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The Affective Domain in Nursing Education: Educators' Perspectives

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THE AFFECTIVE DOMAIN IN NURSING EDUCATION: EDUCATORS' PERSPECTIVES

by

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ABSTRACT

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Affective learning in nursing education continues to be important in the development of professional values. Affective learning is defined as a type of learning that reaches the emotional and belief system of those who facilitate and participate in it and establishes attitudes and professional values. There is limited exploration of affective learning in nursing education. How educators are facilitating learning in this domain is important to future nursing education practice as it transforms to meet new societal and health care demands. The purpose of this study was to explore the meaning, experience and the act of teaching in the affective domain as described by experienced nurse educators. Naturalistic inquiry techniques were used to answer the research question. Fifteen experienced nurse educators were recruited via snowball technique and asked to contribute stories about the affective domain and engage in a conversation about affective learning. Protections of human subjects' protocols were followed. Face-to-face interviews were conducted and data were collected via digital audiotape and field texts. Data were coded and examined with attention to the research relationship utilizing thematic and structural analysis techniques.

Naturalistic inquiry trustworthiness was established with evidence in an audit trail. This audit trail included documentation of the research process, transcriptions of the narratives generated, and reflective notes on made during the inquiry. Participants shared experiences with affective learning and a process for learning in the affective domain was described. The richness of the data is anticipated to contribute to the science of nursing education in the development of professional nurses.

Dedication

This work is dedicated to the nurse educators who participated in this study and generously gave their time and stories of their experiences to further the science of nursing education. This work is also dedicated to all nurse educators who strive for teaching excellence as they develop the nursing workforce of the future.

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Many individuals have contributed to this dissertation and I am indebted to each of them. I would like to thank my major professor, Susan Dean-Baar, PhD, FAAN, for encouragement and oversight of this project. Her patient persistence encouraged me to finish even when I did not think I could. I would also like to thank the members of my committee who gave freely of their time and expertise during my learning.

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In memory: Steven W. Taylor
December 8, 1957 – April 30, 2012

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Chapter I

Introduction to the Problem

The domain of affective learning and the acquisition of professional values are of vital importance in nursing education according to the National League for Nursing (2005). Nurse educators have a responsibility to educate the future nurse workforce and assure student development of professional nursing values. The affective domain is linked to ethical and moral development and has been associated with values acquisition, including those of the profession since the middle of the last century. Nursing education has been evolving to prepare individuals to meet the dynamic health care needs of the nation (National League for Nursing [NLN], 2005). The profession of nursing faces some significant challenges in the nurse workforce. The healthcare system continues to grow in complexity, as there is a corresponding increase in demand for services (National Advisory Council on Nurse Education and Practice [NACNEP], 2008). Health care is evolving dramatically with changes in technology and nursing practice. These changes will require new competencies of nurses. The development of professional values is critically important in educating the next generation of nurses.

Educating the nurse of the future will require a balance between nursing knowledge and professional values. Evidence-based nursing education must not only focus on content but also on professional values to establish the nurse-patient relationship. Knowledge and skills will need to be taught along with caring and compassion (American Association of Colleges of Nursing [AACN], 2008). Caring and compassion are essential in the education and practice of nursing (Brown, 2011).

The nurse-patient relationship is paramount in nursing practice. Professional nursing values provide the basis upon which to establish a trusting relationship between the nurse and the patient. These values are distinguished, distinctive, and definite moral and ethical traditions in nursing practice (Fowler, 2008). An integral part of the foundation of nursing, these values are essential to nursing practice and healthy patient outcomes (Shultz, 2009). Nurses in practice are applying principles of altruism, excellence, caring, ethics, respect, communication and accountability in patient care (AACN, 2008).

Nurse educators have a responsibility to educate the future nurse workforce and assure the development of professional nursing values in nursing students. The development of professional values is critically important to develop in nursing students and future generation of nurses. In 2001, the American Nurses Association (ANA) delineated the Code of Ethics for Nursing which were expanded upon by Fowler (2008). Nurses are expected to adhere to the ideals and norms of the profession and embrace them as a part of what it means to be a nurse (Fowler, 2008).

Nursing faculty will be called to educate more nurses and to create new nursing education pedagogies for the future of nursing practice. The National League for Nursing (NLN) indicates that what is needed in nursing is innovation and an overhaul of traditional pedagogies in the way the nursing workforce is educated (NLN, 2003). This overhaul of traditional pedagogies must be conducted with accountability of faculty to the educational system and to the profession of nursing itself. This overhaul and transformation in nursing education is driven by societal need, societal demand, and accountability (NLN, 2005). It is important that nursing faculty focus on creating

environments for student learning characterized by collaboration, understanding, trust, and respect (NLN, 2005).

The transformation of nursing education includes a call for evidence-based pedagogies. The expansion of knowledge over the past two decades has made the traditional focus on nursing content increasingly difficult to manage for both students and faculty. The nursing education system cannot continue within the current framework of additive curricula (Bevis, 2007). The NLN (2003) issued a position statement calling for innovation in nursing education and educational systems to help meet the needs of the health care delivery system and to educate the nursing workforce of the future. The position statement encouraged innovative and evidence-based pedagogies to educate future generations of the nursing workforce for the dynamic and diverse health care environment (NLN, 2003).

The development of professional values is closely associated with the affective domain. Nursing education has traditionally been described in the three domains of cognitive, psychomotor, and affective learning (Shultz, 2009). According to Bloom (1956), the American Psychological Association (APA) originally identified these domains in 1948. Educators at that time felt there should be a taxonomy classification system for educational objectives to help organize the goals of higher education. The *Taxonomy of educational objectives, Handbook I: Cognitive domain* (1956) was the documented result of the committee assigned to review educational objectives submitted by many higher education institutions of the time. This committee found that college educational objectives fell into three basic categories or domains; psychomotor,

cognitive, and affective. These behavioralist domains are an important model for nurse educators and faculty to understand when transforming nursing education.

The cognitive domain encompasses knowledge acquisition in traditional terms such as reading, memorizing and examinations. Cognitive learning resources abound in nursing education with textbooks, workbooks, lecture, and computerized resources as examples of available teaching tools. The psychomotor domain was also identified through review of objectives. This domain involves skill mastery and knowledge acquisition in physical ways. Practice and refinement of skills are essential psychomotor learning tools. Psychomotor resources include skills labs and practice labs as well as clinical experiences. The APA described the affective domain as objectives that described changes in "interest, attitudes, and values and the development of appreciations and adequate adjustments (Bloom 1956, p. 7)." The APA committee described the difficulty in establishing an evaluation of the affective domain because internal behaviors are manifested as feelings and emotions (Bloom, 1956).

Quality and safety in patient care has become a national initiative. The Institute of Medicine has identified a quality gap in health care and identified competencies needed for the current health care environment (Fetter, 2009). Funded by the Robert Wood Johnson Foundation, the Quality and Safety Education for Nurses (QSEN) project began in 2005 to identify competencies needed for current nursing entry into practice. Six competencies were developed; patient-centered care, teamwork, evidence-based practice, quality improvement, safety, and informatics (Smith, Cronenwett, & Sherwood, 2007). These six competencies were further developed into the knowledge, skills, and attitudes (KSAs) needed to demonstrate competency (Cronenwett, et. al., 2007). A

practical application of the cognitive, psychomotor, and affective domains described by Bloom (1956), the KSAs illustrate for nurse educators that competencies are not just measured in the cognitive domain.

For this study, affective learning is defined as a type of learning that reaches the emotional and belief system of those who facilitate and participate in it and establishes attitudes and professional values. It is important that affective learning and the underlying processes involved in professional values acquisition are integrated into healthcare system changes and nursing education transformation. Understanding values in the therapeutic relationship is critical in providing quality patient care and in facilitating healthy patient outcomes (Shultz, 2009).

There has been some work in nursing education regarding the affective domain. King (1984) developed a comprehensive approach to teaching and learning in the affective domain. Based on the belief that it is appropriate to teach ethics and morals, she developed a resource for nurse educators interested in the affective domain. Instructional strategies and assessments are described but rely heavily on psychometric techniques and measurement of behavioral objectives. These methods were designed to measure the cognitive domain and may not be applicable to the affective domain.

Reilly and Oermann (1992) describe the approach to teaching in the affective domain as valuing within value systems and skills in moral reasoning and utilize Bloom's affective taxonomy. They define values as judgments and moral reasoning. They also use "belief" and "attitude" as descriptors of affect in discussing nursing education. They discuss beliefs as a guiding influence on behavior and are highly vulnerable to social forces in a situation at any given time. The imperative for nursing education is to

develop nursing professionals with outcomes that include the integration of ethical values and beliefs that are fundamentally important to the profession of nursing.

There is little research on educational practices conducted by nurse educators despite new innovations in nursing education (Shultz, 2009). There is currently a need to examine nursing education practices and contribute to the scholarship of nursing education (American Association of Colleges of Nursing, 1999; AACN, 2006; Shultz, 2009).

Educating the nursing workforce of the future is a challenge for the profession of nursing. The healthcare system demands the profession continues to adapt to new knowledge and technologies (National Advisory Council on Nurse Education and Practice [NACNEP] 2008). Educating nurses is a priority for the profession of nursing to help meet the current and projected demands for nursing care (Kaufman, 2008; Rosseter, 2009). Nursing education is undergoing a transformation towards evidence-based curricula and it is critical that educating the nurses of the future also includes the foundation of professional nursing values.

Statement of the Problem

Affective learning is important to the professional values development in the nursing profession and must accompany any current and future changes in the transformation of nursing education. The evidence generated from this study will enhance the understanding of nurse educators teaching in the affective domain and contribute to the science of nursing education.

The development of values consistent with the profession of nursing continues to be important to the nurse-patient relationship and to positive patient outcomes (Shultz,

2009). There is limited exploration of the practice of experienced nurse educators and the use of affective techniques (Shultz, 2009). The affective domain as described by Bloom (1956) is associated with emotions and values acquisition. Nurse educators need to continue to address this domain and develop professional values within their students. There has been limited evidence available for nurse educators to understand and articulate the processes involved in teaching to the affective domain and values acquisition. Further research is needed.

Purpose of the Study

The purpose of this study was to explore the meaning, experience, and the act of teaching and learning in the affective domain as described by experienced nurse educators. This study was based on Bloom's taxonomy of educational objectives. The affective domain is the area of interest. This study incorporated the meanings and practical wisdom of experienced nurse educators within naturalistic research design to explore how teaching in the affective domain is utilized in the development of professional values in nursing education and practice.

Need for the Study

The profession of nursing is working to educate nurses in an environment that includes shortages of both nurses and nursing faculty. Evidence in nursing education research has limited empirical evidence of affective learning. Many studies look at a certain aspects of affect, such as humor or critical thinking, and define it as part of affect (Ulloth, 2002; 2003; Woods, 1993; Zimmerman & Phillips, 2000). There is no consistent description of teaching in the affective domain in the nursing education literature. Nurse educators continue to incorporate important components of affective teaching and

learning. The affective domain may facilitate student development of professional values but this needs exploration.

A pilot study was conducted by the primary investigator (PI) in 2005 to explore nurse educator's understanding and utilization of the affective domain in the classroom (*n*=6). Preliminary results of the study indicated that nurse educators were developing strategies that address the affective domain in the classroom. Additionally nurse educators identified barriers to the use of affective learning in the classroom such as time and institutional support. In spite of barriers they identified, nurse educators continue to develop and incorporate affective learning techniques.

Inspection of the findings indicated that nurse educators value teaching and learning in the affective domain and understand the results they see in their students as important to future nursing practice. They incorporate affective techniques in the classroom and clinical and preliminary findings indicate it is important to understand the process of teaching and learning in the affective domain. How these educators teach in this domain is important and needs to be explored. However, there has been limited exploration of the affective domain in nursing education due to the complexity of the domain and the limitations of epistemological research.

Exploration of affective learning in nursing in this study included naturalistic inquiry methodology to examine the stories of experienced nurse educators (Lincoln & Guba, 1985). This qualitative research design can include autobiographical data, oral history, and storytelling methods for research investigation. Nurse educators were requested to share their stories of experiences developing, utilizing, and evaluating

teaching techniques designed to facilitate nursing student learning in the affective domain.

Research Question

1. How do nurse educators describe facilitating learning in the affective domain in nursing education?

The profession of nursing educates future nurses within a dynamic and changing healthcare delivery system. Professional values continue to be an important aspect of nursing education. The meaning, experience, and the act of teaching and learning in the affective domain is an important beginning to explore how nurse educators continue to develop professional values in future nurses.

Chapter 2

Review of the Literature

Societal need for nursing care in the dynamic health care system and the demand for transformation in nursing education will need to include best practices based on research evidence (NLN, 2005). A historical perspective provides an overview of the development of the affective domain and a review of the literature describes the state of the science of the affective domain.

Reflexivity and Native Philosophy

Lincoln and Guba (1985) describe the human as the instrument of choice in naturalistic inquiry. Guba and Lincoln (in Denzin & Lincoln Eds. 2005) describe reflexivity and the need for critical subjectivity on the part of the investigator. The authors clarify that the researcher is both the inquirer and the respondent – knowing oneself within the process of research.

In naturalistic inquiry, the researcher is both the inquirer and the respondent in and described as the instrument of inquiry (Lincoln & Guba 1985). Because the researcher is the instrument of inquiry, the researcher must question the identity of the self and the interactions with the participants, as the research process is a process of discovery. This discovery is not only the subject, but also a discovery of the self (Denzin & Lincoln, 2005).

Naturalistic inquiry demands reflection on the part of the researcher to identify links to personal philosophy and examine worldviews that represent the researcher. The researcher brings the voice of a particular class, gender, racial, cultural, and ethnic community to the research process (Denzin & Lincoln, 2005). Reflexivity for this study

by the researcher was conducted as an exploration of Native heritage and philosophy. The PI for this study is an enrolled member of the Oneida Nation in Wisconsin.

> "We participate in the meaning-making of the world. There is no world, no truth without meaning and value, and meaning and value arise in the intersection between us and all that is around us. How we behave, then, in a certain sense shapes meaning, gives shape to the world… We can think of this as the meaning-shaping principle of action" (Burkhart, 2004, p. 16).

Vine Deloria (2004) examines the philosophical underpinnings of epistemology from an American Indian perspective. He posits that people influenced by Western philosophical ideals of 'real' and 'truth' predispose scientific thinking that experience be subjected to some form of mechanical testing. He contrasts scientific testing to Indian thought that allows for the existence of real but non-physical realities. Western thought is arranged to support the proposition that matter produces mind. But Indian thought is that mind produces reality. The transmission of stories of ancient times, along with social elations with other peoples provided truths specific to the people and others were entitled to their truths. According to Deloria, all knowledge begins with experience.

Brian Burkhart (2004) further develops the understanding of experience and how that influences us to act. He posits that all people participate in the making of meaning within the world and that it is through experiences and stories that we participate in the meaning-making of the world. No truth exists without meaning and value and that meaning and value arise from the intersection between the individual and all that is around us. Important to note that Burkhart does not imply that "all" that is around the individual is limited to other humans. This is the cornerstone of American Indian philosophical thought, that it is the intersection between the individual, the place, the creatures and all elements around us. American Indian philosophy is concerned with the

questions asked and how those questions lead us to make meaning. An underlying assumption is that the answer to a question often lies in the question itself rather than in some solution outside of the question.

> "Knowledge is not such that if we just peer into the world long enough or just sit and think long enough, it will come to us in all of its unabated glory. Knowledge is shaped and guided by human actions, endeavors, desires, and goals. Knowledge is what we put to use. Knowledge can never be divorced from human action and experience" (Burkhart, 2004, p. 21).

In western tradition, Ricoeur (2007) explains how meaningful action can be considered as text. He elaborates on the dialectic process that occurs during the interpretation of written text and the meaning of a discourse that has a new meaning when looked at from explanation (*Erkaren*) to understanding (*Verstehen*). He explains that we can have a naïve understanding or interpretation but to truly get a projection of a world that is more than a situation, we must examine many explanations.

In Native American thought, the concept of knowledge is not a separate entity that can be packaged as truth. Native science is interested in applying the knowledge gained from *participation* and encourages the individual to act as a participant in research rather than trying to control it. In other words, knowledge cannot be removed from action and experience. It is this embodiment of the research that then gives meaning and value. Native science encourages the use of the researcher's senses to create a bond between the mind of the researcher and the research experience. The goal of Native science is to understand the essence of things, to give meaning to what is right and what is true. In order to achieve this level of understanding, the researcher must utilize not only rational thought, but also include their heart and their being to move beyond surface understanding of an experience (Waters, 2004).

Historical Perspective of the Affective Domain

Identified in 1948, affective learning is a method of knowledge acquisition that has historical foundation (Bloom 1956). Educators in academic settings prior to that time understood the need to develop morals and values important to decision making within the professions. Many learning objectives had been developed that addressed affective learning across the nation's colleges and universities.

The middle of the twentieth century was a time of biologic discovery and classification systems. At the dawn of the profession of educational psychology, the American Psychological Association felt there should be a taxonomy classification system for educational objectives. This would be a first step to help organize the goals and establish some baseline standards in higher education. Beginning in 1948, the committee invited educators and institutions of higher education to participate and submit educational objectives to be reviewed. *The Taxonomy of educational objectives, Handbook I: Cognitive domain* (1956) was the published result this endeavor. The committee categorized submitted objectives into the three domains of cognitive, psychomotor, and affective. The document establishes baseline criteria for higher education and became the basis for educational theory that dominated the last half of the twentieth century. The committee described the difficulty in establishing an evaluation of the affective domain and posited they would elaborate on the domain in the future (Bloom, 1956). At this point in history, evaluation of the affective domain included changes in feeling and emotion.

The original handbook led to the development of the second handbook that described the nature of the affective domain and describes a classification structure

(Krathwohl, Bloom, & Masia, 1964). *Taxonomy of educational objectives, Handbook II: Affective domain* (1964) further classifies the affective domain as educational objectives that emphasize a feeling tone, an emotion or a degree of acceptance or rejection. Objectives were expressed as "interests, attitudes, appreciations, values and emotional sets or biases (Krathwohl, Bloom and Masia, 1964, p. 7)." Even at the time, a mere eight years after the original establishment of the educational domains, the authors were concerned at the erosion of affective objectives because of limited attention and lack of measurement or examination of affective objectives.

Krathwohl, Bloom, and Masia (1964) further developed an affective taxonomy that was developmentally oriented. The authors relied on Freud's consciousness development and consequently the affective taxonomy reflects a developmental values acquisition. This taxonomy was developed from existing educational objectives at the middle of the 20th century and reflects known psychology theory of the time. The authors emphasized that this taxonomy should only be a beginning exploration and was not reflective of the entire affective domain (Krathwohl, Bloom, and Masia, 1964).

There have been numerous critiques of the affective taxonomy developed by Krathwohl, Bloom and Masia, (1964). Research by Gilligan (1982) and other social science researchers beginning in the early 1980s illustrated that moral development and the affective taxonomy developed by Krathwohl, et al. (1964) may not apply to women. Gilligan (1982) was one of the first to identify that the taxonomy developed by Krathwohl Bloom, and Masia, (1964) may be gender specific. She identified that girls tended to develop values based on care and boys tended to developed values based on justice (Gilligan, 1982). Because of the potential for gender specific discrepancies in the

affective taxonomy developed by Krathwohl Bloom and Masia (1964), this study will utilize the original *The Taxonomy of educational objectives, Handbook I: Cognitive domain* (1956) as an investigative framework for this study.

The identification of the affective domain by early researchers identified the need for moral education and practice. However, the need for moral practice in the professions has been identified for centuries. In the latter part of the twentieth century, the field of educational psychology focused on the measurement of the cognitive domain. The inadequacy of cognitive based measurement systems to articulate teaching and learning in the affective domain has resulted in limited research in affective learning. A definition of affective learning based on behavioral objectives leads to the development of instruments based on psychometric techniques designed not for the measurement of values and morals, but for the acquisition of cognitive learning (King, 1984).

The affective domain existed long before it was identified and classified by the APA committee (Hilton & Slotnick, 2005). Values, morals, and ethics have been important since the inception of the three original professions, law, medicine, and clergy, which began in mediaeval European universities (Hilton & Slotnick, 2005). Society grants all professions the ability to self-regulate with the understanding that professionals will put the clients needs above their own (Hilton & Slotnick, 2005). This potential conflict of interest must be taught to students learning the values of the professions (Hilton & Slotnick, 2005). Values, morals, and ethics consistent with the profession of nursing are fundamentally important in the education of nurses.

Affective learning may be examined by other models and may date back to the ancient Greeks. Aristotle identified five intellectual virtues; sophia, epistme, nous,

phroneis, and techne. He grouped these virtues into three classes. Theoretical knowledge encompassed sophia, the wisdom of the eternal; epistme, scientific empirical knowledge; and nous, intuitive understanding. Productive knowledge or techne included the knowledge of art, craft, and making. Practical wisdom and knowledge, he identified as phronesis or prudence (Aristotle trans. 1819).

There is great parallel between the domains identified by the APA committee and Aristotle's intellectual virtues. *Epistme*, theoretical knowledge also interpreted in modern philosophy as scientific empirical knowledge, seems to parallel the APA cognitive domain. *Techne*, productive knowledge, art, or making has a close relationship to the psychomotor domain. *Phronesis*, practical wisdom or judgment seems to parallel affective learning.

Phronesis has no literal translation into the English language. Aristotle described the virtue of phronesis as separate from science or techne (art):

> "…practical wisdom [phronesis] cannot be scientific knowledge or art; not science because that which can be done is capable of being otherwise, not art because action and making are different kinds of thing. The remaining alternative, then, is that it is a true and reasoned state of capacity to act with regard to the things that are good or bad for man." (Aristotle, trans . 1980, p. 142.)

This distinction of phronesis as separate from science (episteme) and art (techne) is important in the study of professional values and judgment. Practical wisdom is learned only through experience. Therefore, there is an element of time involved with the attainment of phronesis. Aristotle does, however, note that practical wisdom can be taught. With an example of a mathematics student, Aristotle demonstrates how a version of practical wisdom (phronesis) is taught to students that lack experience. This level of knowledge in action has been translated as prudence (Aristotle, trans. 1980).

Affective learning and practical wisdom are not a science or episteme. Therefore, it may be inappropriate to establish an epistemological link to the ontology of affective learning. This may explain the difficulty in the measurement descriptions by King (1984) and nursing authors since that time (Reilly & Oermann, 1992; Shultz, 2009). Measurement of a product or outcome may not be possible because the end product of affective learning and phronesis is action. They are a process that results in action.

