon the participants' part of this journey will be revealed. Campbell uses both male and female when he is describing the hero, but for clarity of reading, the masculine pronoun will be used to discuss Campbell's hero and the feminine pronoun will be used when discussing the participants or heroines throughout the discussions.

The first stage in Campbell's hero journey is the departure. This stage begins with the call to adventure, which beckons the hero to analyze his current life and contemplate the possibilities of what his life can be if he decides to achieve or accomplish something outside of the ordinary (Campbell, 1968). The hero will contemplate the possible opportunities and make a decision to accept this call to adventure or to refuse the call.

The hero who senses he is unworthy, unprepared and lacks confidence will probably refuse the journey. However, for the hero who accepts this call to adventure, his life will soon change from what it once was and he will never again be the same (Campbell 1968).

For those heroes who accept the call to adventure, they will soon meet a supernatural spirit, or guide who will help them along the journey by giving them advice,

knowledge, or sometimes mystical amulets and talisman. These guides or supernatural spirits are advocates for the hero, and without the guides the hero would not be able to succeed on his journey. The hero needs the help of the guides to cross over the many thresholds that are protected by the threshold guardians. The fundamental importance of the guides and their assistance is clear.

As the hero goes deeper and deeper into the forest or into his adventurous journey, he finds he must traverse across many thresholds and these thresholds can become more and more difficult the deeper he goes. These thresholds are protected by the threshold guardians. The threshold guardians give the hero difficult tasks or trials to perform before allowing the hero entry through the threshold to continue on his way. The victorious conquest of these various tasks and trials is made possible due to the assistance of the guides who share their knowledge, advice, and mystical amulets that the hero can use.

Once the hero has crossed the first threshold and has committed himself to the journey, he is said to enter into the belly of the whale. The belly is symbolic for digestion or the taking apart of something to enable it to become a different substance. Therefore, when the hero enters into the belly of the whale, a dark and mysterious place, the symbolic digestion or change begins and there is no turning back to what he once was. Once the change has occurred, the belly now becomes symbolic as the birth place or womb and the hero, now a changed entity, is born again from this worldly womb (Campbell, 1968).

Stage I: Departure Stage

These elements will now be discussed and compared with the orientees' journey. For this discussion and comparison, I will use my observations from my field log and paraphrase what the orientees have told me and have written in their journals. I will use my observations from my field log and paraphrase what the orientees have both told me and have written in their journals. Themes of caring preceptor behaviors, welcoming, advocating, and including that emerged from data analysis will be revealed during the crossing of the threshold.

The Call to Adventure

It is during this departure stage that the hero is called to adventure. The adventure can be many things, but the outcome of following this call to adventure results in a critical change to the hero. Campbell (1991) discusses that the usual hero adventure begins when a person feels there is more to his current life, and feels a need or has a passion to find out more, and to be more than what he currently is. Campbell gives the example of the essential psychological transformation of a child becoming an adult. As children, our parents supervise and protect us, and we know it is best to be obedient and follow our parent's and our teacher's advice to receive rewards along the way (Campbell, 1991). Campbell explains that to grow up, we must let go or experience a psychological death of childhood and be born as adults. Campbell postulates that this call to adventure summons the hero to step outside of his comfort zone, and to experience both the fear of the unknown as well as the tremendous delight of the journey (Campbell, 1968). This call to adventure is stimulated by a passion that the hero experiences and is similar to the

orientees' passion as they strive to become independent, safe, accountable and professional nurses.

For four or more years these new graduate nursing orientees have been studying and practicing nursing under the watchful eyes of their nursing teachers. Their college teachers have taught them the theoretical aspects of nursing and have also looked after them and supported their learning and development in the clinical arena. Once their formal education is completed, and they have developed the beginning buds of self-confidence in their abilities, they are ready to cautiously try out their new knowledge and skills. Their desire comes from within and beckons them to leave the safe student environment dependent upon teachers to become a professional nurse upon whom others depend. The desire to begin the journey and accomplish and achieve something that is above and beyond their ordinary experiences is strong and propels them forward through their fears and self-doubts.

They are fearful of making mistakes, they are fearful of looking stupid in front of their peers, patients, families, and physicians; and they are overwhelmed about how much there is to learn. They feel of vulnerable, anxious, and stressed, and at times become very emotional. However, they are also very excited and find their new autonomy to be very rewarding. Their detailed journals describe how happy they are when they accomplish a new skill or manage their time wisely or receive a compliment from a patient or family member. They grin broadly when reflecting such experiences during their interviews.

Accepting the Call to Adventure

These new nursing graduate orientees, while fearful and anxious, hold their heads high, smile broadly and begin their journey with high hopes, and high spirits as they

accept their call to the adventure. The adventure is to further increase their nursing knowledge and skills and thus develop their individual nursing practices. Leaving behind the familiarity, safety, and protection of their nursing schools and nursing instructors, they commit themselves to the journey and cross the threshold into the unknown. By accepting the call to adventure, the participants are now ready for changes to take place within them.

Refusal of the Call to Adventure

In myths as well as in real life, there are times when the hero refuses to make the journey. The hero may be frozen with fear, feelings of inadequacy, or other reasons may preclude the hero to continuing his journey. When the hero refuses the call to adventure, his life stays the same, and he becomes entrapped in dullness, and in the end, he becomes a victim to be saved (Campbell, 1968). These new graduate nurse orientees were quick to admit that they felt vulnerable, incompetent and at times downright scared, but because their calling was so powerful, they did not refuse this call to adventure and continued on their professional orientation journey. Their goal was to learn all they could learn, and begin to build a foundation for the development of their own independent, safe, and accountable nursing practice. While none of the orientees refused the call to adventure or did not finish their journey, there were times when they journaled about their fears of not ever being able to get their charting correct, their medications figured out, and their routine developed that would allow them to manage patient care in a timely manner. Their eyes would look down at their hands as they told stories of feeling foolish or making mistakes. Their eyes would squint, they would look off in the distance and their hands would gesture when talking about things that frustrated them and made them

angry. They did not refuse the journey, but there were certainly times when they considered abandoning the journey.

The call to adventure was a strong and motivating force for both the orientees and the heroes and was one factor that influenced them to move forward rather than abandoning their journeys. The orientees' professional journey, like the hero's journey, contained many trials and tribulations and the orientees and the heroes needed support, advice, and assistance to be successful on their journeys. The heroes received this support, advice and assistance from their mythological guides who provided them with supernatural aid. The orientees received caring behaviors and interactions from preceptors that supported and assisted them to successfully reach the end of their professional journey. The following paragraphs will delve further into the comparison of supernatural aid from the mythological figures and the preceptor's caring behaviors.

Supernatural Aid from the Guides

For those who do not refuse the call to adventure, Campbell describes a supernatural aid or protective figure that is soon met along the hero's journey to assist the hero in his success (Campbell, 1968). Campbell gives an example of such a supernatural aid when he describes the mythological Spider Woman, a favorite personage among the American Indians. The Spider Woman is a wise helper who tells the hero what to expect and watch out for along the way. Besides sharing her knowledge and advice she also gives the hero charms and amulets to assist and support his successful journey (Campbell, 1968). The preceptors are analogous to the Spider Woman because they assist the orientee along the professional journey.

Preceptors are those more knowledgeable nurses who have successfully traversed this professional journey 2 or more years ago. These nurses have discovered that they enjoy teaching others and have volunteered to be preceptors for their units. These preceptors do not receive a pay increase for their teaching efforts; the value of being a preceptor is intrinsic reward for these men and women who enjoy teaching and sharing their expertise with others. Preceptors have attended special training sessions to give them increased knowledge in adult learning theories, communication techniques and strategies to help struggling orientees. They attend regular preceptor meetings and have been taught about the significant impact their actions have on the retention of these new nurses. Preceptors are valued by their nursing and administrative leadership peers, and especially by the new nursing orientees. Preceptors are assigned to the orientees to act as their guides and helpers during the orientation period. Like the mythological supernatural creatures whose help is imperative for the hero to make his journey, these preceptors are instrumental in helping the new nursing graduate orientees successfully complete their professional journey. The mythological spirits or guides assist the hero by giving him charms, magical potions, knowledge, and advice. In comparison, the preceptors also shared their knowledge and advice but instead of the charms and talisman, it was their caring behaviors and interactions that were analogous to the charms and magical potions the supernatural guides gave. The preceptor's caring behaviors and interactions support and encourage the orientee, and help to facilitate the orientees learning to become an independent, safe, and accountable nurse. Preceptor's caring behaviors and interactions are at the very heart of this professional journey and a total of six themes of caring behaviors emerged.

The first three critical themes identifying these important preceptor caring behaviors are advocating, welcoming, and including. These three caring behaviors will be discussed in the next section entitled crossing the thresholds.

Crossing the Thresholds

Once the hero has accepted the call to adventure, he moves forward on the journey and reaches the first threshold. Campbell (1968) shares a myth about a young prince who had just finished his military training and sets out on his journey with the five weapons given to him by his military school instructor. Along his journey he soon becomes involved in a battle with an ogre. The prince quickly uses all five weapons in the battle but none of the weapons subdue the ogre. Just when it appears the prince will perish, he utilizes his inner weapon of knowledge, which ultimately saves his life. In this myth, the prince or hero has used the inner knowledge gained from his life and military school teachers to cross that first threshold.

This story of the prince is similar to the new nursing graduates' first threshold crossing. The new nursing graduates, fresh out of their nursing schools, are armed with the nursing knowledge they have obtained from their instructors, as well as the knowledge they have acquired from their personal life experiences. Like the prince these new graduates accept the call to adventure and get ready to cross their first threshold to obtain their first registered nurse job. They applied at the medical center and were called for an interview. They answered many questions and proved to the human resource department, the symbolic guardians of the medical center threshold that they were capable of beginning this professional journey.

Nursing theory knowledge learned in school and acquired life skills served as their first guide to provide through the first threshold just as the inner knowledge gained from the military school helped the prince succeed through his first threshold. Both the new nursing graduates and the prince went through a transition after successful passage through the first threshold. The new nursing graduate transitioned to new nursing graduate orientee and the young hero transitioned from prince to the future Buddha.

The new title of nursing orientee allowed deeper access into the medical center. The new nursing orientees were now required to attend a ten week central orientation. The first two weeks consisted mainly of classroom study, where the orientees were armed with a deeper knowledge of the institution's cultures. After leaving the safety of the classroom once again, the orientees met their primary preceptors.

The primary preceptor's responsibility is to travel with the orientee as she crosses the many thresholds and continues moving deeper and deeper into the medical center's environment and culture. The orientees are often assigned associate preceptors who assume the role of the primary preceptors' responsibilities when the schedules do not allow the orientee and primary preceptor to work together due to illness, vacations, or shift rotations. The role of the primary and associate preceptors is two fold: the first role is to share his or her knowledge about various skills, policies, and procedures as well as to make sure all orientation paperwork is complete and finished. The second role is to assist the orientee to adapt and fit into the culture of their respective units.

The interactions and relationships between the orientee and her primary and associate preceptors were the heart of this study. As the orientees worked with either their primary or associate preceptors, they journaled and later spoke about preceptor

behaviors that made them feel cared about and preceptor behaviors that made them not feel cared about. The purpose of the study was to determine if caring interactions between preceptors and orientees were occurring and if so what this meant to the orientee. Primary preceptors were delineated as PP in the journals and interview transcripts and any associate preceptors with whom that an orientee may have worked were represented as simply OP. Using PP and OP rather than the preceptors' actual names provided preceptor confidentiality. After crossing the first threshold and meeting with the preceptor, the orientee is now ready to travel forward to challenge the next threshold and meet it's guardian.

These subsequent guardians the orientees will meet are represented by the nurses or other staff on the unit who were not acting as the orientees' preceptors. The guardians or other nurses and staff need reassurance that the orientee is prepared and will be guided and observed by a trusted preceptor to do patient assignments in a safe manner. In Campbell's hero's journey, the hero had to demonstrate and prove to the guardians of the threshold why he should be allowed passage. This justification usually ended with the hero doing battle with the guardian. The hero used the supernatural aids, advice or knowledge bestowed upon him by his guide to win the battle and successfully gain threshold passage.

The orientee also used her preceptor's advice and knowledge during this phase of the journey. The equivalent of the supernatural elements, potions, and amulets the orientee received from her preceptors were the caring behaviors of welcoming, advocating, and including. The orientees declared that when the preceptors welcomed them to the unit, advocated for them, and included them in unit activities, they were able

to ask the preceptors questions freely and better learn from their preceptors. As they learned from their preceptors, they felt a sense of safety in knowing their preceptors were advocating for them and were making a point of including them in the unit's activities; their self confidence blossomed which enabled them to try to attend higher level nursing tasks, which in turn increased their nursing experiences. The boost in self-confidence and increased experiences were the outcomes of these caring interactions and were a sort of mystical substance that helped the orientees accomplish the tasks set forth by the threshold guardians as well as to battle with their internal dragons that represented their feelings of being unworthy. The following paragraphs will illustrate the first three caring behaviors that emerged: advocating, welcoming, and including.

Caring behavior: advocating. In the orientees' journey, preceptors demonstrated the caring behaviors of advocacy for the orientees by speaking up for them and making sure the guardians of the threshold were not asking unfair requests of them. The preceptors did this by looking over the orientees' assignments and making sure the assignments were not too difficult or so easy that the orientee would not have a good learning experience. If the preceptor found unacceptable assignments he or she spoke up and refused or changed the assignment accordingly. The preceptors also looked at the other staff assignments and kept abreast of all the procedures that would be occurring on the unit during the shift. If the preceptor found there were any new procedures that the orientee has not had experience with, the preceptor advocated for the orientee and obtained that specific procedure for the orientee to perform. The following statements show that the preceptors worked hard to obtain assignments that facilitated a good learning experience for their orientees.

> I felt cared about when my preceptors were concerned about getting the kinds of experiences I needed to help me to be successful in my orientation journey (Beth's interview).
>
> One of the nurses was orientating to the night charge role and it was her first night on her own. So right after dinner she asked my OP, while I was standing right there, if I could sit in a one to one for an hour or so. I was not sure how to respond since the charge nurse was talking about me in the third person, so I stayed quiet. My OP spoke up immediately and informed the new charge nurse that it would not be good to put our new nurse Jill in that type of situation. I was very impressed that my OP stood up for me, and this experience made me feel wanted and important (Jill's Journal entry).
>
> My PP went to the charge nurse to adapt our assignment for tomorrow so that my learning experience would be enhanced; she always asks me if there is anything she could do differently to enhance my learning (Peggy's journal).
>
> I noticed how my primary preceptor really wanted me to have a great orientation experience and went out of her way to get me the experiences that would help me...unique things to see or practice doing, she was always looking for patients that I would be able to learn the most from (Sue's journal).
>
> My primary preceptor made sure I got in on special/unique procedures and meetings, my primary preceptor also stayed with me and guided and assisted me through a special procedure that I had not done before (Beth's journal entry).
>
> My primary preceptor shows me she cares about me when she asks me about my plan for the day and serves as a sounding board. The other day, she showed me she cared about my success when she wanted to get me off to a good start, even though she was sick and needed to go home, she first made sure the second preceptor of the day knew what was going on with me before leaving the unit (Peggy's journal entry).
>
> My PP really had my best interests in mind when she did not have me help out with a new post-op patient. She thought it would be too overwhelming to shift gears from discharging one patient, taking care of another patient and helping with a new post op patient. She wanted me to focus on following through with my two patients and working on plans of care, which we had not done a great deal with (Peggy's journal entry).

In advocating for the orientees, the preceptors also demonstrated excellent listening skills. The preceptors took the time to listen and understand how the orientees

learned best and what they declared to be their learning needs as they traveled the orientation journey together.

> I felt cared about when the preceptor listened to what I told her I needed and made sure to get more practice sessions in that area (Meg's interview).
>
> When my primary preceptor asked me how I learned best, adjusted her schedule to assist my learning needs, and made sure I received the information that I requested, and took a vested interest in me, I felt the preceptor was on my side and wanted me to succeed (Liz's interview).

These significant statements that emerged from the data show the various ways the preceptors advocated for the orientees. The preceptors actively changed assignments, refused assignments, and looked for experiences that would assist the orientees' progression of learning. These behaviors helped to improve the learning experiences for the orientees and made the orientees feel wanted and important. When the preceptors took the time to listen as the orientees identified their particular learning style and expressed their learning needs, the orientees felt the preceptors took a special interest in them, were on their side, and wanted them to have a good learning experience and obtain the knowledge they needed. The orientees were concerned about receiving the best learning experiences possible during their 10 week orientation so they could be successful after orientation was over and safely work on their own. When the preceptors worked hard to get the best learning experiences possible for the orientees, this helped to decrease their anxiety by increasing their self-confidence. Receiving solid, positive learning experiences helped the orientee to appreciate that they can be successful after orientation.

Two other caring behaviors from preceptors were identified by the orientees that began during this phase of the journey and continued on throughout the rest of the

orientation journey. These two caring behaviors from preceptors were welcoming the orientees to the unit and including the orientees in the unit activities. I will first discuss the caring behaviors of welcoming the new orientee to the unit. I will then discuss the caring behaviors of introducing and including the orientee in the unit activities.

Caring behavior: welcoming. The orientees described how they felt cared for when they were welcomed to the unit by warm, friendly, and approachable preceptors. At first glance, this caring behavior may not seem like a crucial, essential element of caring. However, the data revealed that preceptors who welcomed the orientees to the unit, in turn, made the orientees feel appreciated, and needed. This caring behavior assisted the orientees in beginning to meet the task of fitting in and adapting to the unit's practice culture. Preceptors who welcomed orientees to the unit and encouraged them to ask questions were perceived to be approachable people from whom the orientees could learn and with whom they could make connections.

> I was very nervous about the first day of work, but my primary preceptor, sent me an e-mail welcoming me to the unit, and telling me she was looking forward to meeting with me and to be sure and let her know if I was finding everything OK or needed additional assistance. Because of this welcoming e-mail I was able to later openly talk with my preceptor about how I best learned and what I would like to get out of her orientation (Liz's journal entry).
>
> All of the nurses on my unit were excited to have new graduates and were always happy and never intimidating or mean (Meg's interview).
>
> She greeted me with a smile, and she was enthusiastic about precepting, and portrayed a kind and friendly demeanor (Jill's journal entries).
>
> When the preceptors and other staff nurses were patient with me, welcomed me with open arms, and encouraged me to ask questions, this helped to make the orientation journey a very positive, caring experience for me (Jean interview).

Preceptors who were open and welcoming to the orientees made the orientees feel cared about. Orientees felt encouraged to open up and ask questions; this was an

important first step because most of these orientees did not feel comfortable in asking questions for fear of ridicule or looking stupid. Feeling free to ask questions of the preceptors was an important part of learning. Nervousness and anxiety was decreased when the preceptors smiled warmly and were kind and friendly. Warm, open, and welcoming preceptors set a positive tone on those beginning days of orientation and helped to open up the lines of communication between the orientees and preceptors.

Besides being warm, open, and friendly, the orientees also talked and journaled about the importance of preceptors who were approachable. Orientees astutely watched preceptors' reactions and looked for preceptors who were approachable and welcoming.

> It took me awhile to get to know which of the nurses were welcoming and approachable, but once I knew which preceptors were approachable, I felt comfortable in becoming more open myself and asking questions in order to learn more about being a nurse (Liz's interview).

> One of my other preceptors (OP) had a great communication style and made this learning opportunity fun and interesting by being very approachable and understanding my personal learning needs (Jean's journal entry). This OP told me that the more questions I had the better and I knew that I could ask her anything about patient care and she would explain things to me very thoroughly (Jean's journal entry).

> I was apprehensive about my evening shift with OP as I had never worked with her before...she always had seemed so busy and unapproachable when I had seen her in action before. I was pleasantly surprised by OP's willingness to share her expertise and lend a hand to anyone who asked, I found I was soon no longer apprehensive and I no longer feared OP and I was able to learn from her expertise (Jill's, journal entry).

These simple, caring, congenial behaviors of smiling warmly, openly welcoming orientees, encouraging orientees to ask questions, and illustrating approachability are probably taken for granted by most preceptors; however, the outcomes are powerful. The orientees were less anxious around these preceptors, and they were able to be more open

themselves and asked questions to learn and were successful in their journeys. This story from Sue sums up the idea of feeling welcomed.

> I was really nervous to meet my PP, I knew that I'd be working closely with this person for the next two months, and I really wanted to be spending my time with someone who was easy going, and a good teacher, and who would be patient with me, since I am a slow learner. I knew that my preceptor could make or break my experience! My nurse manager, also had told me that my PP was very direct...this made me even more worried. But when I finally met her, I knew things would be fine. She was friendly from the start, and made me feel very welcomed on my unit! We talked over lunch and I got the feeling that being my preceptor was a big deal to her. She wanted my nursing transition to be a good one. I thanked her for her initial friendliness and things were much easier. I already was very nervous about my new job and I was not sure if I was on the right unit. But my PP helped me feel that, since I was here, that things should be the best they can be for me. The initial caring attitude of being friendly and welcoming is huge from a preceptor when you are feeling like a fish out of water on you new job (Sue's journal entry).

Uncaring behavior: not feeling welcomed. Orientees felt welcomed and relieved to know they had a preceptor who was approachable and willing to help them succeed, by being a resource to them throughout the orientation journey. However, the opposite response was also noted in the only non caring welcoming experiences shared by Annie and Gina.

> I met one of my other preceptors that I will have in a week, and I don't think he even looked up at me or greeted me. I am already becoming nervous about this OP; he doesn't seem to look anyone in the eyes and says very little...I want to keep my PP (Annie's journal entry).

> I had a new OP today and she made me very upset, I almost said something to her about it but I kept busy and things with her went a little better later on that night so I didn't say anything. She was sort of rude and abrupt when I first met her at report, I got the impression she did not choose to be my preceptor, it was just sort of pushed on her....thankfully I do not have to have her as a preceptor again (Gina's journal entry).

Annie refers to this preceptor as the "Old sergeant" throughout the rest of her journaling. The mannerisms described by these two OP are not behaviors previously

described indicating friendliness, openness, and approachability. Unwelcoming preceptors stirred up feelings of anger in Gina, and Annie became anxious and was dreading her time working with her OP. In other journal entries from Annie she describes this preceptor as the old army sergeant and stated that he made her feel intimidated and incompetent by his approach.