Nursing science has focused on instruments and outcomes as measures of the action of nursing and nursing education. Necessary and important to establish the epistemologic ontology of nursing education, it is more difficult to establish the phronetic ontology of nursing education. Aristotle saw phronesis as the most valuable of the intellectual virtues because phronesis is the activity by which instrument rationality is balanced with value-rationality, and because this balancing is important to sustain a society or profession (Flyvbjerg, 2001).

Exploring a similar episteme-phronesis duality in the social sciences, Flyvbjerg (2001) describes the link between phronesis and the analysis of values as a point of departure for action, "It (phronesis) focuses on what is variable, on that which cannot be encapsulated by universal rules, on specific cases. Phronesis requires an interaction between the general and the concrete" (p. 57).

Clinical wisdom in nursing practice includes the process of reflective judgment within the context of uncertainty (McKie, et al., 2012). This happens at the interplay of emotional and cognitive awareness that allows the healthcare practitioner to assess and apply the appropriate best evidence for the clinical situation. This wisdom is an important feature of nursing practice (McKie, et al., 2012).

The importance of phronesis and clinical wisdom in nursing practice is beginning to be explored in nursing education. Clinical wisdom can be described as a collective and shared attribute that can be learned through sharing and interaction. Introducing practical wisdom into nursing education could include writing assignments, mentorship, and case scenarios (D'Antonio, 2014).

In a study of the sphere of practical wisdom and nurse educators, Patton (2007) conducted 32 interviews with a total of nine nurse educator participants. The participants described incidences with students in the clinical setting where there was an interruption in smooth activity, where the educator felt "paralyzed" or a moment of consciously pausing or shifting cognizance. Three domains of practice were found after phenomenological analysis, preserving the ideal, salvaging learning, and sustaining the self. Preserving the ideal reflected moral commitment and social responsibility. Salvaging learning nurse educators created opportunity for learning in uncertainty and allowed teaching and learning to happen in a supportive context. Sustaining the self described the nurse educators maintaining integrity in uncertainty (Patton, 2007).

Key to understanding teaching and learning in the affective domain and the development of practical wisdom is to conceptualize it as a process (Rodriguez, Plax, & Kearney, 1996). Something happens to emotions and feelings that are individually processed and result in beliefs, values, and attitudes and ultimately action. The developmental taxonomy of the affective domain developed by Krathwohl, Bloom, and Masia (1964) indicates a point were affect is 'internalized' by the individual and they begin to *act* consistently in accordance with their values. The outcome of teaching and learning in the affective domain is action, and this action may occur at a future time. The

word “action” is used to differentiate it from “behavior.” Behavior correlates closely with a passive adaptation of the individual to a society. It is through action and speech that an individual reveals unique personal identity. (Dunne, 1993). It is through action that affective learning is incorporated in all learning, influences cognition and cognitive processes and it is important to identify what happens. In the realm of process, research methods designed to explain or measure an outcome will not capture the process inherent in the affective domain.

In the nursing literature, Reilly and Oermann (1992) use Bloom’s affective taxonomy to describe the approach to teaching in the affective domain as valuing within value systems and skills in moral reasoning. They define values as judgments and moral reasoning as the "cognitive processes of analysis and interpretation of a moral dilemma as a basis for determining some course of action" (p. 302). “Belief” and “attitude” are also included as descriptors of affect in nursing education (Reilly & Oermann, 1992). Both beliefs and attitudes were considered as vulnerable to outside influence, changing over time, and considered by the authors as being difficult to measure. This variability is integral to the process of phronesis. The authors utilized Krathwhol, Bloom and Maisa (1964) to structure affective learning in the clinical setting for nursing education.

In the nursing education literature, most articles that address the affective domain describe a learning intervention. These articles are a sharing of ideas but not evidence based educational interventions (Maier-Lorentz, 1999; Woods, 1993; Zimmerman & Phillips, 2000). This is consistent with the contemporary understanding of epistemology-based research as a measurement of scientific truth. The difficulty in measuring values and morals that result in action is problematic within a scientific paradigm.

Affective Domain Literature Review

Affect, as defined in Taber's Cyclopedic Medical Dictionary in psychology, "the emotional reactions associated with an experience" (Venes, 2001). Affect has also been defined as a feeling or emotion as distinguished from cognition, thought, or action. Emotions and feelings are the critical attributes in affective learning across disciplines. The disciplines of psychology and neuroscience include the critical attributes of emotion and feeling in discussions of affective learning (Kritzer & Phillips, 1966; Everhart, Demaree, & Wuensch, 2003). Emotions and feelings are also important in the discipline of communications (Myers, 2002).

Reilly and Oermann, (1992) utilize Krathwhol, Bloom and Maisa (1964) to structure affective learning in the clinical setting for nursing education and make only cursory reference to feelings and emotions. Concepts central to their definition of the affective domain include beliefs, values, and attitudes along with a moral reasoning development model (Reilly & Oermann, 1992).

With a focus on affect and affective disorders, the field of psychology has done some initial work on affect and the affective domain. Kritzer and Phillips (1966) described an affective learning experience among psychology students learning psychotherapy. The authors described learning that involves change and emotional experience. After observing group psychotherapy, students were allowed role reversal to experience subsequent feelings. Affective learning involved change and required an emotional experience in which the student could make some self-adjustments.

Diaz and De la Casa (2002) discussed affective learning and affective conditioning as the change in affective rating of a neutral stimulus. Within this study

they described that learning in the affective domain is strongly resistant to extinction. In other words, once affective learning occurs, it is not forgotten. Everhart and Demaree (2003) described the Affective Auditory Verbal Learning Test as an instrument measuring emotional stimuli that can be useful in examining valence on learning and a possible tool for mood induction studies among clinical populations.

Education is another field with interest in affective learning. Rodriguez, Plax and Kearney (1996) developed a causal model explaining teacher immediacy and student learning. In this model, teacher immediacy influences student affective learning, which influences student cognitive learning. From this model, it is important to note that teachers can *do* something to influence a student's affective learning experience. Snider (2001) discussed both cognitive and affective learning in a ninth grade poetry class. This investigation also utilized the taxonomy developed by Krathwhol, Bloom and Masia (1964, as cited in Rodriguez, Plax, & Kearney, 1996) and found that there was value development as a result of poetry.

In the past decade, the field of neuroscience has made great strides in understanding the neuroanatomical structures involved in affect. The memory of facts is improved when the facts are learned in connection with an emotion but in cases of extreme stress, emotions can impair memory (Cahill, Babinsky, Markowitsch, and McGaugh, 1995; Bechara, Damasio, & Damasio, 2000). The anatomical structures associated with emotion are midline limbic structures such as the cingulate, thalamus, hypothalamus, hippocampus, and the amygdala (Cahill, et al, 1995; Mayberg, et al, 1999; Bechara, Damasio, & Damasio, 2000; Anderson & Phelps, 2002). The thalamus incorporates three different types of nuclei including synaptic relays for all sensory

systems except olfactory. Therefore, all sensory input perceived by the individual is perceived *through* brain structures associated with affect.

Brain based affect and emotion is being integrated into education. Sylvestry (1994) described how emotions are perceived by the brain and the application to the classroom. Role playing and simulations were school activities that drew out emotions and provided memory prompts. No disruptive and nonjudgmental venting of emotion was encouraged.

Physiological measures utilized to trace brain based affective learning include positive emission tomography (PET) scans described by Morris, Ohman, and Dolan, (1998), magnetic resonance imaging (MRI) scan described by Simpson et al, (2000), and electroencephalograph (EEG) tracings described by Everhart and Demaree, (2003) and Everhart and Heath, (2003). Other secondary physiologic measures included eye blink reflex, skin conductance response, startle response, and handedness (Everhart & Demaree, 2003; Everhart & Heath, 2003; Morris et al, 1999; Simpson et al, 2000). Psychometric measures were also incorporated with physiologic measures and included the Auditory Affective Verbal Learning test developed by Everhart and Demaree, (2003), Positive and Negative Affective States developed by Anderson and Phelps, (2002), International Affective Picture Systems by Hamm and Vaitl, (1996) and Simpson, et al, (2000), and the Affective Learning Scale by Titsworth, (2001).

Descriptors of affect in neuroscience include mood, emotions, and feelings. Emotions are deeply rooted in brain structure. They are also vulnerable to internal and external manipulation by drugs or interactions and physiological state. Persons experiencing an affective state typically cannot easily describe it because

it is experienced outside of cognition. Description of this type of knowledge can include tacit knowledge. Tacit knowledge as described by Michael Polanyi (1974) is the hidden understandings that guide actions but are not easy to communicate. (as cited in Greenwood & Levin, 2005). Polanyi's tacit knowledge includes part of what Aristotle describes as *techne* and includes actions such as playing a musical instrument.

Based on the literature review, competing and complementary concepts related to affective learning include attitude, beliefs, values, moral reasoning, and spirituality (Neidt & Hedlund, 1969; Lamude & Chow, 1993; Maier-Lorentz, 1999; Martin, Mottet, & Myers, 2000; Rodriguez, Plax, & Kearney, 1996; Snider, 2001). Affective processes occur in the limbic system of the brain. Affect is emotion or feeling. Therefore, the person must be able to experience emotion and have the capacity to learn. External forces should be present to facilitate affective learning. The antecedents of affective learning are a sentient person, emotionally and cognitively capable, in a learning environment facilitated by forces external to the person.

Consequences of affective learning include inhibition or enhancement of long-term cognitive memory processes (Bechara, Damasio & Damasio, 2000; Cahill, Prins, Weber, & McGaugh; 1994; Cahill, et al, 1995). If this memory consequence is correct, learning accomplished by the person can be enhanced or inhibited by educators and external forces. Potential consequences of long-term memory enhancement manipulated by educators could lead to the development of an affective-cognitive process for the nurturing of caring, values, beliefs, and moral reasoning in nursing students.

Conceptual attributes central to the affective domain include emotions, feelings, beliefs, values, attitudes, and moral reasoning. Other attributes include self-adjustment

and self image (Kritzer et al, 1996; Stancato and Hamachek, 1990). Most models of beliefs, values, attitudes, and moral reasoning were behavioral or cognitive applications to the emotive environment in which learning occurs.

Nursing as well as education, and neuroscience have defined affective learning as a process (Cahill, Babinsky, Markowitsch & McGaugh, 1995; Hirschlein & Jones, 1971; Reilly &Oermann, 1992; Stancato, & Hamachek, 1990). Education and neuroscience state that affective learning is brain based or reflected in self-esteem. Most disciplines define affective learning as able to be manipulated by teachers and various external forces (Cahill, Babinsky, Markowitsch & McGaugh, 1995; Hirschlein & Jones, 1971; Reilly &Oermann, 1992; Stancato, & Hamachek, 1990).

Outcomes of teaching in the affective domain include an actual change in student emotion, learning, memory retention, understanding, values, beliefs, and attitude. All of these processes eventually result in student action.

Affective teaching methods could include visual imaging, auditory manipulation, movies or videos, written text, storytelling. All of these could potentially impact affective learning and are only beginning to be researched. Student self-adjustment techniques should be initiated within the student but can be facilitated with guidance from the educator. Ethical decision making and moral reasoning can be classroom techniques utilized to assist the student in processing affective information resulting in self-adjustment.

The affective domain has been an area of interest for nursing education. King (1984) developed an approach to teaching and learning in the affective domain. Instructional strategies and assessment techniques developed by King (1984) were

heavily influenced by the impetus for measurement of behavioral objectives and the use of psychometric techniques. It was an attempt to include ethics and moral development in the classroom. Many limitations listed by the author to the techniques may be a result of the inability of the methods to capture the outcome of affective learning.

In a model of the role of the nurse educator in the affective domain, Shultz (2009) equates the nurse educator to that of facilitator of the affective teaching-learning process. The student's affective learning response is connected to the patient and patient outcomes through the affective learning process. Affective concepts of nursing practice included student attitudes, professional identity, values and responses to emotional states. Recommendations from a review of the literature included examination of curricula, development of nurse educators and appropriate instruments, clarifying and defining affective competencies and further research (Shultz, 2009).

Research interest in affective learning in nursing education was determined by performing a search of the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and ProQuest Nursing Journals, in peer reviewed journals where "affective" and "learning" both appeared as major descriptors. Articles were screened for definitions of affect and practice area. Most articles describe an affective learning intervention in nursing education literature. They are more of sharing of ideas than evidence based educational interventions (Maier-Lorentz, 1999; Woods, 1993; Zimmerman & Phillips, 2000).

Affective learning was not an outcome or measurement in most of the studies reviewed. Most nursing educational research articles were descriptive. Ulloth (2002; 2003), Ritchie (2003), Letizia (1998), and McCausland (2002) conceptualized

instructional methodologies to target affective learning. Humor, journaling, clinical experience, and clinical post-conferences were posited as instructional methodologies that target the affective learning domain. However, no studies measured change in affect. Some examples of instruments designed to measure affect were found but none were utilized in assessment or measurement of learning in the affective domain.

Oermann, Saewert, Charasika, and Yarbrough (2009) reported on the results of a national survey of assessment practices in schools of nursing. The 29-item web-based survey evaluated nurse educator strategies for assessment across cognitive, psychomotor, and affective domains. Student assessment strategies included direct observation in clinical, participation in discussion, written assignments, and case study analyses (Oermann, et. al., 2009).

In a qualitative analysis of student beliefs and attitudes after a controlled clinical evaluation, Cazzell and Rodriguez (2011) utilized an exploratory focus group design. Twenty students were recruited to participate in focus groups. They were asked open-ended questions about their feelings, beliefs, and attitudes. Students reported feelings of loss of control and anxiety. Students identified two common beliefs: the need for immediate feedback and reaction under pressure after the experience. Students' attitudes reported a need for safety as a priority. The investigators concluded that students integrated the attitude of safety into future practice but felt that anxiety, loss of control, reacting under pressure, and no feedback impacted their clinical performance. The investigators also indicated that future nursing research should develop assessment rubrics to measure the affective domain (Cazzell & Rodriguez, 2011).

Keeley and Chase (2012) describe a classroom technique designed to promote affective learning in students. To address the affective domain of students learning mental health and the nursing care of the families of individuals with mental illness, the authors invited a family caregiver to be interviewed by nursing faculty. This technique was used over a six year period. Approximately 60 students attended the hour long interview and were encouraged to take notes and ask for clarification. An additional 30 minutes after the interview were spent in small group work. Formal assessment of the experience was conducted via a scholarly paper completed by the student. The graded paper had an intentional affective component included that instructed the student to reflect on their self-awareness, core values, and insights. The authors describe that students demonstrated achievement of the goals of the experience by gaining greater insight into the experiences of individuals interviewed. Student stereotypes and preconceived ideas had also been challenged as students identified the strengths and challenges of participants (Keeley & Chase, 2012).

Hanson (2011) utilized a personal narrative as a transformative learning experience for students to address the affective domain. To introduce students to deep learning and advance affective attributes, the author relates a story of nursing care during a terrorist attack to 76 students. A critical incident questionnaire was used to assess the impact of the teaching methodology and student learning. Students reported that the personal narrative was powerful and intensely emotive but addressed the theory and application of clinical skills during a traumatic event. Students were able to understand how professional nursing related to effectively helping people in practice (Hanson, 2011).

Jeffreys and Smodlaka (1999) validated a measurement instrument designed to measure self-efficacy. The Transcultural Self-Efficacy Tool had three subscales that included an affective domain for self-efficacy. The authors attempted to measure learning outcomes within the affective domain in nursing education. The affective subscale addressed values, attitudes, and beliefs that included cognitive and behavioral manifestations of affect.

Ulloth (2002; 2003) conceptualized cognition and affect as interconnected within a holistic person. The author describes an educational technique utilizing humor in the classroom. Other disciplines also describe interconnections between the limbic system and the prefrontal cortex in affective learning.

Maier-Lorentz (1999) described objectives and learning in the affective domain for staff educators. Based on the Krathwohl, Bloom, and Masia (1964, as cited in Maier-Lorentz, 1999) taxonomy for value development, five levels of the affective domain are incorporated into affective competencies necessary for effective nursing practice. Affective competencies are described as moral reasoning in ethical decision-making and the development of a personal value system necessary for ethical decision making. The domain of affective learning was defined as beliefs, values and attitudes. Beliefs were defined as an individual's perception of reality. Values influence perceptions and represent a way of life. Sources of values included standards and codes for nurses. Attitudes were described as a pro or con feeling about a person or event. The affective taxonomy describes a systematic way to assess a student's growth in accepting certain attitudes (Maier-Lorentz, 1999). This developmental description of affective learning then may be a measure of attitude acquisition than actual affective learning.

Affective learning principles are also described as embedded in critical thinking and definitions of ethical decision-making (Woods, 1993). Affective competencies were described as elusive and avoided by faculty in schools of nursing essentially because of misunderstandings and confusion (Woods, 1993). Affective domain was referenced to beliefs, values, and attitudes. In addition to the cognitive and psychomotor domains, affective learning is described as reflection on how a student feels. This reflection was directed to clarify a student's beliefs and attitudes in a patient setting. The affective teaching method described was to allow the student to explore and become aware of feelings and attitudes to develop values.

Zimmerman and Phillips (2000) describe a critical thinking teaching technique designed to develop empathy in caring practice. The authors posit that critical thinking has an emotive or affective component. Described as hard work the authors utilize a variety of techniques designed to allow students to experience disability and reflect on the experience through journaling. Classroom techniques encouraged students to examine and portray their feelings and emotions throughout the class. The goal of the technique was to give meaning to student nurses to value caring.

The affective domain in the online learning environment was studied by Reilly, Gallagher-Lepak, and Killion (2012). Small telephone focus groups, three to five participants, were conducted to assess learning in the affective domain in an online RN-BSN program. A total of 18 students were asked a series of open-ended questions designed to address the affective experience of online learners. A broad range of affective processes were found in nursing students in the virtual classroom. Emotional factors

identified in online learners included aloneness, anonymity, non-verbal communication, trepidations and unknowns (Reilly, Gallagher-Lepak, & Killion, 2012).

Pilot Study

A pilot study of nurse educators was conducted by the Primary Investigator (PI) in the spring of 2005 to explore the current understanding and utilization of the affective domain by nursing faculty teaching at the baccalaureate level (n=6). Teaching experience ranged from 2 years to more than 25 years. Novice educators were thought to have difficulty focusing on nuances of domain learning so educators with at least 2 years of experience were recruited via a convenience snowball sample. A short eight-question survey was conducted to ascertain the educator's experiences with affective learning in the classroom. Results of the pilot survey contributed to the list of possible questions for this study.

Participants were interviewed by telephone and answers were manually recorded. Eight questions were asked to assess the educators experience and views of affective learning in nursing education. Responses were analyzed for relevance to the questions and analyzed for major themes across questions.

Results of the pilot study indicated nurse educators were aware of the importance of the affective domain in nursing education. This knowledge is not intrinsic but appears to develop with experience. This development of understanding with experience is consistent with practical wisdom.

Major themes across questions included a variety of definitions of affective learning. The respondents introduced examples of affective learning situations. Educators also discussed their ability to incorporate affective learning in classroom

learning. Three areas of change that were identified by the nurse educators would facilitate utilization of affective learning techniques. Barriers to the utilization of affective learning were also identified in the pilot study.

Definition of affective learning varied across educators from very specific "emotions and feelings" to broad conceptualization "standards of nursing … scope of practice." All responses could be reviewed in four major domains: education, student, recipient of care, and professional nursing.

Educators described that nurse educators actively teach in the affective domain, "Trying to reach students on emotional or feeling level…" Many educators described an interaction between student and patient and others described an interaction between student and the profession of nursing. Consistent with varied definitions many educators described affective learning by what it is not 'not cognitive, not practice." Educators conflicted in some areas. One educator stating that affective learning was "not skills" and another describing affective learning as "respecting patients – this is a skill."

Educators were asked to give an example of an affective learning objective or teaching method they used in the classroom. Educators with less experience were able to give a specific example and educators with more experience were able to give several examples of different methodologies. Methods were categorized into educator solitary activities, student solitary activities and interactive activities (see Table 1).

Table 1

Pilot Study: Affective Teaching-Learning Methodologies of Nurse Educators

Educator solitary activities	
	Story telling
		Funny stories
		Practical stories
		Inspirational stories
		Nursing stories
	Listening
	Videos
		Showing videos of actual patients
Student solitary activities	
	Writing
		Nursing philosophy paper
		Who demonstrates nursing?
		What are students' future career goals?
	Drawing
		Crayons and construction paper to illustrate nursing
Interactive activities	
	Discussion
	Facilitating
	Role playing
		Videotaping therapeutic communication
	Experience
		Experience in community with devices simulating elderly experiences

Note: Aggregated results from 2005 pilot study.

All activities were designed to increase the perceptual awareness of the student self and the relationship between the student and the recipient of care and the relationship between the student and the profession. All activities were designed by the educators to elicit an emotional response from the students and move that response into awareness for exploration either by the student alone or with the guidance of the educator and support

of peers in the classroom. Specific emotions targeted by the educators included respect, grief, humor, attitude, caring, sadness, and conflict.

Educators were asked how adequately they felt they incorporated affective learning in the classroom. Most educators felt they adequately incorporated affective learning in the classroom (n=4) with one educator describing affective learning "For me it's a priority." Several educators described the desire to increase affective learning "we need to deliberately make room for it (affective learning methods)" and "How do we measure it?" All educators indicated the desire to improve or increase the use of affective learning in the classroom.

Educators indicated that change in three major areas would increase the ability of educators to use affective learning in the classroom. Mentoring when beginning in nursing education, available resources, and clear expectations of higher learning institutions would increase utilization of the affective domain in nursing education.

Barriers to the use of affective learning in the classroom identified by the educators included barriers in the preparation of nurse educators, barriers of the institutions of higher learning and barriers of the profession. Many nurse educators do not come from an education background and may have difficulty incorporating affective learning, "I think a lot of nurses become educators without a teaching background. We need step by step instructions." Barriers of the institution included time, the expectation of the lecture format, lack of teacher evaluations with novel teaching methods, and the value of testing and measurement of outcomes. Included in the institutional expectations were barriers of the students, "They (students) want hands on doing. They're not really a

nurse until they start an I.V." Professional barriers include the professional competency models as well as the pressure for students to pass state board licensure.

Nurse educators seem to develop the ability to target and utilize affective learning with teaching experience. Affective learning may be an important tool in nursing education as content knowledge has increased exponentially precipitating the necessity to transform nursing education. Affective learning may be an ancient method of learning and nursing students may benefit from this tool for knowledge acquisition. Experienced educators may hold some keys to the use of affective learning in nursing education.

The philosophical foundation of this study has been explored from a Native philosophical standpoint. The historical aspects of affective learning are an important contribution to organize and understand affective learning. The weaknesses in past and current inquiries in affective learning have been explored and will help guide this inquiry.