When preceptors were welcoming to the new orientees, they began to gain more self-confidence and an interest in wanting to get to know other staff on the unit and be included as part of the nursing team. The next section will discuss the data that delineates the caring behaviors of introducing and including orientees.

Caring behavior: introducing and including. Caring behaviors from preceptors were described by the orientees as times when the preceptor made a point of introducing them to other staff and including them as a part of the unit's nursing team. To feel included as a vital member of the nursing team, the orientees first needed to get to know the other staff on their unit. Introducing new orientees to members of the nursing staff on the units was not discussed in the interviews but was a common theme noted in the orientees' journal entries. Orientees felt cared about when their preceptors introduced them to other staff throughout their orientation journey.

> PP shows she cares about me by introducing me to the other staff as we come across new individuals (Jill's journal entry).
>
> Every morning she takes time to introduce me to the other nurses if I have not already worked with them (Mary's journal entry).
>
> I felt cared about when my supervisor took a picture of me and posted the picture with a short information sheet about me on the nursing bulletin board so that staff could get to know me better (Mary's journal entry).
>
> I was included in on all the nursing activities she performed. She also introduced me to the other nurses /staff I had not met before (Jill's journal entry).

Introducing orientees to other staff on the unit helped the orientees get to know the different persons on their units and helped the other staff get to know the orientees as well. This was the first step to feeling included and a part of the unit. It would be difficult to feel included and a part of the team if the orientees did not know other staff's names and the staff did not know the new orientees' names.

Orientees gave examples of feeling cared for when the preceptors included them in the unit activities. When the orientees felt included and part of the team, they also felt important and needed. Work became a comfortable place to be when the orientees sensed they were part of the nursing team.

> I often felt overwhelmed by all I had to learn, but knowing that I had become part of the team, and that I had other nurses to call upon and to ask questions of, helped me to realize that I was not on my own nor was I alone (Peggy's journal entry).

> After a particularly busy day on the unit, I felt a lot of love and support from all the staff working with me on this day, we were able to pull together in unison and handle the work of nursing. I wanted to give everyone a big hug and high fives (Meg's journal entry).

> I cared for four extremely ill patients today and actually made it through the day!" The other nurses were great help to me and were wonderful to help me with all of my nursing tasks. I felt like I built up camaraderie with my PP, it seemed as if we were more on 'co-worker' terms than 'preceptor-student' terms. Maybe it was just because we were so busy and collaboration was essential today but it was not so much her telling me/explaining to me what to do but rather us working closely together to get the job done (Mary's journal entry).

> I felt included in the group because there were so many other new graduate orientees on my unit and because we all were so close to the same place on our journey, I had much in common with them (Meg's interview).

> The preceptors and other staff nurses were always asking me to go to lunch with them (Meg's interview).

> I did not feel ignored when I was able to be friends with co-workers, joke around with them and feel part of the team and that this made coming to work feel comfortable (Mary's interview).

> When I felt included in conversations, this helped me to acclimate socially to the unit (Beth's interview).

Including orientees in conversations, asking them to go to lunch, and working with them as colleagues and team members helped the orientees to acclimate to the social dynamics of the unit. Building camaraderie with the preceptors and being included as a part of the team, gave the orientees a sense of security. The orientees came to realize they were not alone and that other nurses were there to help them with patient assignments and to talk over patient situations. When the orientees were able to pitch in and work hard to hold up their end of the work load, this gave them a feeling of satisfaction in their new role because they felt included, needed, and accepted by others on their units. Feeling included on the unit opened the door to deeper human to human connections as the orientees and preceptors got to know more about each other over the seven weeks.

When the preceptors demonstrated caring behaviors of advocating for the orientees, welcoming the orientees to the unit, introducing them to the guardians, and including them in unit activities, passage through many of the thresholds was made possible. As the levels of comfort and trust increased between the orientee and preceptor, there was a sharing of self that occurred at both a personal and work related nature, a caring, human to human connection. Caring human to human connections are depicted in the next stage of the hero's journey called initiation and will be discussed in more detail under the subheading of meeting of the goddess.

The last element in the departure stage is the belly of the whale. The orientees have now crossed through the beginning thresholds and are already beginning to change and grow into their new role. They have had good learning experiences and are beginning to develop their nursing knowledge and skills more fully. They have been welcomed to their units and are using their socialization skills to understand their unit's culture and way of nursing. They have been introduced to many if not all of the staff on their units and, in turn, the nursing staff on their units has gotten to know them. They have gone to lunch with others, have had conversations with others, and have begun to explore the various personalities of other staff members while other staff members have gotten a chance to get to know them on a more personal level as well. The orientees have entered into the symbolic belly of the whale and are morphing away from that new nursing orientee toward the independent, safe, and accountable nurse.

The Belly of the Whale

Like the heroes in Campbell's hero journey, the orientees have also entered into the belly of the whale and have begun the symbolic digestion which will forever change them. Once the hero plunges into the first threshold, he has committed to the metamorphosis of change. Campbell describes this as the belly of the whale where rebirth is symbolized in the worldwide womb image of the belly of the whale (Campbell, 1968). This symbolizes the final disconnect from the hero's known self and known world to the unknown self and the unknown world. As the new nursing graduate orientee plunges forward into each dark and unseeing path of the threshold, she commits at deeper and deeper levels into becoming her new self and leaving behind her role of new nursing

graduate orientee to an independent, safe, and accountable practicing registered professional nurse.

Once she has entered into the belly of the whale, she is committed and ready to learn and experience the trials and tribulations of nursing practice which includes the rigors of nursing skills, as well as the psychosocial aspects of giving nursing care. Nursing orientees need freedom or autonomy to safely learn these technical and psychosocial skills. The preceptors who continually assessed and gauged their orientees' abilities gave their orientees autonomy, and provided appropriate presence that assisted their orientees learning. Orientees delineated that appropriate preceptor presence was a caring behavior that was instrumental in assisting them to learn and develop their nursing skills. This theme of preceptor presence will be discussed in the next section entitled the initiation stage and was most predominately noted in the road of trials.

The next section will discuss Stage II of the hero's journey. Stage II includes the road of trials, meeting with the goddess, and the atonement.

Stage II: Initiation

An Overview of the Initiation Stage and the Elements

The initiation stage is the center of the story or myth and is where the action takes place. Campbell postulates that this is the favorite part of the myth for readers. It is during this stage that the rituals, tests, learning, and initiation take place for the newest hero member. It is during the initiation stage that the hero faces extreme challenges that are unique to him and make his story his own as he travels down the road of trials. In the first part of this section, I will first give an overview of the initiation stage and each of its elements contained within this stage These include the road of trials, the meeting with the

goddess, the atonement, and the ultimate boon. The second part of this section will be a discussion of the comparison of the orientees' initiation stage of their professional journey to that of the hero's journey.

The road of trials is the period of initiation, the hero must survive a series of trials and tribulations as he continues to be assisted by the counsel, amulets, and secret agents of the supernatural helper whom he met at the beginning of the journey (Campbell, 1968). The mythological heroes met great challenges and fought off many demons. They were given much instruction from their guides and helpers and therefore, the hero's gained much knowledge along the road of trials.

Meeting of the goddess represents the keeper of all knowledge. It is with her that the deepest knowledge and wisdom lie. She represents the totality of all that is known in the world (Campbell, 1968). Because the hero is on a quest for knowledge and enlightenment, meeting with her is a highlight of his story, for the goddess is the person who can help to quench his deepest thirst for knowledge and enlightenment.

It is during this time called atonement in the myth that the hero takes a good look at himself. Campbell describes atonement as at-one-ment with the self (Campbell 1991). The hero has been given advice, knowledge, and enlightenment; he now must look deep within himself and amend and readjust his ways. To receive knowledge, advice, and enlightenment means little if it is not incorporated into the soul and put to practice.

The ultimate boon is the gift that the hero obtains from his journey. In mythology the ultimate boon can be special water with magical powers, a special elixir or concoction, or other magical substances. The gift or boon can also be knowledge or lessons that will help to save the hero's town or community.

Comparing the Hero's Journey and the Orientees Journey During the Initiation Stage

A deeper look at each of these elements will now be discussed and the comparison with the orientees' journey will be included. The fourth theme of caring preceptor behaviors was autonomy with various levels of preceptor presence will be discussed during the road of trials. The fifth theme of preceptor caring behaviors was making human connections and will be discussed in the meeting with the goddess. The sixth and final theme of preceptor caring behaviors was feedback from preceptors this theme will be discussed under the element titled atonement.

Road of Trials

Campbell (1968) gives the mythological story of Psyche's quest for Cupid to better explain this element of the road of trials. Psyche had been assigned multiple difficult tasks to perform to win her Cupid. Cupid was the son of Venus who was a jealous, overbearing mother and worked hard to keep Psyche from obtaining her son (the gift). Venus told Psyche that to win her son she must first accomplish four very difficult tasks. Psyche was able to accomplish all of the tasks with the help of many benevolent helpers and guides throughout her journey. During this action packed leg of the journey, it is not uncommon for the hero to also slay a dragon or two as well as conquer momentous tasks, trials, and tribulations. Campbell (1968) declares that the dragons represent the hero's inner fears and feelings of inadequacy.

The heroines or orientees in my study also traversed an orientation path that was very challenging and offered many tests, trials, and tribulations that were extremely difficult to learn and achieve because of the rigors of nursing and caring for seriously ill patients. The orientees were able to learn and continue forward down the orientation path

with their preceptor's assistance, support, and encouragement. Orientees' significant statements revealed caring and not so caring preceptor behaviors during this element of the initiation stage. The theme that was formed during this time of their journey has been called the giving of autonomy with three levels of preceptor presence.

Orientees stated many times that they needed the autonomy to spread their wings and try to do nursing tasks and procedures on their own. Most orientees reported they learned best by actually doing tasks themselves. They journaled and stated in their interviews how excited they became when they were able to successfully hang numerous IV fluids and IV piggy back medications on a pump, change complex dressings, and other such nursing tasks. Successfully accomplishing these experiences boosted their confidence. While the orientees declared the need for autonomy, they also stated that it was these same complex procedures that caused them anxiety. Preceptors who gave autonomy to the orientees, but who were present physically and mentally made doing these scary procedures great learning experiences for the orientees. This type of caring behavior is called as autonomy with appropriate preceptor presence. Orientees declared this first level of presence to be desirable and preceptors displaying autonomy with appropriate presence were deemed to be caring preceptors.

There were other instances noted during this time in their journey where preceptors gave the orientees plenty of autonomy but were not present either physically or mentally to the orientees during this time. Orientees declared this second level of presence to be very undesirable and instances where preceptors gave autonomy with little or no presence were deemed to be very uncaring because preceptors were not physically

or mentally available. This level of presence is titled autonomy with unsafe preceptor presence.

The third level of presence noted was that of over-presence, which was sometimes described as "hovering" by the orientees. When preceptors performed all of the tasks and allowed orientees minimal or no autonomy, the orientees struggled to develop their nursing skills. Orientees have also deemed these preceptor behaviors of over presence as non-caring and this level of presence is noted to be preceptor over presencing, because little or no autonomy was given to the orientees experiencing this. All three levels of autonomy and preceptor presence are discussed in the following paragraphs.

Autonomy with appropriate preceptor presence. The orientees found difficulty in learning all the different nursing tasks and dealing with the many trials that accompany seriously ill patients and their families. The orientees wanted to have the autonomy to strike out on their own and learn what it was like to be a nurse, but they also needed to be reassured that the preceptor would be there to prevent them from making mistakes that could harm the patient.

The first level of preceptor presence was identified as times when the preceptors gave the orientees autonomy and were available to the orientees both physically and mentally. Preceptors offered their physical presence to help the orientee with actual nursing tasks and procedures as the orientees needed. The preceptors were also available mentally to answer questions, teach the orientees, and check on their work. Orientees indicated they needed the preceptors to assess and gauge the amount of autonomy they should have as well as to act as a safety net for the patients and the orientees to prevent

orientees from making mistakes and avoiding patient harm during their fledgling attempts at independence.

> My preceptor was very supportive and watched me closely to make sure that patients received what they needed and would not be harmed by my cares (Liz's interview).
>
> My preceptors continuously gauged my abilities throughout the day and kept checking on me. I knew they were available and I felt I could always ask for help...I never felt abandoned (Meg's interview).
>
> For the new orientee, autonomy can be scary, intimidating, and lonely at first, but knowing the preceptor is there as a very close backup for questions allows the orientee to grow in her independence and helps her to realize she does know what she is doing and can be a competent nurse (Beth's interview).
>
> The preceptors should be like a safety net for the orientees and catch them if they fall. I want and need to do things on my own in order to learn, but I need the security of knowing that my preceptor is keeping an eye out for me so that the patient will not be harmed as I learn about being a nurse (Jill's interview).

Caring preceptor and orientee interactions occurred when the preceptors gauged and assessed the orientees' capabilities and were supportive of their needs. Preceptors were vigilant and attentive throughout the shift observing interactions between the orientee and patient. The preceptors acted as a safety net to catch the orientees' falls thus protecting both the orientee and the patient from harmful mistakes.

Meg had an experience or tribulation during her orientation period when her patient unexpectedly took a turn for the worse, had a cardiac arrest, and later died. Her interview relays this very scary incident.

> My patient just coded on me all of a sudden...it was totally unexpected. I called for help and everyone came running in and then the code team came and just took over. I was pretty upset, and my colleagues noted this right away...you get to know these patients because they are in and out of the hospital due to being chronically ill. After my patient died, my colleagues cared about how I was doing and took me to lunch to get me off of the unit. They helped me debrief about the incident. They told me I did not do anything wrong and that eventually all nurses lose patients if they are a nurse for very long. I really felt cared about because I

> was never alone when my patient coded, everyone just rushed in and helped me deal with the situation. The incident ended up being a very good learning experience because I knew that I had not done anything wrong and my preceptors explained what happened to my patient (Meg's interview).

This story told by Meg is a great example of preceptors and staff nurses being available and present both mentally and physically for an orientee. Meg's preceptor and the nursing staff certainly were available and present for her physically when they rushed into the room and assisted with the emergency needs of the patient's cardiac arrest. Once the patient's emergent needs were over, her preceptor assessed and gauged Meg's emotional needs, and she and some of the staff nurses took her off of the unit for lunch. They were there for her mentally as well as they let Meg talk about the incident (debrief) and gave Meg reassurance that she had not done anything wrong and that patients on this unit were extremely ill and frequently died. Meg was able to ask questions and learn more about the situation and from a very frightening incident.

Jean gives another example of a preceptor who is continually assessing and gauging the orientees' level of autonomy and is providing the correct amount of presence. The following journal entry by Jean demonstrates the trials of caring for a critically ill patient.

> Today I was with my PP and our unit had a very critical patient who had been flown in via the helicopter from a terrible car accident the previous night. I asked my PP if we could care for this patient. I knew I was not ready to take care of such a complex patient by myself; however, I thought it would be a great learning opportunity. My PP asked me if I was sure I was ready for such a difficult patient assignment, and I told her I knew I was not ready, but I'd like to watch and learn how to take care of a patient with such complex issues. We ended up having a great night and with her help and teaching, I learned so much! The next day, my PP and I continued to care for this patient, and it was nice to have continuity of care and watch the patient progress. The next day my PP and I once again took care of this patient...I was gaining more confidence in caring for this patient and my preceptor backed off, gave me more autonomy, and let me do more and more

> cares. It was exciting for me to be able to perform skills and assessments on my own. I was able to care for this patient on my own with my preceptor checking on me and assessing my nursing abilities. The next day I was to be with an OP because my PP was going on vacation. My PP told this OP to assign me with the same patient we had the last three days and to have me care for the patient on my own and to only use the OP as a resource. This made me feel like a competent nurse, and my PP showed me she cared by verbalizing confidence in my ability to care for this patient on my own (Jean's interview).

In this example, Jean was able to care for a critically ill patient with the confidence and security of having her expert preceptor available to help her, and side by side the preceptor worked with her to teach her about performing the many complex skills required. As Jean grew in her confidence and abilities, the preceptor backed off slowly and gave her more and more autonomy while being close by for her physically and mentally to continue to answer questions that came up. In the end, Jean was able to care for this very ill patient with very little assistance from her preceptor or the other staff nurses.

Giving the orientee space and autonomy to really learn and experience nursing was a common thread echoed in many other journal entries. Being able to do things with the security of the preceptor being there to keep close tabs on the orientee and back them up when needed is a strong theme noted throughout the many orientee journal entries.

> I tried to be as independent as possible, but I still needed help from OP. OP showed she cared by pushing me beyond my comfort level and allowing me to branch out on my own. She was there to break my fall but I yet I could still be independent. It was a good day because I now have more faith in my self and what I can handle and I also know more specifically what areas I need to focus on and improve. My PP also gives me room to branch out on my own but she is right there when I need to ask a questions. For example she will sit outside the room while I care for the patient but when I have a question, all I have to do is turn toward the door of the patient's room and say her name and she is right by my side to answer my question. This boosts my confidence by allowing me to do as much as I can on my own (Jill's journal entry).

My OP is a fantastic person to work with because she was always available for me but also gave me the space I needed to do lots of hands on nursing, and this is good for nurses because we are so hands on (Liz's journal entry).

I felt my OP was very helpful to me. She helped assist with things, but I didn't want her to help me too much because I need to do everything on my own (Gina's journal entry).

I have decided my PP really knows me and understands my needs and work style. She is quietly insightful when she steps back and gives me space to work, I know I am not entirely alone and that she is always nearby watching over me (Mary's journal entry).

My PP pretty much let me be autonomous today and the evening went really well, it boosted my confidence, I still have lots of questions but I feel like I am where I should be in terms of orientation (Meg's journal entry).

My PP will be back from vacation tomorrow and I am really glad because I like her style of precepting the best. She checks up on some of the things I do, but she also gives me space to work on my own and ask questions as needed (Gina's journal entry).

My OP as always was very supportive and consistently asked me if I needed help or had any questions, I remained autonomous and I did not feel watched over (Meg's journal entry).

My PP is so helpful and is always checking to see if I need help or have any questions. I feel very comfortable going to her with questions (Gina's journal entry).

I was with my OP today and we had two patients. She was very nice and let me just go about my day with her being available to me for questions and issues, this helped me form somewhat of a routine for myself without feeling like someone was breathing down my back and critiquing (Liz's journal entry).

I felt independent today but I like the security of my preceptor because she has my interest in mind. I am going to think of her as a resource though and not a crutch (Peggy's journal entry).

Today was a good day! I had a different OP and she did a great job. She was very helpful, but didn't stand over my shoulder and make me nervous (Gina's journal entry).

Preceptors who constantly assess and gauge the orientees' capabilities as they traverse this professional journey together are able to give autonomy with appropriate levels of presence. Insightful preceptors give the orientees space to do hands on nursing, yet are available physically to assist the orientee and mentally to answer questions without being obtrusive. They provide excellent opportunities for learning. Orientees feel secure and confident when they know their preceptor is close by checking their work, keeping up to date on their patient's progress, and acting as a safety net to avoid patient error. Feeling confident and secure allows the orientees to learn more because they are able to do and experience more. The orientees' confidence is boosted and they gain faith in themselves as they build on their nursing skills, and they begin to see they are capable of being independent, safe, and accountable nurses.

Orientees do not always have these feelings of confidence and security when preceptors are not mentally or physically present. Uncaring preceptor behaviors exhibiting autonomy with unsafe preceptor presence will be discussed in the next section.

Autonomy with unsafe preceptor presence. Not being present and available for the orientee was characterized as uncaring by many orientees. While the first type of presence, autonomy with appropriate levels of preceptor presence was described as just right, this type of preceptor presence was almost non-existent. The preceptors did not constantly assess and gauge the orientees' needs, did not teach the orientee, did not keep up to date regarding the patient's conditions, did not keep a check on the orientees' work, and allowed orientees to make serious mistakes. Autonomy without appropriate preceptor presence was devastating and distressful for the orientee.

When the preceptor was not present to act as a safety net for the orientee and the patient, serious mistakes are made. The following significant statement from Jill during her interview demonstrates how quickly autonomy can turn from experiences of exhilaration to experiences of trepidation.

> The orientee needs autonomy to learn the RN role. She does not need preceptors to be hovering and in her face, but to be there, to check on her work, and keep up to date with the patients and act as a safety net for me and the patients. Give me a chance to see if I remember to give those medications or do those treatments and if I have not done these things in a timely manner, then ask me, hey Jill, are you going to give those meds today? Don't let the patients suffer just because I am learning. My preceptor was not present physically or mentally to teach, assist, and observe me, thus I was given full autonomy without any kind of safety net, and I made some terrible patient mistakes. I did not even know about many of the things that I should have been taught and needed to know in order to care for this patient...I was devastated when I had to call the event line! This caused me a lot of distress and made me wonder if nursing was the right career choice for me. I had always heard that orientation was not over until the orientee cried....and I had definitely been crying because of those experiences with one non caring preceptor. I went home that night and told my husband that I did not know if I could come back to work on this unit (Jill's interview).

This example from Jill demonstrates that new nursing graduate orientees need continuous surveillance and assessing from their preceptors because many times they do not even know what they do not know. In the above example, Jill made a serious medication error and had to call the event line to report the error which then determines through a systematic process the seriousness of the error. To give a new orientee full autonomy without preceptor presence is very uncaring and leads to decreased confidence and increased anxiety for the orientee. Uncaring interactions such as this one described by Jill causes the orientee to question her choice of nursing as a career, and to have consternation about coming back to work as a nurse on this particular unit.

Time was a major factor in the following journal entries. When the preceptors were not available physically or mentally to answer questions and teach orientees due to

time constraints, the learning slowed or stopped for the orientees. Feelings of frustration and dissatisfaction with orientation are apparent in these journal entries.

> I had three patients tonight, I felt rushed and like I had no time to discuss anything...as the days go on, I feel more and more frustrated and more and more discouraged (Liz's journal entry).
>
> I have almost given up on the chance to actually sit down and read over orientation materials. I tend to learn best in reading, then going out and figuring it out on my own, but my PP never seems to have time to go over the teaching materials (Mary's journal entry).
>
> I have noticed that my preceptors sometimes are helping the float staff or nursing students when I could use their time (Annie's journal).
>
> I need help! Although I ask questions no one is answering them and I bumble around like an idiot, heck I practically had to beg her to teach me about the simple scheduling and PTO (Mary's journal entry).
>
> My preceptor has little time to show me or teach me about anything and this is very frustrating to me, I got in my car tonight and cried on my way home (Annie's journal entry).