Chapter 3

Methods

The review of the literature identified the paucity of research in the affective domain in nursing education. Most studies employed descriptive designs. Little empirical evidence was found for teaching and learning in the affective domain in nursing education.

This inquiry explored the meaning, experience, and act of teaching in the affective domain as reflected in the stories of experienced nurse educators. The affective domain and the development of nursing education practice had limited exploration within the context of nursing education. The complexity and difficulty of measurement in the affective domain contribute to the lack of empirical evidence. Studies in nursing education literature have contributed to a beginning understanding of the affective domain but there is a lack of empirical evidence.

Naturalistic inquiry describes five axioms or "basic beliefs" that are accepted by convention or established by practice (Lincoln & Guba, 1985, p. 33). The nature of reality (ontology) is the belief that there are multiple realities and that multiple realities will eventually diverge. These realities are constructed by persons from different backgrounds and experiences. As in Native philosophy, all knowledge begins with experience (Deloria, 2004). Because of the fluid nature of these experienced realities they can only be studied holistically so prediction and control are unlikely, although understanding (verstechen) can be achieved (Lincoln & Guba, 1985).

The second axiom of naturalistic inquiry is the relationship of the knower to known (epistemology). This is the belief that the knower and the known are interactive

and inseparable. Naturalistic inquiry builds upon the interaction of investigator and respondent as the source of data (Lincoln & Guba, 1985).

The third axiom discusses the possibility of generalizability. It is not possible to apply the results of naturalistic inquiry to a larger population. Instead, the aim of naturalistic inquiry is to develop a "working hypothesis" (Lincoln & Guba, 1985, p. 38). Naturalistic inquiry depends on contexts that are unique. It is the congruence between the contexts that establish the "fittingness" of the working hypothesis (Lincoln & Gruba, 1985, p.124). The congruence of the contexts provide the base of information to establish the fittingness of the working hypothesis and transferability to other contexts (Lincoln & Guba, 1985).

The fourth axiom, the possibility of causal linkages is the belief that causal linkages cannot be established in naturalistic inquiry. The investigator and the respondent together create the data in a continuous unfolding of iterations. Mutual simultaneous shaping of the data makes it impossible to establish a cause and effect (Lincoln & Guba, 1985).

Axiom five describes the role of values in inquiry (axiology). This is the belief that values influence all inquiry. Naturalistic inquiry is value-bound, influenced by the values of the researcher and research decisions regarding paradigm, theory, and context. Naturalistic inquiry is either value-resonant, or value-dissonant (Lincoln & Guba, 1985).

These five axioms have implications for conducting naturalistic inquiry, but the research design needs more than beliefs to operationalize an inquiry. Lincoln and Guba (1985) describe fourteen characteristics of operational naturalistic inquiry. These characteristics depend on the five axioms and share coherence and interdependence. The

characteristic of operational naturalistic inquiry include: natural setting, human instrument, utilization of tacit knowledge, qualitative methods, purposive sampling, inductive data analysis, grounded theory, emergent design, negotiated outcomes, case study reporting mode, idiographic interpretation, tentative application, focus-determined boundaries and special criteria for trustworthiness (Lincoln & Guba 1985, pp. 39-43).

Research Design and Rationale for the Methodology

An exploratory qualitative design was used for this study. The phenomenon of interest was the experience of teaching in the affective domain in nursing education. Situations and contexts of nurse educators' stories were examined utilizing naturalistic inquiry methodology. Lincoln and Guba (1985) describe that qualitative methods come more easily when the instrument is a human being.

Preliminary results of the 2005 pilot study of nurse educators teaching in the affective domain indicated that affective learning is developed through experience. Naturalistic inquiry methods can link the meaning of the experience and resultant action of the nurse educators through the voices of persons with experience teaching in the affective domain.

Participants

Fifteen nursing faculty were recruited to participate in this study. To explore nurse educators' experience teaching in the affective domain, data were collected from a convenience sample of nursing faculty with whom the PI has networked at nursing education conferences utilizing a snowball technique. Participating nurse educators had at least five years experience teaching. Teaching experience was preferred at the

baccalaureate level. A list of participants' pseudonyms and characteristics are listed in Table 2.

Table 2

Characteristics of Participants

Pseudonym	Experience Teaching (years)	Teaching Institution	Nursing Specialty
Adele	12	Public/Private University	Leadership/Management/Legal
Beverly	12	Public/Private University	Medical Surgical
Carol	6	Private College	Mental Health
Diane	18	Faith-based College	Emergency/Trauma
Elaine	8	Faith-based College	Population/Public Health
Faye	25	Faith-based College	Mental Health
Gloria	8	Faith-based College	Global Health
Holly	8	Private College	Obstetrics
Ida	32	Public/Private University	Population/Public Health
Julia	32	Public/Private University	Medical Surgical
Kay	14	Private College	Pediatrics
Leah	6	Private College	Pediatrics
Melody	7	Public/Private University	Critical Care
Nancy	12	Faith-based College	Leadership/Management/Legal
Olivia	32	Public/Private University	Global Health

Purposive sampling is selection of participants for particular purposes as opposed to random selection procedures (Lincoln & Guba, 1985). Purposive sampling of participants maximized the quality and richness of information. The objective of naturalistic inquiry is "not to focus on the similarities that can be developed into generalizations, but to detail the many specifics that give the context its unique flavor" (Lincoln & Guba, 1985, p. 201).

Data were obtained in face-to-face interviews. Lincoln and Guba (1985) describe the human as instrument in naturalistic inquiry. Humans have specific characteristics that qualify them as the instrument of choice in naturalistic inquiry: responsiveness

adaptability, holistic emphasis, knowledge base expansion, processual immediacy, opportunities for clarification and summarization, and opportunity to explore atypical or idiosyncratic responses. Lincoln and Guba (1985) establish that the trustworthiness of the human instrument is as accessible as any other instrument.

Potential participants were limited geographically. Participants were requested to submit a potential time and place for the interview. The geographic limitation of the interview location was within a four-hour commute for the PI. The PI for this study is located in the Midwestern United States of America.

Naturalistic inquiry necessitates a natural setting because the phenomena of study take their meaning from the contexts. Reality constructions cannot be separated from the setting in which they were experienced. Reality constructions are also time dependent and cannot be understood out of context (Lincoln & Guba, 1985).

Based on the results of the 2005 pilot study, educators with more experience were able to define and give examples of techniques to facilitate affective learning. In the pilot study, participants experience as educators ranged from 2 to 25 years. Educators with more experience were able to define and give examples of techniques to facilitate affective learning.

Naturalistic inquiry should draw upon tacit knowledge. Heron (as cited in Lincoln and Guba, 1985) described three kinds of knowledge: propositional, practical, and experiential. Tacit knowledge arises from experience and it is from this experience that understanding can be achieved (Lincoln & Guba, 1985).

Protection of Human Subjects

Institutional review board approval was exempt under Category 2 because it involved the use of interview procedures and no identification of participants was recorded. Before data collection, participants were informed of their rights as research participants. A request for voluntary participation, approximate duration of participation, and detailed description of the study were provided via email (Appendix A). Attached to the email was a document describing informed consent procedures (Appendix B). The informed consent document included a description of the study and detailed procedures. Potential risks, potential benefits, the plan for confidentiality procedures, freedom to withdraw and who to contact regarding the research were also described in the informed consent document. There was no known immediate or delayed risk for participation in these interviews. Potential benefits included increased awareness of affective learning within nursing education. There was no honorarium for participation in the interview. Time required for participation was approximately 60-90 minutes depending on the participants' response needs.

The PI digitally taped responses and journal field notes were documented. All notes, recordings, and transcribed data were stored in a password controlled computer word processing program accessible only to the PI. Participants were informed they could request a copy of their interview transcripts..

Aggregate data obtained from the participants were used to describe the results of the study. Individual participants were not identified. Participant data were recorded but no data that could identify any individual participant was linked with the data obtained from that participant.

Data Collection

In the email request for voluntary participation potential participants were requested to reflect on their experience teaching in the affective domain so the participant could develop a narrative account (Appendix A). Participants were directed to reflect on personal and social aspects of teaching in the affective domain as well as to reflect on temporal descriptions.

An attempt to establish rapport with participants began at the telephone request for an interview. The request for the interview was done in a relaxed conversational tone with open exchange of information. The face-to-face interviews were conducted at a location and time chosen by the participant to facilitate a natural setting.

Open-ended questions helped generate participant stories. During and after participant stories, questions posited by the researcher were relevant to the conversation. These questions were developed from responses to the pilot study and the literature review. The responses of the pilot study were reviewed, gaps identified, and the resultant questions were designed to facilitate conversation. Potential questions that were used by the PI are listed in Appendix C.

Naturalistic inquiry research design must be emergent. Inderterminacy was evident in the data collection in the conversations between investigator and participant. Multiple realities and interactions between the investigator and participant created mutual shaping (Lincoln & Guba, 1985).

Journal field texts in this study were generated by the PI. An electronic journal was kept by the PI documenting field notes including date, time, place, and reflections of

the interviews. Journal field texts were generated to help establish the credibility of the inquiry and contribute to the audit trail (Lincoln & Guba, 1985).

Data Analysis

Recorded conversations of the interviews were transcribed by the PI and six transcriptions were outsourced to a professional transcription service. Protection of human subjects was maintained with a confidentiality agreement within the contract for services signed with the transcription service.

Transcribed data were read and re-read with the application of a variety of analytical techniques. To derive interpretation, transcribed data were examined and coded across participants. Data were coded with inductive techniques to identify themes and subthemes that represented shared realities of nurse educators' experiences with the affective domain. Coded data were then reviewed again and categorized. Categorizing coded data provides descriptive or inferential information about context. Data were sorted into provisional categories based on characteristics of the data (Lincoln & Guba, 1985).

The decision to examine the data across participants only was made to protect the identity of the participants. The population of nurse educators is limited in number. Analysis of the individual participant responses could have inadvertently identified the participants. The case report described by Lincoln and Guba (1985) was not included in this study.

Trustworthiness

This study established validity utilizing trustworthiness as described by Lincoln and Guba (1985). Journal field notes were maintained during the inquiry. Journal field

notes documented activities during the interview, methodological decisions, and reflections of the PI.

Credibility of the inquiry was strengthened by prolonged engagement and building trust with the participants (Lincoln & Guba, 1985). An inquiry audit was completed to establish dependability and confirmability of the data (Lincoln & Guba, 1985). Audio transcripts and coded data were reviewed by a faculty auditor to confirm appropriate data reduction and methodology.

Research across disciplines has traditionally been thought of as a method to discover truth. The epistemological perspective that has dominated research in the past century defines truth as an accurate representation of an independently existing reality. The sum of the accumulated knowledge was considered an accurate representation of phenomena that existed outside of the human experience (Smith & Hodkinson, 2005).

Thematic understanding of affective learning in nursing education was based on the stories of experienced nurse educators. The richness of the data contributed to the knowledge of nursing education, how nurse educators connect with their students during the process of teaching in the affective domain, and the intent of educators to develop professional nursing values. Naturalistic methods explored current innovation by nurse educators with experience teaching in the affective domain. This study contributed to the science of nursing education as the nursing profession continues to meet the societal need and demand for nurses in the future in the increasingly dynamic healthcare system of the future.

Chapter 4

Presentation, Analysis, and Interpretation of the Data Across Individuals

Nurse educators that participated in this study shared their stories of teaching and learning in the affective domain. A total of fifteen educators participated in the study. Participant names were changed to protect their identity. Characteristics of participants are listed in Table 2.

Participants reported nursing and nursing education experience in response to open ended questions. This allowed the participants to structure their experience in their own contextualization. All participants were experienced educators reporting between 6 and 32 years of nursing education experience. The participants' total years of nursing education experience was 232 years with a mean of 15.5 (*s.d.*=9.9) years as educators. Participants represented a wide variety of nursing practice and education. Two nurse educators were transitioning to administrative positions at the time of participation. All educators had recently taught in the classroom environment. Important to note that educators shared stories across practice and educational settings and some stories were historical in nature. Participant experience is listed in Table 3.

Table 3

Participant Experience

Gender of participants (n=15)	15 Female
Years of Educational Experience	Range 6 to 32 years Mean 15.5 (s.d. = 9.9) Total aggregate years of teaching 232
Educational Institution settings (n=15)	Faith-based College (n=5) Private College (n=4) Public/Private University (n=6)
Reported nursing specialties (n=15)	Critical Care (n=1) Emergency/Trauma (n=1) Global Health (n=2) Leadership/Management/Legal (n=2) Medical Surgical (n=2) Mental Health (n=2) Obstetrics (n=1) Pediatrics (n=2) Population/Public Health (n=2)
Educational practice settings Note: Participants reported more than one educational practice setting.	Clinical Acute Care (n=8) Chronic Care (n=5) Community/Outpatient (n=6) Didactic Face to face classroom (n=15) Online (n=3) Nursing Skills Laboratory (n=3) Laboratory Simulation (n=2)

Participants described affective learning across nursing educational settings, classroom, clinical and skills laboratory. All participants shared stories of classroom techniques to facilitate learning in the affective domain. Educators in the online environment were very focused on including the affective domain as an important aspect of teaching and learning online. Clinical techniques were described by current clinical educators as well as educators who had taught clinical courses in the past. Clinical experiences included acute care, chronic care, and the community/outpatient

environment. Educators teaching in the laboratory setting described teaching techniques including simulation experiences. All participants appeared enthusiastic about teaching and learning within the affective domain and expended efforts to include the domain in all areas of the nursing learning environment.

Data were coded and inductive techniques were used to identify eight themes. Nurse educators described affective learning in nursing education. Self-reflection was identified for both the nurse educator and the student. The process of teaching in the affective domain identified eight sub-themes: trust, emotions, beliefs, memory/recall, concepts, story, culture, and skills laboratory. Patient interactions included two subthemes: empathy and therapeutic boundaries. Three subthemes were identified as student outcomes; adjustment in attitude, professional values, and ethics. Assessment of learning in the affective domain and institutional support for affective learning were also themes identified. See Figure 1 for an illustration of participants in the teaching-learning interaction, domains of learning, and data themes identified in the data.

Figure 1. Data Themes Identified by Participants.

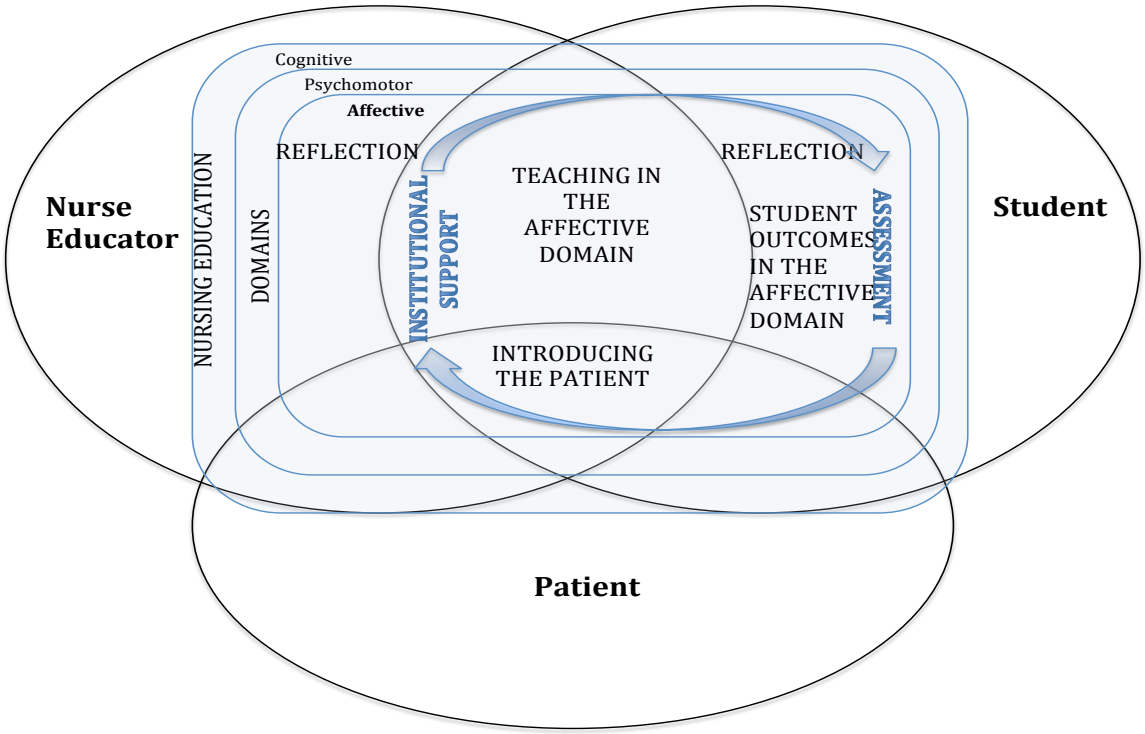

Figure 1. Data themes identified by participants illustrated across persons involved in teaching-learning and the domains of nursing. Large circles denote persons involved in teaching and learning in the affective domain. Blue squares illustrate nursing education and domains of learning as described by nurse educators. The themes described in the data have been placed to indicate the actions and interactions between persons during the process of teaching and learning in the affective domain.

The teaching process in the affective domain illustrates the persons involved in the process by three circles. The persons are the nurse educator, the student, and the patient. Nursing education and the three domains of learning are illustrated by the blue squares. Nurse educators described the affective domain as the "core" of nursing education and the affective domain is represented in the center. Themes are identified within the circles to indicate the interactions between persons and where teaching-

learning occurs during the learning process. The upper center represents interactive teaching and learning between the nurse educator and the student, in classroom and laboratory. In the lower center, teaching and learning is occurring between the nurse, the student, and the patient. This teaching-learning would occur in clinical but also in classroom by educators who introduced actual patients in class. The blue arrows illustrate the circular nature of assessing student outcomes and institutional support for faculty to develop and implement affective techniques to address gaps in learning identified during student assessment.

Affective learning as described by nurse educators indicated a complex and cyclical process of development and assessment. Nursing educators described a process of self-reflection, student self-reflection, facilitating learning, application to the patient, development of attitudes and professional values for future practice as major aspects involved in nursing education. This process is not linear and participants described student progress assessments designed in the nursing education process. Students were exposed to an experience and asked to reflect verbally or written. Educators would assess student progress and design new experiences for students to address gaps. Educational gaps were identified by educators based on their own nursing practice and experience as opposed to measurement instruments or rubrics. Students were then exposed to new experiences and reflection was again required.

Descriptions of Affective Learning in Nursing Education

Affective learning in nursing education, defined as a type of learning that reaches the emotional and belief systems of those who participate in it, was supported by the nurse educators. Nurse educators were passionate about the affective domain and

described it as very important in nursing practice. Nurse educators described three subthemes of teaching and learning in the affective domain; learning, emotions, and the heart of nursing (see Table 4).

Table 4

Participant Descriptions of Affective Learning

(n=15)
Learning
Deal with everyone you meet
Self-reflective habits of mind
Change in behavior that comes from learning
Learning in the realm of thoughts and feelings
Emotions
Emotions
Unexpected, challenging, patient experience
Stress response
How I feel, how you feel
Passion, empathy (n=2)
Heart of nursing
Heart responding to what I see
Changes the heart
Touches my heart as well as my brain
Gets you in the heart
Whole heart of nursing

The description of learning indicated the outcomes educators desired to facilitate in their students. Emotions and feelings were described as stress and passion. "The heart " was used as a descriptor of the affective domain by educators teaching in this domain and integrated both learning and emotions. Because the heart of nursing incorporated both the descriptions of learning and emotions, the affective domain as central to the teaching learning process is illustrated in Figure 1 as the central domain covering all persons involved in the teaching learning process. Several educators described affective

learning as an "emotion" or "emotional response that changes the heart." Educators also described affective learning as being a part of their own being.

Beverly teaches at a public/private university and has 12 years of nursing education experience. She describes the intensity with which nurse educators view teaching in this domain:

> "…it's the gut, it's the core, it's my heart and soul responding to what I see, but using my brain and my mind from my knowledge… it's how my core and my soul responds to that knowledge in relationship to the situation… how can I engage my mind in dealing with the emotions that I feel."

Echoing the centrality of educating nursing students in this domain, Kay has 14 years of nursing education experience and teaches at a private college:

> "It's something that touches you to your core. It gets you in the heart… It really touches you here."

Educators indicated that the affective domain was "normal." One educator felt that nurses need to acknowledge that they have an affective experience working with patients. The affective domain was important for understanding, caring and knowing the patient.

Leah with 6 years of nursing education experience teaching at a private college connected the affective domain to critical thinking:

> "… to me, the whole heart of nursing is in the affective domain. I feel that. You can't just have all the cognitive skills and be a critical thinker. You have to have that affective attributes in order to really develop… to be able to critically think. Just like the affective domain. You can't just be able to figure out problems. You have to see the whole person and deal with every situation because it's all unique."

Passion also was used as a descriptor used by two nurse educators in describing the affective domain. Affect was seen as an essential ingredient for passion.

Educators also described teaching and learning in the affective domain as important in the development of the professional nurse. Understanding the intricacies of the affective domain and the impact on care was important for educators to instill in the student.

Nancy is a nurse educator with 12 years of nursing education experience. She describes her specialty in leadership and management. Nancy teaches at a faith-based college. She described the importance of teaching in the affective domain in the development of nurses:

> "It's finding ways to help students to develop the habits of mind that go along with all the more esoteric things about caring, about being a professional, about understanding how their belief system impacts their patients and vice versa. So for me it's all about self-reflection. Its about the less measureable pieces of what we do and how they develop those thing that make them great nurses."

Defining affective learning as the "heart" and the "core" of nursing, educators were passionate about including the affective domain in nursing education. Educators were highly motivated to include the affective domain in the educational experience of student nurses.

Nurse Educators and Self-Reflection

Self-reflection was important in how nurse educators viewed teaching and learning in the affective domain. Reflections on nursing practice and experience as well as reflection on how the educators themselves were educated helped them create and evaluate learning experiences in this domain. Educator self-reflection also influenced the utilization of affective techniques. Self-reflection by the nurse educator is illustrated in Figure 1 as within the affective domain but outside of the interaction with students or patients.

Holly teaches at a private college and has 8 years of experience. She reflected on how she was educated:

> "I think of how I remember things and I remember the first time something happened to me as a nurse… The first IM injection I had to give or the first time you walk in a patients room and I think those firsts you connect with on an emotional level than you do on the physical things around you."

Holly continued to describe how her own experience encourages her to teach in her specialty even though she knows most graduates will not immediately go into maternity nursing.

Holly described her own self-reflection that initiated teaching in the affective domain. Describing frustration with student focus on "tasks," she explained that tasks are only one portion of being a nurse. Holly described various tasks she never got to do as a nursing student such as starting an IV on an adult. Knowing how to do a task was important but skills can be taught to anyone. She gave an example of parents who are taught to care for a critically ill infant. Holly explains to students, "It's the rest of it, that's why you're a nurse. It's pulling all of that together to see the big picture, to include the psycho-social, the emotional side." Holly went on to explain how this process of teaching in the affective domain evolves over time. Illustrated with Maslow's hierarchy of needs, she described the basic concepts need to be learned before the emotional, the "self actualization":

> "Part of caring is knowing how… having the knowledge base to make good decisions. But there is also the part of caring of sitting next to somebody and holding their hand, and talking to them. And being, you know making eye contact. But I don't think you can do it until you're comfortable with those other things because you're so focused with getting the blood pressure cuff attached to the arm correctly that you completely loose sight of the patient even breathing. Once you get comfortable with taking the blood pressure, you can start to see some of the other things."

Ida has 32 years of nursing education experience with a background in community and public health. She shared how she became aware of the strength and impact of learning in the affective domain. As a nursing student, Ida participated in a disaster drill scenario in which student nurses were recruited to play the role of victim in a simulated plane crash:

> "And they had billows of smoke coming up… And they parted the field at the airport and we were all there. It ended up… a very cold day. And after they gave everybody their injury – you had to look it up first. And they had makeup artists and they made you up and everything. But then, you were laying out there on the grass, or on the tarmac… waiting to be picked up and it took a long time… And it was very cold. And what happened was the injured people became panicky because they… were not supposed to move. And they were freezing and they weren't dressed appropriately to be laying in the wet for the whole time. And they were like panicking. Including myself. Like 'please take me, take me.' Because you were so cold… It was drizzling too. And it was this panicky feeling that you needed to be taken next because… people were violently shivering. And that to me was like wow… without anything hurting and people weren't really in shock but they were shivering. And not knowing how long they would be there until they were tagged… and that really for me as a learner, I think that was like a great example of… I'll never forget that… And I think a lot of things that we really remember from our clinical experiences also as when we were nursing students, it's the emotion."

Ida verbalized that this experience assisted her in developing affective techniques as she teaches community nursing.

Melody is an educator with 7 years of education experience. Melody teaches at a public/private university and described a learning experience that was challenging for her. Taking a class on vulnerable populations, Melody described how that change facilitated her own belief systems:

> "One of the things, and this is actually something that happened to me, a very affective experience. Vulnerable populations were in… I was not looking forward to that class. All the whiny babies, you know, cry, cry, cry; can't get a job, blah, blah, blah. And I was very much coming into that class with a very conservative, very working class, very military wife view on the world… you have heard the term I'm sure, education is not comfortable. That was the first

> time I think probably in my life where I truly understood the concept (of vulnerable populations) and I ended up with an intense reversal of everything that I have ever believed about poverty, about getting out of poverty, about the American dream. About all of those things was completely different. And one of the things I came to understand gutturally along with this change was the concept of… the nurse as advocate for communities, for populations, you know, in a global sense. But in order for nurses to be able to do that we have to get away from that image of the nurse holding hands and the nurse crying and the nurse hugging. Those things are important but it's not all that we do."

Melody went on to clarify how her experience learning about vulnerable populations came about in a timely manner. She was ready to learn:

> "I am sure that my maturity level was such that I was ready. I don't know had it happened a few years early would have had the same effect. I cant' sure for sure. I would like to think yes because it was pretty profound for me."

Melody described how this experience influenced how she educates students. Targeted readings were assigned to illustrate how healthcare is not just a hospital bed, but inclusive of the socioeconomic setting of the patient. She uses the targeted readings to help students examine their biases and experience similar discomfort to the discomfort she felt as she learned to understand vulnerable populations. Melody felt it important that students' opinions be challenged and broaden their worldview. Melody asked students to complete a reflective journal:

> "…it's good to see sometimes the student who says, "you know, I never thought about this. I never thought minimum wage could mean somebody was living in poverty. I never thought about what it meant to have to work two jobs to feed your kids… and to see them actually think about these things and talk about what they believed and how they were challenged, to me means they got it. It means that even if it doesn't change their beliefs, the fact that they… had to get a little less comfortable with where their worldview is to me means that the exercise was overall successful and I tell them that."

Faye has 25 years of nursing education and teaches in a faith-based college. A mental health professional both in education and practice, she gave the example of graduating from nursing school and wanting to go into psychiatric nursing. She reflected

her own experience with good mentors and role models in an excellent work environment even with "the hardest job in the world." Faye elaborated that nurses were with patients 12 hours straight. Some nurses became "robots" going through the motions but not with the patients. Faye theorized that those nurses were "burnt out" because they gave so much they need to set up a barrier. Early in her practice, she encountered nurses who were viewed as far removed from the patient. The nurse who is not burnt out was described as in the day room with the patients. As a result of this experience, she encouraged the students to be out with the patients talking with them absorbing the experience.

Faye wanted to create a positive experience for students. Faye described some experiences that she did not want students to experience and it dictated her teaching methodology. It was important to her that the student had a better experience in clinical than her own experience. Faye described being dropped off in the locked ward of a psychiatric hospital with an instructor that was emotionally distant during her educational experience. She had to work with mentors after school to learn psychiatric content. Faye wants to be a positive role model and exhibit excitement and passion for psychiatric nursing as she develops learning experiences for her students.

Leah described how self-reflection and need for educating student nurses in the affective domain developed over time. Early in her teaching career, Leah was focused on content:

> "When I first started teaching I was so worried about the content and the risk being in front of people and following the PowerPoint. I didn't have a brain in my head even though I did… But as time went on and I was more comfortable in front of the classroom… some of these scenarios (stories) just come right into your head."

Self-reflection assisted Leah in the development of strategies for teaching in the affective domain.

Nancy discussed the desire to help students gain wisdom. Describing that wisdom comes with age, she reflected that early in her career she did not view patients as persons with lives, histories, and families. As a nursing assistant her thinking was task oriented and how many baths, how many people to toilet. This gave her insight into student thinking:

> "I think you get wisdom through life experiences. And nursing is a unique profession because we are literally with people from beginning to the end. So it's a unique profession… And therefore I think you need to instill it (wisdom), quicker."

Self-reflection on the part of nurse educators helps them to create learning experiences for nursing students. Nurse educators described their own experiences learning in the affective domain as influencing how they teach nursing students within this domain. Personal and professional experiences are reflected upon and facilitate educator insight into teaching nursing students. This reflection addresses how nurse educators begin and continue teaching in the affective domain.

Nursing Students and Self-Reflection

Nurse educator self-reflection lays the groundwork for the encouragement of self-reflection in nursing students. Nurse educators utilized a variety of strategies to facilitate student self-reflection. Self-reflection was done by the student and illustrated in Figure 1 as outside of interactions with nurse educators or patients. While student self-reflection was guided or facilitated by nurse educators, the assignments were a reflection of the students themselves.

The most common form of nursing student self-reflection in the classroom reported by the nurse educators was reflective journaling or logs. Participants described some type of written formant for assessing student self-reflection.

Addressing students' preconceived ideas was important to most educators in the affective domain. This included pushing student emotions, values, and beliefs into cognition for exploration verbally or in written form. Verbal self-reflection was a common educational technique in the clinical setting.

Nursing students were not expected to self reflect without guidance from nurse educators, especially beginning students. Nurse educators described a series of questions designed to facilitate student self-reflection about thinking and feelings associated with the role of the nurse and the intimacy of care. This was an important prequel to working with patients and clients whose values and ethics are divergent from the students' experience.

Carol is a nurse educator with 6 years of nursing education experience. She teaches at a private college and describes her specialty as mental health nursing. Carol asked specific questions in a reflective journal format designed to facilitate student examination of values and beliefs:

> "I challenge students from the very beginning to reflect on their assumptions and preconceptions about mental illness… They quickly find out that they have a lot more than they thought they did. And that way I encourage students to connect with their feelings as well as… the cognitive learning that is going on."

Carol encourages self-reflection of student preconceptions to bring them into student awareness along with content.

Self-reflection was seen as important for students to develop a sense of self-awareness and who they are in terms of an "affective self." Educators describe this self-

awareness as necessary to provide nursing care to clients and helps. Students giving cognitive/physical care were seen as impacting the affective realm of the client and students were encouraged to develop an affective awareness that started with the nursing student.

Olivia is a nurse educator with 32 years of nursing education experience. Moving into an administrative role she teaches at a public/private university. She describes how nursing students needed to be aware of themselves and observe the reaction they evoke in patients or they can experience dissonance:

> "I see that students who are not aware of themselves in that way have a real hard time being aware of their client. And so, the dissonance that can happen because of that can be very great. We know of the nurses that can go in, do a skill, and leave for instance, or communicate with the thought of doing patient education, but not tapping into that affective piece. Their effectiveness is not that great."

Olivia saw this self-awareness as something that is taught and is tied back into professional behavior:

> "… I really felt, if I could move them along to a place of owning their practice… there's nothing like having them look at themselves in action that facilities that, and then tied back to their standards of practice, their code of conduct their ethics – our ethical conduct, our social policy and what our commitment is to society… How does it (practice) impact nurses? How does it impact patient care? How does it impact patient outcomes. You need to think about those things."

Olivia continued and contrasted self-awareness with self-centeredness. Student outside commitments were seen to compete with affective learning and the commitment to self-reflection in journals and logs. She was able to discern when students were not committing the time needed to grow in self-awareness.

Olivia also described verbal self-reflection in nursing students in the technique of debriefing after clinical experiences. Debriefing was seen as an important guided self-

reflection for nursing students. She explained the debriefing process with students as important in affective learning to create a context around the clinical experience:

> "It has to happen if I am going to think of myself in any way as a competent educator. I need to build that in along the journey. We can't take students into a clinical environment and have them leave for the day without some processing of that, and that includes that affective domain. They are exposed to new experiences. Often it is fast paced. They need to think on their feet. They see others doing - and not doing. They're just taking is so much experience and information. Helping them create context around that is so critical… I think that creating that pattern that when they graduate, they continue that behavior with their peers of debriefing those situations that are daily in our work life as nurses… We need to build that in. So again, it's not just going and doing and leaving."

Olivia explained the debriefing process as necessary to assist students resolve dissonance:

> "So there's a difference between my thoughts, feelings, and those values perhaps that are at play that have formed those feelings and thoughts and what my experience is now. And I love dissonance. I love to see students uncomfortable… Its in that realm of dissonance that I know they're (students) working hard to try to create some sense about their experience and I want them to work hard like that in trying tot get to that new place… I want to support them getting to that place… I want that discomfort to happen because that's where you, yourself are connecting to the world that's around you as a professional and that's where a lot of learning and growth happen."

Self-evaluations were also utilized by educators to assist students in the self-reflection process. These tools were usually designed with specific course objectives in mind. Use of self-evaluation tool in the form of assessment tools, communication tools, and critical thinking tools were discussed.

Holly describes her nursing specialty as obstetrics. She described a pre-conception checklist as having a self-reflective affective component. Instead of lecturing on what should be involved in pre-conception care, she had a standard pre-conception checklist that was handed out to students in a class of young adults to complete. The realization of the multi-dimensions of pre conception care was understood by the students

as they filled out the checklist. Holly indicated the success of the method was because the students were able to connect to it and relate to the experience personally.

In the psychiatric setting, Carol acknowledges and validates the students' self-reflection with a communication tool. Carol requests that the students review the self-evaluation and set aside negative feelings when dealing with patients experiencing mental health issues. She describes this technique as helping the student to quickly develop the ability to set aside negative feelings.

Faye in the mental health setting spent a considerable amount of time preparing students to be comfortable in the clinical setting:

> "…there's truth, and there's stigma, negative stigma against the psych(iatric) patients, against the psych(iatric) hospitals. And so they come in and I would say fully a third to a half of every clinical group is scared…"

Orientation, role play, awareness, and general behaviors to address fear were discussed prior to entering the clinical. Faye's desire for the student to be comfortable was based on the impression that students could not integrate the nursing process emotionally if the students were fearful, uncomfortable or worried about safety:

> "… it's different when you're on the unit because when you walk in and that big heavy door slams behind you and you walk down this hallway and you've had no experience with psychiatric patients before, psychiatric clients before, it can be very, very scary."

To help alleviate some of the fear, Faye would share her own story of the first time she was on an inpatient psychiatric facility. She gave examples of her fear and how she addressed and overcame fear herself to eventually practice in the setting.

Gloria is a nurse educator with 8 years of nursing education experience. Teaching in a faith-based college she described her area of teaching in community nursing with a global perspective. She described the use of a cultural competency self-assessment and a

mini mental health assessment tool designed to assist the students in identifying stereotypical biases. Gloria described these tools as helpful to students who may be judging others without having sufficient knowledge. She used these exercises were a lead in to the need for appropriate assessment and how to incorporate interventions and develop clinical judgment.

Nurse educators described the importance of nursing student self-reflection as important in the affective domain. Nursing students are not expected to self-reflect with out guidance. Educators described developed written, verbal, and targeted self-assessment tools are used to facilitate nursing student self-reflection. Measurement of self-reflection was not described as measuring the affective domain, but exposure to the process of guided self-reflection assisted students in understanding the role of the self in professional nursing care.

Teaching in the Affective Domain

Data were analyzed and reviewed to obtain teaching strategies of participants**.** Teaching in the affective domain occurred both in the classroom and in the clinical/laboratory setting. Classroom strategies for teaching and learning in the affective domain described by nurse educators demonstrate a variety of independent and group activities (see Table 5).

Table 5

Classroom Affective Teaching-Learning Strategies Described by Participants

Student self-assessment - tools, written assignments (n=13)
Clinical stories of faculty experience (n=8)
Stories of faculty personal experience (n=6)
Stories of student personal experience (n=4)
Group discussions (n=4)
Written assignments (n=4)
Patient in class - videoconference, audio, case study (n=5)
Create controversy in class – dilemma, debate (n=4)
Reading assignment of patient story (n=3)
Application of patient story to theoretical models (n=3)
In class participatory exercises (n=3)
Peer to peer sharing (n=2)
In class clicker response devices (n=2)
Games (n=2)
In class movie, video stream online (n=2)
Acknowledge and validate students (n=1)
Create a code of conduct (n=1)
Pop quiz ((n=1)
Create mental rehearsal (n=1)

Note: Participants reported more than one classroom teaching-learning strategy.

The most frequently described strategy designed to facilitate affective learning described by the nurse educators were strategies to facilitate student reflection (n=13). Sharing experience through story was also frequently mentioned and stories could be generated from nurse educator experience or student experience.

Strategies for teaching and learning in the affective domain in the clinical and laboratory setting are listed in Table 6.

Table 6

Clinical and Skills Laboratory Affective Teaching-Learning Strategies Described by Participants

Debriefing (n=11)
Reflective journal/log (n=7)
Role modeling (n=7)
Role playing (n=6)
Articulating clear expectations (n=3)
Orientation to clinical site (n=2)
Scripting (n=2)
Encourage cultural activities (n=2)
Students involved in homeless shelters (n=2)
Clinical evaluation tools (n=1)
Simulated patient (n=1)
Exit strategy (n=1)
Rehearsal (n=1)
Tailored coaching (n=1)
Students involved in meal programs (n=1)
Students involved in head start programs (n=1)
Encourage prayer with patients (n=1)

Note: Participants reported more than one clinical/laboratory teaching-learning strategy.

Nurse educators described a variety of strategies across various clinical and laboratory settings. The most frequent strategy described was debriefing post clinical (n=11). Debriefing is an interaction between faculty and student. Reflective journaling was also an important tool for nurse educators teaching in the clinical area but as a process of the student, it is illustrated in Figure 1 as a process completed by the student.

The process of teaching and learning in the affective domain is illustrated in Figure 1 as the overlap between the nurse educator and the student at the center. Eight sub-themes were identified as teaching-learning processes occurring within the theme of teaching in the affective domain. Figure 2 illustrates the process that occurs during

teaching-learning in the affective domain as described by participants and major themes have been replaced with sub-themes identified.

Figure 2. Illustration of the Process of Teaching and Learning in the Affective Domain

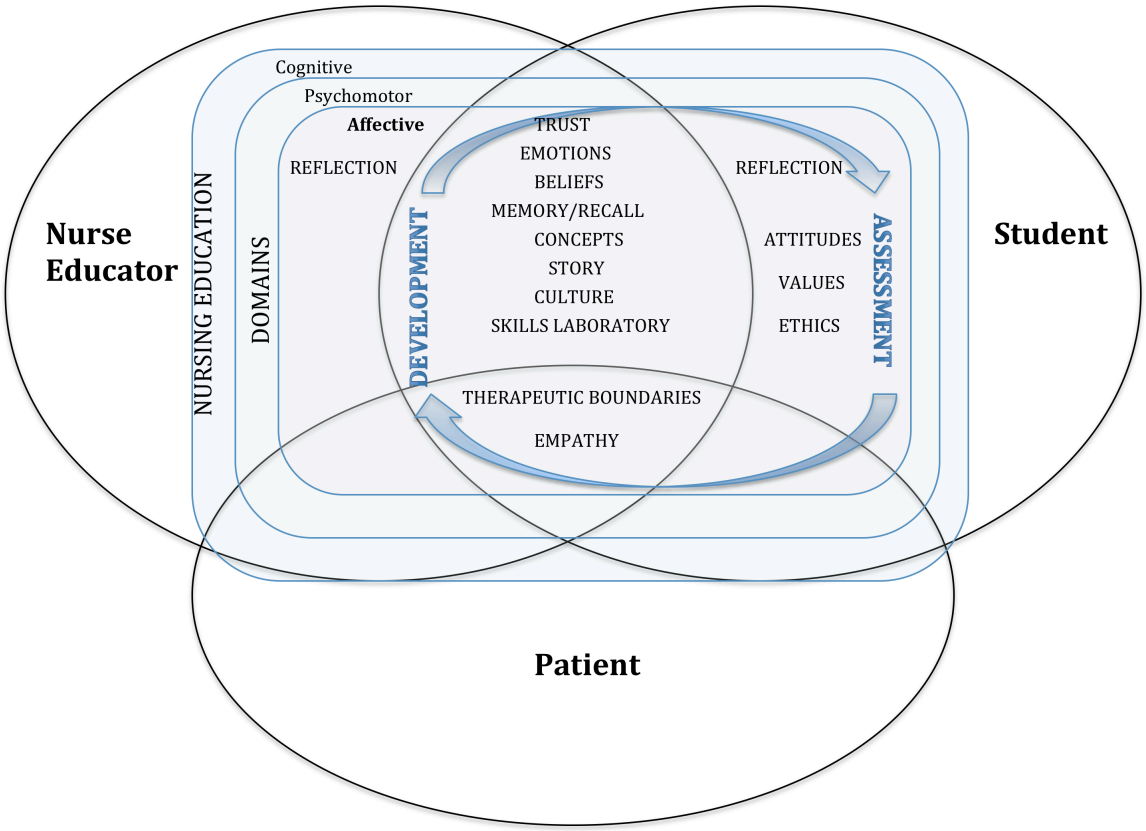

Figure 2. Illustration of the process of teaching and learning in the affective domain. This illustration builds on Figure 1. The sub-themes described in the data have replaced the major themes of Teaching in the Affective Domain, Introducing the Patient, and Student Outcomes in the Affective Domain to better illustrate the intricacies of the process of teaching and learning in the affective domain described by nurse educators.

Development of a trusting partnership. Several educators described a partnership or trust with students as an important beginning for teaching and learning in the affective domain. Educators explain that they have the knowledge but do not impart knowledge to the student. Rather educators partner with the student to help the student

attain the knowledge. Educators describe this partnership as important in creating a teachable moment. Beverly wanted to improve her teaching skills and required student feedback:

> "…they can help me understand how to be a better teaching with them if I solicit information from them. If I'm intimidating them, and they don't say anything to me, how do I know to change that behavior?"

Beverly continued to illustrate the power base in nursing education that can negatively impact student learning and the need to develop a partnership with students:

> "I'm in a position of power, so you have to be careful not to abuse that position of power with them (students) and get feedback to make their learning experience such that they can learn from it and not just a terrorizing experience… it's gonna involve both of us as individuals because how I approach their learning can set the stage to make it or break it. And if I'm not aware of that for each student and I do something that breaks it, it's not then a teachable moment. So it has to be a partnership."

Beverly intentionally seeks out a partnership with students to develop trust and facilitates learning in the affective domain.

Melody illustrated the difficulties inherent in building trust with students in large classrooms. In a class of 82 students she described the logistics of building trust with students:

> "…if you are asking someone to share those kinds of feelings, to examine themselves in that kind of depth where it is going to be put out for review, it's kind of asking them to put their neck out on the line and it's very difficult to have a trusting relationship with the professor who can't remember your name. And it's something that I definitely struggle with because one of the things that I also believe is that trust is a big part of the education experience."

In spite of a larger class size, Melody continues to develop activities designed to facilitate trust between herself and students.

Adjusting student emotion for affective learning. The trusting partnership with students was important because nurse educators described student emotions as important

for learning in the affective domain. A trusting partnership with students was necessary because educators described several methods to moderate or potentiate student emotions to achieve learning outcomes.

Several educators pointed out that emotion was necessary to learning in the affective domain. The educators also addressed that too much emotion has a detrimental effect on learning. Striving for increased student attention, educators described students as unable to learn if the burden of emotion was too great.

Several educators described students as stressed or having anxiety. Educators were aware of the students' emotional state and worked to assist students through those emotions to be able to provide care in the clinical area. Educators understood that their presence in the clinical area could be intimidating to the student and that anxiety was an individual response. Moderating anxiety was seen as important to do before the students began safe care. Stressful and anxious emotions were moderated using a variety of techniques including physical rehearsal, role play, conversation, coaching, and debriefing with reflective practice,

Melody described the issues assisting students with difficult emotions in clinical. Occasionally educators struggle trying to assist students handle emotions:

> "I had one student who every time a patient cried, would just run sobbing from the room. And by the time it was all said and done, she ended up being a hospice nurse and was brilliant… When I first had her, she was in her early clinicals and it was very frustrating for me. How do I help this girl to – she is going to have to learn to deal with difficult emotions because we all have them… So I tried to steer her towards, in this case, more of an analytic (thought)… And so over the course of the semester, she talked about some of the things that bothered her in those rooms and I guess over the course of the rest of her experience that she got from the beginning where I had her to, towards the end, she managed to figure something out."

Decreasing student anxiety was seen as important to practice in the clinical area so student could better access learned memory and skills. Having an exit strategy with students was helpful when the student was expected to give care under the direct supervision of the educator.

Melody described humor in the clinical setting and how it helps students remember under stress and the decrease in student anxiety:

> "Some of the things they (students) remember me saying crack me up. My first-ever clinical group… They were first rotation in the hospital and I told them, 'You know, you've got to remember, where there's pee there's life." And sure enough at the end of the semester, they made me a big card with notes in it and it said, "Where there's pee there's life. I have it hanging in my office… They need to have that stress relief."