Teaching new orientees takes time, but in the examples above the preceptors are not taking the time needed to teach the orientees. Some reasons for the time constraints include preceptors who are too busy teaching the float staff or nursing students, and heavy patient assignments. Orientees are asking questions but no one is listening and answering those questions. Learning opportunities are being missed when preceptors cannot be or choose not to be present for the orientees.

Beth and Mary express thoughts of abandonment in the following interview and journal entries. When preceptors are not checking on the orientee and the patient's status the orientees are left in precarious positions that could ultimately be devastating for them and their patients. Feeling frantically abandoned by a preceptor does not feel like caring by either Beth or Mary. I think Mary says it best as she shouts out in her entry below.

> When the preceptor is giving lots of autonomy, but is not frequently checking on me or the patient's status, and I am asked to perform emergent procedures by the physician that I have never done before, I felt frantically abandoned (Beth's interview).
>
> Today was the third day this week that I have stayed over time. That is OK with me except my OP did not stay over with me and this made me quite upset. It was a very busy day and I was assigned three patients while my OP had one. In my opinion, my OP should therefore be first and foremost available to me as a resource then to help out other people on the unit. There was a celebration on my unit and there were lots of treats in the back room. It seemed many times I was the only nurse out on the unit, and I was running around and answering lights and trying to take care of my own three patients. To top it off, my OP asked me to give the 2:00 medications for her one patient at 3:00. What really showed me she didn't care too much about how I was doing was the fact that she left at shift change without even saying good-bye or letting me know she had left! She had told me she was going to check my charting at the end of the day but she obviously had not because I caught several things I had not charted. I felt like I was left with chaos and that she had totally abandoned me. Overall, it was a highly stressful day too and I would have liked to have talked to someone about it and how to deal with patients who have just gotten bad news about their diagnosis...but she was not there. My advice to preceptors would be: NEVER LEAVE YOUR ORIENTEE WHEN THE JOB IS NOT DONE!! THAT SHOWS A LACK OF RESPONSIBILITY AND CARING (Mary's journal entry).

Wanting to quit and not come back to continue one's professional journey or feeling "frantically abandoned" as well as feeling extremely frustrated and discouraged because your preceptor won't or can't take time to teach, clearly illustrate that preceptor behaviors are very powerful when they are perceived uncaring. It is during these times that orientees question their reasons for choosing nursing and are scared and think about not coming back to work. I believe the orientees are working on slaying their psychological dragons during this phase of the journey. Preceptors should be available physically and mentally to assist them with the slaying of the dragons of frustrations, discouragement, lack of self confidence, and fear. The preceptor interactions described in the above uncaring episodes lead me to think the preceptors are on the dragon's side of the battle instead of on the orientees' side.

The orientees described the opposite of lack of presence from their preceptors; the next section will discuss the data that emerged indicating over presence from preceptors. Over presence from preceptors was delineated as an uncaring preceptor behavior leading to uncaring interactions between the preceptor and orientee.

Preceptor over-presencing. Orientees described examples of over presencing from preceptors when the orientees sensed that preceptors did not take the time to gauge and assess their abilities and went ahead and did everything for them, repeated their work, or watched their every move. This over-presence is described by two of the orientees as a hovering type of presence. This type of hovering presence was frustrating for the orientees and made them nervous. Looking over the orientee's shoulder as if she does not know anything and giving instructions like a drill sergeant was very upsetting for the orientee.

> My PP is constantly hovering around me...she is a hovercraft and this makes me very nervous and I perform poorly (Mary's journal entry).

> My OP is very nice but she sort of hovered all evening, she did tell me that I am doing well as a new grad so that was encouraging (Meg's journal entry).

> She followed me into the first patient's room and stood over my shoulder basically while I did my assessment. The patient was a 28 year old man and he had three family members in the room. The OP stood there and told me how to do my assessment such as to check bowel, heart and lung sounds. She made me upset because, no I am no longer in nursing school, and yes I know how to do an assessment. She was very belittling. She also made comments to do other things that I already knew how to do so to the patient and family it looked like I didn't know anything. Instead of allowing me to give patient care and ask questions as needed, she followed me around for everything (Gina's journal entry).

Orientees felt like they were back in nursing school when the preceptor stood over their shoulder and told them every move to make. Over presence by preceptors caused orientees to feel belittled, stupid, and embarrassed in front of patients and families.

The following significant statements from Annie and Gina demonstrate more instances when preceptors did not take the time to assess and gauge the orientees' capabilities and went ahead and did nursing tasks that orientees felt they were capable of doing. This was frustrating for the orientees because they felt they needed to do these things in order to learn and grow.

> During report we may be informed about things that need to be ordered for patients such as a cot for a family member or TED stockings, and just when I am about to order these things, my preceptor states that he has already done so even when it was for my patient. I need to do these things! Sometimes I feel like I am being babied or he is trying to show me just how capable he is. Here is an example: a nursing student was supposed to hang an IV medication with her instructor but this preceptor went ahead and hung it early...knowing the student was planning to do it. He told me he was not going to wait around for some nursing student, he had other things to do....I guess this is probably his attitude toward me as well (Annie's journal entry).

> I wish she would have let me process some of the orders, as I need more experience with that, and other things such as changing PCA medications. I think the preceptors often do these things without thinking about teaching it to the orientees because they think it is either helping us out or it will take too much time, or the orientee must know that already (Annie's journal entry).

> She called the doctor on my patient who was shivering uncontrollably, I should have been the one to handle that and she took over...I was really frustrated! My three patients were busy and my OP drove me crazy, following OP makes me look forward to being done with orientation (Gina's journal entry).

It was very frustrating and demeaning for the orientees when the preceptors stepped in and did things for them that they felt they are capable of doing. Orientees felt like they were being babied, the preceptor did not want to take the time for the orientee, or the preceptor thought she was incapable of doing these things herself. These actions from the preceptors slowed down or stopped the learning process because the orientees were not allowed to actually do and experience these learning opportunities.

Gina gave examples of when her preceptors felt they needed to re-do everything she had previously done. This redoing of everything the orientee had already done made the orientee quite upset and mad. Gina stated that she felt these uncaring preceptor behaviors were demeaning to her and unnecessary for the patient.

> Today I worked with a new OP and I kind of got annoyed with how she double checked everything I did. I kind of felt like I was back in school. She would do assessments right after I had done them (Gina's journal entry).

> For the first four hours, my patients had just about everything done to them twice. I assessed them, did routine checks, asked them about their pain levels, and when I came back in the room, my OP was doing the same things all over again. This made me mad because it was unnecessary. I only have one week left of orientation, I need to do things on my own and she doesn't need to check up on me like that (Gina's journal entry).

It was very distressing for the orientee when preceptors unnecessarily repeated the work that orientees had done such as redoing the patient's vital signs and routine checks. It was annoying for the orientees because rechecking and redoing these various nursing tasks was unnecessary and can be taxing for patients who are already very ill and in pain after their surgeries. Orientees felt they were back in the role of dependent nursing student and they were not able to learn from these preceptors because the orientees were too frustrated and angry.

Orientees felt the preceptors did not trust them or lacked confidence in them when they did not allow them autonomy. Running around behind a preceptor all day or just being able to observe instead of actually perform patient cares made the orientees feel that they were regressing instead of progressing in their orientation journey.

> She gives me the direct sense that she does not have confidence or lacks trust in my abilities of being a nurse (Mary's journal entry).

> I felt like my preceptor was treating me like a small child, like I had never seen a hospital before, instead of progressing, I felt like she was regressing me. I feel

> like she does not care about me when she holds me back and does not try to help me to advance in my nursing practice (Mary's journal entry).
>
> Today I was with another preceptor. This preceptor was a very experienced nurse who has been on the unit for a long time. I felt like I was chasing her around all night and just observing her, it is difficult to feel so competent one day and completely helpless on the next day (Jean's journal entry).

Nurses learn by hands on types of experiences and need these in order to gain experience and build confidence, running around behind a preceptor all shift did not allow for good learning opportunities. When the orientees felt capable and self confident in their work one day and were treated like a small child who knows nothing and has never seen a hospital the next day it was understandably very frustrating for the orientee. Orientees concluded that such actions by preceptors demonstrated that the preceptors did not care about them, trust them, or lacked confidence in them.

Liz talked about over presencing by her preceptors. Liz explained that she felt it was due to the fact that she had a total of seven other preceptors (OP).

> It was just so overwhelming because every day you go to work, you feel like you are starting over new and you don't feel like you can progress and continue because people don't know you, and you don't know them, so you always feel like you are starting from scratch (Liz's interview).

When preceptors hovered or over presenced with the orientees, it was usually due to the fact that the preceptors had not taken the time to assess and gauge the orientees' abilities. However, in this case the preceptors were not with orientees long enough to get to know the orientees capabilities, learning styles and learning needs. This type of over presence from preceptors was noted when orientees had many associate preceptors, unfortunately this was the case in several of the orientees experiences.

Over presencing by the preceptors was frustrating for orientees and made them feel that the preceptors did not trust them to become independent, safe, and accountable

professional nurses. It was not unusual for orientees to feel vulnerable and emotional during this time of their professional learning and when they were getting signals that their preceptors did not trust them it added to their distress. Over presence by preceptors was the source of many negative feelings from orientees such as frustration, feeling demeaned, angry, not trusted, dependent, and stupid. These emotions were strong and showed that preceptors who over presenced with orientees caused many uncaring interactions to occur. Orientees who experienced numerous associate preceptors understood more clearly why preceptors did not feel comfortable giving them much autonomy, but it was still frustrating for them as they were not able to do much and thus missed numerous learning opportunities.

When preceptors spent minimal time with the orientees, they did not get to know them on a more personal level, truly understand their learning styles, wants and needs and thereby connect with the orientee at a deeper level and build rapport with the orientee. Making these deeper human to human connections was found to be extremely important from the orientees' point of view. The next section will depict the correlation between the mythological meeting with the goddess as described by Campbell (1968) with these deeper human to human connections that were made between orientees and special preceptors.

The Meeting with the Goddess

As the hero travels on his journey, he meets a woman of great power termed a goddess by Campbell (1968). This goddess usually has something vital he needs such as great wisdom or a special supernatural device that is imperative for him to face his greatest challenges along his journey. The Goddess will give the hero what he needs if he

first proves to her that he has a "gentle heart or a gentle sympathy" (Campbell, 1968 p.118). Campbell illustrates this type of meeting with the goddess when he refers to the tale of the five sons of the Irish King Eochaid. These five brothers were out hunting and subsequently become lost, hungry, and very thirsty. The brothers soon find a drinking well that was protected by a haggardly looking lady who asked them for a kiss in order to obtain a drink from the well. The first four brothers adamantly declined to give her a kiss but the fifth brother told the old haggardly looking lady that he would not only give her a kiss but that he also would give her a hug! The sons get the much needed drinking water to quench their thirst, and as a bonus, the haggardly looking old lady turns into a beautiful goddess, and she and Niall are married (Campbell, 1968).

The analogy of this myth with my orientees' journey is that they also make a special connection, not with a goddess but with one or more special preceptors. This section will explore the preceptor's caring behaviors that led to caring human connections. These caring human connections with a preceptor served to enrich the relationship from that of student-preceptor to mentor, role model, or in some cases friend. I will now present the data to show how preceptors and orientees made these caring human connections during the initiation stage of the meeting of the goddess.

Taking the time to connect with orientees. These special preceptors demonstrated the usual caring behaviors previously described, such as advocating for the orientee, welcoming her to the unit and including her as an important part of the unit's nursing team, as well as allowing autonomy with appropriate presence. However, these particular preceptors (goddesses) went beyond these usual caring behaviors and took extra time with the orientees to make sure they understood nursing interventions and procedures and

took time to get to know the orientees' learning wants and needs. When the preceptors took this extra time with the orientees, the orientee and preceptor relationship blossomed into a deeper and more meaningful connection such as mentor, role model and even friend. The following journal and interview entries demonstrate the importance of preceptors taking the time to connect with them at a deeper level.

> I worked with my OP today and I love her. Although my PP is great, I felt the OP and I connected better and was more similar in personalities. She is awesome, she took time with me to go over the procedures that frequently happen on the floor and this was extremely helpful and gave me more confidence with my patients cares (Mary's journal entry).
>
> Today I was with my PP and she took time to go over prioritization and discussed our patients in great detail. I found this to be extremely helpful because this information gave me more confidence in caring for my patients (Jean's journal entry).
>
> My OP took extra time today to explain the roles and relationships of the people's titles outlined in my orientation booklet. She purposefully took the time to come back where I was sitting to continue to go over things to help me, for example, the correct way to do certain procedures and things (Beth's journal entry).
>
> I felt cared for today when my OP took time to just be with me and make sure I was meeting my appointed learning objectives. When she sought me out to see if there was anything she could do for me this made me feel like we were a team rather than a teacher and student (Sue's journal entry).

Preceptors at the goddess level did not hesitate to take the extra time that was necessary to make the orientee feel special and a part of the nursing team. These preceptors made sure the orientees were heading down the right path in obtaining their learning objectives. These preceptors did not hesitate to actively seek out the orientees and work with them in such a way as to boost their self-confidence.

Excellent communication and listening skills. These preceptors (goddesses) had excellent communication styles and listened intently to learn how the orientees learned.

These preceptors were able to teach the orientee in a non-threatening manner and orientees felt like they were not inferior to the preceptor.

> This one preceptor that I connected with asked me one question that none of the other preceptors asked me, she asked me how I best learned and this opened up the communication between us and I was able to discuss how I best learned (Liz's interview).

> My PP took the time to teach, explain and ask me questions so that she knew I was learning, she taught me in such a way that I felt her equal, she understood that explaining and teaching all the time is caring because orientees often do not know what they don't know, learning what questions to even ask is a process itself (Sue's journal).

Connecting with the orientees at their educational level, and trying to understand how they learned and what was important to them versus telling them if they had questions to just ask, was especially caring to the orientees because they often times did not even know what questions to ask.

Taking a genuine interest in the orientee. When the preceptor took a genuine interest in getting to know the orientee, this helped to build trust and a subsequent deeper connection where the orientee looked upon the preceptor as more of a role model, mentor, or even a friend.

> I think my PP and I are developing more of a personal rapport, we are carefully finding out more about each other without prying, I admire her and hope I know as much as she does after two years on this floor (Peggy's journal entry).

> I felt cared for when my preceptor asked me if I wanted to be a substitute volley ball player for the league she plays on, It made me feel more accepted than just being her apprentice...like we can possibly be friends outside of work (Mary's journal entry).

> I admired these preceptors and felt the preceptors had become a role model for the kind of nurse they would strive to become (Journals entries of Jill and Peggy).

> My PP and I had two patients today. I noticed that I was a little hesitant about making sure that I was doing things correctly and I was constantly asking my PP to check things and to help me with things. I think she could tell that I was nervous today. She helped me without mentioning my nervousness. She is always very calm and collective and is an excellent role model (Jean's journal entry

> When my preceptor asks me how I am doing, she really wanted to know...*how I am doing* (Jill's interview)!

> Just she and I ate lunch together today and I could have sat and chatted with her all day. She made me feel like she was really interested in my life outside of work by asking questions and relating to me. Even though we do not a have a lot of similarities, she made me feel like there were plenty of commonalities to start a basis for a friendship. When someone shows an interest in my life outside of work that is the best way anyone can show they care! When the other staff and preceptors include me in their lives, including me in conversations about life outside of the hospital and asking about my life...joking around etc, that stuff makes me feel cared for and accepted much more than having someone demonstrate site care! (Mary's journal entry).

These goddess level preceptors took a genuine interest to discover more about the orientees' personal life and goals. Preceptors went out of their way to build personal rapport with the orientees and the orientees admired and loved these co-workers. Orientees looked up to these preceptors as role models and even friends. As the trust was being built between the orientee and preceptor, a deeper and caring human to human connection continued to grow and there was a sharing of selves, humor and the unwritten rules or the unit's culture.

Sharing of self. These first three significant statements gave examples of a sharing of self that occurred between preceptors and orientees when caring human connections were made.

> My PP confided in me about the obvious distress she was experiencing in dealing with her mother who was suffering from the ravages of metastatic breast cancer. I listened to her and understood her distress; my own mother went through the same struggle 5 years ago (Annie's journal).

> When one of my patients had his life support mechanisms discontinued, my preceptor took me aside and sat down with me and talked about his approach to death as a nurse and gave me pointers on how to come to terms with this part of my job (Beth's Journal entry).
>
> My preceptor often shared with me what her personal tricks are that have worked well for her in the past in regards to organizing and implementing cares and this meant a lot to me, these are survival skills! (Jean's journal entry).

Sharing of self on a professional basis was indicated when preceptors shared important nursing survival skills. Survival skills ranged from "tricks" or strategies for organization of patient cares to helpful hints when learning to deal with critically ill and dying patients. Sharing of selves was also indicated on a personal level, and preceptors and orientees were able to share common events in their personal lives.

Sharing of humor and nursing stories. Sharing of humor and nursing stories occurred when these trusting, relationships were formed. These statements demonstrated how humor and positive attitude were so vital and decreased stress, on busy days and during stressful times.

> I always have a comfortable feeling when I work with PP because I know that no matter what our assignment or how crazy it gets, we will make it through together, and we will manage to have a good laugh or two to brighten the day (Jill's journal entry).
>
> My PP is by far my favorite preceptor; she puts a positive spin on the beginning and end of each day. She always stays upbeat and positive even on difficult days. Sometimes her humor is a bit cynical and sarcastic when things are crazy, but it is not directed at anyone and I am right there with her, we are just joking around and this really helps release the tension and helps me not take things too seriously (Peggy's journal entry).
>
> My favorite PP was a lot of fun to work with; she made me laugh which kept me from being too serious, I have a tendency to be too serious when I am trying to learn new things (Sue's journal entry).

Annie journaled about an episode when she went to give a patient an injection with one of the new safety heparin syringes and the heparin squirted out all over the patient's IV pump that was next to the patient's bed.

> I felt so embarrassed but my OP gently laughed and told me it was alright and that the same thing had happened to her several times before, this was so important for me to know that this was a common mistake (Annie's journal entry).

Jean described a comical episode in her interview; she did not have her stethoscope on the patient's stomach when she reported to her preceptors that she could not hear the typical whoosh sound when she was listening for NG tube placement. The two preceptors then pointed to the bell of the stethoscope hanging freely around her neck and all three of them got a great chuckle out of this. I asked her how it made her feel when she and her preceptors were able to laugh about things and that it was OK to not be perfect.

> I think if they had not laughed I would have felt very stupid but the fact that they did laugh made me laugh. Those kinds of things are humorous but I felt if they had not laughed, I would've felt very intimidated every time that I would be in a room with them, but to be able to laugh about it kind of broke the ice (Jean's interview).

Jill summed up her thoughts on how humor made work much more bearable when she described in her interview how working with her favorite preceptor who had a wicked sense of humor, and was able to laugh and not take herself too seriously, made coming to work tolerable.

> Even though it is very hard to get out of bed at 5:20 AM to make my 6:10 bus, at least I had the encouragement that I would be working with my favorite PP (Jill's interview).

Humor helped to release stress during busy days and stressful events. This is vital in the nursing profession as stress is a major part of the nurse's daily world of practice.

Preceptors who were able to share some of their own silly stories with the orientees reassured the orientees that it is OK to be human.

Sharing the unwritten rules. Preceptors and orientees who make a connection are able to discuss some of the unwritten rules of the units and the medical center. Jill and Peggy discussed how they connected with preceptors who explained some of the unwritten rules, which are a part of the unit's culture.

> Unwritten rules are those rules that no one has written down anywhere, they are the rules that are second nature to nurses who have been on the unit for some time (Jill interview).

> I began feeling comfortable enough to ask more about the 'rules' of the floor. In other words, how long is a lunch break, how do holidays work; I did not want to be too pushy with this initially (Peggy's journal entry).

Communicating with the doctors was portrayed as one of the unwritten rules described by the orientees. Mary and Jill found all the different levels of doctors in this institution to be confusing and knowing which one to call and basic communication skills with doctors at the institution to be a bit overwhelming. Jill talks about this in her interview.

> I met with my favorite preceptor one day and told her that I was really frustrated because there's all these unwritten things that I don't know about, because we have so many different surgeons that we work with, and you just don't know this stuff until you get chewed out one day and....I am trying to prevent that! So I just said....tell me stuff you don't think of usually to tell people..... and so we just sat there for like an hour and talked about just you know the random little tidbits that are very important things but no one has not written them down and nobody bothers to tell you just because it is so second nature to them that they don't think about it so she was willing to take time to tell me about that stuff (Jill's interview).

Mary echoes this frustration of which doctor to call when a patient needs something. Her experience with these unwritten rules and the genuine caring support of a

nurse educator who went out of her way to connect with Mary gives the reader a clear idea of how important it is for these deeper caring connections to take place.

> I paged the general number last night on my shift well and I got a consultant and when I hung up and the preceptor asked me who I was talking to and I said so and so and the preceptor said, you paged the consultant? Well, he was the one on call. What else am I supposed to do? It is like the consultant, you never call him, then what is he there for? But people I am realizing that the nurses just have this thing about the consultants, and I am realizing that the last straw is that if you call them the patient is dying then you can call them. I feel like I can talk to a doctor because he is in the same level as me and we are working together. I feel like there is a gap between that, here and we're on a different level than them. My nurse educator shared something with me that I thought was good advice. I was under the impression that if I needed something ordered, I needed to get the doctors to first think that they're coming up with the idea themselves not me..like to suggest it and then they feel like it is their idea and that they are brilliant because they came up with that idea. But my nurse educator told me don't EVER think that....you just take a stand for yourself and the patient, and if you think there is something that you need to have done make sure they know that it is your idea. Prior to coming here I thought I could share my ideas with a doctor that I am working with but when I came here I was like ooo scary! She really helped me out one other day too with the doctors, I had a patient I was going to call a code on him and she happened to actually be there to experience with me the dialog between me and the doctor, and later she came up to me and reaffirmed me you know you said everything you needed to say He was not listening to you just stick to your guns and you did not do **anything** wrong in there. Wow, that was just so very important for me to hear that from her (Mary's interview).