Faye described a technique designed to potentiate the experience of anxiety in nursing students. Preparing for a class discussion on anxiety she wanted to create an emotional connection in the students with the emotional experience of anxiety. Faye designed a pop quiz to open the class. The class activity was not graded but simply utilized to create the uncomfortable feeling of anxiety within students so the student could have a better understanding of the patient experience of anxiety. When the students understood the purpose of the classroom activity, processing anger and frustration, they were receptive to the anxiety inducing experience.

Reaching student beliefs. Affective techniques designed to address student beliefs had mixed reaction from educators. Most educators describe altering student belief as difficult with some educators stating it is not possible or desirable to address student belief systems.

Some nurse educators conceptualized student beliefs as a faith-based phenomenon. Educators who described student belief from a faith-based perspective did not seek to alter or change student belief systems.

Diane is a nurse educator with 18 years of nursing education experience. She teaches at a faith based college. Diane explained, "We don't attempt or even want to try to change their own personal beliefs. That's not our goal. It's on a professional level." Described as developing a professional belief system, acknowledging a personal belief system and become accepting of the value systems of others were seen as important in the development of a professional belief system:

> "We do not have the students evaluate or assess their own personal belief system… We ask them that they, on a professional level, that they acknowledge a set of values."

Diane went on to elaborate that the expectation was to provide the patient with the best care. The student does not need to believe the patient behavior was appropriate or to be tolerated. But the patient was still entitled to the best nursing care.

Although student faith was not intentionally addressed by any of the participants, Kay did provide exposure to the faith of others to facilitate student understanding of different faiths:

> "I talk about people's belief and where they get their source of strength. So the Native Americans and the elders, and the Shamans… the two more major groups (are) the Hmong and Hispanic… what I'm trying to get them to see is how important, whether it's a unified religious group or whether it's just a core belief system… that they really try to seek that out for the patients because that's a source of strength for them."

Kay continued to describe the rapid turnover of patients in the hospital and the difference with patients in a rehabilitation setting. She encouraged students to integrate patient beliefs in planning nursing care:

> "…they're here long enough that it is important that they get to a service or the chaplain comes and visits them. Or that, if they have a leader in their community come and do prayers or a ritual with them."

Gloria described the broadening of student beliefs by the integration of a diverse student body in the classroom and how the challenges of a diverse student body itself encouraged demonstration and role modeling of caring behaviors and support of student learning. This structure of support was seen as affecting student belief. Gloria was at a faith based single purpose nursing school and she described how integrating not only the diversity of student in the classroom, but also the diversity of faith that was important. She explained this diversity of faith and beliefs assisted students in believing in themselves and the strength of their faith.

Student belief systems were described by some educators in broader, more general worldview terms. Usually this type of belief was not described as faith based. The term "preconceived ideas" was a descriptor of this type of belief. These preconceived ideas included belief in the effectiveness of complimentary therapies, patient expectations, elderly care, and justice and disparity. These educators did see it possible and desirable to address student belief systems.

Educators that described faith based belief described it as something that is internal to the student, which may or may not have to do with previous experience. Preconceived beliefs were associated with previous experience and participants did indicate that this type of belief could be changed. Educators explained that students could change belief as a preconceived idea by being exposed to a new situation or learning experience. Educators felt that students may demonstrate belief as a

preconceived idea but must also demonstrate a willingness and openness to the experience in order to change beliefs.

Julia is a nurse educator with 32 years of nursing education experience. She teaches at a public university both online and face-to-face. Julia described designing an experience for students to apply complementary therapy techniques. Applying cognitive learning and the application of complimentary therapy she described a change in student belief in complimentary therapies.

To address the student belief systems regarding complimentary therapy, Julia set up a debate with students both face-to-face and online. She continued to explain students are expected to address the scientific rationale of complementary therapy interventions and an additional assignment literature review of complimentary therapies:

> "I want them to understand that a lot of these therapies are pleasant to get… But there's far more to it than that. They need to be specific to a condition. I mean, they're not just feel good therapies. And I want nurses to use those specific (interventions) to a specific condition.

Julia also encouraged application of complimentary therapy techniques. Students were encouraged to practice a complimentary therapy for a total of five times with a patient, relative, or friend and journal results:

> "There's no way one bought of therapeutic touch is gonna cure anybody you know. And I don't talk about these things as curing either. They just help the patient adjust to their medical diagnosis and live a more quality of life. But they (students) like that one 'cause in that one they get to see a lot of change. Because they have to rate the patient before and after the intervention.

Julia described the experiences of scientific rationale, literature review, and practice was enough to address the belief systems of students skeptical of complimentary therapies. She also elaborated that students still had the underlying scientific belief system intact,

which was described as the domain of medicine. Students were encouraged to utilize complimentary therapies and collaborative practice with medicine.

Diane gave an example of a student whose patient wanted to talk. The student was fearful the patient would ask questions she could not answer and left the room quickly. After discussing the preconceived idea that the patient had questions she could not answer, the student went back in and talked with the patient. The patient only wanted to talk and had no questions the student could not answer. Diane explained that the experience of addressing a preconceived idea broke down the student fear of talking to patient. The new experience gave the student courage.

Elaine is a nurse educator with 8 years experience teaching in nursing education. She describes herself as a public health nurse. Elaine discussed student beliefs about aging and elderly care. She saw this as important in nursing because most nurses will deal with elderly at some point during their careers. Elaine described a teaching session with a student in an elderly person's home where the student moved some personal items. She described how that negatively impacted the teaching session. Elaine utilized this exemplar in subsequent learning sessions with students and beliefs about elderly care.

Beliefs about justice and disparity are challenged when students realize that accesses to healthcare resources are not available to all populations. Several educators indicated learning experiences occurring with vulnerable populations, corrections, and poverty as affecting student preconceived beliefs about justice.

Not all educators thought that true student beliefs could be expanded or changed. Holly described a student who was unable to embrace the belief of others. Upon completing a successful mental health rotation a student approached Holly explained:

> "…she (student) said, "I think you should know you did a fine job teaching and the patients were interesting, but I really believe that all psychiatric patients are possessed by the devil and it's not a mental illness. It's an evil and it's something they've done wrong in their lives." And of course, that shocked me."

Holly elaborated how the student was very rigid in her belief system but was able to meet the parameters of the clinical experience and hid her belief well during the clinical rotation. Holly reviewed how the student was able to perform to the standard in the clinical setting but "to be a good nurse, you have to have your heart in it." She went on to elaborate how the student did enough to pass the course but the student's heart was not in nursing.

Holly described the limits of influencing beliefs in nursing education:

> "…I have given up trying to do a personality reconstruction of the nursing student… And so I'm not gonna change people really. But at least if they can put on their therapeutic hat and know how to behave appropriately with patients, without being demeaning, without being frightened, without evidencing any stigma… I get them to work on is to identify how they feel, to identify what sort of reaction do they have upon patients… to know their nursing skills, the good, the bad, the ugly, their nursing skills."

Facilitating memory and recall in the classroom. The least complex application of teaching and learning in the affective domain was the application to recall and memory of content. Faculty described students struggling with the amount of content and helping students recall information when needed. Educators described engaging students through humor, stories, and classroom activities to engage students and help them remember.

In the classroom setting educators were able to assess the students struggling with content or passively attending class. Many educators noted students were not engaged and many were on social media during class time. Faye described disengaged students as "tourists" in the classroom. Educators would pull in extraneous examples to get students

engaged in learning. Educators would share stories of their experience as adjunct to classroom or spontaneously design a learning experience such as staffing a nursing unit to facilitate student learning. Active student engagement in the classroom was an important feedback loop for nurse educators. Also important in active engagement was the description of students sharing experiences and learning from each other.

To facilitate student engagement through the use of humor, Beverly described helping the student remember basic content:

> "I mean yes we had to get through a certain amount of material, yeah, we know we have to do that for our students because our body of knowledge changes everyday. But how do you engage them in that material so that material becomes real and alive? If you don't get the passage, you know, of fluid though the kidney, by the lecture? What do I have to do that's stupid so that you always remember? Do I need to dress up like a nephron, do I need to have people in the classroom so they'll have a cue or something that allows them to "oh! Now I remember! I get it" and when they go in the clinical arena they understand "oh yeah that drug worked here and they wouldn't let so and so out of the box in the classroom!"

Several faculty described classroom learning as a certain amount of content that needed to be covered. Beverly continued to describe the challenges of lecture:

> "So in the classroom when you, I mean, we lecture blah, blah, blah. Who wants to hear Charlie Brown's teacher? We don't. And so to engage the students in a manner that is meaningful for them."

Nurse educators teaching at the beginning levels of nursing education described methods for students to connect to other students as practice for connecting with patients later in their education. Gloria described the need to develop a sense of respect utilizing the development of a code of conduct collaboratively with students in the classroom:

> "…code of conduct is a little bit more focused on respect. Respect for self and respect for others… What about advocacy? What about care? What about compassion? What about success? Support of one another? Respect again. Because I think without them, nursing is not a career… then we had maybe 10 or 15 minutes of discussion after. And somebody will bring up, well can I add this here? Do you think it's important? Like even speaking when someone else is

> presenting. With assignments, what does that mean to you? What does it mean to someone else? Especially when you come in late all the time. It's a certain value that we have. And part of it is accountability. And so, that is a priority… accountably, respect, care and compassion."

Educators in the online environment were particularly aware of the affective domain. Understanding the unique learning in this domain, educators were concerned that auditory learning as part of the affective domain was not ignored. Ida described this technique to address affective learning in the online environment:

> "…so actually having a client or a bogus client actually talk first person that they can hear somebody's voice about what happened… Poverty. I'm thinking you know, the first person account of Hmong people who crossed the Magong river, and lost all their family and then are now dealing with depression. That's what drives home… the incidence of depression among immigrants… So I think that story is something that we've done more. We've found that in distance education that hearing somebody's voice, that the aural story is better than just the written story in some ways."

Ida continued to describe the unique text based environment of early online learning and how the technology has advanced to allow streaming video and audio. This advancement was working well and the faculty at the institution considered conducting a research study to measure emotion in the online student. But emotive measurement technology could not be integrated into a dispersed online environment. Ida also researched at self-report tools to measure student emotion, but was unable to effectively initiate affective measurement in the online environment:

> "And we were concerned with our distance teaching and learning that we were just doing the cognitive stuff, and that the affective learning was perhaps not as strong as it was in a face to face class. And also that was something that our faculty… I mean that was one of the reasons that they felt perhaps that the distance teaching and learning was a little hard for them… A core group of senior faculty felt that we needed to pay more attention to the affective learning."

Ida continued to describe work on a poverty simulation designed to facilitate student affective learning in the online environment. Utilizing second life, the simulation was under development and described as a high learning curve to learn.

Ida also described an unexpected online affective learning experience. Students were taking a course in conjunction with students in another country whose main language was not English. Students had to learn to utilize translation software in order to communicate with students in the class. For many American students it was the first experience where the language of the course was not their native language. Student feedback indicated a change in attitude towards professionals struggling to communicate in English:

> "So that experiential learning that has really helped them better empathize with people in the United States who don't have English as a first language. And they talked about how this helps them understand professionals that are struggling with English and clients. It was not something we taught… And it changed their attitude about… just how frustrating it is to try to communicate something when something is not in your language."

Melody described being connected to students via social media after graduation. When questioned if she pursued this connection with students, she described the need for appropriate boundaries between educators and former students:

> "I haven't figured out a way to do it where the professionalism would be maintained and I think that especially in the early – as they are learning what it means to be a professional, it's so important. There have to be some boundaries… If I don't give them that, how can I expect them to the turn around and know how to keep that boundary but still touch the human side of what we are doing (nursing care) and maintain their professional integrity?"

Understanding nursing concepts. Concepts in nursing practice were another area of nursing education described by several nurse educators as good application of the

affective domain. Loss, suffering, caring, and nurse advocate were some concepts nurse educators were working to facilitate student understanding.

Kay described a classroom technique designed to assist students understand the concept of loss. Her classroom was a largely traditional young nursing student group with possibly limited experience with loss. Kay requested that students put away something meaningful to them for a week. As an example, it could be an electronic devise or caring for a pet. She then asked students to reflect on the experience and how that loss affected their daily function. Kay acknowledged that some students went through the motions of the assignment with little engagement but other students really wanted the experience and embraced the assignment. Those students' reflective journal entries showed insight into how disruptive a loss can be to a lifestyle and students also expressed appreciation for the experience.

Nancy described a research project she was interested in conducting. One class assignment was for students to write on the concept of suffering. Specifically, relate a time when they experienced suffering. Nancy reported that the student writing was profound. The intent of the assignment was to ask students to connect to a time of personal suffering so when the student interacts with a patient later; they were able to have a better understanding of what suffering is:

> "I would like to argue that once they do that experience, when they encounter a patient, they're going to stop and may even have a caring moment… and make a connection with that person. And what I like about a caring moment is… That thought process is that when two lives with their own experiences interact and they walk away forever changed."

Nancy elaborated that many young students have a limited understanding of suffering and that understanding moves through time. "I think some of that is the

wisdom that comes with age. So I would like to bring that to them, knowledge, early on."

Nancy continued and elaborated on Watson's Caring Theory and carative factors as the possible foundation for a research project. Describing the understanding of Watson's Caring Theory as a light bulb moment, she wanted students to have a similar understanding.

Julia views complementary therapy as caring and important for students to learn in the affective domain:

> "When someone is caring for someone, I see that as affective, I see as emotion. And many of these interventions such as massage, or music therapy, or reflexology even. Many of thee interventions, Reiki, show that they care for the person. They demonstrate human caring.

Julia went on to explain complimentary therapy as one of the aspects of the affective domain. Tying the interventions to nursing theory, she also stressed the importance of documenting interventions in the affective domain. "If you don't know what you're doing you can't chart it. I want them to chart it."

Julia cited several examples of how past clinical experiences in complementary therapy demonstrated caring nursing practice:

> "One time I saw a patient that had a stroke and was paralyzed on the left side. And my student put on music therapy, and then started to do, read a very beautiful guided imagery script. And during this imagery script, everybody in the room saw the patient move the paralyzed leg, you know. There was not doubt about that. That was something that really moved me.

Julia described how currently students are sent out into the community with practitioners of complimentary therapies.

The use of story to form meaning and memory. Educators with clinical experience preferred to utilize story in the classroom. These nurse educators want to

facilitate not only memory and recall, but also assist the student to form meaning from cognitive information. Stories included experiences from faculty, students, and patients invited into the classroom.

Leah explained the use of personal nursing experience in the development of stories in the classroom:

> "So I had a lot of experiences. So when I'm talking about, I'll call it juvenile idiopathic arthritis, JRA, I can talk about patients that I've taken care of. Most of these patients have chronic illnesses… I have so many situations that come to mind when I talk, so I bring in a real person into the scenario, and my relations to that person, or the person's reaction to the complexity of their chronic illness. And in fact, when they know they're dying, cystic fibrosis you know, and some kids with… JRA and lupus. With those kinds of illnesses they can present very ill. You can have varying degrees of those illnesses, they can have varying stories to tell… I bring in the real person."

When asked why Leah thought stories were appropriate, she explained:

> "Because first of all I want them (students) to remember… I want them to see – to feel a real person when I tell a story… I have all eyeballs on me. Otherwise maybe a fourth of the class has their eyes on me max. And the other ones have their eyes on the computer… so the minute I start with the storytelling, all eyeball. And I know they'll remember."

Citing several stories that illustrated specific content, Leah described the rationale for stories in the classroom:

> "…I think it's just that these are real people and that they do touch your lives and how kids can be so incredible. And how you discover things. I discovered that… you know you cant get too involved but you do. You get – these people need you. They can't speak for themselves necessarily if they're 12 years old and their mom isn't there and the doctors want to do a liver biopsy in the room. You know, you have to be their advocate."

Leah continued to illustrate a scenario she shares with students where patient advocacy was important:

> "…like this past year I taught, talk about pyloric stenosis… my daughter called me and she had twins – a boy and a girl. The boy was spitting up. He was one month old. I said OMG he has pyloric stenosis. No, the doctor said it was reflux

> disease… her husband finally said, "You know, I think I had that when I was a little boy…" I talked about how when he was in the hospital he waited two days for surgery because it was a weekend. I thought, those little babies want to suck on their bottle… My daughter sat by the crib for two days… So I'm trying to say, (to students), if you're in this situation, get a hold of the surgeon and say, "You know, you can't do this!" Mom is sitting there 24 hours a day trying to comfort him… those are the things we do in nursing. Things that'll look at the whole scenario… remember that they need fluids and surgery and that these are four weeks old and the father had the same thing… and this kid needs to drink. You have to be those people's advocate… And that's not something you're going to find in the textbooks or PowerPoints."

Holly described the learning process utilizing storytelling as the desire for students to "form a memory" as opposed to just learning content:

> "I think I try and connect with students even the regular theory material somewhat on an emotional level because I think that's how we remember things. We remember a patient that had something and we make that emotional connection. It's remembering the facts but through an emotional piece."

Holly described how she integrates stories both personal and practice into lecture to exemplify content. Describing a personal connection with the story and assisting the student to connect to content through story:

> "when they (students) need to recall that information it will be easier for them to do it, if they can connect it to something else. That it's not just some random fact that they need to pull from. That if there's some bigger meaning to it that they remember this as part of the experience that they had… more than memorizing the fact, is connect it to something."

Holly went on to illustrate storytelling in the classroom:

> "it's always connected with some theoretical information. So one… had pre-eclampsia. So when we talk about pre-eclampsia I can talk about this is what happened… and this is what I was when we had her baby shower, and this is how much weight she gained by 32 weeks gestation, and this is what happened with her lab work. As we talk about health, talk about HELLP syndrome and so it's putting all of that together. And my little… that died had respiratory distress syndrome, he had grade 2 intraventricular hemorrhage, he had necrotizing enterocolitis secondary to the patent ductus arteriosus and the indomethacin. So as we talk about all that I can sort of use him as a case study… when this happened what would we need to be concerned about, and what would we need to be thinking, and what would you watch for, and look here's what happened to him

> the next day. So I think, it makes it more of a personal connection… it's somebody they can connect to... So it's always in relation to not just remember it (the case) but to remember the pathophysiology, or the assessment piece, or talking about grief and loss."

Holly indicated she did use case studies when her own experience was not broad enough.

When questioned why not just use case studies, the educator replied:

> "Just because they (stories) are more real to me. I remember them and so I have a personal connection with them. I remember what happened… A case study is great, but I don't have that personal connection with it… And so if I can draw from my background and share my personal experience, and this is what happened to me, this is what happened to a friend of mine who's a nurse or whatever that makes the same point. I tend to use that."

When asked if the personal connection was important Holly explained:

> "Right, so really you know experience, I think is so valuable and they (students) have limited experience. so if I can use mine to give them some pseudo experience, then I want to be able to do that."

Holly also integrated nursing theory into the application of affective learning. Citing Carpers Four Ways of Knowing and through story telling, students can add knowledge through storytelling into personal knowledge. Based on her own learning experiences, Holly believed the information learned through storytelling would stay with the students longer than "cramming" for an exam. She felt the stories formed a meaning for the students.

Holly described the learning process happening during her story telling as the students "forming a memory" which helps student interweave cognitive and affective learning:

> "…when you're gonna pull out some piece of information, what do you connect it to? And if there's a memory that you connect it to… that you can attach that… I remember that story and this is what happened and that was respiratory distress syndrome that lead to this, which lead to that. Then you start to form that weave of information. And so it becomes less than the story. The story was the vehicle to get you to those other pieces of information. If it becomes part of your

> memory, it sort of networks and intertwines into other pieces. But you're more likely to be able to connect to that and pull it back."

Kay described utilizing story in the classroom to illustrate pediatric care and facilitate scripting for young patients:

> "So really be careful about the words. The kids, well as soon as you're done with surgery you'll come back to the floor. And you can see the little kid thinking, I don't even get a bed? I get put on the floor..? I tell them about when I was working as a staff nurse… a pretty small little boy… I got him there and the parent, but then the parent had to leave and I remember I needed to ask him something. So instead of walking down to the room, I used the speaker… and there was silence… so I walked down to the room and he was standing on his tiptoes on the top of the bed talking to that thing (speaker)… I hadn't oriented him well enough to the room to understand there might be voices talking to him. So I try to remember some of those experiences… But they (students) also then can, you know, they laugh, and I think when you enjoy something you remember it."

Kay continued to describe how the stories help students in the clinical setting:

> "They (students) say, well I remember you telling me to take a blood pressure on the doll first… and then I remembered you telling me to tell the child it's going to be like a hug around your arm so when they feel it tighten up, they're not scared that their arm is going to fall off."

According to Kay, story telling facilitated student understanding in pediatric nursing care.

Ida illustrated community nursing content that was difficult for students to incorporate. Describing biostatistics and epidemiology as "not delicious" to learn, Ida illustrates the meaning of the statistics with stories, especially stories that touch the heart:

> "Stories of individuals and groups and how they overcome adversity… the challenges they have, and the ways that nursing helps them move forward. And those are things that grab students attention and make them believe. That while making a rate, what's going to be in the numerator or the denominator is worthwhile because of the individuals. And also for the policy makers, when you have the stories and you can link that to something that happens to an individual or a group and it's personalized. It tugs at their heart and makes them want to read the statistics."

Ida went on to explain that students are naturally drawn to some areas of nursing. Other content areas were more difficult to get across to students:

> "Why is neonatal ICU sexy? What is it? There's… the adrenalin rush that people are critically ill. That the clients are innocent babes. Or a trauma unit, there's adrenalin with that… That adrenalin rush is part of… where emotions go. And if you think about… what percentage of the population is not covered by insurance, there's not that adrenalin rush… You need to be telling the stories... What it's like to be there sitting in a home visit and have roaches crawling up and down the wall. Those are the things that heighten peoples' engagement… you need to be making that sexy."

Nancy describes a story technique that elicits stories from the students in the classroom. Students would be asked to submit stories of family or friends who may be living with chronic illness:

> "If the student were just asking you to tell me about somebody that you know who has CHF is not probably going to change a patient outcome but its going to tune the student in to be a better listener, because when I have something in the classroom setting to relate to them, I can learn it better. If I never see a CHF patient in my life, and your going to be the wah, wah, wah, talking at me like that, as compared if… I were able to say here is my grandma. My grandma had heart failure and these were the systems that she had and I can connect that grandma suffered because she had swollen legs and had hard time walking. Or if I can make that physical connection then as a student, when I presumably encounter a patient who has elephant size legs, I can connect with what happened with my grandma… Presumably if I wrote a care plan, and I were successful, then at some point we would measure an outcome."