These are good examples of preceptors sharing some of the rules of the unit's culture that are not written down anywhere. Orientees did not feel comfortable at first asking about many of these more intricate rules and did not want to appear too pushy. Orientees have also given examples regarding nurse and physician communications which is another one of the unwritten rules of nursing. Orientees do not usually communicate very much with physicians while in nursing school. If a patient takes a turn for the worse, the instructor or staff nurse steps up to the plate and calls the doctor. Larger teaching institutions such as this medical center have many levels of doctors, and it can be quite confusing when

trying to understand which doctor should be called. Difficulties with nurse and doctor communication can be a scary interaction when new nurses are so vulnerable and unsure of themselves. The statements above illustrate examples where preceptors took time to support and explain some of these unwritten rules of nurse and doctor communications. They are symbolic of the goddess passing on the "secrets" for survival of the journey.

Opening up the lines of communication. The outcomes of these genuine caring human to human connections that were made between the preceptors and the orientees were extremely positive. Lines of communication were opened up between preceptor and orientee and the orientee was able to learn more, to better receive feedback and actually provide improved patient care.

> Because I felt so comfortable with my preceptor, I was able to open up and freely discuss patient related problems; this in turn helped her to provide better patient cares (Jean interview).

> I think by being more connected to her... I think that opens the lines of communication to a better level of understanding cuz you know there's that initial wondering if she will take this or take that too personally. When there is that more open.... not threatening ground I think that it allows the relationship to develop you know. That doesn't mean that you're going out together all the time after work but that I have a level of personal connection, and I think it allows better communication. It made me feel more comfortable I would rather be able to communicate openly with someone (Peggy's interview).

Making human caring connections supported the flow of communication between preceptor and orientee and this in turn allowed the orientee to feel freer to discuss concerns and to ask questions that would eventually improve patient cares. These closer connections also supported a non threatening environment where feedback could be taken and given without it being taken too personally.

Going above and beyond the ordinary caring behaviors, goddess type preceptors took the time needed to listen intently to the orientees and discover their work goals and

get to know their personal goals and life values. They were genuinely interested in the orientees and when they asked them how they are doing, it is because they truly wanted to know how things were going. These preceptors have learned the importance of good communication styles and active listening which opened up the lines of communications between the orientee and preceptor. When the lines of communication were open and the orientees felt like they could discuss patients and their concerns in a non threatening environment, they were able to learn more, better receive feedback and thus improve the cares they gave their patients. These preceptors became role models, mentors and sometimes friends. There was a sharing of self, stories, and humor that took some of the stress out of a stressful busy day. When orientees had to get up early and come to work on busy, stressful units, they knew it would be OK if they were working with preceptors who had positive attitudes and a good sense of humor. Teaching about some of the more sensitive customs, cultures, and unwritten rules were made possible when the preceptors took the time to connect with the orientees and form these caring connecting relationships. Preceptors, who have made caring human to human connections with their orientees, were instrumental in helping the orientees develop and grow into independent, accountable, and safe practitioners of nursing.

Orientees have thus far been welcomed to the units and preceptors have advocated for them and included them in unit activities. They have successfully survived some of the trials and tribulations of their journey and many have met those special goddess type preceptors that have given them vital information and advice. Taking the advice or feedback given them by all of their caring preceptors and changing and amending their way of doing nursing in response to the feedback will be discussed in the next section.

The impact of caring preceptor advice and feedback and the analogy of the element of atonement as described by Campbell will be explored.

The Atonement

In the hero's journey, the stage of atonement or the making of amends has similarities to the caring behaviors of feedback in my study. There is a myth that Campbell (1968) discusses that I think has similarities with the journey of the orientees. Twin boys set out on a journey to go and meet their father, the Sun, for the first time in their lives. As the twin boys eagerly set out on the journey to find their father, they soon met the Spider Woman. The Spider Woman helped the boys by giving them her sage advice, charms, and amulets. After successfully crossing four different thresholds and victoriously managing all the trials and tribulations set before them, they came to the threshold of their father's door. This door was guarded by two bears, but because they had listened and learned the words of the Spider Woman, they were able to make the bears lie down, and they entered into their father's home. The twins were then threatened by serpents, wind, and lightening upon entering their father's threshold, but because they had learned and espoused the prayers that the Spider Woman had taught them, all these threats were appeased. When their father the Sun threw them into the air, they held onto their life feathers as the Spider Woman had instructed them. After a few more trials that the twins were able to overcome, the Sun finally agreed that the twin boys were indeed his sons.

To successfully manage all of the trials and tribulations the orientees were given during their professional journey they, like the twins looking for their father, also needed the advice and feedback from their wise and experienced preceptors. When given caring

feedback and advice, not by the Spider Woman, but by their preceptors, they could improve or amend their nursing skills or practices, and cross over that final threshold of their professional journey.

Caring feedback has been described by the orientees as feedback that is continuous, constructive, non punitive, concise, and specifically focused. Positive outcomes of caring feedback were many; orientees felt motivated because this type of feedback allowed them to see that they were progressing. This type of feedback clearly let them see what practice elements continued to need further improvement and gave them ideas about new and different ways of nursing practice. Campbell states, "The teacher is like a lighthouse that says there are rocks over here, steer clear. There is a channel, however, out there" (Campbell, 1988, p.185).

Feedback and advice from preceptors acted as a symbolic lighthouse to show orientees the best way to perform patient cares in a safe manner. The first part of this section will explore the significant statements expounding the elements of caring feedback defined as non punitive, concise and specific. Feedback that is not specific, constructive, and is not given in a timely manner, was perceived to be uncaring and will be discussed at the end of this section.

Non-punitive feedback. The following examples described the importance of non punitive feedback from preceptors. These examples illustrated how non punitive feedback helped the orientees' problem solve mistakes and reassured them that it is OK to be human.

> Caring preceptors have a lot of patience and tolerance and are not punitive when mistakes are made but instead, they help you see how to problem solve the mistakes (Peggy's interview).

> In my previous job, mistakes were looked upon in a punitive manner. Nursing looks at mistakes as an opportunity to learn, and to make the process better, so for me to have somebody tell me it is OK, we can work it out and fix it and so in a sense there is nothing punitive attached to it. My preceptor also lets me know that he also makes mistakes and is human and does not have all the answers either, so, for me this is a huge thing. Constant suggestions from preceptors that are not punitive in nature really helped me improve on my job performance (Peggy's interview).

> My PP comments on what I do well and what seems to take me more time to learn, she never focuses on my weakness as a novice nurse (Jean journal entry).

> My OP is very diplomatic and never criticizes me personally; he only makes constructive suggestions without pointing fingers or hurting my feelings. He is able to give feedback in a way that does not make me feel like I am a bad nurse. Even when I make little mistakes he is encouraging and reminds me that everyone makes them. Because of his attitude, I really enjoy learning with him. He makes it seem like everything can be broken down simply and he makes it fun to learn about our patients and their diseases (Meg's journal entry).

Caring preceptors were quick to let orientees know that being human meant making mistakes. They did not point fingers and make the orientees feel that they were bad nurses. Instead caring preceptors gave suggestions to help the orientees to problem solve what to do next. These continuous, non-punitive suggestions and feedback from preceptors allowed the orientee to learn how to improve her job performance.

Concise and specific feedback. Concise and specific feedback from preceptors was vital to help the orientees learn best and improve upon their work. Clear and concise feedback that was both positive and negative helped the orientee to see what she needed to improve upon and the positive feedback helped the orientees see that they were progressing. One of the orientees claimed that she did not even know she was improving and progressing until her preceptor pointed it out to her.

> Feedback that was specifically focused on certain points helped me to learn best (Meg's interview).

> Feedback that was constructive and very clear helped me to learn what things I needed to work on with my preceptor (Peggy's interview).
>
> Today I was with my PP, she told me I did very well with organizing my day, her encouraging comments make me eager to learn (Jean's journal entry).
>
> My preceptor takes the time to explain things to me and is right there to give me feedback that is specific and concrete. When the preceptor gives you precise and specific feedback this shows the orientee that the preceptor is really paying attention to what you are doing. Concrete positive and negative feedback was helpful for me to see which areas I needed to improve upon and to see which areas I was doing well with. This feedback is so important because you do not even realize how much you are improving until someone lets you know, it is motivating (Jill's interview).
>
> My preceptor gave me feedback that I needed to brush up on my IV skills and I agreed! So we went to the IV room and practiced for a while and I learned a lot and now I feel much more comfortable with all of the IVs (Meg's journal entry).
>
> I was with the same OP as yesterday. We had two patients again today and I asked her for some constructive criticism on how I can improve my work. She had some good advice for me which she nicely backed up with examples. Usually I am pretty sensitive person, but she let me know in a way that is important to my job, and was not a personality attack. I think this is helping me become more of a member of my profession, I am realizing that I need to be asking for criticism and I need to be open to people's suggestions and not take too much to heart regarding what people say (Liz's journal entry).

Listening to concrete and specific feedback from preceptors was essential for learning and change to take place. Feedback that was negative helped the orientees understand what practice areas they needed to change and improve and positive, clear feedback was motivating to the orientee because it helped her to see that she really was progressing. When preceptors gave constructive criticism that was backed up by actual examples versus being judgmental, orientees were less likely to feel it was a personality attack.

Many orientees relayed in their journals or interviews that one way their preceptors taught them was by questioning and quizzing them on specific patient care examples and then giving them specific and concrete feedback in response to their answers. These

scenarios helped the orientees to think in a critical fashion and gave them ideas to draw from in the real world.

> Today I was with my PP and we went through some emergent patient situations. She gave me time to think through these situations, then she offered feedback. I like this type of feedback and consequent learning because even when I give incorrect answers; my preceptor is still reassuring and she encourages me to stay confident (Jean's journal entry).

> My preceptor challenged me without making me feel stupid by asking me questions and testing my knowledge, I felt this to be challenging without feeling stupid if I did not always have the correct answer. This type of quizzing helped the information stick in my head better (Meg's interview)

> I remember we were in a one to one in the patient's room and we had finished the care's we needed to do.... we were sitting in there observing this patient closely and when we would have some down time, she would quiz me. She would say, what would you do for instance if you walked into your patient's room and you're patient was like this and this...and she would kind of nicely clue me in and ask me questions. I appreciated the fact that when she did ask those kind of questions that no family members were in the room...because that is the last thing I would want to have her do! I would not have wanted her to ask me those questions when the family was present and then me having to say, 'I don't know'.... that would put the family members in an uncomfortable situation. Every time she would do one of the scenarios it was just the patient, her and me and of course the patient was sedated and ventilated, so I think it was appropriate for her to ask me in front of that patient because of the circumstances. I really liked and wanted her to give me those types of scenarios like that because it helped me to really think what **would** I do if I walked in and found some of the situations we discussed (Jean's Journal entry).

Preceptors gave case studies and or asked critical thinking types of questions to help the orientees think outside of the ordinary. This type of teaching and giving of specific feedback to answers the orientees supplied was declared as a good way to think about what they would do if other circumstances arose with their patients. The preceptors gave feedback in such a way that the orientees did not feel stupid or inadequate. Orientees

claimed that this type of teaching and consequent feedback was challenging, but resulted in good learning experiences.

Outcomes of caring feedback. The following significant statements from orientees show the powerful outcomes that resulted from caring feedback. Orientees receiving clear and concrete feedback from preceptors felt their preceptors cared about them and were interested in their success. They were encouraged, motivated, and their confidence was boosted.

> Getting constructive and clear feedback let me know that the preceptor was interested in my success (Peggy's interview).
>
> Caring is receiving constructive criticism, when the preceptor sat down and helped me look at different ways of doing things (Beth's interview).
>
> My PP and I had a very good, private pow-wow today. She supplied me with helpful hints and constructive criticism and encouragement. I really appreciated her effort and time (Peggy's journal entry).
>
> Today I took care of 4 patients, and it was crazy, but the day went very well, my OP said he thought I was adapting very well and getting along just fine, my confidence was really boosted by today and I hope things continue to go this way (Meg's journal entry).
>
> Today was a great day! I had my performance review, which I was very nervous about, and my PP and nurse manager had nice feedback to give me, I was completely put at ease and felt reassured about how I was doing on the unit (Meg's journal entry).
>
> My PP told me I did a good job today and would trust me with four patients again; this meant a lot to me because I felt totally incompetent today and was feeling discouraged (Mary journal entry).
>
> My PP was teasing me throughout the night that I really didn't need her because I was doing a very good job, I appreciated her compliment and it meant a great deal to me because my PP is an excellent nurse (Jill's journal entry).

Sue's journal entry sums up the outcomes of caring preceptor feedback.

> When my OP commented on how I was doing such a great job, and gave me specific feedback, my confidence went through the roof! I was being independent and hearing specific reasons why my OP thought I was doing well. I suddenly felt that I was capable of being a nurse on this floor. (I didn't always feel this way!) When someone takes the time to notices what it is about your performance that is going good, this is very caring and it is a huge confidence booster (Sue's journal entry).

Uncaring feedback. Orientees also gave examples of uncaring feedback from preceptors. The following significant statements demonstrated examples where preceptors quizzed the orientees a bit too vigorously, gave confusing, conflicting, and or untimely feedback. Orientees also claimed that while they learned from constructive feedback, they also needed positive feedback interspersed within the constructive feedback to keep them energized and positive. When the quizzing seemed endless, orientees became frustrated and unable to correctly answer the questions put before them.

> Constant quizzing and feedback was sometimes just too much for the orientee and made me feel frustrated (Peggy's interview).

> She kept quizzing me the entire day, but I did not get even one of her questions right all day, and at times I felt very stupid. I voiced this to her and she did not have any encouraging words and that discouraged me. I felt very sad and discouraged, she did not try to encourage me much, nor did she have anything else to say (Liz's journal entry).

For the most part the orientees stated they enjoyed the quizzing and learned from it; however, there were times when the quizzing caused the orientees to feel discouraged when they were not able to respond to many questions correctly.

When feedback given was not specific and constructive, orientees determined this kind of feedback to not be genuine or helpful in the learning process.

> Feedback that is confusing and conflicting is very frustrating and upsetting to me because I could not filter out what to learn from the feedback (Liz's interview).

> General comments like 'good job' were not at all helpful in the learning process (Mary's interview).

> Feedback that is generic and not authentic meant nothing to me (Jill's interview).

Feedback that was not concrete and specific was confusing to the orientees and learning came to a standstill. General comments such as good job were not considered to give enough clarity for learning to occur and orientees felt these comments were not genuine or authentic.

The following journal entries by Jill and Beth characterize the frustration of not receiving timely feedback from preceptors.

> There was a day when a patient came back from surgery, my OP was no where to be found so I settled the patient with another experienced nurse and she gave me instructions regarding how to care for this patient. Her advice made sense to me and because she was an experienced nurse, I did what she told me to do. Three hour later, my OP mentions that what I had done was wrong and should have been done differently! I was extremely frustrated because why did he wait three hours to tell me? When I do something wrong, I want to be corrected right away (Jill's journal entry).

> When feedback is not given in a timely manner it is frustrating to me. I did not feel cared for when my PP made some changes to my charting and did not immediately explain this to me. This made me feel dumb (Beth's journal).

The outcomes of not receiving positive feedback interspersed with constructive criticism were illustrated in Sue's journal entries.

> While constructive criticism is great for learning, I also need some more positive feedback about what I am doing right. My PP's biggest flaw is that she does not give enough positive feedback and this feels so non caring to me. My PP was definitely good at critiquing me. Especially my charting, negative feedback can be good because it helps you learn but it must be given along with positive feedback (Sue's journal entry).

> I get very down on myself, I start to feel overwhelmed by what I do not know or like I will never get things right, I begin to wonder if there is something wrong with me (Sue's journal entry).

These examples clearly have shown the importance of preceptors giving constructive feedback with a good mix of positive feedback. Constructive feedback was great for learning but positive feedback was necessary to help the orientee feel energized.

In summarizing and comparing the caring and non caring behaviors of feedback, it is clear to see they are opposite in actions as well as resultant outcomes. Non-caring feedback from preceptors was characterized as feedback that was not clear, concise, timely, and genuine in nature. Non caring feedback slowed or stopped learning because orientees were not given clear instruction on what they should learn and amend in their practice. When little or no positive feedback was given, the orientees felt they could do nothing right. Orientees' described non-caring feedback as a discouraging and non-motivating entity. On the other hand, caring feedback that was concise, specific, was given in a timely manner and was non punitive in nature made the orientee feel cared about and was of great value to the orientees' learning and subsequent passage in their journey. Orientees declared the ultimate in caring feedback to be a mix of feedback that lent constructive criticism as well as feedback that praised and encouraged their behaviors when they did something well. Orientees declared caring feedback to be a positive, genuine feedback was a supporting and motivating force in learning and growing in the art and science of nursing practice.

It was this learning and growth in the profession that supported the orientees in becoming independent, safe, and accountable nurses that was the ultimate goal or gift of this professional journey. Campbell (1968) describes this gift as the boon of the hero journey and this will be discussed in the next section of this study.

The Ultimate Boon

The ultimate gift or boon is described in Campbell's (1968) hero's journey during the last step of the initiation phase. Campbell describes two phases to this element of the initiation stage. The first phase is the gifts received from the journey that the hero experiences when he decides to answer the call to the adventure (Campbell 1988). This is the action packed trials and tribulations, the eloquent fighting of ogres, dragons and other mythological creatures with the assistance of knowledge, advice and magical potions from the supernatural guides. This gift from traveling the journey gives the hero both exquisite delights and intolerable despair. The second phase of this element described by Campbell (1968) is the ultimate gift or boon and is what the hero becomes and or brings home from his journey that will be of benefit to his community or society. This section will concentrate on the gifts of the journey and their effects on the ultimate boon which is what the orientee becomes and brings home from their journey.

In life, as in mythology each participant received gifts from her vital professional journey, and will receive the ultimate boon. The participants were given the gifts of the journey which included the assistance of caring and not so caring behaviors from their preceptors or guides as they fought to overcome their trials and tribulations. The gifts from the journey assisted the participant to develop and mature in her chosen vocation of nursing to become an independent, caring, safe and accountable professional nurse which is the ultimate gift or boon received from the journey. It is how each participant perceived the trials and tribulations that were bestowed upon her and how she learned to mature and develop from these ordeals that became her unique story and ultimate gift or boon. While each participant's story and ultimate boon contain similar threads as others, they are still

very unique because each participant walked away from their professional journey with different levels of knowledge and experiences.

The caring behaviors from preceptors acted as the mythological supernatural aid and formed the infrastructure that supported and allowed knowledge and experience about the scientific as well as the more humanistic side of nursing to take place. Learning about and experiencing the scientific and humanistic factors of nursing was essential in supporting the participant to gain the ultimate boon which was becoming a caring, independent, safe, and accountable nurse. Preceptor uncaring behaviors were also apparent and were opposite in action and resultant outcomes. These uncaring behaviors served as mythological termites that weakened the infrastructure that allowed knowledge and experience to take place, and negatively affected the result of the orientees' ultimate boon. The following paragraphs will demonstrate the effects of the preceptor's caring and uncaring behaviors that the orientees received as a result of their professional journey.

The more scientific elements of nursing that orientees learned about and experienced will be discussed first. The assistance from preceptor's caring behaviors included times when the preceptor advocated for the orientee by finding good learning experiences, gave her the autonomy to safely practice the skills and procedures, and provided her with feedback to change or amend her practice as needed. Second, I will discuss the more humanistic elements of nursing that the orientees learned and experienced as a result of preceptor's caring behaviors. Interspersed within the caring preceptor behaviors I will discuss any corresponding uncaring preceptor behaviors as both of these behaviors from preceptors have an essential affect on the outcome of the participant's ultimate boon.

Scientific gifts. The more scientific gifts of the journey will be discussed first. These gifts include advocacy, autonomy with appropriate preceptor presence, under presence and over presence of the preceptors, feedback that was caring and uncaring.

Advocacy. The orientees learned about the skills and the procedures when their preceptors demonstrated the caring behaviors that exhibited advocacy for them by making sure they were given opportunities to learn about specific skills and procedures. When Meg's preceptor noted that she was struggling with all of the different IV medications and IV pumps, her preceptor took time out from the daily unit routines and took her off the unit to work specifically on these tasks.

> We went to the IV room and practiced for a while and I learned a lot and now feel much more comfortable with all of the IVs" (Meg's journal entry).

The participants learned about procedures, when the preceptors advocated for them and made sure their assignments actually gave opportunities to learn about specific procedures on their units. Having solid assignments helped the orientees to gain more nursing experience.

Autonomy with appropriate preceptor presence. Orientees were allowed to learn and practice nursing skills and procedures when the preceptors gave the orientees autonomy to actually perform these skills safely by being present as their safety net. In order to give this type of autonomy, the preceptors had to take the time to first carefully assess and gauge the orientees' abilities. Beth's journal entry clearly shows the advantage of being given autonomy with appropriate preceptor presence.

> Increased my comfort and autonomy with IV pumps, feeding tubes and working with IV ports as well as increased comfort with medications, assessments and charting (Beth's journal entry).

Autonomy with minimal preceptor presence. The orientees' journals and interviews illustrated intense frustration when autonomy was given with minimal preceptor presence. Giving maximum autonomy and responsibility to orientees who were not yet ready or capable for handling such skills and procedures was frightening and orientees felt like they had been abandoned.

> I felt like I was frantically abandoned (Beth's interview).
>
> I cried because I felt so frustrated with the day's chaos and felt offended that the preceptor put her frustrations of the day upon me (Annie's journal entry).
>
> I did not want to come back to work (Jill's interview).

These journal and interview entries illustrate the impact that this non caring preceptor behavior elicits and stresses the importance of the preceptors continual need to assess and gauge orientees before assigning them experiences they cannot handle.

As powerful as these statements were, interviews and journal entries did not once depict that orientees talked with the preceptors about these uncaring behaviors. Annie did not say anything to her preceptor and excused her because being a preceptor was hard work. Beth did not speak to her preceptor about her frustrations; she felt he could see how frustrated she was with him by her actions of asking her nurse educator to schedule her with a preceptor who was more black and white. Jill relayed in her interview that she did not want to come back to work and continue on her journey, when she made patient errors as a result of her preceptor was not backing her up and being a safety net for her. Jill learned from this uncaring experience to rely upon the support of those preceptors who had previously backed her up and were present for her. Jill stated the following in her interview.

> I have decided that when I work with my favorite preceptor that I will have to ask as many questions as I can possibly think of so that when I am out there on my own, I will remember what she has taught me she told me and I will ask a million questions of everyone of my preceptors who is dependable so that when I have to work with the preceptor who is just not present for me, and I am on my own I will have some valid information to go on (Jill's interview).

I asked Jill if she had confronted this preceptor and let him know that she felt his behavior was uncaring and she told me she had not. She told me she did speak with Mindi, the nursing education specialist and she asked Mindi to please not schedule her with this preceptor again.

Over presence of preceptors. When preceptors were a hovering type of presence and did not allow the orientees to experience hands on tasks, learning opportunities were missed. Orientees felt the preceptors did not trust them and the orientees felt that instead of progressing in their orientation they were regressing. The following journal entry by Gina shows the frustration felt when over presence by preceptors was apparent.

> She followed me into the first patient's room and stood over my shoulder basically while I did my assessment. The patient was a 28 year old man and he had three family members in the room. The OP stood there and told me how to do my assessment such as to check bowel, heart and lung sounds. She made me upset because, no I am no longer in nursing school, and yes I know how to do an assessment. She was very belittling. She also made comments to do other things that I already knew how to do so to the patient and family it looked like I didn't know anything. Instead of allowing me to give patient care and ask questions as needed, she followed me around for everything (Gina's journal entry).

Gina states that she was very mad and upset, but she did not discuss her feelings with her preceptor. There were no interview transcripts or journal entries from any of the orientees indicating that they talked with their preceptors about the uncaring behaviors of over presence.

Feedback that was clear, concise and non-punitive. Feedback was also discussed as being a caring behavior from preceptors when preceptors gave feedback in a timely manner, and gave feedback that was clear, concise and non-punitive in nature. When given this type of caring feedback, the orientees learned how to amend the way they were performing their nursing tasks in order to be competent and safe. They were able to learn what they were doing well and what they needed to work on.

> Concrete positive and negative feedback was helpful for me to see which areas I needed to improve upon and to see which areas I was doing well with. This feedback is so important because you do not even realize how much you are improving until someone lets you know, it is motivating (Jill's interview).

> My PP is kind and patient with me, there is so much to learn and I wonder if I will ever learn it all, My PP tells me that my feelings are normal and I am doing well, she shares with me that even after working on this unit for several years, she is still learning about things, it is so important for me to hear that my mistakes are normal as I tend to be a bit of a perfectionist (Annie's journal entry).

Uncaring feedback. When Liz and Jill described their examples of when feedback was not given in a timely manner, and was not concrete and concise, both of these orientees expressed feelings of frustration, confusion and anger. The orientees basically avoided these preceptors when ever possible.

> Three hours later, he told me I should not have positioned the surgical extremity as I had, why did he wait for three hours to tell me this! (Jill's interview)

> She gives me such confusing feedback, first it is bad what I have done then when I try to talk to her about how I can improve, she just says, oh don't worry it just takes time, you are doing fine...I just knew I could not learn from her (Liz's interview).

> I knew that when I worked with him, I have to have my game on 120 percent (Jill's interview).

When I asked Liz and Jill if they talked to their preceptors about how they were feeling, both replied that they had not done so.

Advocacy for the orientee to give them the best learning experiences possible, Autonomy with safety to learn and practice skills and procedures; and receiving feedback along the way to give the orientees ideas regarding what they were doing well and what they needed to practice were caring preceptor behaviors that assisted the orientees to receive the journey's gifts of safe, competent practice of skills and procedures. The uncaring behaviors outlined above slowed the learning process and experiences.

In addition, all of the orientees had to pass certain basic nursing skills and tasks that were listed on the general orientation forms and most of the orientees had to also prove competency in nursing skills and tasks that were specific to each of their unit's type of patients. These types of elements are more specific to the scientific segment of the nursing spectrum and are the boon or gifts that are more easily measured.

In the next few paragraphs, the preceptor caring behaviors of welcoming, including and being able to make caring human to human connections are more abstract in nature and because they are more on the affective or humanistic side of learning versus the more concrete skills and procedures, outcomes may be harder to measure.

The more artistic or humanistic gifts of the journey. Each orientees' lived experience of this vital professional journey are uniquely their own. The following boons or gifts of learning and self-growth are more related to the affective and humanistic side of nursing and are extremely important gifts of the journey. These lived experiences of the professional journey are as important as the more clinical or scientific side of nursing and both of these gifts of the journey help to shape and to make each of the orientees unique in their nursing roles. It is this uniqueness of each nurse in performing her role as a

caring, safe, independent and accountable professional nurse that is her ultimate gift or boon.

Gift of critical thinking. The first gift or boon learned in this more humanistic spectrum of nursing is the importance of critical thinking and application of critical problem solving during emergency situations by actually experiencing emergent situations and by preceptors who quizzed the orientees and made them think about things in different ways.

> She challenged me sometimes, but only because she knew I needed to get used to situations that I was not necessarily comfortable with (Sue's journal entry).
>
> My PP lets me ask lots of questions but does not immediately supply answers so I have to critically think things through. She pushes me but not too hard, maybe pushing is not the right work. Perhaps I should say she is honing my critical thinking skills to the 'real' world of nursing, not the textbook world I am accustomed to (Peggy's journal entry).

Gift of welcoming. Welcoming the orientee to their respective unit is the first preceptor caring behavior to be reviewed. From these welcoming experiences delineated by the orientees it is clear to see how being open and approachable can open up the lines of communication.

> She greeted me with a smile and was very welcoming (Jill's journal entry).
>
> She is very approachable and told me the more questions the better, I knew that I could ask her anything about patient care and she would explain them to me (Jean's journal entry).
>
> She sent me an e-mail welcoming me ahead of time to the unit and letting me know if there was anything she could do for me to just let her know, this made me feel very comfortable going to her for questions and concerns (Liz's interview).
>
> I feel free to ask my PP any questions and she has never made me feel silly or dumb for asking (Annie's journal).

Annie and Gina were the only orientees who experienced unwelcoming incidents from one their preceptors. Annie's preceptor did not even look at her when they were introduced and she felt anxious and dreaded the next week with him. Annie did not write in her journal that she talked with him about his actions and her feelings. Gina stated this preceptor made her very upset when she was rude and abrupt and that she almost said something to her about it but since the rest of the day went OK she did not.

Gift of inclusion and teamwork. They have learned the importance of the gift of teamwork and being included as a part of their unit.

> My PP worked especially hard to enable me to attend our team day meeting even though he could not go himself, and he made sure to ask me about my thoughts on the meeting afterwards (Beth's journal entry).
>
> I felt a lot of love and support, (excellent teamwork) from all of the staff that I worked with today (Mary's journal entry).
>
> It is so helpful to draw from my other colleague's experiences and they make me feel like I am an important part of the unit and a part of the team (Beth's interview).
>
> It was a busy, but very good day, I felt like her and I were a team as we plowed our way through the day (Annie's journal entry).

The orientees learned the value of teamwork in order to get patient cares completed in a timely and safe manner.

The gift of humor. Some of the orientees stated that when their preceptors shared their humor and shared stories with them about some of the silly things they had done when they were new on the unit; it made the orientees feel included and trusted (Jill, Peggy, and Sue). The orientees also learned the value of sharing humor and stories to decrease the tension and anxiety that is commonly seen on busy nursing units.

The gift of human connections. The orientees have learned the value of connecting with another colleague at a deeper level, that of role model, mentor and even friend. Certain preceptors went the extra mile to get to know and really understand their orientees not only a collegial basis, but they also showed an interest in them as persons outside of work. These preceptors also opened up to the orientees and shared things about their own personal lives outside of work. Jill describes her connection with her preceptor in her journal.

> My PP and I worked together quite closely when I was here during the summer, we are on the same page and I understand her well, and I can read what she saying by the tone of her voice (Jill's journal entry).

These deeper relationships helped the orientee to experience and understand the importance of open and honest discourse that ultimately allowed for better patient care. Not surprisingly, none of the orientees discussed difficulties or non caring behaviors from these special preceptors.

The gifts of the orientees' journey were similar to the hero's journey because they contained experiences of extreme delights and accomplishments, but also experiences of frustration, anger, and despair. The caring behaviors of preceptors supported the foundation of the positive experiences while the uncaring behaviors of preceptors were at the root of the experiences of frustration, anger and despair. The orientees were given the opportunities for hands on, safe learning experiences, were given feedback regarding their performance so they could learn from their mistakes and amend their practice. The orientees were welcomed by open, approachable preceptors and were introduced to others and were included to be a part of the unit's culture. They experienced advocacy from their preceptors when they spoke up for the orientees and made sure that assignments

were solid and provided good learning experiences. They made human connections with some of the preceptors and formed closer relationships such as role model, mentor and friend. The non caring preceptor behaviors did not support these positive learning experiences and in many instances even prevented some of the positive experiences from occurring. Orientees claimed powerful emotions of anger, sadness, despair, discouragement, frustration, abandonment, and fear during these non caring moments but not once in the interviews or journal entries did the orientees confront the preceptors with these feelings. The orientees will incorporate all of these gifts into themselves, what they learn from their trials and tribulations, the non caring preceptor behaviors, and the moments of extreme delight and accomplishment championed by preceptor caring behaviors will be perceived uniquely by each of them. They will use these gifts of the journey to fashion their own similar yet unique caring, safe, independent and accountable practices of nursing.

What the orientees have learned from their professional journey is their own unique gift from the journey. What they then give back to their schools, communities, jobs, from this professional journey is their mythological return with the boon.

Stage III: The Return

The last stage of Campbell's hero journey is declared as the return and has been described as having the elements of returning with the boon or the refusal to return. Campbell (1968) claims that once the hero quest has been accomplished, it is now time for him to return to the everyday world with his ultimate boon. In the hero's journey the ultimate boon is usually some kind of elixir or great knowledge and wisdom that has life transforming properties capable of saving the community or the world. On occasion, the

hero refuses the return because he refuses the responsibility or because he passes away before he can return.

Thankfully, none of the participants passed away during their professional journey or refused to return to the units with their gifts from the journey and their ultimate boons. I have discussed the gifts that the orientees have received from the journey that are more elemental of the scientific side of nursing. The orientees will bring this boon back to their units as they can now practice these skills of nursing much more safely. The administration of medications, handling the various IV pumps and IV solutions that the patients receive, assessing patient's conditions, charting skills, and the ability to perform specific procedures that are unique to each of the units are all aspects of nursing that the orientees have described as feeling more confident and competent doing as a result of their professional journey. These are extremely important pieces of being a caring, independent, safe, and accountable nurse.

Some of the orientees also were given the gift of uncaring preceptor behaviors such as untimely, confusing feedback and autonomy with too much or too little presence. Some learned to how to deal with these gifts by developing a sturdy support system; some felt avoidance of the preceptors, ignoring the situation, or having another person intervene for them was appropriate at this time on their journey. Though many examples of uncaring behaviors were discussed there was not one example where the orientees felt comfortable enough to talk to the preceptors about the behaviors and the consequent feelings they had. Beth's comments on openly discussing and confronting the preceptors during the orientation journey are probably shared by other orientees.

> Can you really say anything to critique your preceptor during this time? I mean during the progress review when you are sitting in a room with the nurse

> manager, and your preceptor.... is it really a smart thing to say anything...I mean, you have to continue to work with this preceptor afterwards, besides it is not the 'Midwestern Nice' culture (Beth's interview).

It is important to note, they will return with these gifts as well as those demonstrating their improved skills.

This return with the gift of improved skills will become more apparent after their orientation journey, but even during this professional journey there are journal entries and interviews signifying a giving back of the knowledge they have learned.

> Today I actually caught a problem with one of my patients, it was quite serious and I put her on the heart monitor, my preceptor told me I had done a good job and that he would have concluded the same as I did about the patient's condition (Peggy's journal entry).

> I noticed a change in one of my patient's condition today and immediately reported this change to the charge nurse; my OP commended me on this fast action (Beth's journal entry).

> I was able to flex with a very confusing and changing assignment today and my OP told me that I did a great job because I did not become rattled and stayed together; she told me that even a seasoned nurse would have struggled with such an assignment (Jill's journal entry).

The more affective gifts of their journey have shown them the advantages of teamwork and a spirit of unity that is of great importance in order to accomplish all the numerous, complex skills, and procedures that are performed on their units on a daily basis. They have felt the warmth of welcoming and the inclusion from their colleagues, and in their journals and interviews they discussed how they had valued these elements during their professional journey. They have also learned the value of human to human connections, humor and sharing of stories and the lessons of unwritten rules. It is not known at present if they will give back these gifts to their patients, their colleagues and to new graduate orientees with whom they will work with in the future.

One of the orientees summed up this idea of returning to the unit with the gifts or boon when she was talking about the end of her professional journey. I asked Peggy when she thought of all the times she felt cared for by her preceptors if these experiences were still fresh on her mind she told me.

> The time being, cared for yeah...there's always somebody saying is there something that I can do? Is there something that I can help you with? And the nice thing for me is to be able to now say to someone else is there something ***that I*** can do to help you? (Peggy's interview).

Conclusion

In the first part of this chapter, I discussed how I would use Campbell's hero journey as a comparative framework for the professional journey made by the participants. I described the stages of the hero's journey and the placement of the six themes of caring preceptor behaviors that emerged. I described the reasons why I chose the heroes journey as a comparative framework.

In the second part of this chapter I explored the first stage of the hero's journey that Campbell called the departure and I gave a brief overview of this stage as well as all of the elements contained within this stage. The elements of the departure stage were briefly reviewed and included the call to adventure, refusal of the call, supernatural aid from helpers, crossing of the thresholds and guardians of the threshold. I then gave examples from Campbell's work that helped the reader to understand the mythological examples of each of the elements. I then compared and contrasted the analogies between the participants call to adventure, assistance from their preceptors and the aid they received, as well as the many thresholds and threshold guardians they came in contact with.

In the third part of this chapter I discussed the second stage of the hero's journey which is designated as the initiation phase, I explained this stage and the elements contained within the stage that included the road of trials, the meeting with the goddess, atonement and the ultimate boon. I then gave the mythological examples of this stage and the elements from Campbell's work. Last, I demonstrated the analogies between the initiation stage and elements of the hero's journey and the participants' professional journey. I compared the hero's road of trials to the participant's trials and tribulations. I demonstrated the analogies between the hero's journey and the orientees professional journey as they made special human connections with certain preceptors (Goddesses), made amends in their practice from preceptor feedback and obtained the gifts of the journey and the ultimate boon. By listening to the advice, suggestions and feedback of their preceptors, the participants in my study, like the twin Navajo boys were able to make atonement, and be accepted into their work "family." The gifts of the journey were discussed as well as the ultimate boon of becoming a caring, safe, independent and accountable professional nurse.

The fourth part of this chapter explored the stage of the return with the ultimate boon. I discussed the stage of the return as well as the refusal of the return. I compared the participant's return with their boon or gifts of the journey and how these gifts are already being returned to help patients and colleagues on their units.

The gifts of what the orientee learned from their trials and tribulations of this professional journey is now within each of their core beings and as such they become the mythological elixir, because they themselves are the gift. The gifts each person receives in life are developed as each person lives through the ordeals in their life (Campbell

1988). It is how each person perceives these trials and tribulations that are bestowed upon him or her and how each person learns to grow and develop from these ordeals. These trials and tribulations are uniquely each person's story and thus each person's gift is uniquely their own. What we learn from life, is our unique gift and what we give back to our schools, communities, jobs, from our development and metamorphosis in life is our mythological return with the boon.

CHAPTER V DISCUSSION

Introduction

The purpose of this phenomenological study was to discover new nursing orientees lived experiences of caring behaviors from preceptors during a 10-week orientation period. The research questions are listed below for the reader's convenience.

1. Are caring interactions occurring between the orientee and preceptors during the 10-week orientation period at the medical center environment.
2. If the orientees do perceive caring interactions from their preceptors what does this mean to them.

For over 142 years caring has been a core element of nursing and this study demonstrates that caring behaviors in nursing continue to thrive. Caring behaviors that the new nursing orientees received from their preceptors, led to caring interactions that supported and replenished them throughout their professional orientation journey. Caring preceptor behaviors and interactions between the orientees and preceptors have been identified and clustered into six themes. The first three themes that emerged were advocating, welcoming, and including. Autonomy with varying levels of preceptor presence was identified as a fourth theme. Making caring human connections became the fifth theme; the sixth and final theme revealed was clear, specific, and non-punitive preceptor feedback. Participants also disclosed not so caring interactions that occurred within the auspices of these six themes. The not so caring interactions emerged as antithesis of the caring interactions.

First, I will explore the first research question and determine if this question has been answered from the data obtained in this study. Next, I will address the second

research question which asks; if orientees do perceive caring interactions from their preceptors what does this mean to them. The meanings of the positive and negative preceptor-orientee interactions that occurred as a result of caring and not so caring preceptor behaviors will be reviewed. Comparison of each of the themes that emerged with any similar findings in the literature will also be done at this time. Third, I will present my exhaustive descriptions and meanings of caring preceptor behaviors. The forming of exhaustive descriptions is the fifth step of the Colaizzi methodology. Fourth, I will discuss the implications of my research findings, and last I will discuss my recommendations for further study.

Research Question One

The emergence of these six themes of caring preceptor behaviors indicates that caring interactions between the preceptors and orientees did indeed occur during the 10 week orientation period at this medical center. Therefore, the first research question is answered with a resounding yes. The orientees provided rich data in their journal entries as well as during their interviews. I could feel the excitement, humor and encouragement as I listened intently to them as they told their stories about the caring behaviors their preceptors demonstrated that led to caring interactions. Discussing emotions is not always an easy task, but these orientees explained caring interactions that occurred between themselves and their preceptors. The journal entries were very complete and easy to follow, their underlining, bolding of words, and capitalized phrases let me know, which of the experiences were designated as being important to them. The rich data gleaned from this study also gave information about not so caring preceptor behaviors that led to uncaring interactions. The not so caring interactions emerged as an antithesis to the

caring themes. The not so caring behaviors and the outcomes of the not so caring behaviors were opposite of those behaviors and outcomes indicating caring. The emotions and meanings of these caring and not so caring preceptor behaviors and interactions to the orientees were clear and powerful.

Research Question Two

The second research question asked whether orientees perceived caring interactions from their preceptors and if so, what that meant to them. The following section will review the caring and not so caring preceptor behaviors that were grouped into six themes and I have listed their resultant outcomes or meanings of these caring and not so caring interactions as bulleted items. A review of these themes and outcomes will clearly show that the second research question was indeed answered from data that emerged in this study.

A comparison of the literature will be explored within each theme and groups of meanings. A review of the literature did not reveal studies that explored preceptor and orientee caring behaviors and resultant outcomes. There were many studies that reviewed new nurse transition and orientation programs. Therefore, much of the literature supported the significance of the caring behaviors that were discovered in this study; however, there was little or no depth and detail regarding actual caring behaviors and the resultant powerful outcomes.

Caring and Non-caring Interactions and Meaning for Orientees

Advocating behaviors from preceptors

Caring preceptor behaviors indicating advocacy for the orientees were displayed when preceptors demonstrated excellent listening skills and put the success of the

orientee first and foremost. Preceptors took the time to find out how the orientee learned best and continually adjusted the orientation schedule and events to meet the orientees' wants and needs. Preceptors changed assignments and made sure orientees got to watch or participate in quality learning experiences. Outcomes of these caring interactions were:

- I felt cared about
- I felt the preceptor was on my side.
- I was very impressed that my preceptor immediately spoke up for me
- I felt important and wanted
- I felt my preceptor had my best interests in mind.
- My preceptor cares about my success.
- My preceptor made sure I had the best learning experiences

Caring preceptor behaviors indicating advocacy for the orientees elicited positive meanings and outcomes for the orientee. Feeling cared about, important and wanted are very important to these new orientees who are feeling like they have little to contribute from their novice experiences. Having the preceptor stand by her side and knowing that the preceptor is there to help her to succeed, is comforting to new nursing orientees who are unsure about what they do or do not know.

Two articles were found that discussed the idea of advocacy for new orientees. Steed (2004) declares that preceptors should take the time and energy to maximize the orientees' experiences early in their practice. The idea of taking a vested interest in the orientees and putting their needs foremost was noted in a study from Santucci (2004). Santucci stated that new orientees need consistent and qualified preceptors who will take a vested interest in supporting them in a successful transition (Santucci, 2004). Both of these articles support the basic premise that preceptor advocacy is a positive orientation experience for the orientees; however, neither of these studies list specific preceptor behaviors that can give guidance for championing these advocacy behaviors. These

studies did not reveal the powerful outcomes that can result from caring advocating preceptors.

The results of this study took a deeper look at the caring theme of advocacy between orientee and preceptor and gave examples of actual preceptor behaviors indicating caring advocacy for the orientees. The powerful outcomes from these caring interactions listed above serve to clarify the importance of preceptor advocacy. The second theme that emerged from this study was that of welcoming will be examined next.

Welcoming

Caring welcoming preceptor behaviors were displayed when the preceptors warmly greeted the orientees, welcomed them to the unit, and the preceptors demonstrated friendly, open, approachable attitudes, and encouraged questions. At first glance this caring behavior may not seem like a crucial element of caring. However, the orientees' interview transcripts and journal entries gave positive and powerful examples indicating that this caring interaction decreased anxiety, and released the floodgates for the flow of open communication. These caring behavior outcomes follow:

- I was able to openly talk with my preceptor about how I best learned and what I would like to get out of orientation.
- I always felt they were glad to have me on the unit.
- I felt comfortable in being more open myself and asking questions in order to learn more about being a nurse.
- She made this learning opportunity fun and interesting.
- I knew I could ask her anything about patient care.
- My fear and apprehension went away and I was able to learn from my preceptor's expertise.
- When preceptors welcomed me and encouraged me to ask questions, this helped to make the orientation journey a very positive and caring experience for me.
- The initial caring attitude of being friendly and welcoming is huge from a preceptor when you are feeling like a fish out of water on your new job!

Caring welcoming preceptors elicited positive responses from orientees. Each orientee experienced the feeling of being the new person on the job and most described feelings of being uncomfortable, fearful, and apprehensive. One orientee summed these feelings up nicely when she stated that she felt like a fish out of water in her new job. This described how most these new orientees felt in their new job settings. A preceptor's warm smile and open and approachable demeanor soon helped the orientees' fear and apprehension. Decreasing the fear and apprehension opened the door to better communication, and the orientees felt like they could ask questions of these welcoming preceptors. Comfort in asking the preceptors questions was vital in the orientee's learning process; if the orientees did not feel welcomed to their units, they were not able to open up to the preceptors and ask those vital questions that need answering to become an independent, safe and accountable nurse.