Gloria shares the story of her global nursing experiences in several third world countries. She presented examples of nursing in the "bush" to nursing students:

> "Because in describing how nursing is involved globally… in Zambia was actually starting at the very bottom, if you will, of the ant hill. Because we had to get rid of the ant hills before we could even build the clinic… And I think sharing that, some of the students came out of the woodwork and asked me questions about mission work… I see more openness from the students and I think there's less selfishness… And so they (students) don't sell the book for $20, they give them to me and we mail them out and we go for nursing to nursing and I think they are supporting the nurses. Each other if you will."

Gloria described sharing the story as opening the student to experience. With the student learning to be open to experience, she described the sequelae of the learning experience as giving back to the community:

> "Not just getting the experiences they have gained here, they're also sharing that knowledge. Teaching… I can hear about them (students), and I can see some of it, they are giving back."

Several educators described the risk of spontaneous classroom learning experiences. Some educators were concerned the learning experiences of story sharing, especially end of life experiences, could be emotionally difficult for the student and faculty were diligent in monitoring the student response during class time. The educators explained that the learning experience might not work or fail outright and the educators needed the confidence to fail in front of students to be able to spontaneously create learning experiences in the classroom.

Olivia described sharing a nursing experience with students in a global setting. This was seen as influencing students who may come from a background without much diversity. Developed around a community nursing focus, students establish relationships and embrace cultures different from their own during an immersion experience and gained insight into different cultures:

> "(During the immersion experience) we have to talk about the affective domain. We have to talk about you're gonna have feelings through this and we're going to, daily, have a debriefing about feelings, about connecting with what your values are, what you're seeing at play, what the dissonance is that's being experienced."

After the immersion experience, students routinely say they would have liked to learn more about the culture before the experience, even though students were exposed to multiple opportunities for study before disembarking. The educator posited that the students did not feel the need to study the culture before the experience:

> "I love being with students on this journey because they come back different people."

Olivia then attempts to capture student change through targeted reflective journaling.

Exploration of diverse cultures. Several educators described the use of affective teaching techniques as effective in helping students understand culture. Educators created various experiences to expose students to different cultures.

Kay described a cultural situation in which the student was able to explain cultural differences to the class. The student had notified the educator that she would not be in class:

> "…her culture is Hmong… and I talked with her afterwards and she explained that it was actually her mother-in-law who had died… but the whole family went and she ended up having to drive down after clinical one night and she was up all night cooking because they had to do a meal for like 200 people. The funeral lasted for about a week and then all the food and all the preparation. So I asked her to share that with the class, what it meant to be a part of a culture where that much was demanded of you. It wasn't even her own blood relative, but her husbands. But that, the clan is expected to put on this huge feast… It was amazing the amount of work involved that she was required to do."

Kay encouraged the student to share the details she could with the entire class.

Gloria was involved in international work in healthcare. She had students do a cultural assessment of their own competency:

> "What we think occurs in other countries, or even other areas in the United States which, is actually not true. And how we actually come with certain biases… There where a few tears in the group that they brought out their own feelings about not having had the ability to talk with grandparents and other family members, to find about where they came from,. Where the whole group, their whole family came from and the transitions from being … immigrating here to the United States."

During the self-assessment student emotions were able to identify cultural biases and stereotypes and discuss in class.

Melody had a similar assessment assignment. She asked students to do an assessment on a culture with a presentation to the class:

> "And the response that I got back for the group that I asked to do a presentation about African-Americans and their interactions with healthcare and their cultural differences and all that business. "That's racist," was a total different – it was almost like I got the feeling that we had swung almost too far in terms of they are not different… But in the end… there was an awful lot of discussion about what it meant – what is it we mean when we say somebody is racist? What is it that it means to be culturally different versus ethnically different. And some of the things that I learned from the students about their beliefs about different cultures, about what it means to be black in this country… they were very politically correct views… There is no difference in how they experience the world or how they are treated… I think it comes from the fact that they have never experienced what it means to be A: poor, or B: in a situation where they were the other."

Expanding the student experience to include "the other" was an important learning experience.

Olivia described an exercise in cultural diversity where students needed to bring to class an example of working with a person who was culturally different from themselves. She had noted that some students come to nursing education with a sense of self awareness and other students need to develop self awareness. The instructor utilized the exercise to identify which students she would need to work with to achieve understanding of diversity:

> "And the students who come from very homogenous, very small communities where sameness ahs dominated in terms of race, ethnicity, any form of variation, they're the students I identify early on as students I will need to work with more intensely. And it's such a good discussion that occurs, and it's one I just need to facilitate. And I don't need to lead (the discussion) because the students take over."

Olivia viewed this peer-to-peer cultural learning as important for students understanding of cultural diversity.

Student learning in nursing skills laboratory and simulation. Kay described affective learning in the nursing skills laboratory by having students practice non-invasive skills on each other. Instructed to come in shorts and tank tops, students practice

bathing and basic cares on each other. Kay wanted to get the students "to be physically the patient."

Kay also felt it important that the student be able to experience the patient when she took students to the clinical setting for orientation. Students would start in the foyer of the facility and be asked to find main areas of the hospital. Students are instructed not to ask for directions in English, but to try to experience the hospital as if they could not read, write or speak English.

Adele is a nurse educator with 12 years of nursing education experience. She describes the use of moulage in the nursing skills laboratory as facilitating an emotional response in students. Creating a goopy dressing to change or simulating feces to elicit an emotional response from students facilitated learning.

Three instructors described the peer-to-peer learning in the laboratory setting. Understanding the intimate nature of nursing from the perspective of being cared for was an important consideration when setting up learning in the nursing skills laboratory. Olivia described this peer-to-peer learning experience:

> "And that's an important piece in a health assessment course for undergraduate students, because so often in curriculums, that the first time they are in close proximity with another and the thoughts and feelings that are elicited from that experience and beginning to tie into that aspect of who they are as part of a professional. Do they feel comfortable? What are they doing to manage their anxiety? What are they doing to identify what the patient's feelings are?.. It's through journaling, its through discussions (students identify feelings)… Because that is apiece that I really feel drives higher level nursing. It begins that journey of that self-assessment, which, to me is critical in owning their selves as a professional nurse. Becoming in tune with who their professional self is, their professional identity and part of that identity is in the affective domain."

The nursing simulation laboratory was another area where students were exposed to affective situations. Kay described a pediatric simulation designed to challenge

students. She titled the simulation as "Friday Night in the Emergency Department." Six pediatric simulation scenarios were set up. Students are given some preliminary information regarding each patient and then are rotated in small groups through all six scenarios. They are limited on time at each station to assess and question. Then students are expected to prioritize and triage care for all six patients. Every 15 minutes the scenario evolved with data, laboratory results and patient status changes:

> "Then they're (students) going, I cant think about six at a time. so I think that's good… they're getting nervous now… (students say) you're not giving us enough time and I say, you don't have the time, you have to make a decision here."

Kay described ending the simulation with diagnosis and placement of each scenario so the students could have some resolution. At the end of the simulation, students are asked to write a reflective paper on the simulation.

Introducing the Patient

Nurse educators described that the teaching and learning process in the affective domain involved not only the educator and student, but also the patient. The patient is illustrated in Figure 1 within the teaching and learning process between nurse educator and student and sub-themes illustrated in Figure 2. Educators identified empathy and therapeutic boundaries as subthemes in the process of teaching and learning with patients in the affective domain.

Developing empathy. Empathy as understanding the emotion of another person was potentiated both in classroom activities and story telling. An important nursing value, empathy was introduced in the classroom and clinical with direct contact with patients. The development of empathy as a part of the process of teaching and learning is illustrated in Figure 2.

Adele described a classroom technique where a patient was directly connected to the classroom via an electronic video format. This technique was used as an adjunct to oncology content in class. The educator described a difference between reading in a textbook and hearing graphic descriptions of treatment.

The patient was a former patient with a devastating illness that had many experiences in the healthcare system. The nurse educator designed this experience so students could understand the patient experience and connect with the patient to understand "where the patient was coming from." The nurse educator encouraged the patient to tell his own story of the experience and describe feelings and frustrations with care. The educator encouraged the patient to talk about experiences that caused anger and pain but also encouraged the patient to describe experiences where the care was excellent and healing.

Adele designed this experience to elicit an emotional response from students. She described students as "shocked" by some aspects of the patient story. The story illustrated to students holistic care of the patient and the need to incorporate psychosocial and spiritual care as well as the physical care of the patient. To then apply the learning, the educator applied the discussion with the patient to a theoretical nursing model. The Adele outlined the model on the board and the proceeded to elicit from the students where aspects of care described by the patient fell into congruence with the theoretical model. The overall objective for this experience was to create a sense of empathy in the student. She described empathy as important in the profession of nursing:

> "I think empathy is gonna be the thing that separates the nurse just doing their job from the nurse who really…tries to connect with the patient on all levels and try to meet their psychological, spiritual needs, not just their physical needs. That nurse is gonna try to understand the patient experience and will show compassion

> to them… One of the things I learned from my friend (patient) is that he can tell in a moment which nurses really connect with him… and really care for him as a human being."

Adele described the development of this classroom experience over years and across institutions. Technology capabilities changed over the years but the nurse educator did not think that it was dependent on technology to create the sense of connection between the patient and students. Even if connected only by phone, the students were able to have a beginning understanding of the patient experience. Adele described the students as feeling the compassion when students and patients connect and real caring on both sides. Adele did not have an evaluation tool to assess student learning but described positive feedback and students were described as engaged.

Connection to the patient was also encouraged by educators through the use of movies and articles in the classroom. The movie of a patient dying of cancer and connection to the patient perspective, the family member perspective and the healthcare members perspective allows students to integrate the experience with the life experiences students have at home. Educators chose media based on time constraints and desired outcomes of the experience.

Olivia took the student and patient relationship began to tie it in to patient outcomes. Describing the need to include family in patient education she illustrated how the affective domain influences patient outcomes:

> "And can we see that in patient outcomes? Outcomes in terms of their (clients) ability to adhere to what needs to happen… Are we able to see that? And if the focus has been just for the sake of the client and not addressing all those other variables, including family and the affective domain within the family? … the nurse needs to be astute to that and really spend time then with with family as well as client. Because we know that support systems, what is provided by that support can really have, you know, impact and define outcomes."

Exploration of therapeutic boundaries. Connection to the patient in a therapeutic communication framework was important to nurse educators. The different stages of the nurse/patient relationship was outlined by Carol who indicated not only was it important to get students to establish a relationship with the patient, but terminating the nurse/patient was emotionally difficult for many students:

> "Yes, the patients often do (have difficulty disconnecting in the therapeutic relationship). But I've found that the students have almost as much trouble. Because they've invested some of their emotion into working with this patient. They've found that they have something to offer this patient. And now clinical is over and they won't see them again."

Carol described moderating the uncomfortable feelings of the student and helping them deal with ending the relationship. Scripting was used when necessary. Post-conference frequently included discussions of terminating the relationship. The nursing process was used as a guide. She encouraged anticipation of the evaluation phase of the nursing process so students could anticipate termination of the nurse/patient relationship.

Elaine described a setting where the educator and the patients work together to teach certain outcomes to students. In a long-term residence setting, the educator described how the residents would set the boundaries for students. Instruct students on how to enter their space respectfully and approach them for optimum communication.

Empathy was described as necessary by educators but some educators elaborated that students could have too much empathy. Faye described working with a student during a psychiatric rotation:

> "…she didn't have any boundaries with some patients. She had empathy almost too much. She started to identify with the patient."

Faye described the student as too connected to the patient. The student had a lack of boundaries with the patient and moving into a social relationship with the patient:

> "…social relationship is give and take. Where as a professional relationship with empathy you are giving to the patient… Too much empathy can lead to burn out… But to have empathy is, as you know, to walk in their shoes, but not become their friend, or family member."

Faye went on to distinguish between too much empathy and lack of boundaries. She reflected that perhaps there was no such thing as too much empathy, but rather a boundary issue where student needs are met through the patient. Faye then described her own experience with blurring of boundaries and how she was able to put the experience in perspective for her students.

Balancing student emotions and developing empathy, the awareness of emotion in others was facilitated with appropriate therapeutic boundaries. Educators created learning experiences that would either potentiate or moderate an emotional response in contained within professional boundaries. Carol explained:

> "That they (students) would deliberately not stand in their clients' shoes, but beside them or behind them and try to look at the world through the lens that the patient is."

Student Outcomes in the Affective Domain

Affective learning in nursing education can be defined as establishing attitudes and values consistent with the profession. The student outcomes are illustrated in Figure 1 as occurring within the student. Nurse educators described subthemes establishing student attitudes and values consistent with the profession, but the subtheme of ethics was also identified as separate from attitudes or values. The subthemes identified of professional attitudes, values, and ethics are illustrated in Figure 2.

Establishing professional attitudes. Nurse educators identified positive and negative student attitudes. Nurse educators were quick to note any student whose

attitude was outside the professional norm. Similar to preconceived beliefs, student attitudes were described as changed by experience.

Kay described a student with a good attitude. Students were assigned to arrive at the clinical facility and she instructed them to arrive at 5:30 am. One student was fine with the early start and had no complaints:

> "And I said, oh you've got a great attitude… I just love that you're so chipper about it. She says, I milk cows at 4:00 am. That's nothing. We do get some students who, they understand what work means."

Carol described how two students with a previous bad experience in mental health nursing were able to change their attitude towards care in this setting by being challenged and exposed to an increased diversity of patient. The students were able to apply psychosocial skills and techniques and change their attitude towards the mental health practice setting by being presented with a different experience.

Julia described negative attitudes in students towards. The research course was seen as potentially "dry." Julia described students' understanding of research as evidence based practice or research utilization. Julia contrasted those traditional forms of research with original research conducted by students. Students were required to think up an original research idea and create a research proposal:

> "But after they're done with it, they have written a very fine proposal that can be published after we collect the data. And they all seem to appreciate it very much so it changes their attitude about research.

Attitude about the practice environment was important to Elaine. In delivering care to vulnerable populations in their home environment, some students were concerned about the safety of the environment they were asked to go in to. Elaine encouraged students and informed them that there had never been a safety issue in the area they were

asked to deliver care. Through the experience students attitude were changed about delivering care to vulnerable populations. Even though the students were uncomfortable at first, students finished the clinical enjoying the experience.

Attitude was linked with student perception by some nurse educators and an adjustment in attitude was thought to be made through expanding the student's perspective. Expanding the student perspective assisted the student with attitude.

Some educators targeted verbal questions to assess student attitude in the classroom. Socratic Method was used to expand student perspectives and to look beyond behavior to cause. Beverly described how targeted questions could assist student attitudes:

> "So I give examples of…. I can think of one… adolescents that are perpetrating sexual perpetrators on kids and… gee where did they learn that from. And then we look in the history and the victim becomes the perpetrators."

Students' preconceived judgment of patient behavior was seen as influencing attitude. Students are instructed on the positive aspects (root cause) of perceived negative behavior in patients to expand their understanding and allow them to suspend judgment.

Telling stories was also seen as a venue to assist student attitude adjustment. Discussing student attitudes towards poverty, Ida described stories designed to have students empathize with the complexity of people in adverse situations. To understand that some people really don't have complete agency which can result in blaming the victim. The purpose of the stories were two-fold, to engage the student's attention and to try to change their attitude. The stories were designed to create empathy in the student so as not to depersonalize the client, individuals, families or groups of people. This was seen to create a respect for persons.

Gloria also noted that educators might exhibit certain attitudes towards students:

> "You can tell right away in the beginning that they like or don't like a certain student because of their attitude, quote, unquote… she doesn't have a good attitude to be a nurse. And I'm like OK, whatever. I think that's a judgment call again. And I think I've learned that in my life. That you cannot judge others at all until you actually be with them, work with them, and be with them. So when you look at like the values and I think about all of nursing, I think that's been our downfall. Is that one. Try and put people to our expectations. And that can't happen. Just cannot happen."

Gloria continued to discuss how some nurse educators can get punitive with punishing students. The importance of other educators was seen as necessary to adjust faculty attitudes. If nurse educator attitude was not corrected, the "students lose." Students also pick up on faculty attitudes and assume that they are correct. It was viewed as an important task for faculty to assist other faculty with attitude adjustment.

Establishing professional values. The ability to recognize values specific to the profession as separate and different from personal values was described by several educators. Educators were concerned that the students' ability to distinguish personal values and professional values was potentially incongruent. Educators assisted students to be distinguish and function under professional values as a caregiver.

Educators developed this basis of personal values and professional values and applied strategies to assist students to recognize patient values and beliefs that were different from their own and sought out experiences in the clinical setting to encourage students to provide care even under stressful circumstances.

Value clarification exercises were described by all educators as important to assist the student in addressing personal values and interpersonal values. Negotiating ethical scenarios utilizing values was also important to educators. Several educators described applying the values to discussions in ethical scenarios.

Leah described a values clarification exercise done in the classroom. She would put a value statement up on the board and ask students to line up along the wall as to whether they agreed or disagreed with the statement one side or the other based on their feeling of agreement:

> "That's kind of a good exercise to understand that people come from different places. And I also tell them, "You know, when I started nursing… I had very black and white opinions about things," and I said, "that has gone out the window as I dealt with real people in a multi-cultural setting and inner city kids."

Leah continued to describe an encounter with students that was disturbing to her. The students were "bragging" about being able to see victims of auto accidents and trauma in the emergency room and how it did not bother them. Leah described the dilemma she felt in trying to address values:

> "In nursing it's not what you'd call a scoop and run… kind of deal. You're getting to know the family and you are, part of nursing is feeling. You know, having empathy… I found it disturbing, and it really took me aback… I have to think about that too, because I need to intercede when a student, because that scares me a little bit… That concerns me."

Leah felt that students valued the ability to disconnect from the humanity inherent in nursing. She was working on different methods to address that value and place it in the appropriate connotation.

Some educators thought professional values needed to exist within the student prior to the educational setting. This was evident in students who went above adequate care to patients and extended to taking accountability for their practice and deliver great care. This was also contrasted by stories of students who did not take an internal value of accountability and delivered minimum care and the educators' intent to provide feedback. Diane would have liked to teach accountability but stated the value was more likely awakened or perhaps made stronger.

During the development of values in the student, Diane would superimpose her values as the basis for actions and behaviors in students:

> "…(Teaching) clarified my own values, my own beliefs, and made it much easier then to articulate to the student this is what, what believe and therefore for 10 weeks this is what you will do…"

This clarification was important to Diane to role model values for the student.

> "I have a three sterile glove minimum. If you can't get a pair of sterile gloves on within three attempts your not doing this procedure that requires sterile gloves. It costs the institution money, it's not good for the environment, and most important, the patient is now waiting."

Values clarification and awareness was important as educators encouraged students to look at practice areas. Elaine explained:

> "Because our job as a profession is to care for everyone there is, that crosses our path."

Elaine continued to clarify that students would need to clarify values across practice settings and carefully choose where to work to avoid a conflict of values:

> "…like when we start talking about STDs…sex is not a value issue here, it's a public health issue and you have to come to grips with that or not work in that area.. You have to know yourself to do that."

Julia took values clarification and applied it to organizational values. Instructing students to research organizational value statements in both educational and care delivery systems:

> "They have to go on the internet whether on campus or internet students and look for either three hospitals… or schools of nursing and find their philosophies."

Students are then asked to choose an organization based on their own value statements. Julia did see occasional incongruences in organizational choice.

Several educators shared several stories about end of life decisions in the clinical setting and helping students understand how to deal with conflicting professional values

and the dimensions of family decision making in end of life situations. These learning experiences were not pre-planned or measured but more of a spontaneous learning opportunity. Educators assisted students in understanding the patient experience but also the effect theses situations had on the caregiving staff and how nurses will sometimes allow their feelings to show in handoff report. Educators described the debriefing session post clinical conference as the opportunity to assist the student in understanding professional values. Several describing intentionally allowing more time for post conference or scrapping intended planned post conference learning to assist students in transitioning conflicting personal and professional values. This was a priority for educators because at times there was no resolution of values. Educators assisted students emotional processing of the situation so students would not remain troubled by the situation, even if the educator had to make an effort to work one on one with struggling students. Adele explained:

> "The nursing values are the ones that are going to direct what with do with the patient despite our personal disagreement… we're going to continue to provide care for the patient."

Conflicts between patient decisions and student values were seen as one of the greatest challenges to students in their careers later on.

Nancy related one end of life story as a positive example of care. Describing a non-English speaking hospitalized patient she related:

> "She was telling me about a patient who had stomach cancer and he was Polish, had come from another country and was basically abandoned, no family… she made that connection with him and was able to help him during the dying process… she was bringing him cards and she would sit and talk with him and he would cry. That experience which is very difficult to measure, she felt gave him peace, because he died there. He died in the hospital, away from all family and friends. And she became very connected to him. I would like to teach that to

> students to understand what that feeling is, because I think that's the foundation of what nursing is."

Several educators indicated values they felt important and strived to help students integrate. Caring, trust, tolerance, accountability and integrity were values that several educators specifically discussed.

Caring as a value was cited by most educators. In discussing vulnerable populations of homeless and head start caring was paramount, as a health care professional in spite of the students desire to provide direct patient care. Elaine explained the purpose of providing care in the environment of vulnerable populations. There was a real desire that the student experience care for children who did not have breakfast or had no coat. Diane gave an example of a course requirement that students participate in a meal program for the homeless. She described the experience especially if the student ha a limited experience of the world. Diane needed to explain why even the simple caring tasks are important in the professional nursing values. Gloria also explained how her values were changed by working with the elderly and disabled and how her own caring values had changed.

Gloria illustrated the value of developing trust between the student and the patient. She related that when assessing the patient, trust must be established with 5-10 seconds of meeting a new patient. This is the initial trust building time for student and patient.

Gloria continued to illustrate the importance of establishing trust by having students do a mental health assessment on a classroom peer. They had not read the document or understood the questions and were asking health related questions during one of the first classes in the first semester of nursing. This illustrated how the lack of a

therapeutic relationship initiates uncomfortable feelings of vulnerability in the students. This lead into the discussion of methods to properly addresses a patient and establish trust. Gloria did not measure this exercise but she was able to discuss behavioral cues that she looked for in the student. Then the 'meet and greet' was reinforced during the semester of laboratory assignments.

Elaine described tolerance was a professional value. Students were instructed that they would be taking care of a number of people most of who would be different and have different values than the student. But all people deserve care no matter the value system of the patient.

Accountability was a value cited by educators. Gloria described how a student was disappointed in the care she gave and corrected the care. Ida described the difficulty in teaching accountability in current nursing education:

> "(Teaching) the younger generation is that whole idea of accountability. And how we hold them accountable for everything. It seems that it's getting harder to teach as time goes on. And I don't know if it's a reflection more of the influence of the greater society or the political scene. I don't know it just seems to be. I just was reflecting that it is getting harder to teach them that kind of stuff. That the values and have them assimilate those values. Cause I would never ever think about not being held accountable for my practice."

Closely related to accountability, several educators discussed integrity as a value. Educators discussed examinations, medications, and dress codes as areas important in integrity. Kay explained:

> "I think that's just across this generation. I know that study came out of Harvard that 80% of students leaving high school cheat and it's just a way of life… And I just say over and over again, the person you're caring for, pretend like that is your mother… Would you want that person caring for your mother to have cheated on their med clac exam and gotten the answers from a peer so they don't really know how to do their own calculations for correct dosages?.. I try to get them to understand the importance of that, that they have to be diligent and have integrity about what they're doing."

While professional values were important to all educators, Ida described the nebulous nature of values. Contrasting the value of accountability across the profession of nursing and social work Ida pointed out that professional values are not a concrete set of behaviors:

> "…we talk about our values in nursing as if they are a given. And these are the values that you are supposed to have, that we are supposed to develop. And if you don't have them, pretend that you do. You know, things like respect for the individual. In public health it's called the greater good, that what's good for the group is sometimes more important than what is good for the individual and the importance of good use of resources for the sake of the individual or for society at large."

Some educators formulated value conflicts within an ethical framework. Ethical issues in nursing practice were described by several educators as the application of affective learning in the clinical area. Value conflicts and patient choices were seen as opportunities for student learning.

Ethics and affective learning. While not described within the definition of affective learning, participants described the study of ethics as a dimension of affective learning. Closely tied to professional values, it was important to note that nurse educators deliberately discussed ethics as a separate theme.

Diane described an integrated ethics curriculum where the student was asked to reflect on ethical and legal aspects of decision-making. Important in the designed classroom experiences was that the students juxtapose the client and self-views. The case studies introduce the student to the concept of autonomy of decision and the financial and emotional sequelae of those decisions. The students were asked to justify the patient autonomy based on the outcome of the case scenario. Diane described several case studies where client decision-making did not result in an optimal outcome. Autonomy in

the decision making process of assisted suicide was also discussed. Diane asked the students to reflect:

> "…how does the student feel about that? I mean what do they think should have happened? How would they have handled that? So that's how we introduce our students to that affective level."

The primary objective of the case studies was to examine ethical principles but the secondary objective at the affective level was how students felt. In the scenarios, it was not always easy to carry out the client's wishes. Diane elaborated that sometimes determination of right and wrong is outside the nurse's own ethical structure.

The ethics surrounding access to care was described by Ida after a clinical experience in correctional nursing. She described the reaction to the experience by students in the class:

> "And two of the students were extremely upset at the health care that was available to the clients that was not available… as they said, to their families… it became a huge schism in the group with very, very heated arguments about the rightness and wrongness of care deliver for certain groups of clients and resource allocation. So I think it became an ethical discussion in my experience that was about the hottest discussion that I've ever had in a clinical group. To such an extent that I had to like cut it off."

Ida continued to explain, even years afterwards, graduates would occasionally contact her and still reminisce about the powerful discussions surrounding access to care.

Ethical dilemmas within specialties were important to educate students. The role of the nurse, vulnerable populations and the application to specialty practice was important for educators to communicate.

Leah described an ethical dilemma in a specialty nursing area that impacted students. Describing a case where a baby was admitted with failure to thrive, staff and

students worked together to figure out if the symptoms were organic or inorganic.

Whether there was some problem with the baby or the parent understanding of care:

> "We had a baby that was very, very ill – failure to thrive. The mother was mixing the formal half strength, so the baby was obviously not getting all the calories… actually had a heart arrhythmia subsequent to starvation. But we didn't know that initially… as the days unrolled they found out the mother was getting the formula through WIC so it wasn't the problem of supply. But she was turning around and selling half of it to have money for her own drugs. I didn't plan that encounter… It wasn't organic. The kid just wolfed everything down that you gave her. But they (students) were really upset about that… My role was to make sure that we put a good hour post-conference around it… I jettisoned my original plan for that evening and we talked about this and the kinds of things we need to do… they (students) never encountered that before. And when you talk in the lecture or class about abuse or neglect, they don't have a frame of reference."

Melody described how students are guided in discussions regarding ethical dilemmas in the classroom. She describes a situation where the caregiver feels it is wrong to participate in the care of patients in certain situations:

> "I like to use the code of ethics and the standards of practice and all of that as a framework for those types of discussions because perhaps, if I can bring it back to a professional rather than an emotional issue in some way… You have the ethical right to decide that you cannot ethically participate in something, but bear in mind that we still have a professional responsibility to - if there is no one else to take care of them… I bring it back to – I call it a mental rehearsal where they kind of walk through the what-ifs…"

Melody continues to share with students a personal story that influences patients she has difficulty caring for in the clinical area. The educator also told of an experience where she did not participate in prescribed patient care:

> "I had a do-not-resuscitate patient in my early career who as she became less and responsive, the family said, "We want everything done." And the doctor said, "Well, okay." And basically his explanation to me was, "Well, they can sue because she can't." So I refused to participate and that was something that I can do and there was someone else to take my place. And then I talk to them (students) about what would've happened had there been no one else… Sometimes you have to step in and make your objections known, but sometimes you have to do… And I think that sometimes within reason, sharing our

> experiences (with students) really helps because how else do you illustrate something that for them is still very abstract?"

Melody continued to discuss how students could view nurses as complainers and negative. She tries to help the students understand the need for venting and for debriefing to maintain a mental equilibrium. "Maybe somewhere in the back of their heads, my voice is still there."

Assessment of Learning in the Affective Domain

Nurse educators continued beyond the definition of affective learning to attempt to described measurement in this domain. Measurement was difficult and several educators were unsure how to assess learning in the affective domain. Standard measurement techniques did not apply with the possible exception of one test question identified.

Although standard measurement was difficult, nurse educators were able to describe assessment techniques outside standard measurement (see Table 7).

Table 7

Methods of Assessment of Affective Learning Described by Participants

Written reflective assignments (n=13)
Observation of student performance (n=11)
Student feedback – formative and summative (n=7)
Conversations with students (n=4)
Written student evaluations (n=4)
Appropriate student questions (n=2)
Student responses to open-ended questions (n=2)
Student sharing (n=1)
Coursework (n=1)
Objectives as grading criteria (n=1)

Note: Some participants reported more than one method of assessment.

Educators used a variety of written assignments designed to capture affective learning (*n*=13). Educators could also articulate observations of student behavior that demonstrated proficiency or lack of proficiency in the affective domain. None of the educators could quantify the results of these assessments. Consistent with encouraging nursing student self-reflection, reflective journaling was the most frequent method described by nurse educators as able to capture learning in the affective domain. Observation of student behavior, student self-evaluations, and reflective essays were also method the educators utilized to assess learning in the affective domain. Assessment of student learning in the affective domain is illustrated in Figure 1 as a cyclical process across the teaching learning process in the affective domain. This assessment provided feedback to educators as they developed student experiences in the affective domain (see Figure 2).

Most nurse educators had difficulty describing the evaluation of learning in the affective domain. Melody explains:

> "Its really hard to measure that piece (affective learning)… Sometimes you get clinical students who are so book smart… but they get in there with the patient and their communication with them is very clumsy and they are not able to connect in a way where that patient feels like they can trust that student… but I am not sure how you would measure (affective domain)."

Melody is describing how she assesses student learning yet does not understand how to measure learning in the affective domain. Only one educator described a single exam question that targeted the affective domain. Kay described the question:

> "I know there is one test question I have. It's about a four year-old girl who had an appendectomy and needs the dressing changed and what would be your approach… The right answer is that you use a very tight band aid but the smallest one appropriate for the size because at that age they're afraid that their body is going to leak out. They don't have a well-defined body delineation."

Julia described evaluation of a values clarification exercise as, "The rubric exists in my head." She described steps that needed to happen in the assignment. Points were deducted from the assignment if students did not complete the steps, but confessed she did not use a standardized rubric to assess affective learning in written assignments.

Although difficult to assess with standard measurement, educators were quick to identify students who were struggling when trying to connect with patients. Melody explained:

> "You know, the very technical students… I often wonder are they really just going to be terribly technical or is it just their way of coping right now… It's funny because you can tell… we have our bootcamp. We have our accelerated program for the baccalaureate and we have two very intense weeks where they are doing alternating skills lab with clinicals… You look at them and you can see.. Oh, total ICU nurse."

Describing a student who struggled to connect to patients the she continued:

> "… you're going to have to learn to cope a little bit with the whole talking with the messy human person in front of you. But he had a sense of humor about it and recognized it as something that he needed to work on. And I think ultimately, he'll be just fine."

Faye described student peer associations were not always seen as a positive experience. She described non-productive bonding in the clinical area. A group of students would bond together and not attend to the course outcomes except on a minimal basis. Minimum of care as a result of non-productive peer bonding was seen as a rare occurrence but one that did occasionally happen.

Some educators did not feel it was possible to assess affective learning in the classroom. Confirmation of student learning was assessed in conversations that occurred after class or clinical. Some educators described concomitant content in a didactic class but did not test of measure in clinical. Sometimes the educators would elicit student feedback and ask students what they learned from the experience to generate the conversation.

Melody described feedback from students after graduation:

> "I have several students, former students, who have since joined me on (social network). And every now and again I get a message about something that they have done or letter that they have written because of something they felt passionately about."

Melody does not describe this method of feedback as a continuous conversation with graduates. She only hears from them occasionally.

Some educators were very observant of student behavior, eye contact, and peer integration as possible issues that needed to be worked out. Gloria described the task of listening to lung sounds and how a beginning student will perform the task. Overall the student would perform the procedure, described the theoretical rationale and results. But Gloria elaborated that when the student describes the procedure from the client point of view, the preparation of the client for the procedure, is what she is assessing in students:

> "And that ability to separate, take it to the client's world and talk about something that is not procedure. That is not a stimulus response type of functioning, but rather one that's where they're able to step into that world of grey and to me, acknowledging that aspect of a client, is and important piece of holistic care."

Several instructors discussed a "light bulb" moment where students integrated theory and content into their personal being. Carol elaborated that the student will reflect, "I can apply these ideas in my life, and in my own relationships."

Holly described learning in the affective domain as a personal connection. She described the result she sees in student body language:

> "I think, you know, those ah-ha moments that we think of. I think of a couple. One is often times the first time they (students) put the stethoscope on a baby's chest and hear that heart rate for the first time. And I can talk about a normal heart rate is 120 to 160 beats per minute, and they're like yeah, yeah, yeah. But they put the stethoscope down and their eyes just get like big as saucers… yeah those are fun."

Some educators described that evaluation of affective learning is best accomplished in the nursing skills laboratory. Olivia described the nursing skills laboratory as a place where students can be encouraged to develop in the affective domain:

> "Well, that comes to me very easily in a lab environment where either I can take on the role of their client or the other student takes on the role of the client and I will encourage the other student to provide responses that are in this (affective) domain to challenge that student… 'I really don't want to listen to my lungs. I don't want you to put that stethoscope on my chest. I don't want you to touch me.' And can the student critically thing through that scenario to help him get to that affective place. And to me, there needs to be that continuous opportunity of challenge to get that."

Olivia described a joy in watching students grow in the affective domain. It was also a challenge to her when there was decreased development in students attaining an understanding in the affective domain:

> "It's also very challenging when that does not happen and that's an expectation in the course to say… I've been noting this, and so for the rest of your lab and clinical, I will be expecting that you show development in this area. And then it doesn't happen that you really call it a 'no pass' then in clinical until they can get to that place of assessing the client in the affective domain and researching their affective selves as well in the process. To me, that says that's part of critical thinking as well. That informs critical thinking."

Olivia also described having to failed students in clinical because of medication errors. It was not the error itself that caused the student failure but the student reaction to the error:

> "…when you find out that you gave Ambien at nine o'clock in the morning… I respond differently if you show remorse because you have some understanding of what you did, than the guy that goes ffft… like he doesn't care.

Olivia continued to describe the care in which medication errors were approached. She role modeled appropriate behavior to prevent frightening the student while still maintaining integrity.

Many standard evaluation techniques were substandard for measuring learning in the affective domain. Course evaluations would indicate some affective learning but faculty referred to the evaluation as formal feedback and not a measurement of student learning. Educator peer review was also indicated as a possible evaluation technique but was seen as only a partial evaluation depending on what activities were being done in class during the evaluation.

Olivia did describe feedback from clinical agencies was indicated as evaluating students in the affective domain. Students were delegating to unlicensed assistive personnel in a way she described as "snotty." She spent a significant amount of time in instructing students in compassionate care. Olivia was surprised that the students were not extrapolating compassion to staff. "Actually what I expect is to see compassion towards the people that they delegate to. Not I'm better that you sort of thing."

Although nurse educators were able to verbalize how learning in the affective domain was assessed in post conference, student verbalization and student behavior. Holly expressed the difficulty in evaluating the affective domain:

> "I'm not sure (students learned)… They get it on the intellectual side. But I am not sure it's become part of them yet, and I'm not sure that they really can until they're really socialized into it. They can know it, they can know what the values are, but I think it needs to become part of their practice… We have integrity as one of the values of the college and certainly is a professional value as well. And if you ask them what integrity means, they would always be honest, whatever, and yet they would have no problem with sharing answers on a take home exam and dot see that as a breach of integrity… I think its hard for them to identify those when I think we assume that they have the same starting place that everybody else does, and I'm not sure that they do."

Holly explained the importance of student self-reflection in clinical post conference as one method of evaluation. The self-reflection in her post conference group was guided by questions she developed to assist the student in creating meaning for professional practice.

Two educators described the use of in class "clickers," an in class real time response as an adjunct to formative evaluation in class evaluation. Holly did not utilize the clicker response system to facilitate learning in the affective domain but Beverly explained how this technology could be used in affective learning. The educator would create controversy in the questions posted. Students would have to make a decision on an ethical dilemma where there may be no right answer:

> "I threw up a question to respond to with the clicker. It's a threatening question. It's a great type of question to ask with the clickers. 'Do you believe physician assisted suicide should be legal, illegal, legal in certain conditions, illegal in all conditions…?' So it's very hard to raise your hand in a classroom… and honestly express what your feelings are. But the clickers allow the students to respond, hopefully honestly to a threatening question without being threatened or intimated or sharing something personal from themselves."

The students would then be instructed to work in small groups and engage and share opinions. Students would learn in front of their peers and understand that peers are an important resource for learning. This example was used to discuss professional ethics that the profession must adhere to but also learn that there are other perspectives and how to communicate across ethical issues. This exercise then applied to the patient and how ethical practices, values, and beliefs may be different but nursing care must still be provided. It provided in class experience of the human response as unique and individual and provided an opportunity to relate to the human response in peers in a safe manner. This peer-to-peer learning allowed exploration of student pre-conceived values and encouraged students to explore those values. Then the peer-to-peer interaction also allowed safe exploration of the values of others prior to the application to vulnerable populations.

Evaluation of the clicker experience was not directly assessed. Assessment of learning was described as indirectly assessed by the application of ethical principles on examination.

Gloria, when asked directly about evaluating caring, compassion, acceptance, replied that seeing students demonstrate a gentle touch, even when the student thought no one was looking. She described affective behavior as coming naturally.

Institutional Support for Affective Learning

Most nurse educators reported that teaching in the affective domain was a standard part of the expected workload. Educators were not evaluated by their institutions for utilizing affective learning techniques. Some did report that the affective

domain was intertwined with the mission of the learning institution. Carol described that she does more than what is required because of her passion about mental health.

Educators described institutional support for teaching and learning in the affective domain as important in the development of affective learning strategies. Institutional support is illustrated in Figure 1 supporting the development of affective learning techniques. Some educators described teaching in the affective domain as having been modeled for them by senior educators as they developed their teaching skills.

Leah described a co-worker who was against storytelling in the classroom. The educator used stories from her background experience to augment content. This was not well received by a co-worker. The co-worker felt the content in didactic classes was most important:

> "I'm going to continue it (storytelling). even though she told me that I shouldn't tell too many stories… I get my lessons done. I said to her, "I complete everything I'm supposed to complete…" That's where I come from."

Melody described some resistance to learning in the affective domain at her institution. Describing learning about socio-economic and political influences on health, the educator felt the institution was against political views:

> "I don't feel as supported in the direction that my affective assignments go because they do tend to lean a little bit towards looking at social and sociopolitical issues, and the standard thing is no politics. Even though that should be something that is part of what students are thinking about learning and integrating into how they think about health."

Melody did provide the caveat that the current political climate in the state may be influencing how the assignments are being perceived. She was hopeful that when the political climate mediated, the assignments would be viewed differently.

Nurse educators define affective learning as learning, emotions and the heart of nursing. Self-reflection was described on the part of both the faculty and the student as a necessary prequel to teaching and learning in the affective domain. Seven subthemes were identified that describe nurse educators teaching in the affective domain. The development of therapeutic boundaries and empathy were important subthemes for the nurse educators when including students in the care of patients. Facilitating professional attitudes, values and ethics were the outcomes in students described by nurse educators. Evaluation of learning in the affective domain was difficult for educators to articulate but different forms of assessment were described. Institution support ranged from a barrier to demonstrated support for teaching and learning in the affective domain.

Chapter 5

Summary, Conclusion, Recommendations

Summary of the Study

Nursing education along with higher education has traditionally been compartmentalized into the learning domains Bloom (1956) established (Shultz, 2009). These three domains include cognitive, psychomotor, and affective learning. The affective learning domain is the phenomenon of interest. In this study, affective learning was defined as a type of learning that reaches emotional and belief systems and establishes attitudes and professional values. There has been limited exploration of affective learning in nursing. The purpose of this study was to explore the meaning, experience, and the act of teaching in the affective domain as described by experienced nurse educators. The research question that guided the study was:

1. How do nurse educators describe facilitating learning in the affective domain in nursing education?

The research question was explored during interviews with fifteen-experienced nurse educators recruited to the study utilizing a snowball technique. These expert nurse educators represented a wide variety of nursing practice and education and had recently taught in the classroom. Two nurse educators were transitioning to administrative roles at the time of participation.

The research design was an exploratory qualitative study. The interview questions were based on a review of the literature and after a pilot study that was conducted in 2005. The questions were designed to elicit stories and narrative responses from the participants. The data were coded and analyzed utilizing naturalistic inquiry inductive

techniques to identify themes and subthemes that represent the realities of nurse educators' experience teaching and learning in the affective domain (Lincoln & Guba,1985).

Analysis of the data revealed a definition described by nurse educators as "the heart" of nursing that incorporated both emotions and learning. Data also revealed the complex and cyclical nature of nursing education within the affective domain. Nurse educators described self-reflection and self-reflection in students. This beginning helped to establish the basis for teaching within the affective domain. Teaching in the affective domain identified various strategies and eight subthemes occurring between educators and students A trusting partnership with students was important as nurse educators adjusted and developed student emotions and beliefs for learning. Affective leaning facilitated student recall and understanding of content and concepts central to nursing practice. Nurse educators utilized nursing experience and various techniques to assist student learning in the affective domain including the use of story, exploration of diverse cultures, and nursing skills. Nurse educators built on this learning by incorporating the patient as the recipient of nursing care. The outcomes of teaching and learning in the affective domain identified three subthemes. The development of professional attitudes, professional values, and ethical practice were the results of learning in the affective domain. This process was not linear and nurse educators described the cyclical nature of guiding students learning in this domain. Various student assessment techniques were described, including direct observation and reflective exercises, which assisted nurse educators to assess and evaluate affective learning in students. Institutional support varied from establishing a barrier to demonstrated support as described by participants.

Nurse educator stories and experiential examples of teaching in the affective domain illustrate the complexity of this domain of education.

Discussion of findings

Nurse educators described the affective domain as extremely important in nursing education. Using descriptors such as heart or core of nursing and passion for nursing, nurse educators revealed their enthusiasm for teaching and learning in the affective domain. This was a surprising finding as most affective learning described in the literature was described through the use of a learning strategy. The participants did support definition of affect as an emotional response associated with an experience as described by Venes (2001). Most literature discussed eliciting an emotional response in the student.

The use of self-reflection by the nurse educators was an important finding. This was not reported in the literature reviewed. Nurse educators reflected on previous experiences and learning as they facilitated student learning in the affective domain. The desire to develop wisdom in students was also reflected upon by a nurse educator. This wisdom was consistent with the concept of phronesis and the development of wisdom in the nursing education literature (Aristotle, trans. 1980; Flyvbjerg, 2001; D'Antonio 2014)

Encouraging self-reflection in students was supported by the nursing literature (Woods, 1993; Zimmerman & Phillips, 2000; Ritchie, 2003). The results of this study indicated that it was important that student self-reflection be guided by experienced nurse educators in the affective domain. All nurse educators describing the use of reflective techniques with students utilized a rubric, questions, or outline designed to direct student

learning in the affective domain. Free thinking student reflection was not reported by any participants in this study.

Developing a trusting partnership with students was described as an important part of the teaching learning process in the affective domain. This trusting partnership laid the foundation for teaching-learning in the affective domain. Nurse educators who described this process were concerned about the difficulties in developing a trusting partnership in large classrooms. Similar to teacher immediacy described by Rodriguez, Plax and Kearney (1996), the description of this partnership was not specifically identified in the nursing education literature.

Student emotions were described by nurse educators as facilitating or hindering affective learning in students. This is consistent with neuroscience and education literature and has been demonstrated to have anatomical correlates within brain structures. Student feelings and emotions were also described as important in the affective domain within the nursing education literature (Cazzell & Rodriguez, 2011). An interesting finding was how nurse educators deliberately mediated to potentiate specific emotions in nursing students.

Nurse educators described reaching student belief in two ways. Belief as a faith-based phenomenon was described by some nurse educators. Student reflection of faith-based belief was important to develop student understanding of the faith belief of others but educators conceptualizing belief as faith-based found it impossible and/or inappropriate to address in nursing education. Student beliefs were also conceptualized as pre-conceived ideas by other nurse educators. Nurse educators that described belief as student preconception described beliefs as necessary to address in the affective domain.

Nurse educators addressed this type of belief with the intentional exposure of students to new experiences. Beliefs as a construct in the affective domain have been described in the education and psychology literature (Martin, Mottet, & Myers 2000; Snider, 2001). Beliefs in nursing education have been described as difficult to measure and difficult to impact through traditional teaching methods (Reilly & Oermann, 1992).

The application of affective learning to student recall and memory of content was described by the participants. Nurse educators described the ability to assess student participation and engagement in the learning process. This was addressed by nurse educators through the use of humor and connecting to peers and facilitated student memory and recall. Facilitating student learning of content in this domain was supported by the nursing literature (Ulloth, 2002; 2003).

The virtual classroom was another important consideration in teaching in the affective domain described by participants teaching in the online environment. The lack of real time interaction was disconcerting to nursing educators who value learning in the affective domain. These educators describe this type of learning as necessary and were concerned about the constraints of the virtual classroom. Affective learning in the virtual classroom was supported in the nursing literature and assessed by Reilly, Gallagher-Lepak, and Killion (2012) with student focus groups.

Concepts in nursing practice were addressed by nursing educators teaching in the affective domain. Loss, suffering, caring, and nurse advocate were some concepts nurse educators described. Nurse educators encouraged incorporating nursing concepts into practice in their students. Grief and caring were also affective concepts reflected in the nursing literature and the pilot study (Zimmerman & Phillips 2000).

Storytelling was reported by many participants as a teaching strategy. Sharing personal and professional experiences through storytelling was described as assisting the student to form meaning and increased the student's professional experience. Storytelling assisted students to form a memory and helped to facilitate recall. Important to note that the type of storytelling described by the participants was not just random stories from practice. Stories were chosen with application to content and helped illustrate important constructs. Storytelling as a teaching technique in the affective domain was supported in the pilot study and literature (Shultz, 2009; Ondrejka, 2014). Storytelling also facilitates specific affective learning in the student as they begin to participate in meaning-making of shared stories (Burkhart, 2004). Storytelling is also consistent with American Indian thought that allows for real yet non-physical realities (Deloria, 2004).

Utilizing the affective domain to facilitate student understanding of culture was an unexpected result. Several participants described different methods to expand student exposure to different cultures as an application of the affective domain.

The nursing skills laboratory and simulation was described by nurse educators teaching in the affective domain. The use of moulage was described as eliciting an emotional response in the student. Encouraging the student to assume the role of the patient or the nurse was also part of affective learning. This result was supported by the pilot study but not found in the nursing education literature. This may be associated with the relative newness of the simulation experience in nursing education.

One of the purposes of teaching in the affective domain was described as understanding and developing empathy with the patient. Participants utilized affective techniques prior to and during nursing care of the patient. Developing a sense of

empathy was described by nurse educators who introduced the patient experience in the classroom with patients as guest lectures and the use of movies and videos. The integration of the patient experience in the classroom was also discussed by Keeley and Chase (2012); who interviewed caregivers of persons experiencing mental illness in the classroom.

Another application of affective learning and interactions with patients in the clinical area was the establishment of trust and therapeutic boundaries with patients. The nurse patient relationship was emotionally difficult for some students to incorporate. Too much empathy was described by some educators as a threat to establishing appropriate professional boundaries in the clinical area. Nurse educators assisted students in balancing emotions and establish appropriate therapeutic boundaries. One educator described the student patient relationship as important in facilitating patient outcomes. This application of affective learning was not found in the literature.

Affective learning reaches student emotions and beliefs and establishes student attitudes. Participants were aware of student attitudes that were outside the professional norm. Nurse educators described that student attitudes were linked to perception and could be adjusted by exposing them to new experiences, verbal questions, and story telling. One educator even discussed how the attitudes of nurse educators themselves impacted student attitudes. Establishing student attitudes was well documented in the literature (Cazzell & Rodriguez, 2011; Jeffreys & Smodlaka, 1999, Maier-Lorentz, 1999; Shultz, 2009).

Affective learning also establishes professional values. The ability of students to recognize professional values as distinct and separate from personal values was described

by several participants. Values clarification in the classroom was described by several participants. A progressive assignment that included values clarification, identification of professional values, and application to organizational values across practice settings was also described. Some participants described professional values as intrinsic to the student. Educators also described facilitating student understanding of value conflicts and decision making in professional nursing. Educators also described some values important to the profession of nursing, caring, trust, tolerance, accountability and integrity. Professional values as an outcome of affective learning was well established in the nursing literature and confirmed by participants.

Affective learning was also described by nursing educators as establishing ethics and ethical practice. The emotional aspect of ethical principles in patient care and decision making was described by nurse educators as needing to be addressed in the affective domain. Ethical decision making and practice was well established in the literature and professional nursing practice. Nurse educators value the development of ethics and discussed the application within the affective domain.

Evaluating student learning in the affective domain was difficult for nurse educators to discuss. Many described writing and reflective assignments as indicators of student learning in the affective domain, but the lack of rubrics or affective tools left many without the ability to describe exact measurements. Participants were able to describe assessing student affect by observation, student feedback, and possibly classroom response technology. Nurse educators also described an indicator of affective learning as a “light bulb” or “ah-ha” moment shared with students. None of the participants felt it was possible to measure utilizing standard classroom measurement

techniques. This difficulty in measuring the affective domain was consistent with affective learning in the nursing education literature (King, 1984; Ondrejka, 2014; Reilly & Oermann, 1992; Shultz, 2009).

Educational institutional support was described by participants as a normal part of the educational workload. Some educators indicated that teaching in the affective domain was integrated into the mission/values of their educational institutions. Nurse educators did not describe any evaluation by their educational institutions. Some educators described that experienced faculty mentored the development of teaching in the affective domain. Lack of educational support was identified as a barrier in the pilot study. No investigation of the impact of institutional support for teaching and learning in the affective domain was found in the literature.

Conclusions

The nurse educators in this study were highly motivated to teach in the affective domain. Most nurse educators had examples of teaching in the affective domain. Participants shared examples and stories of teaching in the domain with pleasure and accomplishment.

Affective learning was described by nurse educators as a central foundational experience in nursing and nursing education, the "core" of nursing. Nurse educators described a passion for teaching in the affective domain.

Affective learning as described by nurse educators indicated a complex and cyclical process. Nursing educators describe a process of self-reflection, student self-reflection, facilitating learning, application to the patient, development of attitudes and professional values for future practice as major aspects involved in nursing education.

This process is not linear and participants described student assessments checks designed in the nursing education process. Students are exposed to an experience and asked to reflect verbally or written. Educators assess student progress and design new experiences for students to address gaps. The gaps identified by nurse educators were based on their own nursing practice and experience and not on written competencies or rubrics. Students are then exposed to new experiences.

Patients are central to many student experiences designed by nurse educators. Students develop empathy by being exposed to new experience. Empathy is considered an important value in nursing practice. Affective learning techniques were also used to assist students in processing emotions involved with establishing therapeutic nurse patient relationships.

Establishing profession attitudes was described by nurse educators by exposing students to new experiences and through storytelling. Nurse educators were able to assess student attitudes by observing behavior and verbal responses.

Establishing professional values was described by nurse educators as an important aspect of providing nursing care. The development of professional values as separate from personal values was important to develop in nursing students. Professional values identified by nurse educators included caring, trust, tolerance accountability and integrity.

Establishing ethical values in nursing students to be applied in nursing practice was described as important for nurse educators. Assisting nursing students with the emotional aspects in ethical dilemmas inherent in nursing practice was described by the participants.

Evaluation of student learning was difficult to describe among the participants. Nurse educators described the ability to assess student progress in the affective domain but did not view that ability as evidence of concrete measurement.

Institutional support for teaching and learning in the affective domain was limited to standard workload or incorporation into the mission/values of the instruction. Nurse educators did describe mentoring of experienced peer nurse educators as helping to develop proficiency in the domain.

The complexity of the affective domain was indicated by participant difficulty describing measurement in the domain. Even though participants described strategies used to assess student progress in the domain, they did not describe those assessments as measurements. Participants indicated it was not possible to measure learning in the affective domain. The assessment strategies listed in Table 7 indicate that nurse educators are assessing student learning in the affective domain but have difficulty describing the nuance of the assessment.

The assessment strategies identified by the participants were consistent with recent nursing education research. Oermann et al, (2009) identified strategies used for assessing learning in the affective domain across 1,578 responding nursing education programs and found strategies that included observing students, assessing student comments, and written assignments. The strategies identified by participants in this study were congruent with previous research.

Teaching in the affective domain is a very learner-centered process. Nurse educators described assessing student progress in the domain for improving and designing new experiences for nursing students.

Limitations of the Study

The results of this study apply to the participants and may not be transferable to other nurse educators. The sample size was small (N=15) and all female. Participants were not asked about ethnicity but all were visibly Caucasian. This homogeneity of the sample may also limit the transferability of the results. Gender and ethnicity of the sample may have influenced the participant's personal meaning and perception of teaching and learning in the affective domain.

This study was descriptive and qualitative and results are based upon participant self-report. No inferences can be made to causality, as the narratives of the participants are their personal reflections of past events and experiences. Transferability indicates how the study findings could be implemented in other contexts (Lincoln & Guba, 1985). Thematic analysis of the narrative and transferability may be limited and results may apply only to the participants.

Participants were recruited via snowball technique. Participants may have self-selected to the study because of a personal interest in teaching and learning in the affective domain. This may affect the transferability of the results to nurse educators in different contexts.

Trustworthiness in naturalistic inquiry may be questionable as the stories submitted are solely from the perspective of the participant. The factual nature of the stories may be subject to interpretation. Clandinin and Connelly (2000) discuss fact and fiction from the point of both the participant and the researcher. The data generated and the interpretive processes are described as a memory reconstruction. This reconstruction from memory may or may not be a factual representation of an event (Clandinin &

Connelly, 2000). The participant reconstructs the lived event as story; the researcher relives collective stories and retells their interpretation. Finally the reader of the interpretation reconstructs the data (Clandinin & Connelly, 2000).

The affective domain is complex and participants had difficulty articulating certain constructs such as measurement of student attainment of affective competencies. It may indicate that this construct has not been developed or does not exist. The complexity of the affective domain may contribute to the transferability of the results.

Implications of the Study

By sharing their stories of teaching in the affective domain, nurse educators shared affective teaching experiences they had created. These shared stories will allow nurse educators to review and develop new teaching techniques and innovate in the affective domain.

This study confirms that nurse educators are aware of teaching and learning in the affective domain. Affirmation of teaching strategies in both classroom and clinical can help inform nurse educators. Confirmation of storytelling as a teaching technique in the classroom to address the affective domain may assist nurse educators who may be encouraged to address content in class and lays the foundation for future development of innovative teaching strategies.

Nurse educator descriptions of teaching and learning in the affective domain are consistent with *The Scope and Practice for Nurse Educators*, (NLN, 2012). There are six core competencies of the standards of practice for nurse educators: facilitate learning, facilitate learner development and socialization, use assessment and evaluation strategies, participate in curriculum design and evaluation of program outcomes, function as a

change agent and leader, and pursue continuous quality improvement in the nurse educator role. Teaching and learning in the affective domain corresponds to the first three competencies. Faculty development opportunities could include how to incorporate teaching and learning in the affective domain into the standards and practice of nurse educators.

Nurse educators learn to teach in the affective domain with experience teaching, or on-the-job. Participants in this study indicated that self-reflection on the part of the nurse educator was necessary for teaching in the affective domain. This would imply that development of proficiency teaching in this domain is acquired over time and experience.

Nurse educators can also review the results of the study as they seek to increase quality and safety outcomes for their students. The QSEN competenncies and the KSAs may be supported by this study (Smith, Cronenwett, & Sherwood, 2007).

Student development in the affective domain was important to nurse educators. The three subthemes of attitudes, values, and ethics demonstrate the areas nurse educators are concerned about developing in the nursing student. As healthcare and nursing education continues to evolve and change, professional attitudes, values, and ethics will be important student outcomes in the nurse of the future. As learning moves into the digital age, new strategies for developing values and ethics may need to be developed.

Reported educational institution support varied among participants. This study may increase educational institutional awareness and support for teaching and learning in the affective domain. Nurse educators that described little institutional support were motivated to continue to develop and implement teaching strategies in the affective domain.

Attitudes, values, and ethics are important to the practice of nursing. The beginning development of practical wisdom has implications for nurses in practice and may affect patient safety and outcomes. Patient safety is a professional value and has ethical implications in practice.

Recommendations for Further Research

Future research is indicated on how nurse educators develop competency teaching in the affective domain. Teaching and learning in the affective domain is occurring across all settings of nursing education. Nurse educators develop teaching strategies to facilitate student learning in this domain. Data indicated little formal training for nurse educators teaching in this domain. Formal educational resources should be developed to assist faculty in designing, implementing, and evaluating student learning in the affective domain.

Research should be designed to clarify affective competencies and development of assessment techniques to measure student competencies in the affective domain. Student outcomes included attitude, values, and ethics and nurse educators described activities and competencies to address outcomes. Nurse educators indicated that affective competencies and outcomes were difficult to measure. Nurse educators could identify examples of students attaining competencies and when students were not. Assessment strategies used by nurse educators are listed in Table 7. Nurse educators were assessing students at some level but not formally measuring learning in the affective domain.

Mediating and moderating student emotions was reported by participants teaching in the affective domain. Further research of the outcomes and assessment of directing student emotional states during learning is needed in nursing education. Nurse educators

adjusted student emotions to facilitate learning and these teaching strategies have limited exploration.

Participants indicated they could assess student learning in the affective domain by observation, written assignments, and verbalization. But these educators could not articulate how this assessment could be measured. Exploration of nurse educator assessment of student learning in the affective domain would be a beginning for assessing students in the affective domain and attainment of competencies consistent with entry into practice.

Affective domain competencies are important, as student learning in this domain will be a part of the future of nursing education. The Quality and Safety Education for Nurses has identified six competencies for entry into nursing practice (Smith, Cronenwett, & Sherwood, 2007). These competencies are further developed into knowledge, skills, and attitudes that the student needs to demonstrate for entry into practice. The attitude competencies correspond to the affective domain. Further research is needed to refine and assess student attitudes for entry into nursing practice (Smith, Cronenwett, & Sherwood, 2007).

There is a need for the exploration of clinical judgment and clinical wisdom in nursing education. Beginning research on clinical judgment and clinical wisdom has been explored both in nursing practice and nursing education but confirmation of this as an outcome of the affective domain is needed (D'Antonio, 2014; McKie, et.al., 2012). Participants indicated that teaching and learning in the affective domain may have implications in judgment and clinical wisdom in student nursing practice.

Further research should be conducted on the assessment of student learning in the affective domain in the online environment. Participants teaching in the virtual classroom were particularly aware of the affective domain and the limits of the online environment. There is limited research on the assessment of student competency in the affective domain in the online environment.

Participants reported minimal support at the institutional level for teaching in the affective domain. Future research could explore institutional support for student learning in the affective domain. Institutional awareness and encouragement for this type of learning may impact the motivation for nurse educators to gain competency teaching to the affective domain.

Summary

The results of this study contribute to the science of nursing education by exploring how nurse educators facilitate learning in the affective domain. Results describe a process of teaching and learning in the affective domain that is complex and results in students attaining professional attitudes, values, and ethics.

A summary of the study and discussion of findings explored how nurse educators described how nurse educators describe teaching and learning in the affective domain. Major conclusions from the results of the research were presented. Limitations of the study included limits of the research methodology and limitations of the affective domain. Implications on nursing education, student learning, and nursing practice were described. Suggestions for further research included further investigations into the process of teaching and learning in the affective domain as well as future trends in nursing education research.

Flyvbjerg (2001) describes a dialogue with a polyphony of voices, with no single voice, including that of the researcher, claiming final authority. This study provides input into the ongoing dialogue and practice in nursing and nursing education. Individual educators and future investigation will build upon this dialogue as the nursing profession continues to transform nursing education and the application to an evolving health care environment.

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Appendices

Appendix A.

Dear Colleague,

I would like to invite you to participate in an interview titled *Affective Learning in Nursing Education: The Educators' Perspective.* The purpose of this interview is to evaluate nurse educators' perception and experience with teaching in the affective domain as described by Bloom. Results of this study will assist in the interpretation of practices and meanings of the affective domain. The study has been approved by the Institutional Review Board at the University of Wisconsin-Milwaukee.

Participation will include one personal interview that will be arranged at a mutually convenient time and place and will last approximately 60-90 minutes. Your participation is completely voluntary. This interview will be digitally recorded and you may have a copy of the transcript if you request. You may return this email, or phone (800) 567-2344 x3139. Please include telephone contact information and I will contact you to arrange a time for the interview.

Prior to the interview, please reflect on your experience with teaching in the affective domain in nursing education and how you would describe this teaching. I will ask you to participate in a conversation and ask you to share a few stories about teaching in the affective domain based on your own personal experience. Please feel free to relate any stories or experiences that are meaningful to you. During the interview, I may ask questions for you to reflect on your motivations, or for temporal clarity.

If you have any questions, please feel free to contact me at the address below, by phone (800) 567-2344 x3139, or by email: LTaylor@menominee.edu. I appreciate your participation in this study and look forward to talking with you!

Sincerely,
Linda D. Taylor, MS, RN
College of Menominee Nation
P.O. Box 1179
Keshena, WI 54135

Appendix B.

Participant Informed Consent

Title: Affective Learning in Nursing Education

Description:
I am Linda Taylor a PhD student at the University of Wisconsin at Milwaukee College of Nursing. I am conducting an interview of nurse educators and how they use the affective domain in nursing education. I would appreciate your participation in this study.

Procedures:
If you agree to participate in this interview, I will ask you to participate in a conversation and to share a few stories about teaching in the affective domain. You may relate any story and as many stories as you wish I only ask that it be based on your own personal experience. The interview should take approximately 60-90 minutes depending on your responses to the questions. A total of 15 participants will be interviewed.

Risks and Benefits:
There are no known risks or benefits of your participation in this interview.

Safeguards:
This observation and interview will be confidential and I will not put your name or any potential identity information on your responses. I will digitally record your responses. The data will be kept in a password protected laptop in my possession. Data from this interview may be shared with my instructors and may be published in journals. Only grouped data will be shared.

Freedom to Withdraw:
You do not have to participate in this interview. Your participation is completely voluntary. You can refuse to answer any and all questions for any reason. If you request, your data will be destroyed. There is no penalty for withdrawing. Once the study is completed, I will be glad to share the results with you.

This signature indicates that you are at least eighteen years old and give your informed consent to be a participant in this study.

Signature: _____ Date:_____

If you have any questions please contact me:	**If you have any complaints about your experience as a participant in this study, please call or write:**
Linda D. Taylor College of Menominee Nation P.O. Box 1179 Keshena, WI 54135 ltaylor@menominee.edu	Chris Buth Furness IRB Administrator Institutional Review Board for the Protection of Human Subjects The Graduate School University of Wisconsin-Milwaukee PO Box 340, MIT 206 Milwaukee, WI 53201 414-229-3173 phone 414-229-5000 fax http://www.uwm.edu/Dept/RSA/Public/irb.html Although Ms. Furness will ask your name, all complaints are kept in confidence.

This research project has been approved by the University of Wisconsin-Milwaukee Institutional Review Board for the Protection of Human Subjects for a one year period.

Appendix C.

Potential conversational questions.

Do you have any examples of a teaching or learning experience that targeted the affective domain?

What is your motivation, why, do you actively seek out experiences in the affective domain for your students.

Do you have a story of an affective experience that you thought about and planned?

Where there any learning experiences that you want to discuss that targeted a part of the affective domain such as emotions or beliefs or values?

What results did you want to happen in your students from that experience?

Did you see those results or did you find different results in your students?

Do you have a story of a teaching or learning experience that was not thought out and planned that ended up addressing the affective domain?

How did you evaluate the successfulness of teaching and learning in the affective domain? Do you have a story of an experience in the affective domain that was successful/not successful?

Why do you think that experience was successful/not successful?

Do you have any stories of your own experiences learning in the affective domain?

Do you have any stories of how your own learning experiences influence how you structure educational experiences in the affective domain for your students?

Any teaching or learning experiences in the affective domain target an emotional level of learning. Do you have any stories of an emotional experience that targeted the affective domain?

Any teaching or learning experiences in the affective domain target students attitude. Do you have any stories of experiences that were designed to influence student attitude?

Values are associated with the affective domain. Do you have any stories of how you develop values with your students?

Do you have any other stories of other techniques of teaching and learning in the affective domain that you wish to share?

CURRICULUM VITAE

Linda D. Taylor

Place of birth: Chicago, IL

Education

A.D.N., Triton College, May 1983
Major: Nursing

B.S., Rockford College, May 1997
Major: Psychology

B.S.N., Rockford College, May 1997
Major: Nursing

M.S.N., Northern Illinois University, May 1999
Major: Nursing

Dissertation Title

The Affective Domain in Nursing Education: Educators' Perspectives

Fellowships

Robert Woods Johnson
Executive Nurse Fellow Alumna
2008-2011

Teaching Experience

Founding Dean of Nursing, College of Menominee Nation, Keshena, WI, March 2007 - February 2014.

Interim Coordinator of Masters' Program, Saint Anthony College of Nursing, Rockford, IL, August 2006 – May 2007.

Assistant Professor, Saint Anthony College of Nursing, Rockford, IL, August 2000 – May 2007

Publications

Tousman, S., Zeitz, H., & Taylor, L. (2010). A pilot study assessing the impact of a learner centered adult asthma self-management program on psychological outcomes. *Clinical Nursing Research 19*(1), 71-88.

Taylor, L. (2008). The adult client with a respiratory disorder. In L. Silvestri *Saunders Comprehensive Review of the NCLEX-RN Examination 4e*. St. Louis: Saunders.

Conceição, S., & Taylor, L. (2007). Using a constructivist approach with online concept maps: relationship between theory and nursing education. *Nursing Education Perspectives*, *28*(5), 268-275.

Tousman, S., Taylor, L., Zeitz, H., & Bristol, C. (2007). Development, implementation and evaluation of an adult asthma self management program and the effects on self-efficacy and depression. *Journal of Community Health Nursing, 24*(4). 237-251

Tousman, S., Zeitz, H., Bristol, C., & Taylor, L (2006). A pilot study on a cognitive-behavioral asthma self-management program for adults. *Chronic Respiratory Disease*, *3*(2), 73-82.

Presentations

"Support Academic Progression" presented at Wisconsin Center for Nursing Cultivating a Diverse Nursing Workforce conference, Wisconsin Dells, WI, June, 2013.

"Development of a Nursing Program within the Tribal College System" presented at National Alaska Native American Indian Nurses Association, Cleveland, OH, October, 2007.

"A Cognitive-Behavioral Approach to Asthma Management" presented at Stateline Nurses Network Nurses Expo, Rockford, IL, May, 2005.

Grant

Principle Investigator, "CMN LPN stand alone program with RN Bridge." U.S. Department of Labor CBJT Grant # CB-18214-09-60-A-55, 2008-2010, $2,000,000.00.

Research

Researcher. "Asthma and Allergy Research Cognitive-Behavioral Intervention Study." Rockford College, Rockford, IL 2000-2006

Other

Testimony before the Senate Committee On Indian Affairs on behalf of S.633 "The Tribal Health Promotion and TCU Advancement Act."