A review of the literature found two articles that discussed the importance of welcoming new orientees to their nursing units and support my study's premise that welcoming new orientees is an advisable undertaking. The theme of welcoming new nursing orientees to their units was found to be one of the most important factors in providing a successful transition for the new nursing orientee graduate (Clare & van Loon, 2003). The authors postulate that this is attainable by assigning positive, welcoming preceptors to be with the orientees (Clare & van Loon, 2003). Clare and van Loon found that these welcoming, supportive preceptors facilitated good conversations and role modeled professionalism. These authors concluded their study with the unsurprising findings that the best help for positive transition is to have welcoming, supportive, preceptors who make the orientee feel accepted, valued, and part of the team.

A study by Steed (2004) declares the importance of welcoming new orientees to the unit and gives seven brief techniques of how this can be done: encourage new nurses, accept new and valuable information that novices can bring to practice, allow them to grow into their own practice, encourage the orientees to continue their education, think of new orientees as potential teachers, be quick with compliments and have patience with new orientees. Neither Steed (2004) nor Clare and van Loon (2003) give specific behaviors that could guide preceptors in these welcoming techniques. These articles, unlike my study do not list outcomes from welcoming behaviors to give the reader a take home message of the importance of caring, welcoming preceptor behaviors.

Two of the orientees in my study gave examples of not feeling welcomed by their preceptors; the meanings they construed from these not so caring interactions were very different than the ones listed above.

Unwelcoming behavior

Two examples of non-caring and unwelcoming episodes were described by Annie and Gina. Annie did not feel welcomed to the unit when introduced to a future preceptor who did not greet her warmly, nor did he look up from his charting and make eye contact with her during the introduction. Gina got the impression that one of her preceptors was pushed into being a preceptor against her will as the preceptor was rude and abrupt upon their first meeting. The orientees deemed these preceptor's behaviors to be unwelcoming and uncaring. The outcomes of these meetings were quite the opposite of the positive outcomes described during welcoming preceptor and orientee interactions.

- I am already becoming nervous about working with him.
- I want to keep my other preceptor instead of work with him.
- She made me very upset....thankfully I do not have to work with her again.
- Working with her makes me glad that my orientation is almost over.

Preceptors who were not welcoming to the new orientees incited feelings of nervousness, anxiety even dread at the thoughts of working with the offending preceptor. There were no friendly, warm, open, and approachable attitudes given in these examples. Annie went on to refer to her unwelcoming preceptor as the old sergeant. This does not bode well for open and thoughtful discussion that leads to great learning experiences described in the welcoming examples.

Behaviors or courtesies such as eye contact and proffering a warm greeting are oftentimes taken for granted, but a review of the meanings and outcomes for the orientees demonstrate the power of a welcoming preceptor. Orientees stated they felt important, wanted, and needed when they were welcomed on their units. Including orientees in unit activities served to strengthen this powerful and positive outlook.

Including

Orientees felt included when preceptors introduced them to other staff on the unit and included them in unit activities. The positive outcomes or meaning of being included and feeling like part of the team were clear to see in the examples given below.

- I felt cared about and included as part of the team when my preceptor introduced me to other staff on my unit.
- Knowing I had other nurses to call upon with questions made me realize I was not on my own nor was I alone.
- I felt a lot of love and support from the staff I work with.
- I felt we were more like co-workers rather than like a preceptor-student.
- I felt included in the group
- I felt included when asked to go to lunch
- I did not feel ignored
- Being a part of the group made work a comfortable place to be
- Being included in conversations helped me to socially acclimate to my unit.

Feeling included as a part of the group was extremely important to these new orientees. Being included in conversations and being acclimated socially to the unit's culture was the foundation for being accepted versus being rejected. Building camaraderie with preceptors, and being included as part of the team gave the orientees a sense of security, because they came to realize that they were not alone and they had other nurses to help them and of whom they could ask questions.

The participants in my study discussed how important it was to feel like they were part of the team. Preceptors who took the time to make sure the new orientees were introduced to others on the unit and included them in the unit activities were considered to be caring preceptors. The orientees in my study explained that when they felt like they were a part of the group, coming to work felt comfortable. In reviewing the literature, I found that feeling like a valuable and important part of the nursing team was noted to be of extreme importance.

Baltimore (2004) found that the most common reason for employees to leave within the first year of their new jobs was due to feelings of not being included or not fitting in on a unit. Delaney (2003) found in her study that fitting in or socialization to the unit's culture was very important to new nursing orientees' job satisfaction. Feeling included and connected on the unit helped the orientees to feel accepted instead of rejected. In a study by Winter-Collins and McDaniel (2000) it was noted that a sense of belonging in an environment was dependent on the strength of the relationships within that environment. This study also demonstrated that there was a strong correlation between a sense of belonging and total job satisfaction. Socio-occupational integration was identified by Kramer (1974) as being a vital component in transition. Participants in

Evan's (2001) study clearly indicated that belonging or being a part of the group was fundamentally important and that interactions between the new nurse and others were of key importance in social and professional integration. The impact of practicing in the real world versus the school world and fitting into this new and different culture was highlighted by Kelly (1996) and Hipwell, Tyler and Wilson (1989). Hipwell, Tyler and Wilson went on to claim that the social culture on a unit was the most potent contributing factor to low retention of new nurses on the nursing units.

These studies strongly indicate that it is of vital importance for new nursing orientees to feel like they are included and are considered to be an important member of their unit's nursing team. These studies reinforce my study's findings regarding the importance of inclusion. My study however, explores this theme at a deeper level and furnishes concrete examples of actual caring preceptor behaviors that can support new orientee inclusion to the units. The participants in my study have supplied rich data that provide a clear understanding of what it means to the orientees who experience this caring preceptor behavior. Feeling included helped the orientees to feel secure in the fact that the other nurses were there to help them and be a resource to them. This sense of security gave them the courage to begin to become autonomous in their novice practice.

Autonomy with three levels of presence

Autonomy with appropriate preceptor presence is caring. Caring and appropriate preceptor presence was made possible when the preceptors took the time to assess and gauge their orientees' capabilities and give them autonomy that was challenging yet appropriate. Caring interactions between preceptors and orientees occurred when the preceptors were available physically to help with complex procedures and nursing tasks.

Caring interactions between preceptors and orientees also occurred when preceptors were available mentally to answer the orientees' questions and give support and encouragement. The impact of these caring interactions clearly showed the positive meanings declared by orientees:

- I was confident, secure and felt comfortable that my preceptor would be a safety net for me and allow me to try things on my own yet not let me cause harm to my patients. (noted 3 times)
- My preceptor continuously checked on me and I never felt abandoned.
- I was able to be independent and realized that I *did* know what I was doing and could be a competent nurse.
- I was able to gain confidence in myself. (noted 3 times)
- I have more faith in myself and what I can handle.
- I was able to practice independently and I did not feel like I was being watched over.
- I was able to form somewhat of a routine for myself.
- I felt independent today yet secure that my preceptor was watching me.

Preceptors who gauged and assessed their orientees' capabilities and gave autonomy with appropriate preceptor presence enabled the orientees to learn, and thrive. The orientees had the security of knowing the preceptors were available to them physically and mentally and were acting as their safety net and would be watching closely so that patients were not harmed as they practiced and learned.

A review of the literature helped to strengthen the importance of the theme of autonomy with appropriate preceptor presence that was delineated in my study. The excitement of being able to learn and have hands on experience under the auspices of safe preceptor presence was echoed in the literature and supported my findings that autonomy helped to boost the orientees' confidence by allowing for the occurrences of safe and positive nursing experiences.

Amos (2001) alluded to autonomy as a double edged sword. Amos stated that the enjoyment of autonomy was readily acknowledged by new nursing graduates.

Participants in her study enjoyed the outcomes of being autonomous and liked making decisions, acting as patient advocates, and dealing with patient complaints as well as managing their shift's tasks. Participants in her study spoke of getting a "buzz" from their new role and felt a sense of achievement and satisfaction when they experienced autonomy (Amos, 2001). On the other side of the sword, this autonomy and responsibility was also considered to be a large part of culture shock and caused the new nurse a lot of anxiety. Amos claimed that if managed successfully, autonomy and responsibility actually enhanced role transition and increased the new nurse's knowledge and confidence. Having the confidence necessary to practice was unequivocally associated to the amount and quality of support a new nurse receives. The nurses in Amos's study declared that the single biggest factor that helped them to develop as a staff nurse was the support received from preceptorships (Amos, 2001). When environments can provide a safe, supportive, and non threatening learning environment, new nurses are allowed to learn and experience his or her new role of being a nurse (Clay, Lilley, Borre, & Harris, 1990).

The importance of constantly assessing and gauging the orientees' abilities and learning that was expressed in my study was also echoed in a study by Baltimore (2004). Baltimore suggests that preceptors need to monitor orientees' progress throughout the orientees' orientation and develop check-point types of questions to assess the learner's needs. Asking the orientee what they would like to do today, how they felt about certain experiences, and how they would change what they did if they were to repeat the task are just a few of the questions that can enable the preceptor to get a feel for the orientees' abilities (Baltimore, 2004).

These articles help to fortify my findings about the importance of autonomy with safe preceptor presence and Baltimore (2004) gives some actual examples of questions that preceptors can ask orientees to assess and gauge their learning. None of these studies however give examples of preceptor behaviors that demonstrate how to help facilitate learning experiences that allow for safe hands on practice. The results from my study probe deeper into this theme and provide actual behaviors that can be used as exemplars to champion orientee autonomy with safety. The poignant statements that indicate the meanings for the orientees who are allowed autonomy with safety help to clarify why safe autonomy is very important to the orientees.

Being given the freedom or autonomy to have hands on practice was vital to the orientees in my study. They needed to be able to do various skills with appropriate mental and physical presence from their preceptors. The orientees needed to feel secure and to feel that their preceptors were there for them physically and mentally to act as their safety net and make sure that the patients would not be harmed.

There were two additional themes of preceptor presence that emerged in my study. Both of these levels of preceptor presence were deemed as uncaring by the orientees. When autonomy was given with little or no presence from the preceptor, the orientees felt they were abandoned and not cared about. On the other hand, orientees did not feel cared about when the preceptors gave them little or no autonomy and were hovering or overly present.

Autonomy with under presence from the preceptor. Orientees gave examples of preceptors who gave them autonomy but were not available or present physically or mentally to assist the orientee. In these examples, the preceptor did not gauge the

orientees' capabilities and did not act as a safety net for the patient and orientee. This type of autonomy with little or no preceptor presence was determined by the orientee to be both unsafe and uncaring. The emotional outcomes from this type of under presence from the preceptors were:

- I feel very frustrated
- I cried on the way home (noted 2 times)
- I feel frantically abandoned
- I made terrible patient mistakes
- I was devastated when I had to call the event line
- I did not feel I could go back to work on my unit
- I felt rushed and had no time to discuss anything.
- I feel more and more frustrated and discouraged as time goes on.
- I need help!
- I bumble around like an idiot
- I need the preceptor to help me but they are too busy helping the float staff or nursing students.
- I felt like I was left in total chaos and that she had abandoned me.

The outcomes of these not so caring interactions have powerful meanings for the orientee and are the opposite of the outcomes that were exhibited under the theme of autonomy with appropriate preceptor presence. They reported feeling like a bumbling idiots, like work was total chaos, feeling frantically abandoned, and making patient errors, all of which lowered the orientees' self-confidence and self-esteem. Dealing with these emotions under these negative types of situations had the ability to undermine any potential learning opportunities. Looking to the literature for comparison, I found the following article by Duchscher (2001) that reiterates the negative outcomes of feeling abandoned.

Duchscher (2001) found the orientees in her study felt a strong sense of minimal preceptor presence. One participant described feeling trapped by the overwhelming responsibility of caring for patients with little assistance from the senior nursing staff.

nursing staff. The orientee in this study went on to say that feeling trapped meant that she felt totally alone and knew she was stuck with patients and situations she could not handle yet and had no one to ask for help. The orientees in Clare and van Loon's (2003) study stated that because of their lack of nursing experiences, they feared making mistakes that could harm patients and this was a major cause of their anxiety throughout their orientation. These studies stress the need for preceptors to support their orientees by acting as a safety net for them and allowing the orientees to obtain the hands on experiences they need to increase their knowledge and confidence. Preceptors who are present and closely observing their orientees in an unobtrusive manner provide the orientees with a sense of security. While these studies demonstrated the strong feelings that are elicited from minimal preceptor presence, they did not probe deeper into the theme and give instances of actual preceptor behaviors to be aware of. My study uncovered examples of these uncaring behaviors that can help preceptors better understand this idea of under presence.

The third type of preceptor presence delineated in my study was that of little or no autonomy given by preceptors and is called preceptor over presence. This type of over presence from preceptors was decidedly declared as uncaring by the orientees.

Over presence by preceptors. In these examples, the preceptor did not gauge and assess the orientees capabilities and took over for the orientee, giving her little or no autonomy and was an over presence or hovering preceptor.

- I do not feel the preceptor trusts me and has any confidence in me.
- I am regressing instead of progressing
- I need to do things to learn about them
- I feel like I am being babied
- I feel like he is trying to show me just how capable he is.
- I felt like the preceptor was treating me like a small child.

- It is difficult to feel so competent one day and completely helpless the next day.
- I felt belittled and embarrassed in front of the patient and his family.
- I had 7 different preceptors and every day I felt like I was starting over because they did not let me do anything because they did not know me.

Orientees declared they felt as if the preceptors did not trust them enough to give them autonomy to perform the procedures they felt capable of performing; therefore, they began to regress and not progress on their orientation journey. A review of the literature gleaned three articles exploring this idea of over presencing from preceptors.

Preceptors must refrain from over presencing or hyper-vigilance and the need to constantly rescue the orientee in situations where patient safety is not in immediate jeopardy; instead the preceptor should help to coach the orientee through difficult situations (Baltimore, 2004). Clare's (2003) study demonstrated that participants were just as frustrated when they felt they were being spoon fed as they were when they were not supported physically and or mentally by their preceptors. Duchscher (2001) gives an example of over presence from preceptors when she writes about one particular orientee in her study who was performing a task that she had been doing for some time when one of the senior nurses in this facility walked into the patient's room and asked her what she was doing. After the orientee explained the procedure she was performing, the senior nurse told her she would take over for the orientee and this incident left the orientee feeling totally incompetent (Duchscher, 2001). These articles support my findings on preceptor over presence as being a problem that occurs in other studies that have explored orientee and preceptor relationships. One actual preceptor behavior and resultant consequence were discussed in the article by Duchscher (2001)

Before the preceptor can give appropriate presence, they must first assess the orientees' capabilities. When the preceptors did not assess the orientees and gave them little or no autonomy the orientees were equally frustrated and felt like they were regressing instead of progressing. The orientees missed many learning opportunities and experiences when the preceptors were hovering or over presencing. Under presence or over presence of preceptors was not designated as being caring or desired qualities. Special preceptors whom the orientees were able to make deeper human to human connections with did not display these characteristics of over presence or under presence.

Making human to human connections

When preceptors went above and beyond the usual caring behaviors and took a genuine interest in the orientee, the results were positive, caring interactions between the preceptor and orientee. Preceptors, who took the time to discover more about the orientees' personal lives and their goals, were able to form a deeper human to human connection with their orientees. Within these connections, the preceptor and orientee relationship was changed to a deeper connection in which the preceptor took on the role of mentor, role model, and even friend. The meanings and outcomes of these caring connections are evident in the statements that follow.

- My preceptor is awesome and we connect well, I have so much more confidence with my patient's cares when she is helping me.
- She took time to go over prioritization and this boosted my confidence.
- I felt like we were a team rather than a teacher student.
- The lines of communication between me and this preceptor are always open.
- I felt her equal
- I admire her and hope I know as much as she does someday.
- I felt accepted and more than just her apprentice...like we could possibly be friends outside of work.
- I admired her and felt she was a great role model for me (noted 3 times)
- I feel she genuinely cares about how I am doing.
- I felt like she was really interested in my life outside of work.

- I was able to share similar personal life difficulties.
- I was able to hear and talk about how to handle dying patients with my preceptor.
- Sharing of personal tricks and unwritten rules are survival skills I need to know (noted 4 times)
- We share humor and I know this will get me through any rough day.
- Humor eases the tension and helps me to not take myself so seriously
- I would have felt stupid and intimidated if we could not have laughed about a silly episode that happened.
- I feel encouraged when I am scheduled to work with my favorite preceptor
- Because I know her, I am able to take feedback without feeling it is a personal attack.
- I feel comfortable with my preceptor and so I am able to open up and freely discuss patient related problems, this in turn helps me to provide better patient care.

There was a genuine sharing of self, humor, and those valued nursing tricks-of-the-trade as well as a sharing of unspoken rules that made up the culture of the institution and the nursing units. This genuine sharing was permitted and was sanctioned between the orientee and preceptor who made these caring human connections. Because of these deeper human to human connections, the orientee and preceptor had a deeper understanding of each other and the orientee did not feel stupid or intimidated by the preceptor. The orientee did not fear asking questions of this preceptor and therefore learning was deeper and resulted in better patient care.

This idea of making deeper preceptor and orientee connections was also acknowledged as important in the literature. Preceptors were encouraged to get to know and understand the orientees on a professional and personal level to make strong connections which helped the orientees to succeed (Baltimore, 2004 & Fawcett, 2002). Developing a safe relationship between preceptor and orientee was imperative for the new nurses to feel free in asking questions without ridicule from the preceptors and others (Amos 2001). Nelson and Fells (1989) discovered that interpersonal relationships,

co-worker interactions, recognition and evaluative feedback were rated as imperative elements in nurses' work satisfaction.

My study indicated that some of these caring connections led the orientees to consider their preceptors as role models. Evans (2001) also found that participants in her study declared role models to be critical in the integration and development of new graduate nurses. Participants in Evan's study identified these role models as preceptors who put them at ease, explained things in understandable terms and had effective communication skills. The participants declared that they did not feel envious of such special nurses, they aspired to be like them (Evans, 2001).

Clare and van Loon (2003) stated that it was of extreme importance for the orientee to understand the embedded knowledge of the unit's cultures and make strong connections with preceptors who could share the stories that could help the orientees improve their performance. Clare and van Loon (2003) decreed that it was the enigmatic socialization process that could help the orientee to either succeed and fit in on her unit or become painfully rejected and isolated from her unit (Clare & van Loon, 2003). Connecting with a preceptor and forming a trusting relationship that allows for discussion and education about this socialization process is complex and takes time. Clare and van Loon (2003) found that heavy workloads often decreased the time needed for these relationships to occur that could assist the new orientee in the socialization process.

Sharing nursing tricks-of- the trade as well as the unwritten rules that helped the orientee to understand the culture of the institution and their unit was noted to be of significance in my study. The lack of time and heavy workload discussed in Clare and van Loon's (2003) study were also mentioned as detrimental factors in my study. Another

factor in my study that deterred close connections from taking place was the fact that several of the orientees had too many preceptors. One orientee in my study claimed she had as many as seven other preceptors, and explained that this did not allow for her and the assigned preceptors to really get to know each other and develop a trusting relationship.

The literature supported the significance of deeper connections between preceptor and orientee. Unlike my study, these articles did not give examples of what kinds of behaviors did or did not reinforce these deeper kinds of relationships. These studies did not give the reader examples of the profound outcomes that orientees experienced related to these deeper relationships. My study found that orientees were able to open up to these special preceptors, ask questions, learn, and receive feedback that was valued as sage advice. This profound counsel and feedback from the special preceptors assisted them in becoming independent, safe and accountable registered nurses.

The last theme revealed from this study was preceptor feedback. Feedback was demonstrated to be essential to the orientees and will be reviewed next along with the caring and not so caring outcomes.

Caring feedback

Caring preceptor feedback was described by orientees as being constructive, non-punitive and concise. Caring interactions between the orientees and their preceptors involved caring feedback that enabled the orientees to learn from their preceptors and improve their nursing skills. Caring feedback also gave the orientees new ideas about different ways to practice nursing. Caring feedback from preceptors acted as a symbolic lighthouse and showed the orientees the best way to perform patient care in a safe

manner. The following statements from the orientees show the outcomes of these caring interactions to be very affirmative:

- I learned how to problem solve my mistakes
- Constant suggestions from preceptors that are not punitive in nature really helped me improve on my job performance.
- I really enjoy learning from him, his advice never makes me feel stupid
- He makes learning fun.
- Feedback that is specific and concrete helped me to learn what things I needed to work on.
- Precise and specific feedback showed me that the preceptor is really paying attention to what I am doing.
- Concrete positive and negative feedback was helpful for me to see which areas I need to improve on.
- Feedback is important because you do not even realize how much you are improving until someone lets you know.... so it is motivating.
- I learned a lot and now I feel much more comfortable with IV's.
- My confidence was boosted today after receiving positive feedback
- After I received the feedback from my performance review I felt completely at ease and felt reassured about how I was doing.
- Positive feedback I received today made meant a lot to me because I was feeling incompetent and discouraged.
- I appreciated her feedback, and it meant a great deal to me because she is an excellent nurse.
- My confidence went through the roof!
- I was told I was doing well, I was suddenly felt like I was capable of being a nurse for the first time
- I felt challenged without feeling stupid.
- The feedback really helped me to critically think about things.

Caring feedback was imperative for orientees to grow and learn from their preceptors, examples of caring feedback were a strong theme emerging in this study. Confidence soared which helped the orientees see that they were indeed capable of being nurses. Positive feedback gave the orientees energy, and motivation. Concrete, critical feedback helped the orientees grow in their practice. Both positive and constructive feedback was stressed as being vital for the orientees' learning and development.

Receiving clear, concise, and concrete feedback that was non punitive in nature helped the orientees in this study to learn not only what they were doing well, but to also learn what things they needed to study and improve upon. The orientees needed both constructive feedback to learn and positive feedback to give them motivation to continue on. Providing constructive feedback can be challenging for preceptors, yet it is vital for orientees to grow and learn. Clear, concise, and concrete positive and constructive feedback was also noted to be of importance in many of the studies reviewed. Claire and van Loon (2003) found that orientees respected and appreciated regular feedback that was constructive and not punitive or judgmental. Baltimore (2004) found that orientees needed both constructive and positive feedback to understand what their strengths were as well as to determine what practice areas they needed to improve upon. Baltimore suggested that orientees be told at the beginning of orientation they will be receiving both positive and constructive feedback throughout their orientation (Baltimore, 2004). Preceptors also need to be aware of the proper way to best give feedback which helps orientees to grow versus destroy their self-confidence (Baltimore, 2004). Delaney (2003) found that more experienced preceptors were more consistent with their feedback to orientees and were able to give feedback that was less confusing and less frustrating for the orientees.

Recognition and feedback about performance have been identified as contributions to job satisfaction (Robertson & Cummings, 1991). Evans (2001) found that preceptors were invaluable in giving feedback that helped address the requirements for the job and their advice was vital in assisting the new orientee to develop and grow in their role. In a study by Goh and Watt (2003) new nursing graduates stated the need for

feedback was absolutely essential for self-development and adaptation to the role of nurse. The participants needed and valued any form of feedback. However, the positive informal feedback and encouragement was most valued (Goh & Watt, 2003). Cobal (1998) found that positive feedback has considerable impact in increasing new graduate nurses confidence and better helps them learn and adapt to their new role. Steed (2004) advised preceptors to be quick with positive feedback and encouragement as this helped the new orientee gain confidence. New nursing graduates undergo many highs and lows in their orientation journey and giving positive feedback on performance can actually help them to overcome some of the role strain they experience (Clifford, 1996).

The literature on preceptor feedback supported the findings in my study and showed that feedback was essential to new orientees, and that both positive and constructive feedback is needed for the orientees to become independent, safe and accountable registered nurses. However, the findings in my study gave actual behaviors of caring feedback that helped to clarify what caring feedback was and what it meant to the orientee. The orientees in my study also gave examples of feedback that was not so caring and did little to help the orientee learn and become independent, safe and accountable professional nurses and these examples are discussed in the following segment.

Uncaring Feedback

Uncaring feedback by the preceptors was interpreted as endless quizzing, feedback that was untimely, not specific, not genuine and not constructive. The meanings or outcomes of these uncaring interactions are very clear in the examples given.

- Constant quizzing and feedback made me frustrated

- I felt very sad and discouraged when my preceptor rarely gave me encouraging feedback.
- Confusing, conflicting feedback is frustrating because I cannot filter out what to learn from it.
- General comments like "good job" were not helpful in the learning process
- Feedback that is generic and not authentic meant nothing to me.
- I was extremely frustrated to receive feedback telling me I had done the wrong thing with one of my patients 3 hours ago.
- When changes were made to my charting and I was not told, I was really frustrated.
- I felt dumb when my preceptor did not give me timely feedback.
- I need positive feedback as well as constructive feedback.
- I get very down on my self and start to feel overwhelmed by what I do not know and I wonder if there is something wrong with me when I never get any positive feedback.

The outcomes and meanings from uncaring preceptor feedback are opposite of the outcomes that demonstrate caring preceptor feedback, however, the meanings and outcomes are equally powerful for the orientee. Orientees craved feedback from their preceptors who acted as a sort of barometer for the orientees and helped them to measure their progress. Preceptor feedback helped the orientee to see what they were doing well and also to understand areas they needed to improve upon. Feedback from the preceptors was the cornerstone that helped orientees to reflect upon their nursing practice.

The Exhaustive Descriptions of Caring Preceptor Behaviors

Significant statements, formulated meanings and themes indicating caring preceptor behaviors along with their consequent meaning and effects on the orientees was integrated to form exhaustive descriptions (Colaizzi, 1978). Six exhaustive descriptions are outlined below to give the reader a more solidified mental picture of the degree to which the two research questions were answered.

> Preceptors who advocated for the orientee by assessing and listening to orientees' educational needs, and making it a point to obtain excellent clinical assignments to facilitate their orientees educational needs made the orientees feel that their

preceptors were on their side, wanted them to succeed, and had their best interests at heart.

Preceptors who warmly welcomed new orientees to the unit and encouraged questions were perceived to be open and approachable people with whom orientees can talk, ask questions, and learn.

Preceptors who included orientees in conversations, unit activities, and introduced them to staff on the units made the orientees feel they were needed and were an important part of the team and this made work feel like a comfortable place to be.

Preceptors who gauged and assessed orientees' capabilities and gave appropriate levels of physical and psychological presence gave orientees a sense of security and confidence to practice independently knowing the preceptors were there to act as a safety net for them and their patients.

Preceptors who get to know the orientee on a deeper, more personal level and become a mentor, role model and even friend, allowed for human connections to be made which permitted sharing of self, humor, and unwritten rules, resulting in better communication, learning, receiving of feedback, and provision of improved patient care.

Preceptors who took the time to give continuous, non-punitive, concise and specific feedback motivated orientees because they were able to see their progress as well as the areas where they needed to learn more and improve.

The richness of the data also revealed uncaring preceptor behaviors that resulted in not so caring interactions between orientee and preceptor.

The Exhaustive Description of Not So Caring Preceptor Behaviors

Outcomes and meanings to the orientees were also clearly defined in these uncaring interactions. The four exhaustive descriptions that emerged from the orientees' significant statements, formulated meanings and themes are outlined below for the reader to see the synthesis of behaviors and consequent meanings.

Preceptors who did not warmly greet and welcome orientees to the unit caused the orientee to feel nervous and dread their time together.

Preceptors who did not gauge and assess orientees' capabilities and were not present either physically to help the orientee with tasks or psychologically to give

encouragement, teach and answer questions caused the orientees to cry, feel frustrated, abandoned, devastated, and one orientee wanted to quit.

Preceptors who did not gauge and assess orientees' capabilities and were a hovering presence lead the orientee to sense that they are regressing instead of progressing and caused the orientee to experience non trust from the preceptor, nervousness, decreased confidence, and belittlement in front of patients and family.

Preceptors who did not give authentic, clear, concise, constructive, and positive feedback did not give advice that orientees could learn from and caused the orientee to experience feelings of being overwhelmed and inadequate.

The data demonstrated that caring interactions between preceptors and orientees unquestionably did occur during the 10 week orientation period. Six themes emerged from the data that demonstrated preceptor caring behaviors. Each theme was an essential factor in the cultivation of these caring interactions. The data clearly showed how the meanings of these caring interactions impacted the orientees. In addition to answering the two research questions outlined, the richness of the data gave examples of not so caring behaviors from preceptors and the powerful outcomes and meanings from these not so caring behaviors were also depicted. The emergence of the not so caring preceptor behaviors and their consequent interactions were not completely surprising and were noted to be opposite of the caring preceptor behaviors in both actions and outcomes. The compelling dismay that occurred as a result of these not so caring interactions was as powerful as the unequivocal fortification that resulted from the caring behaviors and interactions.

Unexpected Finding

An unexpected finding that emerged from this study was the fact that none of the orientees communicated to their preceptors how the uncaring behaviors and interactions made them feel. Instead of direct dialogue with the preceptors, the orientees kept their

feelings inside and just put up with the preceptors; asked their nursing education nurses to not assign them with the offending preceptors again; had other nurses act in their behalf; or they ignored the preceptors and their actions. Preceptors who were not aware of how their actions affected others were not given the opportunity to learn and change their techniques for precepting. One orientee asked me, is it really wise to confront these not so caring preceptor behaviors and be honest about your feelings....after all this is not the way things are done in the "Midwest nice" culture.

A review of the literature supported this research finding as a common occurrence in orientation programs. Bradby (1990) stated that it was recognized that the new nurse needed to take some responsibility for a good preceptor-orientee relationship but because they were so desperately trying to settle into the team, they did not feel comfortable discussing controversial things that could make them seem demanding or awkward. Another study indicated that new graduate nurses felt unequipped to assertively discuss their thoughts. Evans (2001) found that new graduate nurses were aware of the complexity of communication as new staff nurses and declared the need for a higher level of appropriate assertiveness in their new staff nurse role. Participants in her study recognized the need for increased confidence to say what was required without saying it in a manner that could cause offense, or be misinterpreted (Evans 2001). The literature warned of a potentially dangerous outcome that all preceptors should be watchful of when working with new nurses. The strong desire of new nurses to fit in, conform, and prove themselves worthy could lead to potentially dangerous outcomes for the new nurse and his or her patients. New nurses who feared rocking the boat or being labeled as trouble makers, often times conformed to their unit's way of performing procedures

instead of accomplishing the procedure in the way they preferred (Goh & Watt, 2003). New nurses have three choices they can make regarding their needs for socialization or fitting in. First, they can assume the beliefs of the organization, second, they can leave the unit, or third they can tolerate rejection (Godinez, 1999). Despite the pressure this fitting in or socialization may cause, Buckenham (1994) found that new nurses did not forfeit their professional values in the work environment and maintained their professional values on important matters such as patient advocacy. One of the participants in the Goh and Watt (2003) study commented that if they were told to do something that could hurt a patient or could make a person upset they would refuse to do it. The participant went on to say that if it was something like doing a procedure a different way, that he or she would probably not mind and would not make a big deal of it (Goh &Watt, 2003). This was similar to the experiences delineated by the new graduate nursing orientees in my study. The orientees indicated they tolerated the uncaring interactions with their preceptors because most of the experiences were not related to patient safety. However, some of the examples given regarding uncaring preceptor behaviors actually caused or had the potential to cause harm to the patients. Buckenham (1994) declared that not speaking up for themselves and their feelings was a major issue for the new graduates and caused them high anxiety and tension as well as decreasing their personal and professional self-concept.

When new nurses gave alternative ways of thinking regarding nursing practice they were given negative feedback; positive feedback was given in such a way to confirm the acceptance of the graduate into the culture of nursing (Hinds & Harley, 2001). The new nurses need for acceptance in the nursing culture was found to be more important

than maintaining the internalized principles and beliefs learned through their formal education and bringing these beliefs and values to their practice (Hinds & Harley, 2001). Duchscher (2001) found that new nursing graduate orientees in her study were intimidated and feared speaking up to the physicians. Her study explored the transition of new graduate nurses over six months and at no time during her study did she find that orientees actively spoke up, confronted the physicians or senior staff nurses. They just found ways to get what they needed without aggravating the doctors or other staff nurses (Duchscher, 2001). Duchscher (2001) discussed the overwhelming importance the new graduate orientees placed on blending in and becoming part of the fabric of the unit's culture, however she found in her study that new graduates did speak up if safety of the patient was compromised. Claire (2003) suggested ways for the orientees to have anonymity to report those nurses who displayed inappropriate behaviors such as bullying, bitchiness, rude, nasty and other forms of horizontal violence because the orientees in her study feared reprisal.

This unexpected finding was of concern to me, and reminded me of one widely publicized incident that happened at Johns Hopkins medical center in March of 2001. An 18 month old girl named Josie King died from complications not associated with a strange unknown disease but instead she died of thirst because the hospital's culture did not allow for nurses to feel comfortable second-guessing doctors by bringing up their questions or concerns. Dr. Peter Pronovost a doctor at Johns Hopkins and a leader in patient safety stated that, "85% of all medical errors were caused by faulty communication and that in most cases someone sensed a problem but did not speak up" (Ayd, 2004 p6). Josie's mother Sorrell King has taken her anger and put it to positive use

by partnering with Dr. Pronovost to change the culture of patient safety at Johns Hopkins. Sorrell King told me that "Anyone who reports an error is my hero and anyone that figures out a way to PREVENT that error from occurring again is REALLY my hero" (S. King personal communication, March 28, 2005). This incident reminds nurses of the importance of clear and open communication between themselves, physicians and other health care workers in order to prevent faulty communication. Clear and open communication, asking questions, reporting errors, is vital for the safe care of patients.

Implications of the Study

Teaching Preceptors

The results from this study can be used as a framework to teach preceptors about caring and not so caring behaviors that are perceived by new nursing graduate orientees. Actual examples of caring and not so caring behaviors depicted in this study can be used to develop case studies for further discussion. The outcomes and meanings these caring and not so caring preceptor behaviors had upon new orientees are very important for the preceptor to be cognizant of. The meanings and outcomes expressed by the orientees clearly demonstrated and reinforced the important influence that the preceptor role has upon the orientee and the institution.

Importance of Communication

This study has shown that the new nursing graduate orientees often felt vulnerable, stupid, and like a fish out of water on their new job. This study reinforced that new graduate nurses did not feel equipped to deal with some of the confrontational issues that frequently occurred on their units. Faulty communication and not speaking up regarding potential problems has been cited to be the cause of 85% of all medical errors.

The importance of helping new graduate nursing orientees learn communication techniques that will increase their confidence and enable them to feel more comfortable in speaking up regarding concerns and questions they may have about nursing or medical interventions is vital. This study gives rich data that can be used as discussion points for teaching preceptors and new orientees how to deal effectively with confrontational matters. Honest and clear communication techniques can help to decrease medical errors which could put a patient's life in jeopardy.

Retention of Nurses

The literature has shown that the first three months of employment as a new graduate nurse depicts the most stressful time in a nurses' career (Godinez, Schweiger, Gruver, & Ryan, 1999). Birkenstock (1991) reported that it can cost as much as $30,000 to replace one nurse. Delaney (2003) found that the need for preceptor support, direction and the recognition of institutional idiosyncrasies and interpersonal dynamics were vital in helping the new graduate nurse transition. Transition has been postulated to be emotionally, intellectually and physically challenging, add to this preceptors who display little or no empathy and or caring behaviors and 96% of the graduates in Clare and van Loon's (2003) study began to contemplate leaving nursing altogether! A study by the Advisory Board Company in 2002 explored five exemplary hospitals in the United States to understand why nurse turnover rate was low. The Advisory Board Company (2002) found that relationships with coworkers were the most important reasons why nurses stayed at these hospitals. The Advisory Board Company found that ties with coworkers exert a strong pull and there was an uncommon degree of connection between the coworkers of these exemplary hospitals. This study presented examples regarding making

deeper human connections between the orientee and preceptor and gave actual caring preceptor behaviors that can demonstrate techniques to make those deeper connections as well as powerful and poignant statements that showed what caring behaviors meant to the orientees to be the recipient of these salient caring behaviors. The research from this study can give examples of preceptor's caring behaviors and demonstrate the powerful outcomes of caring interactions between orientees and their preceptors. Learning and practicing caring preceptor behaviors may prove to be useful to health care facilities having problems retaining new nurses.

Guiding and Supporting New Nursing Orientees

Bowles and Candela (2005) found in their study that the work environment was listed as the second reason why graduate nurses left their first job. These reasons included lack of support and guidance and too much responsibility (Bowles & Candela, 2005). Being supportive and guiding the new orientee is a theme noted throughout this study. This study gave examples of actual caring preceptor behaviors that illustrated how to guide and support orientees and how to provide appropriate preceptor presence when giving autonomy. This study also gave actual examples of not so caring preceptor behaviors that demonstrated behaviors to be aware of that did not assist in guiding, supporting and giving proper autonomy. Powerful outcomes from the caring and not so caring behaviors were also listed and could be used as take home points to assist preceptors in understanding the implications of their behaviors.

Increase Awareness of New Graduate Orientees Vulnerability

The literature indicates that new orientees often feel stupid, inadequate, and have very low self-confidence. These findings are in congruence with my study and it was

very interesting to note the vulnerability of these new nursing orientees whom on the outside appeared so self-confident. Preceptors may see this outward appearance of self confidence and therefore not be attentive to the vulnerability of the new orientee. This study reminds preceptors of the vulnerability of the novice nurse and reminds them to make a definite effort to be respectful, and forbid intimidation, and embarrassment that could crumble the fragile foundation of the new orientees' confidence (Clay, Lilley, Borre & Harris, 1990). One of the main causes of this stress is lack of confidence, self expectations, as well as unrealistic expectations by clinical staff. The feeling of being a novice in a world of experts may at times seem overwhelming. (Hinds & Harley, 2001). Claire and van Loon (2003) noted that the orientees in their study felt under prepared and this in turn caused their confidence levels to dip. The results of this study indicated preceptor behaviors that helped to increase learning and clinical experiences that can boost orientees' confidence and self-esteem. This study also gives examples that can help preceptors recognize and understand behaviors that are not perceived of as caring and to comprehend the powerful negative effects these uncaring behaviors can have on the new orientees' self-confidence.

Recommendations

Orientation is emotionally and physically exhausting, and these new nursing graduates had taxing personal lives as well. Some were recently married, one was planning her wedding. Most of them had recently moved to the city and were trying to get established in new homes or apartments. Because of their busy lives and long orientations, several of the orientees had to drop out of my study. I would recommend

gathering data from orientation groups for over a year due to the high attrition that naturally happens.

Preceptors at this medical facility are the heart of the institution. They not only work with new orientees, they also work closely with the many of the nursing students from the institution's affiliated nursing programs. Their work is difficult and I have been amazed at all they do to share their knowledge and expertise. Sharing the results of this study with them has been one of the main goals of my research. Another recommendation that I would make, would be to have preceptor's journal about their experiences in working with orientees and explore how they feel they have been caring or how they feel they could have done things differently if they felt they were not so caring. A comparison of the orientees' perceptions and the preceptor's perceptions would be helpful information in assisting nurses to understand the multifaceted concepts of caring.

This study is a snapshot of 10 new nursing graduate orientees' lived experiences during their 10 week orientation period. The discomfort these new graduate nursing orientees declared regarding communicating their concerns to preceptors whom they felt acted in uncaring ways was an unexpected finding in this study. It is unknown if this is a common feeling with other new graduate nursing orientees who come to work at this facility. Because of the importance of honest, open communication in nursing, my last recommendation would be to continue to explore orientee and preceptor interactions and look for trends in these relationships that may indicate patterns for producing faulty communication.

I was impressed by the caring behaviors shown by preceptors at this institution. I found it very heartening to see that the process of orientation has become a more

humanistic and caring process from what I experienced over 20 years ago. I can still remember very vividly that first day when I started my nursing career. I was filled with a sense of excitement and accomplishment when I walked up to my preceptor, smiling from ear to ear, held out my hand and introduced myself to her. She looked at me, frowned, and said, "I told them I was not going to train in any more of you new nurses....you just quit anyway!" My excitement quickly faded and was replaced with anxiety, and I wondered what I should do with my outstretched hand. If I were a new nurse beginning my career today, I do not believe that I would experience such a cold entrance into the profession of nursing at this organization. The importance of the work the preceptors do at this institution is vital to both retention and recruitment of future nurses. I hope that my research can help preceptors see the positive impact their caring can have on new orientees as well as to be aware of how uncaring behaviors are perceived by orientees and how these behaviors can be hurtful.

I have felt very privileged to have been a part of these new nursing graduate orientees professional orientation journey. I was impressed with their intelligence, poise and professionalism. Being a new nursing graduate is a daunting task, patient acuity is much higher than it was when I first started my nursing career. Being an older nurse who is looking forward to retirement in the next 12 years, I feel reassured to know there will be nurses such as these new nurses to care for me and my family. I wish them all the best as they begin their new careers as independent, safe and accountable registered nurses.

References

Ahern, K. (1999). Pearls, pith and provocation: Ten tips for reflexive bracketing. *Qualitative Health Research.* 9(3), 407-411.

Alligood, M. & Marriner, A. (2002). *Nursing theory utilization and application.* Mosby, St. Louis.

Amos, D. (2003). An evaluation of staff nurse role transition. *Nursing Standard*, 16(3), 36-41.

Andershed, B., & Ternstedt, B. (1999). Involvement of relatives in care of the dying in different care cultures: Development of a theoretical understanding. *Nursing Science Quarterly*, 12(1), 45-51.

American Association of Colleges in Nursing. *Nursing shortage fact sheet.* Retrieved Feb. 16, 2002, from http://www.aacn.nche.edu/ .

Asp, M., & Fagerberg, I. (2002). The woven fabric-a metaphor nursing care: the major subject in nursing education. *Scandinavian Journal of Caring Science*, 16(4), 115-121.

Ayd, M. (2004). A remedy of errors. *Hopkins Medicine Magazine.* Retrieved March 17, 2005. www.hopkinsmedicine.org/hmn/S04/feature1.cfm

Baldursdottir, G., Jonsdottir, H. (2002). The importance of nurse caring behaviors as perceived by patients receiving care at an emergency department. *Heart & Lung: The Journal of Acute and Critical Care,* 31(1), 67-75.

Barr, W., Bush, H. (1998). Four factors of nurse caring in the ICU. *Dimensions of Critical Care Nursing.* 17(4), 214-223.

Baltimore, J., (2004). The hospital clinical preceptor: Essential preparation for success. *The Journal of Continuing Education in Nursing.* 35(3), 133-140.

Barlow, J., Moller, C. (1996). A complaint is a gift: Using customer feedback as a strategic tool. San Francisco: Berrett-Koehler Publishers.

Bowles, C., & Candela, L., (2005). Improving the work environment. *JONA.* 35(3), 130-137.

Beauchamp, C. (1993). The centrality of caring: A case study. In Nursing Research: A qualitative perspective. National League for Nursing Press New York.

Beck, C. (2001). Caring within nursing education: A metasynthesis. *Journal of Nursing Education,* 40(3), 101-109.

Beck, C. (1993). Caring relationships between nursing students and their patients. *Nurse Educator*, 18(5), 28-32.

Beck, C. (1992 a). Caring among nursing students. *Nurse Educator.* 17(6), 22-27

Beck, C. (1992 b). Caring between nursing students and physically handicapped children: A phenomenological study. *Journal of Nursing Education.* 31 361-366

Beck, C. (1991). How students perceive faculty caring: A phenomenologic study. *Nurse Educator*, 16(5), 18-22.

Belenky, M., Clinchy, B., Goldberger, N., & Tarule, J. (1986). *Women's way of knowing.* Basic Books Inc.:USA.

Benner, P., & Wruble, J. (1988). *The primacy of caring*. Menlo Park, CA: Addison-Wesley.

Bevis, E., & Watson J. (1989) *Toward a caring curriculum: A new pedagogy for nursing.* New York: National League for Nursing.

Bevis, E. (Ed.). (1994, Jan.). *Collaboration of Nursing Education and Practice: Vision for the Future-Part II.* (Available from Legacy workshops).

Birkenstock, M. (1991). Recruitment and retention. *AORN Journal*, 53(4). 110-118.

Boykin, A., & Schoenhofer, S. (2001). Nursing as caring: A model for transforming practice. Boston: Jones & Bartlett publishing.

Bradby, M. (1990). Status passage into nursing: Another view of the process of socialization into nursing. *Journal of Advanced Nursing*, 15(3), 1220-1225.

Buckenham, J. (1994). Socialisation of the beginning professional nurse. PhD thesis. University of Melbourne. Department of Social and Educational Studies. Melbourne, Australia.

Bulach, C., & Brown, C. (1998). Behaviors that create a caring learning community, *Journal for a Just and Caring Education*. 4(4), 441-453.

Burns, N., & Groves, S. (1993). *The practice of nursing research: conduct, critique and utilization.* Philadelphia: W.B. Saunders.

Chickering, A., & Reisser, L. (1993). *Education and identity* (2nd ed.). San Francisco: Jossy Bass.

Charisika, M. (1998). Student Perceptions of faculty caring and instructor perceptions of their own and their colleagues' caring qualities within a community college system (Doctoral dissertation, Spalding University, 1998). *Dissertation Abstracts International*, 59, no. 02B.

Christopher, K., & Hegedus, K. (2000). Oncology patients' and oncology nurses' perceptions of nurses caring behaviors. *European Journal of Oncology nursing* 4(4), 196-206.

Clare, J., & van Loon, A., (2003). Best practice principles for the transition from student to registered nurse. *Collegian*. 10(4), 25-31.

Clay, M., Lilley, S., Borre, K., & Harris, J., (1999). Applying adult education principles to the design of a preceptor program. *Journal of Interprofessional Care.* 13(2),

Clifford, C. (1996). Role:A concept explored in nursing education. *Journal of Advanced Nursing,* 23(4), 1135-1141.

Coleman Folding Campers. (1992). Fleetwood Enterprises. CA

Connellan, T. (2003). *Bringing out the best in others.* Bard Press, Austin Texas.

Covey, F. (1989). *The 7 habits of highly effective people.* Simon & Schuster, New York.

Coward, D. (1990). The lived experience of self transcendence in women with advanced breast cancer. In Munhall 2001 *Nursing research: A qualitative perspective.* New York: National League for Nursing Press.

CNN Interactive news. http://www.cnn.com/WORLD/9709/mother.teresa/ Retrieved from WWW on March 18, 2004.

Creswell, J. (1998). *Qualitative Inquiry and Research Design: Choosing among five traditions.* London: Sage Productions.

Cronin, S., & Harrison, B. (1988). Importance of nurse caring behaviors as perceived by patients after myocardial infarction. *Heart and Lung.* 17(4), 374-380.

Delaney, C. (2003). Walking a fine line: Graduate nurses' transition experiences during orientation. *The Journal of Nursing Education*, 42(10), 437-43.

Dillon, R., & Stines, P. (1996). A phenomenological study of faculty student caring interactions. *Journal of Nursing Education* 35(3), 113-118.

Duchscher Boychuk, J. (2001). Out in the real world: Newly graduated nurses in acute care speak out. *Journal of Nursing Administration*, 31(9), 426-439.

Ellerton, M., & Gregor, F. (2003). A study of transition: The new nurse graduate at 3 months. *Journal of Continuing Education in Nursing.* 34(3), 103-107).

Erci, B., Sayan, A., Tortumloglu, G., Sahin, O. & Gungormus, Z. (2003). The effectiveness of Watson's Caring Model on the quality of life and blood pressure of patients with hypertension. *Journal of Advanced Nursing.* 41(2), 130-139.

Evans, K. (2001). Expectations of newly qualified nurses. *Nursing Standard,* 15(41), 33-38.

Evans, N., Forney, D., & Guido-Dibrito, F. (1998). *Student Development in College.* San Francisco: Jossy-Bass

Fanslow, J. (1987). Compassionate nursing care is it a lost art? *The Journal of Practical Nursing.* 37(2), 36-39.

Foster, R. & Hicks, G. (2000) *How we choose to be happy: The 9 choices of extremely happy people-Their secrets, their stories.* New York: Perigee.

Gerrish, K. (2000). Still fumbling along? A comparative study of newly qualified nurses' perceptions of the transitions form student to qualified nurse. *Journal of Advanced Nursing.* 32(2), 473-480.

Giorgi, A. (1985). *Phenomenology and psychological research,* Pittsburgh:Duquesne University Press.

Godinez, G. Gruver, J., Ryan, P., Schweiger, J. (1999). Role transition from graduate to staff nurse: A qualitative analysis. *Journal for Nurses in Staff Development,* 15(3), 97.

Goh, K., & Watt, E. (2003). From dependent on to depended on: The experience of transition from student to registered nurse in a private hospital graduate program. *Australian Journal of Advanced Nursing*, 21(1), 14-18.

Gooding, B., Sloan, M., & Gagon, L.(1993). Important nurse caring behaviors: Perceptions of oncology patients and nurses. *Canadian Journal of Nursing Research,* 25(3), 65-76.

Grams, K., Kosowski, M., & Wilson, C. (1997). Creating a caring community in nursing education, *Nurse Educator*, 22(3), 10-16.

Green-Hernandez, C. (1992). Being there and caring: A philosophical analysis and theoretical model of professional nurse caring in rural environments. *In Rural Health Nursing: Stories of creativity, commitment, and connectedness*. 31-53. New York: National League for Nursing.

Green-Hernandez, C. (1991). Professional nurse caring in *Caring and nursing: Explorations in feminists perspectives.* New York: National League for Nurses. 85-96.

Greenhalgh, J., Vanhanen, L., & Kyngas, H. (1998). Nurse caring behaviours. *Journal of Advanced Nursing,* 27(5), 927-932.

Grigsby, K., & Megel, M. (1995). Caring experiences of nurse educators. *Journal of Nursing Education,* 34(9), 411-418.

Halldorsdottir, S. (1990). The essential structure of a caring and uncaring encounter with a teacher: The perspectives of the nursing student. In M. Leininger & J. Watson (Eds.) *The Caring Imperative in Nursing Education,* (95-108) New York: NLN press.

Hansen, L. (1992). The experience of being cared for by nursing faculty: A students perspective. Unpublished masters thesis. Winona State University. Winona MN

Hansen, L. & Smith, M. (1996). Nursing students' perspectives: Experiences of caring and not-so-caring interactions with faculty. *Journal of Nursing Education.* 35 (3), 105-111.

Hawley, P. (2000). Moments in nursing practice: An interpretive analysis. *International Journal of Human Caring*, 8(2), 18-22.

Helgesen, S. (1995). *The female advantage: Women's way of leadership.* Doubleday, New York.

Henderson, V. (1966). *The nature of nursing: A definition and its implications for practice, research, and education.* New York: Macmillan.

Hinds, R., & Harley, J. (2001). Exploring the experiences of beginning registered nurses entering the acute care setting, *Contemporary Nurse* 10(1-2), 110-116.

Hipwell, A., Tyler, P., & Wilson, C. (1989). Sources of stress and dissatisfaction among nurses in four hospital environments. *British Journal of Medical Psychology.* 62(1), 71-79.

Hopko, N. (2002). Assessing rigor in qualitative research. *Journal of the Association of Nurses in Aids Care.* 13(4), 84-86.

Houghton, J. (2001). Wrestling with Watson's theory of caring. *Nursing New Zealand.* 7(2), 16-17.

Huggins, K. & Kohut, D. (1993). Emergency department patients' perceptions of nurse caring behaviors. *Heart and Lung*, 22(4), 356-364.

Hughs, L. (1993). Peer group interactions and the student-perceived climate for caring. *Journal of Nursing Education,* 32 (2), 78-83.

Hughs, L. (1992). Faculty-student interactions and the student-perceived climate for caring. *Advances in Nursing Science*, 14(3), 60-71.

Iglesias, A. (2000). Patients' perceptions of important nurse caring behaviors in an adult urgent setting. Unpublished Dissertation Northern Illinois University.

James, L. (1994). *How to really love the one you're with: Affirmative guidelines for a healthy love relationship*. Career Assurance Press, Scottsdale, AZ

Jensen, k., Pettersson, S., & Segesten, K. (1996). Catching my wavelength. *Nursing Science quarterly*. 9(3), 115-120.

Johnson, C. (1993). Is he boyfriend material? *Young Miss* 41(8), 38-48.

Juethong, W. (1998). Thai baccalaureate nursing students' caring and uncaring lived experiences with Thai nursing instructors. Unpublished dissertation George Mason University

Keane McDermott, S., Chastrain, B., & Rudisill, K. (1987). Caring: Nurse-patient perceptions. *Rehabilitation Nursing*, 12 get this 182-187.

Keen, S. (1997). *To love and be loved.* Bantam Book, New York.

Kelly, B. (1996). Hospital nursing: it's a battle! A follow up study of English graduate nurses. *Journal of Advanced Nursing*. 24(5), 1063-1069.

Knowles, M. (1984). *Andragogy in Action.* Jossey-Bass San Francisco, Ca

Kosowski, M. (1995). Clinical learning experiences and professional nurse caring: A critical phenomenological study of female baccalaureate nursing students. *Journal of Nursing Educatio*n 34(5), 235-242.

Kramer, Marlene (1974). *Reality Shock Why Nurses Leave Nursing.* Saint Louis: C.V. Mosby Company

Larson, P. (1984). Important nurse caring behaviors perceived by patients with cancer. *Oncology Nursing Forum.* 11 (6), 46-50.

Larson, P. (1987). Comparison of cancer patients' and professional nurses' perceptions of important nurse caring behaviors. *Heart and Lung.* 16(2), 187-193.

Leininger, M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly*, 1(4), 152-160.

Lemmer, C. (1991). Parental perceptions of caring following perinatal bereavement. *Western Journal of Nursing Research.* 13(4) 475-493.

Lenihan, M. (1995). Patient perceptions of nurse caring on a medical surgical unit. Unpublished Doctoral Dissertation. DAI, 56, no.08B, (1995): 4242. University of Cincinnati.

London Underground feedback web site: http://tube.tfl.gov.uk/content/customer_complaints/default.asp Retrieved from the WWW March 22, 2004.

Mangold, A. (1991). Senior nursing students' and professional nurses' perceptions' of effective caring behaviors: A comparative study. *Journal of Nursing Education.* 30(3). 134-139.

Marini, B. (1999). Institutionalized older adults perceptions of nurse caring behaviors. *Journal of Gerontological Nursing.* 25(5). 10-6.

Maslow, A., Frager, R., Fadiman, J. (1976). *Motivation and personality.* Addison-Wesly Educational Publishers. Boston MA.

Mayer, D. (1987). Oncology nurses' versus cancer patients' perceptions of nurse caring behaviors: A replication study. *Oncology Nursing Forum*, 14(3), 48-52.

Mayeroff, M. (1971). *On Caring*. Harper Perennial, New York

McNamara, S. (1995). Perioperative Nurses' perceptions of caring practices. AORN, 6(12), 377-388

Messmer, P., Abelleria, A., & Erb, P. (1995). Code 50: An orientation matrix to track orientation cost. *Journal of Nursing Staff Development*, 11, (5). 261-264.

Miller, B., Haber, J., &Byrne, M. (1990). The experience of caring in the teaching learning process of nursing education: Student and teacher perspectives. In Leininger & J. Watson (Eds.) *The caring imperative in nursing*. (125-135). New York: NLN Press.

Miller, & Keane. (1992). *Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health.* Philadelphia PA: W.B. Saunders Company.

Mullins, I. (1996). Nurse caring behaviors for persons with acquired immunodeficiency syndrome/human immunodeficiency virus. *Applied Nursing Research*. 9(1). 18-23.

Munhall, P. (2001). *Nursing Research: A Qualitative Perspective*. 3rd ed. New York: National League for Nursing Press.

Munhall, P. (1994). *Revisioning Phenomenology: Nursing and health science research.* New York: Jones & Bartlett.

Nightingale, F. (1992). *Notes on nursing, what is and what is not.* (C.B. Schuler, Ed.) Philadelphia: Lippincott. (Original work published 1859).

Noddings, N. (1986). *Caring: A Feminine Approach to Ethics and MoralEducation.* London England: ISBN.

Norris, C. (1989). To care or not to care--questions! questions! *Nursing and Health Care.*10 (10). 545-550.

Nursing Executive Center (2002). *Destination Nursing: Creating a destination hospital for nurses.* The Advisory Board Company. Washington, D.C.

Orem, D. (1980). *Nursing: Concepts of practice.* New York: McGraw-Hill.

Osterman, P., & Schwartz, D. (1996). Presence: Four ways of being there. *Nursing Forum.* 31(2), 25-28.

Papa Johns Pizza feedback web site. http://www.planetfeedback.com/Fast%20Food/Papa_John's_Pizza/Papa_John's_Pizza_feedback-letters.html Retrieved from the WWW March 22, 2004.

Pallikkathayil, L., & Morgan, S. (1991). Phenomenology as a method for conduction clinical research. *Applied Nursing Research* 4(4) 195-2000

Parsons, E., Kee, C., & Gray, P. (1993). Perioperative nurse caring behaviors: Perceptions of surgical patients. *AORN Journal.* 57(5). 1106-1114.

Patistea, E., & Siamanta, H. (1999). A Literature review of patients' compared with nurses' perceptions of caring: Implications for practice and research. *Journal of Professional Nursing.* 15(5). 302-312.

Perkins, D. (2003). *King Arthur's round table: How collaborative conversations create smart organizations.* John Wiley and Sons. Hoboken, New Jersey.

Polit, D. & Hungler, B. (1993). *Essentials of Nursing Research, Methods, Appraisal and Utilization.* Philadelphia: Lippincott Company.

Randall, L. (1992). Love my leader. *Weight Watcher's Magazine*. 25(8), 56.

Riemen, D. (1986). Noncaring and caring in the clinical setting: Patients' descriptions. *Topics in Clinical Nursing* 8(2), 30-36.

Roach, S. (1984). *Caring: The human mode of being: Implications for nursing.* Toronto: University of Toronto.

Roberts, J. (1990). Uncovering hidden caring. *Nursing Outlook*, 28(2), 67-69.

Robertson, J., & Cummungs, C (1991). What makes long-term nursing attractive? *American Journal of Nursing*. 91(11), 41-46.

Rogers, C. (1977). *Carl Rogers on personal power.* Delecorte Press, New York.

Rosenberg, M. (2003). *Nonviolent Communication: A language of life*. Puddle Dancer Press, Encinitas, CA.

Rosenthal, K. (1992). Coronary care: Patients' and nurses' perceptions of important nurse caring behaviors. *Heart and Lung,* 21(6), 536-539.

Sadler, J. (1997). Defining professional nurse caring: A triangulation study. *Journal of Human Caring*, 1(3), 12-21.

Santucci, J. (2004). Facilitating the transition into nursing practice: Concepts and strategies for mentoring new graduates, Journal for nurses in staff development, 20(6), 274-284.

Scharf, L., Caley, L. (1993). Patients' nurses' and physicians' perceptions of nurse caring behaviors. *Nursing Connections,* 6(1), 3-12.

Schroeder, C., & Mave, M. (1992). Nursing care partnerships at the Denver nursing project in human caring: an application and extension of caring theory in practice. *Advanced Nursing Science,* 15(2), 25-38.

Schumacher, D. (1995). How nursing students perceive caring and noncaring behaviors of nursing faculty. Unpublished master's thesis, Winona State University, Winona MN

Schultz, P. (1992). The lived experience of licensed practical nurses enrolled in an Upgrade associate degree nursing program (Doctoral Dissertation, Peabody College for Teachers of Vanderbilt University, (1992) *Dissertation Abstracts International,* 53, no.04B

Siler, B. & Kleiner, C. (2001) Novice faculty: Encountering expectations in academia. *Nursing Education,* 40(9), 397-403.

Sitzman, K. (2002). Interbeing and mindfulness: A bridge to understanding Jean Watson's theory of human caring. *Nursing Education Perspectives,* 23(3), 118-123.

Steed, C. (2004). Eating our young isn't practiced here. *Nursing 2004.* 34(8), 43.

Swanson, K. (1993). Nursing as informed caring for the well-being of others. *IMAGE: Journal of Nursing Scholarship,* 25(4), 352-357.

The caring Institute The Caring Awards for 2003 http://www.caringinstitute.org/html/ar/CA/2003CA/Tisdale_03.html Retrieved from the WWW March 28, 2004.

The Advisory Board Company (2001). *Nursing Executive Center Destination Nursing Survey* 2001.

Toffler, A. (1970). *Future Shock.* New York: Random House Inc.

Valle, R. & Halling, S. (1989). *Existential-Phenomenological Perspectives in Psychology.* New York: Plenum Press.

Viverais-Dresler, G. & Kutschke, M. (2001). Select RN students' ratings and opinions related to the importance of certain clinical teacher behaviors, *The Journal of Continuing Education in Nursing*, 32(6), 274-282.

Von Essen,L., & Sjoeden, P. (2003). The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. *International Journal of Nursing Studies,* 40(5), 487-97.

Von Essen, L., & Sjoeden, P. (1991 a). The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. *International Journal of Nursing Studies*, 28(3), 267-281.

Von Essen, L., & Sjoeden, P. (1991b) Patient and staff perceptions of caring: Review and replication. *Journal of Advanced Nursing.* 16(11), 1363-1374.

Von Post, I., & Eriksson, K. (2000). The ideal and practice conceptions for professional nursing care. *International Journal for Human Caring.* 14-22.

Wade, G. (2000). Perceptions of instructor caring behaviors, self-esteem and perceived clinical competence: A model of the attitudinal component of professional nurse autonomy in female baccalaureate nursing students. Unpublished Dissertation Widener University.

Walsh, M. (1992). Critical care patients' perceptions of nurse caring behaviors. Unpublished Masters thesis. MAI, 30, no 03. Western Connecticut State University.

Walsh, M., Dolan, B. (1999). Emergency nurses and their perceptions of caring. *The Journal of RCN Accident and Emergency Nursing Association*, 7(4), 24-31.

Watson, J. (2001) Theory of human caring in M. Parker *Nursing theories and nursing practice.* F.A. Davis Philadelphia.

Watson, J. (1994). *Applying the art and science of human caring.* NLN New York.

Watson, J. (1988). *Nursing: Human science and human care: A theory of nursing.* New York: National League of Nursing.

Watson, J. (1985). *Nursing: The philosophy and science of caring.* Boulder, Colorado: Colorado Associated University Press.

Watson, J. (1979). *Nursing: The philosophy and science of caring.* Boston: Little Brown.

Wiles, J. (1995). A comparison of the perceptions held by nursing students and nursing instructors concerning those teaching characteristics that will facilitate augmentation of caring attitudes and caring behaviors (Doctoral Dissertation, University of Southern California, 1995) *Dissertation Abstracts International*, 57, no 03A

Wilkes, L., & Wallis, M. (1993). The three C's of caring: The lived experiences of student nurses. *Australian Journal of Advanced Nursing*, 11(1), 19-25.

Wilkes, L., Wallis, M. (1998). A model of professional nurse caring: nursing students' experience. *Journal of Advanced Nursing*, 27(3).

Winter-Collins, A., & McDaniels, A. (2000). Sense of belonging and new graduate job satisfaction. *Journal for Nurses in Staff Development.* 16(3), 103-111.

Yeakel, S., Maljanian, R., Bohannon, R., & Coulombe, K. (2003). Nurse caring behaviors and patient satisfaction: Improvement after a multifaceted staff intervention. *JONA* 33(9), 434-436.

Appendix A
Watson's Carative Factors

1. A humanistic-altruistic system of values

2. Enabling and sustaining faith-hope.
3. Cultivating a sensitivity to self and others
4. Development of a helping-trusting human caring relationship.
5. Promoting and accepting the expression of positive and negative feelings and emotions.
6. Engaging in creative, individualized, problem-solving caring process.

7. Promoting transpersonal teaching-learning
8. Attending to supportive, protective and/or corrective, mental, physical, social, and spiritual environment.
9. Assisting with gratification of basic human needs, while preserving human dignity and wholeness.

10. Allowing for, being open to existential-phenomenological and spiritual dimensions of healing

Appendix B
Chickering and Reisser's Seven Vectors of Development

1. Developing Competence
2. Managing Emotions
3. Moving through autonomy toward interdependence
4. Developing mature interpersonal relationships
5. Establishing identity
6. Developing purpose
7. Developing integrity.

Appendix C

Letter of Invitation

New nursing graduate orientees

FROM: Donna Schumacher, PhD candidate Colorado State University
RE: Invitation to Participate in Nursing Research

I am studying the new graduate nurse's experience of being cared for by preceptors during the 10-week orientation period here at the medical center. I believe the study will help preceptors to better understand ways they can convey caring, and the impact those caring interactions have on new nursing graduate orientees. If you choose to take part in this study, you will be asked to identify and describe your feelings and thoughts through the process of brief, daily, reflective journaling. You may also be asked to participate in a taped, open-ended interview, which will take approximately 60 to 90 minutes. This interview will take place towards the end of the orientation period. The daily journals will be used as a resource to you during the interview to refresh your memory of feelings and thoughts that occurred over the many weeks of orientation. The journals will be photocopied in order for highlighting to occur for coding process. The journals will be returned to you at the end of the study and successful defense of the dissertation. All photocopied journal pages will be shredded at the end of the study and successful defense of the dissertation. If you are asked to participate in the interview, you will also participate in a brief, follow up interview in order to clarify my perceptions of the findings from your interview. This meeting will take place within one week after the interview.

Your participation will be totally voluntary. You will have the right to withdraw at any time without fear of reprisal. Your identity will be kept confidential. Data will be grouped according to themes and reported as such and any identifying data will be edited out. Neither your name nor those of the preceptors will be included in this study. The name of the medical center will not be identified in this dissertation. Audio tapes will be given pseudonyms chosen by you. After audio tapes have been transcribed, all tapes will be destroyed.

If you have any questions about the study or about being a subject, you can call me at 507-252-1205 (home). You may also contact my dissertation advisor, Dr. Timothy Gray Davies at 970-451-5199.

Please consider this a personal invitation to be a part of the study.

Appendix D

Demographic Form

Investigator: Donna Schumacher, MS, R.N.

AGE:_____

SEX: Male____ Female_____

ETHNIC ORIGIN: LIST

EDUCATION:
College where you received your nursing degree:

Highest degree obtained in nursing education:

Other degrees obtained besides nursing:

Appendix E

Guidelines for Journaling

I am studying the new graduate nurse's experience of being cared for by preceptors during the 10-week orientation period here at the medical center. I believe the study will help preceptors to better understand ways they can convey caring, and the impact those caring or not so caring interactions have on new nursing graduate orientees. The following questions serve as guidelines to assist you with your daily journaling. You may find that some days you have little to journal about and on other days you have much more to journal. Please try to keep journaling to no more than 10 minutes day and journal entries to one page or less. Remember to not use your primary preceptor or other preceptor's actual name. Use PP when discussing primary preceptor and OP when discussing other preceptors.

Questions to consider:

8. Describe what went well for you today.
9. Describe what did not go so well for you today.
10. Today I felt cared for by my primary preceptor (PP) or my other preceptors (OP) because:
11. Today I did not feel cared for by primary preceptor (PP) or other preceptor (OP) because: