

BRIDGING THE GAP BETWEEN LEAVING CLINICAL PRACTICE NURSING
AND THE EFFECT OF PERCEIVED ROLE STRAIN ON SUCCESSFUL
ROLE TRANSITION AND INTENT TO STAY IN ACADEMIA

by

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(Under the Direction of Libby Morris)

ABSTRACT

By the year 2020, 1 million registered nurse positions will be vacant in the United States. The shortage of nurses has been linked to the shortage of nursing faculty. In 2008, 50,000 applicants to professional nursing programs were turned away, including 6,000 students seeking masters and doctoral degrees. Nurses pursuing a career in higher education bring a strong clinical background to their new faculty role. However, transitioning from clinical practice to academia can become problematic, placing individuals in situations without tools to survive. This lack of preparedness for the faculty role results in dissatisfaction with the work place, limited effectiveness, and failure. Studies suggest that soon after nurses enter the nursing faculty role, there is intent to leave within 5 years. Possible factors contributing to this action are role ambiguity and role strain, which are related, according to the literature, to workload and job satisfaction.

The purpose of this study was to determine the effects of age, gender, education level, and previous experience on role strain experienced by nursing faculty, and the extent to which role strain predicted perceived satisfaction with the role transition and intent to stay in academia.

A secondary purpose was to determine nursing faculty members' perceived need for professional development. Nursing faculty in public 2-year and 4-year institutions in a southeastern state in the United States were invited to participate in a researcher-developed survey based on Rizzo and House's Role Conflict/Role Ambiguity Survey.

Simple and multiple regression analyses were conducted to answer the research questions. Role ambiguity (44%), interpersonal support (6%), self-assessed instructional competency (1%), and age (<1%) provided 52% of the variance of role strain. Role strain provided 34% of the variance of role transition, and 11% of the intent to stay in academia. Nursing faculty also viewed mentoring and specific faculty development programs as contributing to the success of nursing faculty in higher education. These findings provide practical contributions for administrators, policy makers, clinical practice nurses, and nursing faculty members who wish to understand and improve the current recruitment and retention issues.

INDEX WORDS: Nursing, Nursing Faculty, Transition, Role Strain, Nursing Faculty Expectations

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A Dissertation Submitted to the Graduate Faculty of the University of Georgia in Partial
Fulfillment of the Requirements for the Degree

DOCTOR OF EDUCATION

Athens, Georgia

2009

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December 2009

DEDICATION

This dissertation is dedicated to my loving family who has supported me with love and encouragement. To My loving husband Harold, I thank you for always being my support and for being the wonderful man that you are. To my sons Kris and Tim, I thank you for your love, support and humor when I needed it most. To my mother who now has dementia, I know that you would be very proud of this accomplishment because you gave me the foundational skills for life, and you were always the wind beneath my wings.

To my committee, I dedicate this work to you for it would not have been possible without you.

Dr. Libby Morris, you are a role model and a wonderful teacher, mentor, and guide. To Dr. Thomas Valentine who spent countless hours guiding and directing me, I thank you for your time and your patience and for sharing your knowledge with me. To

Ms. Marguerite Koepke, thank you for your insight and your positive attitude, and to

Dr. Doug Toma, thank you for your knowledge, wisdom, and support.

Lastly, I thank God for each of you and for giving me strength to persevere.

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CHAPTER 1

THE PROBLEM

Health care utilization is high and it is expected to grow exponentially between 2001 and 2012. Even though the number of community hospitals declined from 5,060 hospitals to 4,936 hospitals between 1997 and 2006, the volume of hospital stays grew by 4.5 million. Hospitals were able to accommodate this increase in volume primarily because of a 4% reduction in the average length of stay. Population growth in general and the aging population are driving the increased demands for health services. While people aged 65 and over represented 13% of the population in 2006, they comprised 34% of the hospitalizations. In 2006, there were 570 hospitalizations for every 1,000 adults ages 85 and older (Healthcare Cost and Utilization Project, 2006). These issues have resulted in a major strain on the healthcare workforce.

A large segment of the healthcare workforce is comprised of nurses. This group of healthcare workers plays a vital role in meeting the needs and challenges of 21st century health care. More than ever nurses will be called upon to educate the public, promote healthy lifestyles, and provide care when individuals move from a state of wellness to one of illness and disability. A 2006 census revealed approximately 2.5 million registered nurses in the United States (U.S. Department of Labor, 2006). Nevertheless, an estimated 1 in 10 nursing jobs is currently unfilled and a 12% shortage of nurses is predicted by 2010 (Morris & Nabors, 2007). There is a projected 27% increase in nursing jobs by 2012 from 2002, the largest increase for any occupation. Meeting the projected demand will require a significant increase, possibly as much as 50% in the number of graduates from schools of nursing (Yordy, 2006).

Furthermore, a significant number of registered nurses are not practicing in the profession. Over 500,000, or 24%, of nurses have left the profession to work in non-health settings including 30% of new graduates who are leaving the profession within 3 years due to job dissatisfaction (Koerner, King, & Leech, 2007). Recruitment and retention efforts by hospitals have forced administrators to realize that there is both a supply and demand issue. There is a decline in the number of nursing students enrolled in schools of nursing although there is a surplus of applicants. This decrease in nurses will adversely affect future health care delivery because there will be fewer nurses to fill the vacant positions of those retiring in the next decade (Craine, 2000).

Historically, the solution to the problem has been to open more associate degree and baccalaureate nursing programs and increase the capacity of current programs, but research into the production of nurses has illustrated another challenge: the inability to increase program capacity. The driving force behind the shortage is a lack of opportunity to obtain a nursing degree, a direct result of an insufficient number of educationally prepared nursing faculty to educate new nurses (Walrath & Belcher, 2006). With the rising shortage of nursing faculty, there is a limit on nursing enrollments and the number of students who can become nurses. Meanwhile, capacity issues continue to plague nursing schools. One of the most pressing and critical needs in nursing education is to increase the number of nursing faculty (Isgur, 2008).

Nursing Faculty

Supply and demand issues exist for nursing faculty coupled with the concern of net replacement of nursing faculty who will retire in the next 5 to 8 years. There is an 8.5% vacancy rate for nursing faculty (Southern Region Education Board [SREB], 2003). The nation is experiencing a worsening faculty shortage compounded by limited financial resources in

institutions of higher learning. Together, this becomes a major challenge as schools attempt to find ways to expand nursing programs in response to the need for more nurses. According to Morris and Nabors (2007), “The combined effect of faculty vacancies and projected retirements in Georgia alone has the potential to reduce the current educational capacity of 10,260 to just over 7,500 students...a reduction of over 2,700 students or 26%” (p. 5). Barlag (2008) described this problem as a domino effect that was finally traced back to the educational system.

If programs are opened, there is not enough nursing faculty to fill the allocated positions. Additionally, nursing programs have high instructor-to-student ratios, therefore a lack of nursing faculty results in a limit on the number of students who can be admitted. In 2005, 147,000 qualified applicants were rejected from schools of nursing due to a faculty shortage (Anderson, 2007). In 2007, 40,285 qualified applicants and several thousand additional applicants to post-graduate nursing programs were rejected (Barlag, 2008). In 2008, 50,000 applicants to professional nursing programs were turned away, including nearly 6,000 prospective students seeking to obtain masters and doctoral degrees (Dunham, 2009). A number of factors contribute to the nursing faculty shortage. Aging faculty is only one piece of a more complex problem. Other factors include insufficient numbers of nurses seeking academia as a career choice, decreased autonomy, salary differences, and increased workload and responsibility.

In 2004, only 412 students graduated from doctoral programs in nursing (Yordy, 2006). This may be explained by a multiplicity of factors. Time constraints with full-time work schedules often present barriers to completing masters and doctoral degrees. In addition, masters programs tend to focus on clinical practice rather than nursing education, and current students are not pursuing education tracks in sufficient numbers. Clinical nurses who might be potential

educator candidates often view faculty careers as limiting in financial opportunities and career mobility (U.S. Department of Health and Human Resources, 2005).

The advanced practice nurses in the clinical setting have more autonomy and realize a much higher salary than their academic counterparts realize. According to Morris and Nabors (2007), “Nurses with advanced training can earn salaries of \$100,000 in the clinical sector, compared to faculty positions that average around \$60,000” (p. 3). Starting salaries for 9-month appointments, master-level faculty in one state ranged from \$38,000 to \$60,000. Analysis of SREB (2003) data revealed that the reason for faculty leaving academia is often listed as returning to practice for better and more consistent work hours as well as better salaries.

Research has shown that nurse educators often view themselves as devalued. The nurse educator has many more responsibilities than one would have in clinical practice, and the workload is an unrelenting source of stress for faculty (American Association of Colleges of Nursing [AACN], 2003). For example, in addition to teaching, there are a number of job expectations, such as mentoring, advising, and performing program administrative duties. In addition, the nurse educator may be called upon to maintain clinical skills. The value of current practice in the classroom is undisputed; consequently, many nurse faculty members are required to maintain some type of current professional practice while keeping current in their educational practice.

In the clinical setting, nurse faculty members face the same group of patients as the practicing registered nurse. Patients in hospitals are sicker than ever before with illnesses that are much more acute. Therefore, the instructor who manages a group of students and a group of patients may have a larger and more difficult load than the hospital staff nurse (AACN, 2003). The clinical faculty has responsibility for nursing students plus accountability for the patients

committed to their care. This responsibility can be and often is overwhelming. Managing 5 to 10 students and their assigned patients can lead to safety issues for the faculty member, students, and patients. These events alone can produce a stressful environment and ultimate burnout, emotional exhaustion, and early retirement for the nurse educator (AACN, 2003).

Away from the clinical setting, nursing instructors have many responsibilities (AACN, 2003). In addition to college and departmental committees, many institutions expect faculty to be active in research, publication, and community service. Combining all of the workload issues that a faculty member can face clarifies the decision by many to leave academia for a different working environment (SREB, 2003).

However, clinical practice nurses continue to be recruited into education, and they continue to leave academia. Many nurses who have chosen to pursue an academic career in nursing are reported to leave because of the stresses and high expectations associated with a career in academia. While many strategies have been proposed to increase the number of doctoral-prepared nursing faculty, these individuals will not be retained if they do not experience job satisfaction. In view of the current nursing faculty shortage, it is imperative that we understand the stressors and expectations faced by new faculty (Lawallen, Crane, Letvak, Jones, & Hu, 2003).

Often times the perceived work role stress is directly related to the persistent gap between practice and education. Mendenhall (2007) described this phenomenon as role discontinuity that exists as the novice transitions between the role of practitioner and educator. Role theory expounds on this concept by examining behaviors in certain contexts. The theory attempts to explain the effects of different roles on behavior and relates this to role situations such as role ambiguity, role conflict, and role transition.

Statement of the Problem

By the year 2020, 1 million registered nurse positions will be vacant (U.S. Department of Labor, 2006). Twenty thousand additional registered nurses will be needed in Georgia alone by 2012. Current graduation rates are producing only two thirds of the state's annual needs (Georgia Association of Nursing Deans and Directors, 2007). Literature pertaining to the nursing shortage by researchers such as AACN (2003) and Buerhaus and Bristol (2006) abounds with information regarding the dire predictions for the future and plausible explanations for causes of the shortage.

One of the major contributing factors to the shortage of nurses has been identified as an insufficient number of educationally prepared nursing faculty to educate new nurses. The inextricable link between the nursing faculty shortage and the nursing shortage has been recognized (Walrath & Belcher, 2006), and it is being addressed by employing more nurses as faculty immediately upon their graduation from a master's program. In addition, younger advanced practice nurses who are currently employed in a clinical setting are being courted by administrators in schools of nursing and encouraged to pursue a career in higher education. These nurses bring a strong clinical background to their new faculty role. However, crossing the threshold from clinical practice to academia can become problematic for novice and experienced faculties when there is a lack of teaching experience, a lack of exposure to education courses, and individuals are placed in situations without the necessary tools to survive. This often results in dissatisfaction with the work place, limited effectiveness, and failure for the nursing faculty member.

Novice faculty members describe academia as a very different culture from clinical practice, with unique expectations and roles resulting in a sense of anxiety and stress during the first years (Siler & Kleiner, 2001). Reality shock and role strain often lead to frustration. If these

states persist for novice faculty, the results are often disengagement and intent to leave. Those nursing faculty who leave academia do so for various reasons. In 2002, according to a National League for Nursing (2003) survey, only 36% of faculty members left their positions because of retirement. The remaining 64% of faculty left for other reasons, including dissatisfaction with the educational setting.

According to Shirey (2006), nursing faculty members are faced with multiple stressors that can result in negative outcomes. One of these negative consequences is burnout—a state that seems to be more prevalent earlier in the career. Individuals with higher levels of educational preparation, and those who held high idealistic expectations seemed to be at higher risk for burnout. Erickson and Grove (2007) found in a similar study that nurses under 30 years of age are more likely to experience agitation and are less likely to engage in techniques to manage these feelings. These younger nurses also reported higher levels of burnout. Yet, these nurses are included in the pool being recruited to academia.

Gender is another demographic factor affecting job satisfaction. According to Hagedorn (2000), men tend to be more satisfied with salary and benefits than women are, and yet nursing remains a predominantly female profession. Life stages also affect job satisfaction with greater job satisfaction found in those with 5 or less years before retirement. According to Hagedorn, “The well being of the university depends on its ability to recruit and retain talented professoriate” (p. 5). The same principle applies to nursing faculty and schools of nursing.

Institutions are now in a quandary endeavoring to determine appropriate strategies for recruitment, and to an even greater degree, strategies for retention of nursing faculty. In particular, little is known about factors that facilitate and those that impede retention and transition of nursing faculty into the nurse educator role. Additionally, research is scanty as it

relates to the transition from novice to expert educator. There is research that addresses faculty behavior within institutions of higher learning and on factors that influence adults entering nursing education. However, it is meager and inconclusive.

A few studies suggest that when adults enter the nursing faculty role, there is intent to leave within 5 years (Garbee & Killacky, 2008). Some possible factors contributing to this action are role ambiguity and role strain, factors that have been reported in the literature as being related to workload and job satisfaction. However, these constructs have not been empirically linked to personal characteristics, commitment, or to the degree of involvement in professional development. Neither have the potential consequences and sources of role strain and role ambiguity of nursing faculty been empirically linked to role transition of nursing faculty. Research on these factors as they relate to nursing faculty is meager. Further research into factors affecting nursing faculty's ability to successfully transition into and remain in the role of the professoriate will benefit higher education, other healthcare institutions, and consumers of healthcare.

The Purpose

The purpose of this study was to determine the effects of age, gender, education level, and previous experience on the extent of role strain experienced by nursing faculty, and to determine the extent to which role strain predicts perceived satisfaction with the role transition and intent to stay in academia. A secondary purpose was to determine nursing faculty members' perceived need for professional development.

Research Questions

1. To what extent did nurse educators experience specific aspects of role strain when transitioning to their faculty roles?

2. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *separately* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?

3. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *jointly* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?

4. To what extent does the level of role strain predict satisfaction with transition?

5. To what extent does the level of role strain predict likelihood of continuing in a faculty position?

6. How do nurse educators rate the value of selected faculty development topics in assisting nurses transitioning to faculty position?

A survey design was employed in the investigation that took place in the southeastern United States. A group of 35 publicly funded, state, higher education institutions was reviewed, and 31 of these were selected because associate degree, bachelors, or higher degrees were offered in nursing. The instrument was sent to 437 nursing faculty members at these institutions.

Significance of the Study

Members of the nursing faculty are socialized into the role of the nursing profession but they must transition into the role of faculty member. Research on the effects of role strain and the extent of challenges affecting the transition of new nursing faculty will add to the literature a body of knowledge that addresses strategies to reduce the nursing faculty shortage. Theoretically, the concepts of role strain and role ambiguity have been identified as problems affecting transition from a clinical role to a faculty role. However, the extent of these variables on role transition and intent to stay has not been identified. The effects of other variables such as self-

assessed instructional competence and interpersonal support will be explored in terms of their effect upon role strain. Other unanswered questions will be addressed such as the relationship of age, education, and experience to the level of role strain perceived.

This study will provide guidelines for developing strategies to recruit, develop, encourage, and provide the support needed to encourage nurse educators to remain in academia. This issue has the potential to affect a number of institutions as well as individuals. Some of these include hospitals, acute care and long-term care facilities, higher education institutions, consumers, and state budget officers. The number of nurses entering the workforce will be addressed by first identifying the factors contributing to the nurse faculty shortage and those that contribute to faculty retention in colleges and universities. This is important because an increase in the number of nursing faculty will allow for an increase in the number of students accepted into nursing programs, thus addressing the shortage and benefiting higher education institutions simultaneously. Increasing faculty leads to an increase in students; thus increasing full-time equivalents in programs of nursing and ultimately increasing revenue for the institution. An increased number of nursing faculty results in an increased number of nursing graduates who are prepared to enter the workforce. This is advantageous to individuals and institutions of higher learning, as well as health care institutions and society. An opportunity to receive an education benefits prospective students and produces a more educated citizenry, which in turn produces a more stable economy.

There are also implications for policy and practice that include the provision of clear expectations for the faculty role that will assist in retention of novice faculty as well as experienced faculty who continue to have difficulty adjusting. This research will guide postsecondary education in developing a process for smooth transition of clinical practice nurses

and new graduates into higher education faculty positions by providing formal education and socialization to the faculty role.

Finally, this research assessed novice and experienced nursing faculty's perception of role transition and their beliefs about the requirements for a successful nurse educator. Once needs are identified, an intervention program can be implemented. A comprehensive faculty development model for clinical practice nurses entering academia can be employed that will reflect identified faculty needs and priorities and as well as meet objectives of nursing practice and performance. This should benefit nursing education as a whole and the University System of Georgia's higher education programs in particular.

Facing the nursing shortage and the nursing faculty shortage requires new ways of examining the current problem. Nursing faculties are leaving academia within the first 3 to 5 years of employment. They may be very well prepared clinically, but may feel ill prepared to assume the role of nurse educator. A number of experienced nursing faculty members have remained in spite of the issues that prevail. New strategies are needed to retain both the novice and the experienced nursing faculty members.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this study was to determine the effects of age, gender, education level, and previous experience on the extent of role strain experienced by nursing faculty, and to determine the extent to which role strain predicts perceived satisfaction with the role transition, and intent to stay in academia. A secondary purpose was to determine nursing faculty members' perceived need for professional development.

1. To what extent did nurse educators experience specific aspects of role strain when transitioning to their faculty roles?
2. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *separately* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?
3. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *jointly* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?
4. To what extent does the level of role strain predict satisfaction with transition?
5. To what extent does the level of role strain predict likelihood of continuing in a faculty position?
6. How do nurse educators rate the value of selected faculty development topics in assisting nurses transitioning to faculty position?

Aging faculty combined with a shortage of nurse educators is a powerful force that has the potential to leave programs of nursing without faculty to educate and prepare the next generation of nurses (Falk, 2007). Nursing faculty became an issue when news of the impending nursing shortage and the implications for the healthcare industry stimulated concern among the general public and nurse educators themselves (Craine, 2000). There was an apparent need to determine the severity of the shortage and the link to the nursing faculty shortage.

This chapter reviews the literature relevant to nursing faculty's role change, role strain experienced, and transition from clinical practitioner to academician. It provides the constructs necessary for understanding the causes of maladaptation to the new role and it discusses theories that explain transition and role change. This review of the literature is divided into four sections. Discussed in the review are the theoretical constructs necessary to understand the challenges involved in role transition of nurse faculty. The first section is a report of the state of the nursing shortage and the faculty shortage, which centers on the magnitude of the problem and plausible explanations. This is followed by a summary of the research conducted that has resulted in creation of theories that form the conceptual framework for role strain, role transition, and nursing practice. Section three focuses on nursing faculty in general and novice nursing faculty in particular converging on their perceptions of the challenges of their roles. The last section discusses the elements of faculty development with respect to nursing faculty transition. A process for implementing a comprehensive faculty development program to facilitate to the nurse faculty transition is explored with respect to the impact on retention of these nursing faculty members.

The Nursing Shortage

Nursing is often defined as a multifaceted profession that uses the environment of patients to assist them in their recovery (Craven & Hirnle, 1996). As a result, nurses are the frontline caregivers of healthcare institutions. According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2002) nurses are the primary sources of care and support for patients at the most vulnerable points in their lives. JCAHO associates fewer complications, lower mortality rates, and fewer adverse events to optimum staffing of registered nurses.

Aiken, Clarke, Sloane, Sochalski, and Silber (2002) examined the impact of nursing on patient outcomes and found that higher nurse staffing levels correlated to lower patient mortality and greater patient satisfaction. Implications from the study suggested that hospitals and other acute care settings provide adequate registered nurse staff and low nurse-patient ratios around the clock to promote the well being and safety of patients and decrease adverse patient outcomes. However, an unintended consequence of financial constraints that has been imposed on health care facilities has been a decrease in the time the nurse has to give direct patient care and to develop any type of nurse patient relationship (JCAHO, 2002).

These constraints have led to the profession of nursing changing to reflect society's values. Healthcare cost containment, technologic advances, and the women's movement that affords more job opportunities with equal rights for women are trends that have had an adverse effect upon the profession (Craven & Hirnle, 1996). As the profession continues to change, nursing must be understood in the larger context of society with a realization that social forces that impinge on the profession, such as diversity of patient populations, rising health care costs, managed care and shorter hospitalization, inappropriate staffing, and mandatory overtime, all

drive many of the workforce issues that have developed. Some of these issues include patient safety, nurse-patient ratios, working conditions, professional practice, and nursing leadership (Zerwekh & Claborn, 2006).

A confluence of societal, economic and environmental factors has contributed to the current shortage of nurses. However, age and extended life span have been a great influence. Demographics and population trends swing toward an aging population. For the age group born between 1944 and 1960, retirement will reach approximately 78 million in the next 15 years. With scientific advances and technology, the average life span of the adult is increasing. More nurses are needed because of the growing elderly population (Atchison, n.d.).

The U.S. Department of Health and Human Services (2006) conducted a survey that provided a statistical profile of older Americans. The older population—persons 65 years or older—numbered 36.8 million in 2005 (the latest year for which data is available). They represented 12% of the U.S. population, about one in every eight Americans. This has tripled from the 4% in 1900. By 2030, there will be about 71.5 million older persons, more than twice their number in 2000. People 65+ represented 12% of the population in the year 2000 but the proportion of the population is expected to grow to be 20% by 2030. The 85+ population is projected to increase from 4.2 million in 2000 to 8.9 million in 2030. Data from 2003 revealed that persons reaching 65 have an average life expectancy of an additional 18.5 years (U.S. Department of Health and Human Services).

Age is accompanied by an increase in the prevalence of chronic disease. Most older adults have at least one chronic condition and many have multiple conditions such as hypertension, heart disease, and diagnosed arthritis. Chronic disease, the increased survival rates of individuals with acute diseases and trauma, and the movement toward a community-based

approach to health care are significant factors that contribute to the need for more nurses (Lewis, Heitkemper, & Dirksen, 2004). However, the current aging of our population comes at a time when the supply of nurses cannot meet the demand.

Another probable cause of the nursing shortage is cost-cutting measures in hospitals in response to Medicare and managed care reimbursement cuts. These cost-cutting measures have resulted in the downsizing of professional nursing positions and the increase of unlicensed assistive personnel positions. In addition, nursing remains a predominantly female profession and women today have more opportunities to make greater advances in other professions. In addition, the nursing workforce is aging with the average age of the practicing nurse at age 44 (RN Careers, 2006).

Other issues that have resulted from economic changes in the budgeting of healthcare include shorter hospital stays, which decrease the amount of valuable time spent with patients, decreased reimbursement, and restrictions on hospital resources—all of which have made nursing roles increasingly more stressful. Concomitantly, there is a changing work environment with inadequate support systems and greater workloads. Health care financing, consumer empowerment, an aging workforce, an aging population, and a new generation of young workers who perceive nursing as unappealing and stressful are all factors that have painted a dismal picture for the future of nursing (Hood & Leddy, 2003). As a result, nurses are leaving the profession at a time when the demand for nursing is greatest; thus, forcing society to look for causes, explanations, and solutions.

Nurses continue to leave the profession in record numbers. Five hundred thousand practicing nurses left over a 2-year span, including 70% over age 50 and 30% of new graduates who left within the first 3 years (Palmer, 2003). According to Koerner et al. (2007), “The

estimated cost to replace a nurse ranges between \$65,000 and \$85,000 because of recruitment and orientation costs, plus the skill loss of an experienced registered nurse” (p. 1). A report from the U.S. Department of Labor (2006) stated that by the year 2020 there will be 1 million vacant registered nurse positions. Simultaneously, the practicing nurses will continue to age with the average age reaching 50 by 2010. The largest cohort of nurses between the years 2000-2010 is the 50-year-old age group. This group is expected to peak around 2010 and then decline (Buerhaus, Staiger, & Auerbach, 2000). More young nurses will be needed to reverse the trend of an aging workforce.

The registered nurse workforce in the year 2000 “consisted of nearly 1.89 million nurses in an economy that required 2 million nurses” (Beres, 2006, p. 28). Studies revealed a 168,000 shortage of practicing registered nurses in 2003 (Grady & Turman, 2006). The shortage is projected to be 29%, equating to an expected 1 million plus by 2020 with 44 states and the District of Columbia currently feeling the effects. California has approximately 198,530 full-time registered nurses (539 nurses per 100,000 residents). The state needs approximately 21,000 more to meet the demand (Schwartz, 2006).

Nurses have not always acknowledged the existence of a shortage. However, according to Hart (2001), there is universal recognition of a nurse shortage by nurses themselves. Eighty-nine percent of all nurses currently providing direct patient care in their local area asserted that there is a moderate to severe shortage. These groups of nurses, as well as nurses who have left direct patient care, attribute the shortage to problems with recruitment and retention

An unprecedented shortage will continue to worsen (Palmer, 2003). Some believe that the shortage is a continuation of the shortage of the 1980s, which was masked by managed care.

However, this is a full-blown nursing shortage rather than the historical cyclical shortage associated with economic changes. This shortage is multifaceted, problematic, and prolonged.

With these predominant issues prevailing, nursing is rapidly sliding into a catastrophic mode that needs to be reversed to sustain health care for all individuals. A study by Bleich et al., (2003) examined the nursing workforce crisis. The objective of the study was to analyze reports that focused on nursing to identify problems and solutions described in each. They identified national themes related to the crisis, such as health care economics, inadequate workforce planning, workforce development, and concern for the public's health. Secondly, institutional themes were identified, which included supply of nurses, demand for services, work environment, and leadership.

When solutions were identified and the researchers attempted to match them with the problems, gaps were identified. For example, the problem themes labeled demand, healthcare economics, and workforce planning had no identifiable solution. Research and data support was identified as a solution but there was no evidence of a problem to match this solution. This gap analysis provided knowledge for a comprehensive action plan to improve the increasing shortage (Bleich et al., 2003).

The implementation of this comprehensive action plan is not apparent as the shortage continues to increase, and nurses continue to leave the bedside. A study of direct patient care nurses who have left the profession revealed that this group of nurses expressed high levels of dissatisfaction with the quality of care given to patients. Seventy-one percent of the nurses surveyed rated staffing and high patient loads as a severe problem that contributed to their leaving. Other severe problems identified by this group that they felt contributed to the exodus of

nurses were decrease in time with patients, physical demands, and lack of autonomy (Hart, 2001).

Quality of care directly affects the consumer. Consumers are being affected in negative ways that compromise patient safety and the ability to provide quality nursing care. This inability to provide safe high quality care often leads to poor outcomes such as infection, delayed wound healing, delayed relief from pain, irreversible brain damage and other safety issues that often result in litigation (Craven & Hirnle, 1996). A prime example of the inability to provide quality nursing care that led to an unfortunate outcome and resultant litigation is the story of Shirley Keck.

In 1998, Shirley Keck was taken to an emergency room in Wichita, Kansas. As the events of that evening unfolded, Shirley died and was resuscitated. Because of this ordeal, Shirley was left with depression and paralysis for her remaining 4 years of life. The family sued the hospital, claiming that two nurses and two nursing assistants were not enough to manage the 42 patients in their care. The courts agreed and in July of 2000, 2 years before her death, Shirley was awarded a \$2.7 million malpractice settlement from the hospital. According to Shirley's attorney, this is one of the earliest malpractice suits related to inadequate nurse staffing (Johnson, 2004).

Shirley Keck's demise stimulated research into the relationship of patient mortality to adequate nursing staff. According to Anderson (2007), the shortage of nurses in the United States has deadly consequences for patients who are hospitalized. A study by the American Medical Association stated, "The odds of patient mortality increased 7% for every additional patient in the average nurse's workload. The researchers also found that increasing a nurse's workload from 4 to 8 patients would be accompanied by a 31% increase in mortality" (Anderson, p. 1). The average workload for a nurse on a medical-surgical unit ranges from five to seven patients

per nurse (New England Public Policy Center and the Massachusetts Health Policy Forum, 2005), which does not allow for increase without compromising patient safety. Other studies, such as the Aiken et al. study (2002) and Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2002), indicate increased nursing staff improves the quality of care given and reduces hospital mortality.

However, the shortage prevails and it has resulted in negative patient outcomes related to understaffing. Nurses report more medical errors, especially medication errors, than reported 10 years earlier. There are longer patient waits for tests, medications, and basic care and comfort. More patient complications lead to longer hospital stays. This is costly, inefficient, and affects not only patient safety but it affects patient satisfaction and the organization as a whole (Johnson, 2004). The production of more nurses cannot occur without faculty to teach the students. Strategies for improvement must include examination of nursing faculty and the nursing faculty role to determine the issues that promote retention, smooth transition, and intent to stay.

Enrollment in nursing schools has decreased because qualified students are being turned away by the thousands due to faculty shortages. This issue of turning away students can be traced to the fact that there are too few faculty for the applicants desiring to enter nursing programs. A prime example of turning students away exists at San Bernardino Valley College where only 40 students are accepted out of 500 applications each semester. This college is not in isolation. Potential nursing students are being turned away each year due to limited nursing faculty. Almost 16,000 qualified applicants were denied admission into nursing schools for the fall 2003 academic year (AACN, 2004). Almost 33,000 qualified applicants were not accepted at schools of nursing in 2005 due to faculty shortages (Parsh, 2006). In 2006, 71% of schools responding to an AACN survey turned away qualified applicants due to a shortage of faculty

(Garbee & Killacky, 2008). Additionally, it was predicted that the 2007-2008 high school graduating class was the largest in history with 3.2 million graduates. With this large number of graduates, there is the possibility that enrollment in schools of nursing will increase. Yet, the question remains, will there be sufficient numbers of nursing faculty to educate them (AACN, 2003)?

Nursing Faculty Shortage

The current faculty population totals 24,320, compared to the overall nursing population of 2,284,000. Nursing faculty comprises 1% of the total nursing population and it continues to decline. The nurse faculty vacancy rate has increased from 7.4% to 8.6%. The SREB found that the combination of 432 faculty vacancies and 350 newly budgeted positions totaled a 12% deficit in the number of nurse educators needed in the 16 SREB states and the District of Columbia alone (Bristol, 2004).

The basic requirement for teaching in nursing is a Masters of Science in Nursing with a PhD preferred (AACN, 2004). Between 200 and 300 doctoral-prepared faculty members will be eligible for retirement annually between 2004 and 2012 and 220 to 280 master's prepared faculty eligible to retire annually between 2012 and 2018. The mean faculty age is 53 for doctoral faculty and 46 to 49 for master's faculty. There has been a steady decline in the 36-45 group of doctoral-prepared faculty mainly due to departure from academic life (AACN, 2003). Additionally, for nurses desiring to further their education, there is the burden of tuition and loans for graduate study. There are fewer graduates from masters programs in nursing and nurses tend to wait longer to obtain doctoral degrees compared to other professions (Gormley, 2003).

The U.S. Department of Labor (2006) found that 39% of registered nurses employed in nursing held baccalaureate or master's degrees in nursing. This means that at least 390,000 of

registered nurse vacancies will be nurses with these degrees. There remains an increasing deficit of graduate prepared nursing faculty. The shortage of faculty further limits the number of students admitted to nursing programs. An AACN (2003) survey revealed in a sample of 220 schools, 5,132 full-time faculty positions with 379 of these vacant. This is a 7% vacancy rate and when viewed in terms of workload for nursing faculty, this percentage has a tremendous impact on the didactic and clinical load of remaining faculty.

Factors contributing to the shortage of faculty are faculty age, retirement timeline, insufficient salary compensation, excessive workload, unrealistic expectations, role ambiguity, diversity, gender, and adjustment to a new role. The median age of current nursing faculty is 52 years (Beres, 2006). As this group moves toward retirement, vacancy rates are expected to increase proportionately, thus exacerbating the nursing shortage. Fewer nurses are choosing to become professors and those who choose to become faculty tend to do so later in their careers (Palmer, 2003).

With recognition of the median age of nursing faculty and the impending retirement crisis, a disparity in wages between clinical nurses and nurse educators still exists. Clinical salaries have risen more than salaries for faculty. In 2003, the median salary for a director of a baccalaureate or masters program was \$78,852. Instructional faculty who ranked as an associate professor with a doctoral degree had a median salary of \$74,556 and those with a master's degree \$60,566 (AACN, 2003). A typical associate professor earns about \$57,000. According to Morris and Nabors (2007), an assistant professor of nursing teaching at the master's level is reported to have a median salary of \$55,262 compared to a clinical nurse manager who earns a median salary of \$69,416, a 20% difference. The median salary for a vice-president for nursing is \$161,879, a clinical nurse manager \$83,000, and a clinical nurse with a master's degree giving

direct care is \$64,500 (Mee, 2006). This disparity stems from the need for colleges and universities to comply with mandated uniform salaries while hospitals continue to offer salaries that are more competitive.

Meanwhile, role expectations have changed tremendously for the professoriate. Teaching is only one expectation. Varied responsibilities, such as conducting research, producing scholarship, and participating in college and community service add to the stress of faculty. Class and course preparation and the need to stay current in the field place more strain on already overburdened professors. Teaching extends beyond the classroom to include mentoring, updating curriculum, developing new courses, and mastering advances in technology (AACN, 2003). This combination of demands often leads to discouragement with academia, especially in those who are not sufficiently prepared. Faculty workload has been cited frequently as a cause of job dissatisfaction and a resultant exit of nursing faculty from academia.

Nursing faculty members also have many roles and responsibilities unique to them. They are expected to practice nursing, maintain their clinical expertise, and teach and supervise students in the clinical area. They are ultimately responsible for 6 to 10 students and the care of 6 to 20 acutely ill patients. Additionally, masters prepared advanced practice nurses are required to maintain clinical practice hours in order to maintain certification. Class and clinical schedules, class preparation time, and committee work are often not amenable to such practices. Nurse faculty members have struggled to balance work while remaining committed to the academic organization (Bartfay & Howse, 2007).

The diverse workforce in nursing has had its toll on nursing faculty as well. Faculty camaraderie has decreased due to the multigenerational factors. The older faculty members reside in the veterans group, born before World War II with core values of dedication, hard

work, conformity, and respect for authority, duty before pleasure, and adherence to rules. The second older group includes the baby boomer generation whose core values are work, team orientation, optimism, and willingness to go the extra mile. These characteristics are in direct conflict with Generation X, whose core values are fun, balance, techno literacy, and independence. Veterans and boomers are even expected to work with Generation Ys, who are truly multitaskers, technologically savvy, and very diverse, yet, very inexperienced with handling difficult people (Moore & Taylor, 2004). This mixture of faculty has led to more stress on an already overburdened group.

Novice faculty members who are younger than 35 consider themselves part of a minority group. They view themselves as Generation Xers who have different priorities than experienced faculty who have been in academia 20 to 30 years. They are willing to work hard but they also seek to find balance in their lives (Hessler & Ritchie, 2006). This combination makes for an interesting and sometimes difficult work environment as the diverse age groups attempt to work in a cooperative setting.

The experienced nursing faculty who have remained in academia have been studied to determine their attitude toward role strain and professional behavior (Gaston, 1981) and to examine the role of insiders in socialization of new faculty. Hessler and Ritchie (2006) found that guidance from more experienced faculty was essential to personal transition. This included flexibility, support, and allowing for mistakes. Experienced nursing faculty members frequently assume the role of mentor to the novice faculty member—a role that affords them an opportunity to observe the level of preparation and the transition process into the faculty role. Yet, there are no studies to confirm positive outcomes from these relationships.

Parallel to age is the gender issue, which also remains a dominant factor in the role of clinical nurse and nurse educator with the profession remaining 94% female. Damiano-Teixeira (2006) described the interface and transactions between the roles individuals need to play in their family and employment environments as a source of positive and negative stressors for women, their employers, and their family members. Gender also plays a role in salary compensation. Wage equity for women is a concern and affects women's stress levels and satisfaction with their jobs, as well as their perceptions of collegiality—all of which affect their decision to remain in academia (Hagedorn & Ladem, 2002).

Adjustment to a new role is not a new problem as it relates to nursing and nursing education. Research in this area can be traced back over more than 3 decades when Gaston (1981) made recommendations for further research to include identification of the causes of nurse educator role strain and application of role theory and reality shock theory to nursing education. Twenty-four years later Gormley (2005) conducted a study of nursing faculty and found that the effects of role ambiguity, role conflict, and work balance on organizational commitment of nursing faculty revealed positive significant relationships between these constructs and disengagement with turnover intention.

As the problem of faculty shortages persists, one solution has been identified. This is a global effort to court novice nursing faculty for entrance into academia. However, this group has not been researched on any large scale and neither have their experienced colleagues who have chosen to remain in academia rather than return to clinical practice to determine reasons for staying in academia versus return to clinical practice. Institutions are now in a quandary endeavoring to determine appropriate strategies for recruitment and to an even greater degree, strategies for retention and successful transition of novice nursing faculty, as well as strategies to

enhance retention and utilization of experienced nursing faculty. The production of more nurses cannot occur without faculty to teach the students. Strategies for improvement must include examination of nursing faculty and the nursing faculty role to determine the issues that promote retention, job satisfaction, and intent to stay. Issues of age, retirement, and diversity of nursing faculty, salary compensation, and workload demands must be addressed as to their impact on nursing faculty's intent to remain in nursing education (Garbee & Killacky, 2008).

While the shortage of nursing faculty increases, accrediting bodies are investigating the effectiveness of the teaching role. This group is attempting to identify a process to determine needs of various faculty role categories (Harvey, Novicevic, Thomas, Thomas, & Keaton, 2006). Colleges and universities are responding to organizational and economic needs to improve and become more efficient and efficacious. Attention has turned to organizational development to provide the faculty development programs that maximize human resources. There is also a realization that new faculty often need more help and guidance than what is provided in the typical new faculty orientation. Coupled with the imminent shortage of nursing faculty, awareness has been heightened that development of new methods to assure satisfaction of new and current faculty members is no longer an option but rather a necessity in order to conserve human resources (Davis et al., 2003). For nursing faculty, this effort begins with identification of factors that facilitate the transition from the role of clinician to the role of academician.

Registered nurses are the largest group of healthcare providers in the United States. Yet, nursing is facing one of the greatest shortages in history. Because of this shortage, care for patients is in question, as well as patient safety. The shortage has persisted for over a decade, and it has been predicted that by the year 2020, the nation will have a shortfall of up to 1 million nurses (HRSA, 2007). Baby boomers are nearing retirement and younger candidates are either

not pursuing nursing careers or those who do face the problem of being turned away. One of the reasons for this growing problem is a shortage of nursing school faculty. Qualified applicants are turned away every year due to a lack of faculty to teach these students. The nursing shortage is inextricably linked to the nursing faculty shortage. While this is a known fact, issues affecting job satisfaction and intent to stay such as workload, increasing demands, increasing diversity, and inadequate compensation remain unresolved. As new faculties are recruited, they are exiting often to return to clinical practice. The transition from clinical practice to academia is often difficult resulting in anxiety, insecurity, and feelings of inadequacy.

Role Transition

To understand adult behavior requires knowledge of their life transitions or the events and nonevents occurring in their lives. The more the event alters their lives, the more they will be affected by the transition. People in transition are often preoccupied and a little confused. They feel that they are on the outside suspended between their old role and their new role (Sargent & Schlossberg, 1988). A life event that occurs in many adults is a change in jobs. Holmes and Rahe (1967) reported that a change in job, irrespective of the nature of the job, is a stressful life event. For nurses who move from clinical practice into academia, a role transition occurs that is often accompanied by anxiety, as the nurse educator attempts to learn a different body of knowledge, skills, behaviors, and values.

Novice faculty members transition from nurse clinician to nurse faculty, just as graduate nurses transition to clinical practice nurses. Novice faculty members have no experience in the situations and roles in which they are expected to perform. They enter a world of academic freedom and autonomy that is valued by experienced faculty. However, new faculties have difficulty making sense of their multiple roles and setting priorities to fill these roles. For novice

nursing faculty, the biggest role conflict might occur during the transition from new graduate or clinician to the world of academe—a time that they feel they are left go *sink or swim* on their own. This results in anxiety and stress (McCoy & Rushing, 2005).

Schlossberg's transition theory (1984) defined transition based on the occurrence of any event or nonevent that results in change in assumptions about oneself and the world and thus requires a corresponding change in one's behavior and relationships. Transitions may lead to growth or decline. The individual must first identify the impact of the progress to determine if successful transition has occurred. Resources will play a key factor in success. Schlossberg described four areas of resources required for effective coping in transition. The first is *situation* wherein the role changes and concurrent stress ensues. The second area of resource is *self* which includes personal and demographic characteristics and psychological resources. The third is *support*—family, friends, and institutional. The last resource is *strategies* that involve coping methods, stress management, direct action, and possible modification of the situation. These four factors have a tremendous impact on the ability to cope with and move through the transition (Schlossberg, 1984).

For nursing faculty the situation occurs when the role changes from practitioner to faculty member. The remaining three areas are where differences exist among nursing faculty. Self is defined as a psychological resource that involves being clear about who you are as a person, which in turn enables one to identify strengths and those areas needing development (Smith, 2007). Individuals bring a combination of assets and deficits to each transition. Identification and utilization of appropriate resources for coping and support will be important to the success of the nursing faculty transition (Schlossberg, 1984).

Nursing faculty must be allowed to make the transition from clinician to academician by progressing through three periods. Moving in is the initial period wherein the faculty member learns the ropes. Moving through is the second period where the faculty member strives to hang in the new role. The third period is moving out where the individual might experience some grief even if the transition is positive (Schlossberg, 1984). As adults transition into a new work role, they become introspective and take stock of themselves continually. They question their sense of belonging to the organization, their competence, and their involvement and influence (Sargent & Schlossberg, 1988).

Work Role Transitions

The role holders' beliefs about their role and how these beliefs influence their behavior at work are critical to understanding work role transition. Chang et al. (2005) described the first year of professional practice as an important transitional time wherein even an experienced nursing expert may perform as a novice when entering a new working environment. This is also true for a clinical practice nurse or a new graduate with a master's degree who enters academia. The decline in competence sometimes results in loss of confidence in knowledge and consequentially high levels of anxiety leading to role strain.

Work role transitions can have profound significance for the future development of individuals and their organizations (West & Rushton, 1989). Nicholson (1984) developed a model of work-role transitions that postulated that when an individual enters a new role, it induces personal and/or role development. This alteration may manifest itself in one of two ways. The alteration may be a personal adjustment wherein the individual changes values, attributes, frame of reference, or other identity related attributes. Alternatively, the environmental manipulation occurs where the individual attempts to change role requirements

such as task objectives, methods, and interpersonal relationships central to role performance that often results in role conflict, an element of role strain. Each of these constructs, adaptation, and manipulation can either positively or negatively influence the outcome.

Figure 1 depicts this concept and the potential consequences of manipulating the environment to meet personal needs, a contribution made by Rizzo, House, and Lirtzman (1970) and Kahn, Wolfe, Quinn, and Rosenthal (1964), in their study of dysfunctional individuals within organizations. They found that existence of role conflict and role ambiguity may lead to use of defense mechanisms that distort the reality of the situation (Rizzo et al.). Other negative outcomes of environmental manipulation discovered by these researchers include dissatisfaction with the role, anxiety, a less effective performance, and intent to leave.

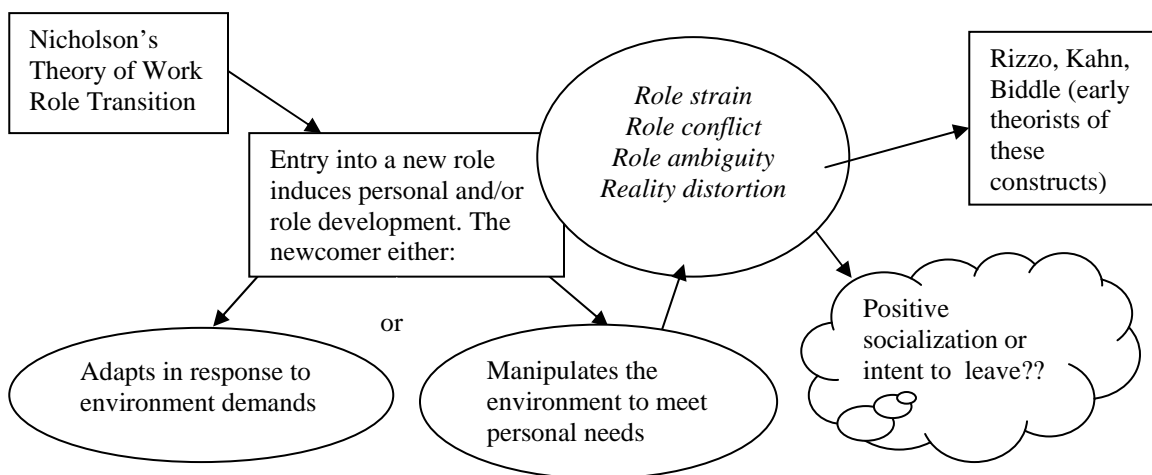


Figure 1. Stages of work role transition.

These symptoms demonstrate a lack of adjustment. There is an overwhelming feeling of disruption because more behaviors are moving into and out of the role components. If individuals are able to adapt the role to their needs and change their perceptions of some of the expectations, they begin to make a transition (Neale & Griffin, 2006). As novice nurses enter the

new role of nursing faculty, they bring certain expectations, beliefs, and attitudes. When these beliefs are incongruent with the beliefs of the organization, role conflict, role strain, and role ambiguity are experienced.

Studies of work roles by Neale and Griffin (2006) focused on the way the role is understood by the role holder and how these beliefs influence their behavior at work. Three interrelated components of roles that lay the groundwork for behavioral expectations include behaviors specifically demanded of the individual by an employing organization (system requirements), pre-existing role schemas that define behaviors in society, and specific facets of an individual's self-concept. System requirements as defined by Neale and Griffin provide a description of the role from the viewpoint of the organization but this does not capture the subjective experience of enacting the role. Role holders respond positively to behaviors that are mandated by all three components. In this situation, the role holder is free from conflicting expectations. These are key factors to role transition and they influence behavior on the job. When these three elements are incongruent, role conflict with role strain is experienced.

Acker (2004) examined the relationship between organizational conditions—role conflict, role ambiguity, opportunities for professional development and social support on job satisfaction and intention to leave. Results indicated that both role conflict and role ambiguity have statistically significant negative correlations with job satisfaction and positive correlations with intention to leave. Research has revealed that new faculty's expectations are often very different from what the role actually entailed. Yet, expert educators have persisted in their role in spite of the stress and anxiety encountered in a teaching position (Dempsey, 2007). Did these faculty members have less role ambiguity and experience less role strain or did they have more resources that better equipped them to handle the transitional issues?

Novice to Expert

Benner's (2001) novice to expert theory addresses the adjustment required for nurses as they shift from expert clinicians to novice educators and from novice to expert educator. The stages of development described by Benner posit that individuals proceed from novice to expert as they acquire skills and experiential learning. Skill acquisition occurs in five stages: novice, advanced beginner, competent, proficient, and expert. The different stages are characterized by (a) a movement from reliance on abstract principles to use of concrete experiences, (b) a change in the learner's perception of the demand situation wherein the situation is seen less as equally relevant bits and more as a complete whole with only certain relevant parts, and (c) the passage from detached observer to involved performer. The performer is no longer a bystander but an engaged participant. The nurse proceeds from novice to expert.

Benner's theory is based on a study of the practice situation and determination of the level of practice evident in the situation. This model elucidates strengths rather than deficits, and it describes capacities. The model focuses on experiential learning, recognizing that at each stage individuals can perform at their best. What the individual cannot do is perform beyond experience or have a role expectation that has not been encountered in practice. If nursing faculty is expected to perform beyond what they encounter in practice, cognitive dissonance, and frustration may result. Experiential learning is enhanced in a supportive learning environment and organizational climate. Benner (2001) also introduced the need for a multitude of experiences based on the principle that experience is a prerequisite to becoming an expert.

The stages described by Benner (2001) are also applicable to the nurse faculty role. Advanced practice nurses have an emphasis on clinical practice rather than education principles. The first teaching job, regardless of the number of years in practice, places the nurse educator in

the category of novice. Mendenhall (2007) contended that there is a disconnect between practice and education and the two are often incongruent. As individuals enter into roles, negotiations occur between the individual's beliefs and behaviors and the beliefs and behaviors consistent with the role.

As a novice, facts and rules are learned and practiced. Benner (1984) described the road to mastery of practice as a lifelong learning process that occurs over time. This learning can occur consciously or unconsciously as the novice begins to understand new concepts and practice new skills. Providing nursing education like providing nursing care involves risks, a specified skill set, and development of thought patterns, and assumption of numerous roles. Role socialization is a key factor in movement through the stages. Adequate socialization helps build pride, loyalty, team spirit, and enthusiasm for the organization.

Role Socialization

Rohrer (1998) discussed the difficult transition that occurs when new faculty members enter the stage of organizational socialization. As the faculty member transitions, ambiguity in fulfilling multiple roles with conflicting demands is experienced. This leads to stress and confusion. Rohrer found that new and junior faculty share similar stresses and similar needs for support during this early socialization period. New faculty needs to understand institutional context, values, and expectations. The socialization process should occur in two stages: anticipatory socialization and in-role socialization.

Olsen (1993) described the developmental stage of a new role as encounter or anticipatory socialization where faculty members see what their chosen profession is truly like. It is during the formation of the performed role image that the reality of the situation becomes more apparent. Reality shock may ensue and produce cognitive dissonance. The novice faculty

member knows what needs to be done but the overwhelming demands of the environment prevent role performance. Role norms evolve from interactions between individuals within those roles. Kahn et al., (1964) emphasized the relationship between expectations and behavior. As novice nurses enter the new role of nursing faculty, they bring certain expectations, beliefs, and attitudes.

Hamric and Taylor (1989) found that those with fewer than 3 years of work experience in a new role move through three phases and exhibit characteristic behaviors. The first phase is the orientation phase characterized by enthusiasm, optimism, and a focus on mastering skills. Role ambiguity and a gap between their idealized role and the reality of the new position may exist. The second phase is frustration where feelings of conflict, maladaptation, frustration, and anxiety develop. It is during this phase of role acquisition where the novice must clarify the new position's requirements in an effort to strengthen knowledge and skills, establish a work support system, and recognize the need to develop autonomy in order to make critical decisions. The third phase is the implementation phase, which involves role modification after interaction with other people. Role implementation demonstrates that the role has gradually emerged and now the novice is able to meet the challenge and broaden the perspective.

Bravo, Peiro, Rodriguez, and Whitley (2003) examined role stress in newcomers to organizations. They found that newcomers experience uncertainty and stress following entry into an organization. The two features they found to be of greatest importance for reducing stress were socialization tactics and relationships with superiors. Socialization tactics have a significant negative association with role conflict. As socialization tactics increase, role conflict decreases. Included in the socialization process is provision of information and structured learning situations to reduce uncertainty and stress. This helped to define their role and therefore reduced

role ambiguity, role conflict, and poor adjustment. Reduction of uncertainty enhanced the newcomer's ability to develop behavioral strategies. The authors used socialization tactics that they grouped into (a) fixed (vs. variable) that prescribed a timetable for assumption of the new role and (b) serial (vs. disjunctive) that included socialization by experienced member rather than unaided learning.

They also implemented a plan to develop role orientation through communication with superiors. This concept was based on a study that proposed that role theory interactions with superiors and co-workers provide learning and promote adjustment of newcomers. This study included past research that had identified a positive correlation between role conflict and role ambiguity. The researchers tested a proposed model based on their hypotheses. Findings revealed that initial socialization tactics and positive social relations can reduce role stress (Bravo et al., 2003)

College professors in general and nursing professors in particular “work in environments that are high pressured, multifaceted, and without clear borders” (Hagedorn, 2000, p. 6). Role expectations continue to change for the professoriate. Full-time faculty spend many hours advising students, mentoring students, serving as faculty advisors to student clubs and organizations, and securing funds in the form of grants and donations in addition to a full-time teaching load. New faculty express disappointments about teaching matched with the frustration of an imbalanced life. This combination of demands often leads to discouragement with academia, especially in those who are not sufficiently prepared.

Role stress occurs as nurse faculty faces the challenge of balancing roles. The novice educator strives to become a competent teacher by developing the knowledge and skills necessary to teach, guide, and evaluate students. The development of skills is often through trial

and error. There is no formal orientation, inservice, or framework of support. The first 1 to 3 years are typically very unsettling for the novice faculty. Multiplicity and diversification of roles often lead to role confusion. It has been documented that role ambiguity and role conflict may lead to role stress, which induces role strain (Goode, 1960; Sienty, 1988)).

New faculty members experience difficulty in adapting to their new roles as educator. According to Bravo et al. (2003), “Increase in role conflict and role ambiguity is an indicator of newcomers’ poor adjustment to organizations” (p. 196). To transition into any role, the individual must be able to define, understand, and make sense of the role. Problems and challenges develop when personal expectations and the reality of the new role do not match. The way in which the role is developed is dependent on socialization into the role and individual self-concept of how the role is fulfilled (Clifford, 1996). Arruda (2005) emphasized trust, perceived control, and respect as essential to successful socialization and successful work role transition.

Role Theory

Transitioning from a clinical practice role to the role of nurse educator with a different set of beliefs can be challenging and difficult. The concept of role, when defining the different experiences of nurse teachers, has been used to illustrate and analyze the complex functions of this group and to provide a framework for understanding behavioral changes. Role theory provides a framework for understanding the behavior of nursing faculty that has made a transition from the clinical area to academia. It is concerned with social behavior and it is grounded in five constructs: role expectations, role conflict, role ambiguity, role conception, and role strain (Horracks & Jackson, 1972).

According to Biddle (1986), “Role theory concerns one of the most important characteristics of social behavior—the fact that human beings behave in ways that are different

and predictable depending on their respective social identities” (p. 68). Behaviors are influenced by societal demands and rules imposed by them. Role norms evolve from interactions between individuals within those roles. Kahn et al. (1964) emphasized the relationship between expectations and behavior.

Role is defined as a set of norms and expectations applied to the incumbent of a particular position. It is the behavior expected of people in a certain status or position. Roles are functional concepts for reality testing which provide a means for social participation. People define roles for themselves and others based on their social learning and knowledge acquired through reading about this concept. The outcome is the creation of expectations about roles that they and others will play and subtle encouragement of others to act within the role expectations they have for them (Horracks & Jackson, 1972). Symbolic interactionists augment the definition by attaching the relationship component. They view roles as interpersonal units involving interaction (Lopata, 1964).

This definition was expounded upon by Lopata (1964) to include social relations between a social person and a social circle involving duties and personal rights. Role is not limited to one person’s behavior but it must include the behavior of others. Consideration of others behavior allows for the interaction to occur by providing others involved the right to perform certain actions. Nurse faculty not only interacts with superiors in the employee role, but they also are involved in an array of other roles relating to colleagues, students, support services, and other nurses in the clinical setting.

Consideration of norms, expectations, interactions, and social relations leads to the concept of role as being viewed as a complex behavioral process. In an examination of the driving force behind role selection, Horracks and Jackson (1972) found that all human behavior

is guided by certain forces: the stronger the drive, the more the likelihood of success in the role. An important drive to role selection is balance or equilibrium, a condition wherein the body attempts to maintain stability both physiologically and psychologically in order to adapt to changes. Psychological adaptation involves self-concept, a major factor in determining role choices. It involves social integrity and knowledge of self. The individual must know who he is in relation to others. This leads to an understanding of personal needs.

Horracks and Jackson (1972) defined needs as learned behavior that is evaluated by an individual as personally satisfying or facilitative. Individual needs are related to behavioral manifestations and self-concept. The role that a person assumes and the behavioral manifestations exhibited are determined by experiences, cognitive restructuring of information and actions, and environmental circumstances. For roles to be important to the self-process, the roles individuals assume must bear some functional relationship to their needs and behavior styles. There is a certain expectation for self for satisfaction of needs.

The theory of modeling and role modeling as described by Arruda (2005) is based on Maslow's hierarchy of needs. It was founded upon the premise that unmet needs such as safety, belongingness, self-esteem and self-actualization transcendence (support and mentoring from others) can lead to increased stress levels and role strain. Another concept of this theory is the affiliation-individuation concept, which is based on the premise that all individuals have the drive to be accepted and are dependent on support systems. Maslow's hierarchy of needs also provides a framework for identifying strengths and weaknesses. This process of identification prepares role holders to evaluate their work role and role behaviors resulting in an image of the role. The role holders develop their own ideas and beliefs about the role and have some idea of how these beliefs influence their behavior at work. Organizations that allow employees to define

their roles often find that role definitions “depend critically on the beliefs the individual brings to the role” (Neale & Griffin, 2006, p. 23). Clifford (1996) described the dramaturgical perspective of role that asserts that the genesis of roles proceeds through two stages—role perception and role enactment. Nursing faculty members must first perceive their role and based on their values and self-concept, test the reality of the role through enactment.

Horracks and Jackson (1972) described role enactments as those behaviors perceived by an individual as appropriate to situational demands placed on them. The more complex each role becomes for nurse faculty, the greater the behavioral change of the individual involved in carrying out the roles. As a nurse educator assuming multiple roles, when the complexities and responsibilities of the role increase, role strain could be expected to intensify also. Sienty (1988) found that by the end of the academic year, demands of the faculty role were interfering with almost half of all novices’ family lives.

Catalano (2003) described three aspects of a given role, ideal role image, perceived role image, and performed role image. When placed in the role of novice faculty, individuals know what they perceive as the ideal role of teacher/professor. This is usually based on how the individual was taught and how the professors presented themselves. The ideal role of professor might be thought of as one that demonstrates superior intelligence, unlimited responsiveness to students, and unlimited stamina. The perceived role is the novice faculty’s definition of the role. It modifies the idealistic view and is somewhat more realistic. After the novice practices the role, it becomes clear what the role actually entails and the individual defines the role based on actual performance. Nursing faculty must move through each of the roles to reach the stage that is characterized by freedom to choose. This choice will involve a determination of roles that can be integrated, complemented, compromised, and developed.

Role theory provides a framework for understanding behavior. According to Biddle (1986), role theory is concerned with characteristic behavior patterns that are generated by expectations. These expectations are learned through experience and individuals are aware of the expectations they hold. To achieve role mastery, clarity of boundaries of a given role must be identified and accuracy of perception of that role evident (Clifford, 1996).

Biddle (1986) used the term *consensus* to denote agreement among expectations that are held by various persons, and the term *conformity* to connote compliance to some pattern of behavior. When an individual's expectations are distinct and incompatible, the person suffers stress due to conflicting pressures. The problem is resolved by adopting some form of coping behavior and identifying interpersonal support as the individual seeks to restore balance. This gives rise to the concepts of role strain and role ambiguity—constructs drawn from the literature that indicate that difficulty might be felt in meeting the norms and expectations of the role. Role strain is the stress generated within individuals when they have difficulty complying with the expectations of a role. Role ambiguity is a condition in which expectations are incomplete or insufficient to guide behavior. Empirical research has “supported the hypotheses that both role conflict and role ambiguity are directly linked to unfavorable personal outcomes such as decreased job satisfaction, job-related tension, low performance and propensity to leave the organization” (Madsen, 2002, p. 6). Coping mechanisms that have been used in resolution of these issues include negotiating with others to change their expectations, restructuring one's views, or withdrawal from the situation. However, social integration, personal satisfaction, and equilibrium are greater when persons conform to their own and others' expectations (Biddle).

Nursing Faculty Expectations and Perceptions

New faculty members are rarely prepared educationally for multiple roles and expectations. There are expectations of the job position and the individual brings their own personal expectations based on their experiences, beliefs, and values. Olsen and Crawford (1998) found that many new faculty members do not have a realistic view of what the role of faculty entails. Even though many graduate programs provide insight and information into the faculty role at a conceptual level, faculty find differences in work roles and the more pedestrian tasks such as balancing demands and setting priorities.

A study conducted by Siler and Kleiner (2001) investigated the meaning of the new faculty experience. They found common meaning in the experience of new faculty. The four themes that emerged from the interviews included expectations, learning the game, being monitored, and fitting in. A major theme from this phenomenological study of novice faculty was expectations (Siler & Kleiner). Novice faculty expressed how the academic culture can either foster or impede the growth of new faculty. They came into the position thinking they were prepared and the work settings would be similar to the clinical setting. Another expectation was that they would be able to finish their work in a timely manner. The academic calendar, which had been a very attractive feature, led them to believe that they would have more time rather than a greater workload and less time for other facets of their lives. Novice faculty also expected more assistance and support from colleagues. Performance and feedback on their performance was an expectation. Their greatest expectation was a formal mentoring process and an orientation with a preceptor (Siler & Kleiner).

Preparation for and socialization into the role are also expectations and essential ingredients for success of novice faculty. According to Gaston (1981), "Socialization into the

nurse educator role is a critical process about which little is known” (p. 100). Socialization involves learning about the culture of the group including its values, attitudes, expectations, skills required, and other characteristics of the organization (Marquis & Huston, 2006). Another expectation and contributing factor in job satisfaction as listed by novice faculty is a positive perception of the leader. Character traits and leadership styles described by this group should include participative leadership, guidance, and support (Siler & Kleiner, 2001).

Gormley (2003) uncovered additional expectations of novice faculty. They expect unfamiliarity. However, they also expect to be mentored and introduced to the world of academia. Other expectations include answers to be available, opportunity for advancement, adequate salary and benefits, time to keep current in the field, formal orientation, clarity of roles, autonomy, collegiality, honesty, fairness, and a reasonable workload. Novice faculty members desire collaboration in scholarship, help in course development, and help in meeting teaching expectations. They do not expect to participate on college and departmental committees during the first year.

Novice faculty need clear expectations, increased availability of programs of nursing education and increased access to faculty role models. They also need and expect formal, well-planned orientation programs that meet informational needs and greater use of mentoring practices, assistantships, and traineeships. Hessler and Ritchie (2006), in a qualitative study of recruitment and retention of nursing faculty, acknowledged the need to foster collegial relationships, provide guidance, foster socialization, encourage flexibility, conduct orientation, provide support, facilitate collaboration, allow for mistakes, and coordinate teaching assignments. They also believed that organizations should grow their own, and offer rewards.

A final expectation of novice faculty is mentoring primarily because nursing is a profession dominated by women. Therefore, mentoring of women in academia is an expectation that takes on even greater importance for this unique group. Quinlan (1999) described women in academia as experiencing greater isolation, higher levels of stress, and a lower sense of self-efficacy and self-confidence. They experience more difficulty in establishing relationships with colleagues and they are often subjected to feelings of being an outsider. They continue to encounter inequity in workloads.

Perceptions of New Faculty Experiences

Boice (1991) conducted a study that addressed initial teaching patterns, the effects of collegial support and outputs in scholarly writing, and the differences in initial teaching experiences at a teaching (comprehensive) campus and a research (doctoral) campus. A distinction was made between types of new faculty. Boice focused on inexperienced newcomers and returning newcomers. Experienced faculty was used for comparison purposes. Collegial support was addressed and overall support for new faculty was high. However, the types of advice provided to new faculty ranged from none to a large number of gossip sessions and talk about politics with a little discussion about teaching-related matters. Additionally, there was not a designated forum or social network for discussing teaching. New faculty at both institutions tended to persist from semester to semester with the same teaching style. They described their most difficult task as determining the level of lecture difficulty and managing the workload.

Inexperienced newcomers who succeeded quickly had some characteristics in common. They included presentation of a positive attitude, provision of lectures that allowed for student involvement, seeking advice about teaching, investing time in scholarly writing and grant writing, and demonstration of a readiness to become involved in faculty development programs.

Faculty development programs did not necessarily affect teaching styles during the first 2 years; however, they did affect classroom comfort and time management. Time management enhanced the new faculty's ability to participate in scholarship activities and it decreased the amount of time spent on over preparation for lectures (Boice, 1991).

Boice's (1991) study provided more insight into how new faculty begin their careers. New faculty tended to teach more cautiously and defensively. They were not ready to assume responsibility for their failures and tended instead, to blame external factors. Early on, they were not able to see improvement in any area except lecture preparation and presentation. Development of comfort, efficiency, and acceptance of students is a slow and gradual process for new faculty. This is further evidence to support the need for faculty development. The research suggested that new faculty members need to be involved in faculty development because it assists them in finding comfort, improving teacher ratings and increasing productivity as scholarly writers.

Schein (1985) described learning objectives for newcomers that included basic responsibilities of the faculty member and behavior patterns required for effective performance. Success will depend on the relative degree to which the newcomer embraces organizational values. Horrocks and Jackson (1972) discussed rules of the organization in terms of their relationship to the individual. Rules and decisions along with event-specific actions are a vital part of the organization; but individual meaning and interpretation are determined by the values held by the individual. These values are conditioned by the affectivity of prior actions, experiences, and beliefs. The role a person takes and the behavior exemplified are grounded in these conditions.

The mission for faculty in university and college settings typically encompasses three parts: teaching, service, and research. Faculty members are expected to be excellent teachers, provide service to the college and the community, and engage in research. Nursing faculty members have an additional expectation as they struggle to balance their work role. In light of scholarship, there is a personal need and a role expectation to sustain a meaningful link between faculty work, the practice of, and the discipline of nursing. They are not only expected to remain current in theory, they are also expected to remain clinically competent and abreast of changes in the clinical setting. Sienty (1988) found that greatest strain on novice faculty were advising, delimiting lecture content, writing exam questions, and evaluating students' clinical performance. Clearly (1980) described *position-related needs* of novice faculty that were obtained from administrators. Administrators felt that these needs actually limit the effectiveness of novice faculty. They identified classroom and instructional-related needs as priority issues for novice faculty. These factors lead to confusion, role ambiguity, and conflict.

Gormley (2005), in a similar study of nurse faculty, found that nurse faculty struggle to balance work and grasp the understanding of scholarship and academia. The correlational study revealed that role ambiguity and role conflict scores were affected by research, teaching, and service components of work role balance. There was a negative relationship for role ambiguity, role conflict, and organizational climate. There was a positive significant relationship between role ambiguity, role conflict, and disengagement. The researcher later performed a meta-analysis in an attempt to synthesize the various studies of nursing faculty satisfaction. The findings again supported the theory that, as role conflict and ambiguity increase, job satisfaction decreases. Conflict and ambiguity are attributed to the nature of the nurse educator's multiple roles and the diversity of these roles. Nursing faculty is expected to remain flexible, to consider the behavior

of others who are active participants of their role, and to respond to the complexity of each interaction involved in the social role.

There are a number of reasons for the resultant anxiety, confusion, role conflict, and role strain that transpire in the role of novice faculty. Schriener (2004) found that nursing faculties are not prepared for the role of educator. They often bring a strong clinical background but they are not educated in the relevant skills necessary for assuming a faculty position. Cultural dissonance also exists in new nursing faculty based on values brought from the clinical setting often causing conflict. Clinical competence does not qualify the nurse as an educator. Many clinicians do not know what they do not know about education. Lack of educational preparation was identified as a key issue that affects transition into the educator role (Schriener, 2007).

In a study of role transition from clinical nurse into faculty role by Schriener (2004), six major themes were identified: stressors and facilitators of transition; deficient role preparation; changing student culture; realities of clinical teaching and practice; hierarchy and reward; and cultural expectation versus cultural reality. The reality of academia leads to experiences of new faculty that include stress, pressure, and uncertainty (Austin, 2002). New faculty discovered that the academic workplace was significantly different from their experiences.

There is a greater potential for success when the novice faculty encounters role clarity instead of role conflict. The group of individuals who share information and act as role models is vital to the success of the newcomer. These individuals must support the newcomer and not give mixed signals or contradictory information. Unmet expectations, role ambiguity, and role conflict greater than expected by the individual can lead to job dissatisfaction, lack of commitment and turnover. Psychosocial and career development will be necessary for success in maintaining new faculty (Siler & Kleiner, 2001).

In addition, when needs and personal expectations are not met, the result is stress and burnout. Shirey (2006) defined burnout as “prolonged response to chronic emotional and interpersonal stressors on the job that include three dimensions: exhaustion, cynicism (depersonalization), and inefficacy” (p. 95). If this problem is not addressed, it may result in illness, disability, and a faculty who have lost their passion for the profession. There is a feeling of hopelessness, helplessness, emotional and physical exhaustion, and a sense of ineffectiveness.

Nursing faculty in particular struggle with burnout as they attempt to meet expectations in the three-part paradigm of teaching, service, and scholarship, and attempt to balance workload, professional life, and personal life. Novice faculty is at the greatest risk for burnout. With a heightened awareness of novice faculty stressors and the need for early socialization and faculty development, a faculty development program assumes greater importance. Maintaining a balance is the key to success. As Austin and Pilat (1990) so eloquently stated, it is a goal that “Professors regard their work not as a job that can be separated from their other responsibilities and interests, but rather as a central thread woven through all aspects of their lives, blurring the personal and the professional” (p. 38).

Faculty Development

A potential contributing factor to the success of novice faculty is whether their expectations are met. Faculty development offers a means for addressing expectations and perceptions. Faculty development refers to those activities that renew or assist faculty in their diverse tasks. For many institutions, faculty development is defined by the way it is practiced (Davis et al., 2003). New faculty realizes that there is a role change involved and for the majority of this group, there is a desire to be an expert teacher but where is that learned?

Historically, knowledge of nursing faculty concerning aspects of the academic role has been researched. Findings support the conclusion that novice faculty in schools of nursing need “formal, well-planned orientation programs that meet the faculty members’ informational needs as they occur” (Reilly, 1986, p. 1). Mentorships, assistantships, and traineeships have been recommended to assist novice faculty.

However, Cole et al. (2004) found that little research had been done on faculty learning how to teach. Rather, teaching was viewed as a personal matter and there was very little evidence to support trying to help people learn to teach. They asserted the fact that systematic professional development programs are needed to support faculty growth. One program at Johns Hopkins used instructional methods of observing, practicing, and applying teaching skills and then reflecting on the experiences. This program emphasized growth by design rather than happenstance. Harrison, Lawson, and Wortley (2005) concurred that there is little reported empirical work that supports the acquisition of professional knowledge or other aspects of professional learning.

Boice (1991) found that teachers who participated in faculty development programs found immediate comfort and success at teaching. Boice described the scholarship of teaching as a continuous challenge that requires the teacher to be well informed and intellectually engaged. Great teachers must have knowledge of pedagogical procedures and stimulate active learning. Harrison et al. (2005) described professional learning and development as “an entitlement and a responsibility for all teachers” (p. 83) which aids in the development of a common language for understanding the processes and outcomes of teaching and learning. It also engages new faculty in making improvements in teaching and learning. New faculty need to be able to perform

professional work with high quality that is only accomplished through knowledge acquisition, professional practice, situated learning, and self-development.

Acker (2004) hypothesized that greater opportunities for professional development are associated with higher levels of job satisfaction. Acker found that there was a strong relationship between professional development, job satisfaction, and intent to leave. AACN (2003) asserted that professional development is required by faculty for a number of reasons. Among these are the fact that higher education has shifted its focus to the learner and learning rather than the teacher and teaching of content. Additionally, the explosion of information on teaching adults is a reminder that faculty cannot be completely successful without formal mechanisms for obtaining professional development. Strong orientation programs and ongoing faculty development opportunities are critical to keeping faculty informed and confident in their teaching role.

Bartels (2007) stressed the need for graduate level preparation in nursing science and practice. Faculty must be well prepared for the role of teaching which is at the heart of the academic enterprise. Role preparation begins with an understanding of the conceptual basis for higher education. Faculty must be supported in their roles in an effort to retain them in academia. Finkelstein and LaCelle-Peterson (1992) discovered that new and junior faculty members are a diverse group that has similarities, including similar stressors. Their findings also support the need to work and build the careers of this group in order to facilitate the transition into the teaching role.

There is a documented need for faculty development to improve teaching and to assist novice faculty in their transition. The most progress was made in the 1980s when 60% of America's colleges and universities developed some type of instructional improvement program.

In the 1990s, faculty development specialists began to examine their role and ways to become more effective in terms of making long-lasting changes. Eleser and Chauvin (1998) surveyed a group of 341 full-time faculty members to determine their priority goals. Results revealed five top priorities: (a) maintain an in-depth knowledge of content in the field of specialization, (b) improve skills as an effective teacher, (c) broaden expertise in general discipline, (d) increase level of productivity in research, and (e) improve skills in research methods and techniques.

This is evidence of the need to have a systematic approach to determining faculty development programs with the values and needs of the faculty as the driving force. This also leads to wise use of resources. However, few institutions have developed a comprehensive model for system-wide use with novice nurse educators and for continued education of experienced faculty members. Austin (2005) stressed the fact that there is no single model for faculty development that is appropriate at all institutions. However, every program must cover three developmental areas: professional, personal, and organizational.

Faculty development begins with three questions: Why does it? For whom should it be done? How can it be accomplished? The next steps of the process include an assessment of purposes, organization, resources, and constraints (Eleser & Chauvin, 1998). This includes an assessment of the organizational climate and culture, and development of guiding principles for a faculty development program. Eleser and Chauvin first established the need to transmit core knowledge, translate the content into practice, focus on teaching before evaluation, and promote consensus and buy in. Other important factors that contribute to the success of the program included building motivation for learning and overcoming resistance. In any program, the focus should be on content and methods, evaluation, and reflections. Appropriate teaching strategies

are necessary and conceptual frameworks need to be used. Follow-up tasks and activities should be incorporated to make the learning relevant.

Creation of a comprehensive faculty development program is a systematic process that requires time, effort, commitment, and resources. A comprehensive program includes professional development, instructional development, leadership development, and organizational development that overlap to make a successful program. Other key elements to success include ongoing assessment, administrative support, a faculty-based program, institutionalized identity and a broad and flexible program design (Davis et al., 2003).

While the shortage of nursing faculty increases, accrediting bodies are investigating the effectiveness of the teaching role. This group is attempting to identify a process to determine needs of various faculty role categories (Harvey et al., 2006). Colleges and universities are responding to organizational and economic needs to improve and become more efficient and efficacious. Attention has turned to organizational development to provide the faculty development programs that maximize human resources. Two additional factors have heightened awareness that assuring the satisfaction of new and current faculty members is necessary to conserve human resources: (a) the realization that new faculty members often need more help and guidance than what is provided in the typical new faculty orientation and (b) the imminent shortage of nursing faculty (Davis et al., 2003). For nursing faculty, this effort begins with identification of factors that cause role strain and those factors that facilitate the transition and retention of nurse faculty from the role of clinician to the role of academician.

CHAPTER 3

METHODS

A severe nursing shortage plagues the United States. One of the contributing factors to the shortage of nurses is the insufficient number of nursing faculty prepared to educate new nurses. As a result, clinical nurses who have a master's degree are regularly recruited into academia. However, nurse clinicians who have joined the academy describe it as a unique culture with different expectations and roles resulting in a sense of anxiety and stress during the first years (Siler & Kleiner, 2001). Reality shock and role strain for novice faculty often leads to frustration, disengagement, and intent to leave. The effect has prompted institutions to search for successful methods for retaining nursing faculty and ways to smooth the transition from clinical practice to academia. This chapter describes the methodology used to answer the research questions associated with this study.

The Purpose

The purpose of this study was to determine the effects of age, gender, education level, and previous experience on the extent of role strain experienced by nursing faculty, and to determine the extent to which role strain predicts perceived satisfaction with the role transition, and intent to stay in academia. A secondary purpose was to determine nursing faculty members' perceived need for professional development. The following research questions were designed to guide the study.

1. To what extent did nurse educators experience specific aspects of role strain when transitioning to their faculty roles?

2. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *separately* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?

3. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *jointly* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?

4. To what extent does the level of role strain predict satisfaction with transition?

5. To what extent does the level of role strain predict likelihood of continuing in a faculty position?

6. How do nurse educators rate the value of selected faculty development topics in assisting nurses transitioning to faculty position?

Theoretical Framework

This study was designed to explore the effects of role strain on nursing faculty transition from clinical practice to nurse educator role. A review of the literature revealed that nurses who make this transition into higher education experience role strain and role ambiguity with consequent behavioral changes. Role theory defines the constructs of role strain and role ambiguity in terms of job expectations, role expectations, and behavior. The role change experienced by nursing faculty can be stressful and traumatic in and of itself due to the transition that occurs. Schlossberg (1984) defined transition as any event or nonevent resulting in behavioral changes and changes in assumptions about oneself and the world. According to Sargent and Schlossberg (1988), the more the transitional event alters the assumptions about oneself and alters the current role of the individual, the more the individual will be affected by

the transition. Coping strategies may include changes in self-concept, use of maladaptive mechanisms, and/or retreat from the situation.

This study was designed to clarify the phenomenon of commitment and intent to stay in the role of nurse faculty by identifying the relationship between variables such as age, years in practice, and educational level on the extent of role strain. In addition, the study was designed to identify the extent to which the level of role ambiguity, self-assessed instructional competence, and interpersonal support affected role strain, and to determine the relationship between experienced role strain and intent to stay in higher education and satisfaction with the transition. The study, as designed, was a quantitative descriptive study that used correlational research. This type of research design was appropriate for this study because it helped to explain behaviors of nursing faculty and predict intent to stay. The study included a survey questionnaire designed to elicit perceptions of nursing faculty about the teaching role, preparation for this role, behaviors associated with the role, and the need for faculty development programs.

A descriptive explanatory study was appropriate because it systematically described the facts and characteristics of nursing faculty relative to the constructs role ambiguity, self-assessed instructional competence, and interpersonal support in terms of their effect on the level of role strain experienced and the success of nursing faculty in making the transition from clinical practice to academia. Descriptive studies allow the researcher to explain the phenomena, which in this study were transition of nursing faculty and intent to stay (Merriam & Simpson, 2000). The description is followed by a search for relationships between demographic and professional data and the degree of role strain experienced.

Making a successful job transition is not an easy accomplishment. Nursing faculty transitioning to the role of academician is influenced by a number of factors such as age, level of education, and years of experience. Additionally, a number of variables affect role strain, the ease of transition, and intent to stay in academia. A model exploring the relationship between the extent of role strain and factors of role ambiguity, self-assessed instructional competency, personal and educational demographics, as well as the level of satisfaction with the role transition and intent to stay was developed (See Figure 2). The research questions were designed

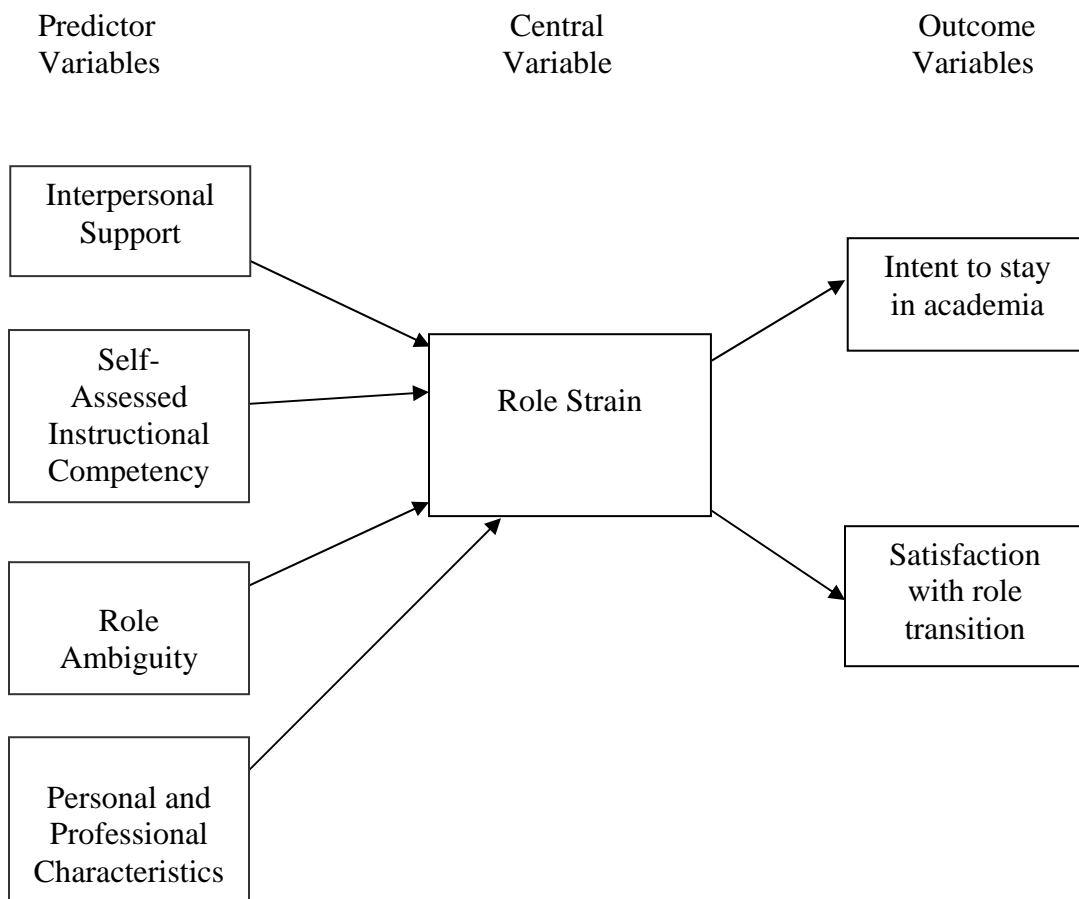


Figure 2. Model for predicting successful role transition and intent to stay in nursing academia.

to detect a direct relationship between role strain and transition and a relationship between role strain on intent to stay in nursing academia. The model calls for a conception of the dimensions of role transition and intent to stay in nursing academia.

The organization is a system of positions with formally defined roles. Role transition is defined as a process of moving in and out of roles in a social system. Role transition is the phase wherein the nursing faculty member has become an engaged participant who responds appropriately to environmental demands. The role holder is free from conflicting expectations and he/she feels a sense of belonging to the organization. There is a perceived opportunity for growth, intellect, and discovery, opportunity to affect others and a sense of accomplishment.

Intent to stay is defined as intention of faculty to remain in their present job position, which in this model is academia. Dimensions include organizational climate (Gormley, 2005), organizational commitment (Garbee & Killacky, 2008), role conflict and ambiguity, and work balance. Role transition and intent to stay are dependent variables that are affected by one central variable, which in turn is affected by four independent variables. They are illustrated in Table 1.

Role strain is the major element confronted in a new operation such as changing jobs. It is defined as the stress generated when a person has difficulty complying with expectations of a role. Role strain is influenced by the amount of activity in a person's life and the presence of incompatible expectations that result in role conflict. Role conflict inversely affects role clarity (Glen & Waddington, 1998).

Self-assessed instructional competence is the ability that allows one to perform a designated work role or task. People succeeding in a job transition carry an enormous amount of personal ability that allows them to negotiate tough times from a reservoir of knowledge and argue the importance of the negotiation. Experiential learning plays a major role in developing

Table 1

Determinants of Successful Role Transition and Intent to Stay for Nursing Educators

Variable	Definition
<i>Central variable</i>	
Role strain	The stress generated within individuals when they have difficulty complying with the expectations of the nurse educator role.
<i>Predictor variables</i>	
Self- assessed instructional competence	Conceptual and procedural knowledge and the ability to apply this knowledge are adequate to perform the tasks of nurse educator.
Role ambiguity	Lack of necessary and clear information available to perform as a nurse educator.
Interpersonal support	A combination of assets and deficits brought to a transition. Determination of these qualities involves taking stock of the situation, self, supports, and strategies for coping.
Personal and professional characteristics	A combination of demographic and educational characteristics such as age, years of clinical experience, highest degree earned
<i>Outcome variables</i>	
Role transition	The phase wherein the nursing faculty member has become an engaged participant who responds appropriately to environmental demands
Intent to stay	The objective of the faculty member is to remain in their present job positions

competence and in role development. Personal competence increases self-confidence and increases the individual’s awareness of the fact that roles do not exist in isolation (Mendenhall, 2007).

Role ambiguity, as defined by Kahn et al. (1964), is a lack of information regarding scope of responsibility, expectations, and lack of information regarding supervisory evaluation of one’s work. Role ambiguity is directly linked to job-related tension (Madsen, 2002). Role behavior is the response of an individual to the information and influence received about the role. When this information is lacking, incomplete, or insufficient to guide behavior, role ambiguity is the outcome.

Interpersonal support is an invaluable resource to the success of transition. As the socialization process occurs, nursing faculty expect collegial support. However, they also expect

support from administration, family, and friends. Transition forces an individual to assess the situation and determine if it is positive or negative. A self-assessment is important to interpersonal support in terms of strengths and weaknesses, confidence, commitment, previous experience, and optimism toward the transition. Individuals must also assess their own strategies for coping with change.

Personal and professional characteristics included age, level of education, year of clinical practice and highest degree earned. These variables were assessed as to the extent to which they affected nursing faculties' ability to transition successfully into their new role. These variables were also assessed as to the effect they had on the intent to remain in academia (Schlossberg, 1984).

Instrumentation

Survey research was selected as the research methodology because it provided the necessary quantitative data. A review of the literature was performed to ascertain information on instruments that might be used to evaluate role strain as it related to nurses transitioning to different job roles. However, few instruments actually measure role strain in nursing education. As a result, this study used a multifaceted researcher-designed instrument to measure the four determinants—role ambiguity, personal and demographic characteristics, self-assessed instructional competence, and interpersonal support. The independent variables age, years in clinical practice, and level of education and the central variable role strain were measured. In addition, satisfaction with role transition and intent to remain in nursing academia were measured. Research on role is a complex one dealing with many permutations such as role conflict, role transition, and role identity. The most viable constructs for nursing education is the combination of role strain and role transition.

These constructs presented considerable challenges in that they first had to be conceptualized and then defined, and characteristics of the constructs had to exist. In a literature search for an existing instrument, Rizzo, House and Lirtz (1970) had developed and used an instrument to measure role conflict and role ambiguity in a large, dysfunctional manufacturing company. Initially, the instrument seemed appropriate, however it proved to be unsatisfactory for use in this study due to questionable discriminant validity and secondly, the items were not written in the context of nursing or nursing faculty.

Further review of the literature was conducted and informal conversations were held with nursing faculty experts to identify perceived challenges to success, retention, and transition of nursing faculties. The outcome was development of new items to measure different constructs that were more appropriate to nursing faculty who had transitioned from clinical practice to the faculty role. Additional items reflected modifications of Kahn's Job Related Tension Index (1964), and Faculty at Work: A Survey of Motivations, Expectations, and Satisfaction by Blackburn and Lawrence (1995). These instruments had been used in similar studies. Items from these instruments were matched with items identified in the literature review as being problematic for new nursing faculty and worded in a manner to gather the data needed for this research. The constructs included nursing faculty perceptions of their own competence, role expectations, interpersonal support, and role transition. This step was followed by development of a draft instrument for review.

An expert panel of seven advanced doctoral students was assembled to conduct a modified validity sort. The panel was given the theoretical model with an explanation and they were asked to complete the survey. Upon completion, the group discussed the survey. Each construct along with the corresponding items was evaluated for appropriateness, saturation and

justification of inclusion. The panel made a determination of whether items were a “fit” for the construct and they discussed whether the results would allow the researcher to make warranted inferences. They also gave suggestions on possible revision of the wording of items.

Modification of the instrument was done based on the opinion of the experts and the results of the validity sort. An instrument was developed which would be piloted on nursing faculty in the Technical System of Georgia to determine if data collection procedures worked, and to assess whether questions in the survey would allow the researcher to draw correct conclusions. From the pilot results, changes were made and the final instrument was developed.

The original survey’s 7-point Liker-style measurement scales were changed to a 4-point Likert scale ranging from 1 (*strongly agree*) to 4 (*strongly disagree*). The four constructs were confirmed and the items measuring each variable sorted accordingly. Tables 2 to 6 contain each scale and the items from the current survey. A number of items were reversed to be in the same direction as the other items in the scale. The wording of the items were such that a score of 1 (*strongly agree*) indicates that role strain is severe, role ambiguity is great, self-assessed instructional competency is low, personal support is low, and role transition is difficult.

Table 2

Items in Role Ambiguity Scale (N=8)

Lack of necessary and clear information available to perform the job of nursing faculty.

#	Item	Reversal
16	There is a lack of policies and guidelines to help me in my faculty position.	
19	I am unsure about how much authority I have as a nursing instructor.	
20	It bothers me that all faculty do not adhere to policies.	
21	Sometimes I have to feel my way in performing my duties.	
22	I understand how I will be evaluated for a raise or promotion.	R
23	I know exactly what is expected of me.	R
24	I receive feedback on how well I am doing my job.	R
25	I receive clear explanations of what has to be done.	R

Table 3

Items in Role Strain Scale (N = 16)

The stress generated within persons when they have difficulty complying with the expectations of the nurse faculty role.

#	Item	Reversal
1	I have enough time to complete my work.	R
3	I am sometimes confused by conflicting departmental policies.	
4	I perform job functions that I think should be done differently.	
5	My workload is reasonable.	R
6	I sometimes feel caught between students and administration.	
7	At the end of the workday, I am exhausted.	
8	I feel that the work is never finished.	
9	I work on things unrelated to my role.	
10	I am overwhelmed because of being involved in other courses in addition to my primary course.	
11	I feel certain that I have divided my time properly between the tasks at hand.	R
13	I am uncomfortable with the pressure to perform scholarly work.	
14	Other people expect me to teach in certain ways that are not right for me or I don't agree.	
17	I was uneasy about making the role transition from clinician/nurse to nursing faculty.	
18	Students do not appreciate my efforts on their behalf.	
28	I have difficulty handling negative reactions of students.	
34	I was unaware of the multiple expectations of the faculty role.	

Table 4

Items in Self-Assessed Instructional Competence Scale (N = 7)

Conceptual and procedural knowledge and the ability to apply this knowledge are adequate to function in the role of nursing faculty.

#	Item	Reversal
26	I am fully qualified to handle the work of a nursing faculty member.	R
27	I feel confident enough about the nursing program requirements to advise students in future course selection.	R
29	I do not know if I will be able to answer the students' questions in class and in clinical.	
30	I find it difficult to write exam questions.	
31	I worry about my teaching ability affecting students' performance.	
32	I receive assignments that are within my educational capabilities.	R
33	Previous education and clinical experience were adequate to prepare me for the nurse faculty role.	R

Table 5

Items in Interpersonal Support Scale (N = 5)

A combination of assets and deficits brought to a transition which involves taking stock of the situation, self, supports and strategies for coping.

#	Item	Reversal
35	I receive support from my colleagues at the college/university.	R
36	Administrators provide me with the support I need to do this job.	R
37	Family is supportive of my work role change	R
38	I receive support from my friends for my work role change.	R
39	I receive support for my work role change from other nurses that I know.	R

Table 6

Items in Role Transition Scale and Intent to Stay Variable (N = 4)

Role transition. The phase wherein the nursing faculty member has become an engaged participant who responds appropriately to environmental demands.

#	Item	Reversal
2	I have adjusted to my role as nursing educator with little difficulty.	R
12	I am unable to view my role change in a more positive light.	
15	I found the transition from clinical practice to academia to be a positive move.	R
Intent to stay. The objective of the faculty member is to remain in his or her present job position.		
72	How likely is it that you will remain in nursing education for the duration of your career?	

Part II of the instrument addresses faculty development programs that have been identified in the literature as necessary for success of nursing faculty in academia. It consists of 22 items ranked on level of importance. This section of the instrument was developed because role preparation was identified in the literature as an outcome variable affecting success. The type of information gained from this section of the survey may suggest a way to improve retention and transition. The remainder of the instrument was comprised of two introductory questions, three open-ended questions, seven items relating to professional experience, and three items pertaining to background information.

Validity and Reliability

In an explanatory study, whatever instrument is used must show evidence of validity (Franked & Wallen, 2003). A validity sort was performed by a 7-person expert panel from the University of Georgia on the 45 items included in Part I of the instrument. Members of the panel were given copies of the instrument, the model, an explanation of the model, and the four determinants for evaluation—role strain, role ambiguity, self-assessed instructional competence,

and interpersonal support. They were also asked to rate the items for clarity. After this step was completed, the group discussion and suggestions were used in eliminating questions, making revisions, establishing a common grammar to improve readability and consistency, grouping of items under appropriate constructs, and rewording of the items. Finally, Part II of the instrument and the background and demographic items were added.

The instrument was created in Survey Monkey, an online hosting company. An electronic survey was selected hoping that it would increase response rates from nursing faculty because of convenience and for its cost efficiency. Additionally, the Survey Monkey program emails invitations to participants, conducts follow-up notices to nonrespondents, and compiles data that can easily be exported for analysis.

After final revision, the pilot survey (See Appendix A) was tested with 51 faculty members in four colleges of nursing. The pilot survey was completed by 36 faculty members, for a 75% response rate. The pilot was performed to answer two broad objectives: (a) did the data collection procedures work and (b) what was the quality of the instrument. This was accomplished by determining if participants were indeed filling out the survey and if there were an excessive number of questions not answered. The pilot gave the researcher an opportunity to review the distribution of items, look for variance, and determine reliabilities. Content-related evidence of validity was collected to determine if the content and format were consistent with the literature and with nursing faculty perceptions of their role and role preparation and the population sample that was measured. Appropriateness of content as well as comprehensiveness of the instrument was assessed.

The pilot study was successful. Certain items were changed from a multiple-choice format to a scale response. Adequacy of the instrument was determined by examination of item

frequency to determine any problems. A need to alter demographic information to improve the quality of data was identified. All scaled items performed very well.

Summary of Results of Pilot Study

The four scales examined all resulted in reliabilities at or above 0.78. A Cronbach's alpha score above 0.60 demonstrates reliability within a variable. Analysis of these statistics indicated that the four scales were reliable (See Table 7). Three of the four scales remained unchanged. Reliability revealed one item to be a poor fit for that construct. The item measured positive change rather than self-assessed competence and as a result, the item was deleted. The predictor variable role strain was identified as a dynamic construct with coefficients of determination ranging from .48 to .81, a moderate to strong correlation. Outcome variables were identified as satisfaction with role transition and intent to stay. Further analysis of frequency distributions indicated variance for all items.

Table 7

Reliabilities of Scales in the Pilot Study

Scales	Cronbach's alpha
Role ambiguity	.81
Role strain	.78
Self-assessed instructional competency	.83
Interpersonal support	.84

The final survey instrument (See Appendix B) contained three sections. Consultation with dissertation committee members and a review of the pilot study necessitated the following changes: (a) the sections included role ambiguity, self-assessed instructional competency, and personal/demographic factors; (b) the key variable became role strain and the outcome variables remained the same. The final instrument contained (a) 2 introductory items; (b) 41 items related

to role strain, role ambiguity, self-assessed instructional competence, and interpersonal support; (c) 21 items related to faculty development programs; (d) 6 items related to personal, demographic, and educational characteristics; (e) 1 item related to compensation; (f) 1 item related to intent to stay; and, (g) 3 open-ended questions.

Population and Sample

The researcher's interest was in the phenomena occurring within the institutions governed by the Board of Regents of the University System of Georgia. There were 31 nursing programs within this system of governance. Since there were many similarities between mission, operations, and external governing bodies for the 31 programs, the researcher chose to focus attention on these institutions. The institutions are all public colleges and universities within the University System of Georgia. The criteria for selection of the nursing programs included:

1. The program must be one that graduates students eligible to sit for the National Council Licensing Exam to become a registered nurse.
2. The program faculty must be composed of novice faculty (those faculty members teaching 3 years or less) and experienced faculty (those faculty members teaching 4 years or more).
3. The program must be accredited by the Georgia Board of Nursing.

Nursing faculties were selected from the 31 Board of Regent institutions and included all nursing faculty in these institutions. An informal survey revealed 300 nursing faculty in 17 of the 34 schools and 87 of this total had been employed as nursing faculty for less than 3 years and the remainder greater than 4 years. Four hundred and thirty-seven surveys were mailed to nursing faculty in 31 University System of Georgia schools (see Appendix C). The total number of surveys returned was 262 and of this number, 248 were useable. A sample of 262 subjects was

needed to obtain a 95% confidence level with $\pm 3\%$ confidence interval. A recommended sample size of 196 for a 95% confidence level, $\pm 5\%$ sampling error, and a 50/50 split (the expected variation in answers to the questions) was recommended by Dillman (2007).

Institutional structural and program characteristics were obtained using the Georgia Board of Nursing Directory and the Board of Regents University System of Georgia Directory. A request was made to the institutions that have nursing programs for email addresses of all full-time nursing faculties. This was followed by a letter of invitation to each participant, requesting their participation, explaining the purpose of the survey, assuring them that their answers would remain confidential, and providing the link to the survey (see Appendix D). Nonrespondents received follow-up requests in order to yield a sufficient number of responses.

Within the respondents, there are some differences in the faculty role as performed. Two research universities, eleven regional universities and twelve two-year colleges were included in the survey. The faculty members at the research universities were likely to have research and teaching included in their work roles; however, the overwhelming majority of the respondents had full-time assignments in instruction.

Data Collection

Data collection of nursing faculty transition from practice to academia lends itself to survey research because questions can be designed to assess attitudes, beliefs, and opinions. Subjective data may be inferred from observation of behavior but it cannot be reliably measured in this way. The survey method allows the researcher to operationally define information that otherwise would almost be impossible to accurately define (Kirby & Goodpaster, 2002). Therefore, the primary method of data collection was administration of a survey. This method was determined to be appropriate owing to the nature of the information discussed.

Part I was a 45-item questionnaire based on four categories. Participants were asked to respond to each item, indicating the degree to which the condition exists on a 4-point scale ranging from (1) *strongly agree* to (4) *strongly disagree*. The second section of the survey involved rating a list of proposed faculty development items as to level of importance, ranging from *very important* to *least important*. A closing question permitted the participants to add additional topics for faculty development that may prove informative in relation to the research questions and the proposed faculty development model. The last section of the survey included professional and demographic data.

The collected responses were exported from Survey Monkey to an Excel spreadsheet for data cleansing. The researcher engaged in data preparation such as recoding items to assure accuracy of the data. Race, work status or jobs maintained other than faculty member, courses taken in preparation for nurse faculty position, intent to stay, and adequate compensation were all assigned to numerical data.

The next step involved removal of open-ended responses that would be evaluated qualitatively. Variables were renamed and recoded to allow for ease of sorting and identification. The item labeled age requested the participant to enter the year of birth. A new variable for age was created and calculated by subtracting the year of birth from 2009. Responses to questions concerning if they felt they were adequately compensated, classes taken, and race were assigned numerical values for ease of data analysis. Four scales were created to capture a total score for the items within each of the theoretical constructs: role strain, role ambiguity, self-assessed competence, and interpersonal support. The scale score for each was created by averaging the responses to each item in each scale.

The outcome variables, satisfaction with role transition and intent to stay in academia, were created. Satisfaction with role transition was created by averaging the responses of the three items in the scale. Intent to stay in academia was measured by the response to Item 72, *How likely is it that you will remain in nursing education for the duration of your career?* The item had a range from 1 (*not likely*) to 4 (*very likely*).

Data Analysis

Six research questions guided this study. The questions and the procedures used to answer the questions are listed below.

Research question 1. To what extent did nurse educators experience specific aspects of role strain when transitioning to their faculty roles?

Faculty responded to the 16 items in the role strain scale using a 4-point Likert scale, ranging from (1) *strongly agree* to (4) *strongly disagree*. Means across the 246 respondents were ranked from most agreed to most disagreed and presented in tabular form.

Research question 2. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *separately* explain observed variance in role strain experienced by nurse educators transitioning to faculty roles?

This question was answered using simple regression analyses. A determination was made of whether the predictor variables explained observed variations in role strain experienced by nurses.

Research question 3. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *jointly* explain observed variance in role strain experienced by nurse educators transitioning to faculty roles?

The six predictor variables were used in a multiple regression analysis to determine the extent to which the predictors jointly explained observed variations in role strain experienced by nurses.

Research question 4. To what extent does level of role strain predict satisfaction with transition?

A simple regression analysis was used to determine the extent to which the predictor explained satisfaction with transition.

Research question 5. To what extent does level of role strain predict intent to stay in a nursing faculty position?

A simple regression analysis was used to determine the extent to which the predictor explained likelihood of continuing in a faculty position.

Research question 6. How do nurse educators rate the value of selected faculty development topics in assisting nurses transitioning to faculty position?

This question was answered by ranking topics according to level of importance. These results served as a guide for development of a faculty development model.

Assumptions

The following assumptions were made in reference to this study:

1. There is a direct correlation between nursing faculty and the nursing shortage.
2. Nurses and nursing faculty have an interest in resolving the issues surrounding the nursing shortage.
3. The research will add to the body of knowledge that addresses the issues involving nursing faculty retention.

4. Nursing faculty are members of social positions and hold expectations for their own behaviors and those of other persons.

Limitations of the Study

There were three limitations relevant to this study. First, the sample is limited to Board of Regents institutions in the state of Georgia; therefore, the findings may not be generalizable to public colleges of nursing across the United States. Second, because the participants were all members of the public colleges and universities, the findings may not be generalizable to the colleges and universities belonging to the private sector, and to the registered nurse programs in the Technical College System of Georgia. Third, the findings do not account for the number of years each faculty member has been in academia, which might explain some of the observed variance.

CHAPTER 4

FINDINGS

The purpose of this study was to determine the effects of age, gender, education level, and previous experience on the extent of role strain experienced by nursing faculty, and to determine the extent to which role strain predicts perceived satisfaction with the role transition, and intent to stay in academia. A secondary purpose was to determine nursing faculty members' perceived need for professional development. Six research questions were used to guide the study:

1. To what extent did nurse educators experience specific aspects of role strain when transitioning to their faculty roles?
2. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *separately* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?
3. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *jointly* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?
4. To what extent does the level of role strain predict satisfaction with transition?
5. To what extent does the level of role strain predict likelihood of continuing in a faculty position?
6. How do nurse educators rate the value of selected faculty development topics in assisting nurses transitioning to faculty position?

Description of the Sample

Responses were received from 262 of the 437 nursing faculty members for a 60% raw response rate. Responses from 16 participants were eliminated due to major blanks left in the survey. The number of useable surveys totaled 246, for a 56% response rate. The demographic and professional description of the respondents is presented in Tables 8, 9, and 10. Respondents ranged in age from 28 to 72 with a mean age of 50.6 ($SD = 9.22$). Clinical experience varied from 1 to 41 years, with a mean of 16.5 ($SD = 8.87$). The majority of respondents were white (85%), followed by 12% of African-American respondents. Two thirds of the respondents reported earning a master's degree in nursing, while another 12% hold a PhD in nursing.

Table 8

Demographic Characteristics of the Respondents

Characteristic	<i>n</i>	<i>%</i>
Ethnicity		
African-American	28	11.9
White	200	85.1
Hispanic	3	1.3
Asian	4	1.7
Highest level of education		
BSN	8	3.3
MSN	167	66.9
PhD (nursing)	30	12.2
PhD (other)	13	5.3
DNP	14	5.7
DScN (DSC)	4	1.6
EDD	10	4.1

More than half of the respondents are in adult health (56%). Between 15% and 20% of the respondents reported pediatrics (19%), maternal-child (18%), critical care (16%), and mental health (15%). More than half of them teach in nursing programs that offer a bachelor's in nursing (60%) and/or a master's in nursing (52%). The great majority of participants held a Masters of Science in nursing (66.9%). The largest specialty area was adult-health nursing.

Table 9

Professional Characteristics of the Respondents

Characteristic	<i>n</i>	%
Degrees offered by nursing program of employment		
ASN	50	20.3
ADN	61	24.8
BSN	147	59.8
MSN	129	52.4
DNP	29	11.8
PhD	34	13.8
DScN	3	1.2
Area of Specialty		
Adult health	124	55.9
Pediatrics	42	18.9
Geriatrics	28	12.6
Maternal-child	39	17.6
Critical care	35	15.8
Women's health	30	13.5
Oncology	9	4.1
Rehabilitation	6	2.7
Mental health	34	15.3

Eighty-five percent of the respondents reported that they do not feel they are adequately compensated for work as a nursing faculty member. Currently, more than half of the nursing faculty members also work as a nurse (59%) in the clinical area. At some time in their career, 80% of the nursing faculty members have worked as a nurse while a member of a nursing faculty. Sixty-one percent indicated that they have taken classes to prepare them to become a nursing faculty member.

The survey responses were dominated by nursing faculty at non-research institutions. The faculty at research institutions would have a different set of factors affecting their careers as well as a different set of role stressors.

Table 10

Professional Experience of Respondents

Characteristic	<i>n</i>	%
Adequately compensated for work as nursing faculty member?		
Yes	37	15.0
No	209	85.0
Working as a nurse and nursing faculty member?		
Yes	100	40.8
No	145	59.2
Ever worked as nurse while employed as a member of a nursing faculty?		
Yes	196	79.7
No	50	20.3
Taken classes to prepare to become a nursing faculty member?		
Yes	150	61.0
No	96	39.0

Variables of Interest in the Study

The data were entered into SPSS and individual scale scores were computed for each respondent. Frequency distributions of the variables of interest were examined. Skewness and kurtosis were within acceptable ranges. Therefore, the distributions of the scales were deemed normal (See Appendix E). Cronbach's alpha was calculated to evaluate reliability. Reliability coefficients were high for four of the five scales. Table 11 contains the means, standard deviations of each scale or variable and the reliability of the five scales.

Table 11

Distributions and Reliabilities of Key Measures

Scale	# of items	<i>M</i>	<i>SD</i>	Cronbach's <i>alpha</i>
Role strain*	16	2.44	.38	.81
Role ambiguity*	8	2.54	.46	.80
Self-assessed instructional competency*	7	2.95	.46	.78
Interpersonal support*	5	3.08	.47	.79
Role transition*	3	2.99	.45	.56
Intent to stay (1 = <i>not likely</i> , 4 = <i>very likely</i>)	1	3.40	.84	

* Response scale ranged from 1 (*strongly agree*) to 4 (*strongly disagree*)

Items in the self-assessed instructional competence scale, the role ambiguity scale, and the interpersonal support scale were measured on a 4-point Likert-style scale. Tables 12 to 14 present the means and standard deviations of the items ranked from most agreement (1 = *strongly agree*) to least agreement (4 = *strongly disagree*). On the self-assessed instructional competence scale (See Table 12), the item means ranged from 2.53 to 3.28. The higher ranked

(more disagreement) items included receiving assignments that are outside their educational capabilities, and feeling that they are not fully qualified to be a nursing faculty member. The lowest ranked *(more agreement)* items dealt with teaching strategies and feeling that their teaching ability may affect students' performance.

Table 12

Rank Order of Items Related to Self-Assessed Instructional Competence Scale

Item	<i>M</i> *	<i>SD</i>
I find it difficult to write exam questions.	2.53	.79
I worry about my teaching ability affecting students' performance.	2.72	.72
Previous education and clinical experience were (not) adequate to prepare me for the nurse faculty role.	2.89	.74
I do not know if I will be able to answer the students' questions in class and in clinical.	2.96	.64
I (do not) feel confident enough about the nursing program requirements to advise students in future course selection.	3.07	.78
I receive assignments that are (outside) my educational capabilities.	3.18	.55
I am (not) fully qualified to handle the work of a nursing faculty member.	3.28	.63

* Response scale ranged from 1 (*strongly agree*) to 4 (*strongly disagree*)

On the role ambiguity scale (See Table 13), the item means ranged from 2.00 to 2.92. All of these items were ranked lower than 3. The low ranking (*agreement*) indicated high role ambiguity. Faculty members indicated that they are bothered that all faculty do not adhere to policies and that they feel they are *feeling their way* while performing their duties.

Items on the interpersonal support scale are higher ranked than on the role ambiguity scale (See Table 14). The item means ranged from 2.84 to 3.32. Faculty, on average, indicated that they receive support from administrators, friends, colleagues, and family.

Table 13

Rank Order of Items Related to Role Ambiguity Scale

Item	<i>M*</i>	<i>SD</i>
It bothers me that all faculty do not adhere to policies.	2.00	.75
Sometimes I have to feel my way in performing my duties.	2.11	.66
I am unsure about how much authority I have as a nursing instructor.	2.48	.74
I (do not) receive clear explanations of what has to be done.	2.60	.67
There is a lack of policies and guidelines to help me in my faculty position.	2.64	.77
I (do not) know exactly what is expected of me.	2.74	.65
I (do not) understand how I will be evaluated for a raise or promotion.	2.83	.73
I (do not) receive feedback on how well I am doing my job.	2.92	.70

* Response scale ranged from 1 (*strongly agree*) to 4 (*strongly disagree*)

Table 14

Rank Order of Items in Interpersonal Support Scale

Item	<i>M*</i>	<i>SD</i>
Administrators (do not) provide me with the support I need to do this job.	2.84	.79
I (do not) receive support for my work role change from other nurses that I know.	2.97	.60
I (do not) receive support from my friends for my work role change.	3.11	.57
I (do not) receive support from my colleagues at the college/university.	3.15	.74
Family is (not) supportive of my work role change	3.32	.56

* Response scale ranged from 1 (*strongly agree*) to 4 (*strongly disagree*)

The final analysis in data preparation was to determine the intercorrelations among the four variables of interest (See Table 15). Due to the large sample size, all the correlations were statistically significant. Role ambiguity was correlated positively and moderately with interpersonal support, indicating that as the role ambiguity scale score increased, so did the scale scores of interpersonal support. An increase in the scale score of role ambiguity indicates less

ambiguity; as does an increased score in role transition indicate more satisfaction in their transition to faculty roles. An increased interpersonal support indicates more satisfaction with support from family, friends, and colleagues.

Table 15

Intercorrelations Among Predictor Variables

Scale	Interpersonal support	Self-assessed instructional competency	Role Ambiguity
Role ambiguity	.60*	.34*	--
Interpersonal support	--	.32*	.60*
Self-assessed instructional competency		--	.34*

* $p < .01$

Findings Related to Research Question 1

To what extent did the nurse educators experience specific aspects of role strain when transitioning to their faculty roles?

The 16 role strain items were measured on a 4-point Likert-style scale. Table 16 presents the means and standard deviations of the items ranked from most agreement (1 = *strongly agree*) to least agreement (4 = *strongly disagree*). The item means ranged from 1.68 (*agree to strongly agree*) to 2.85 (*disagree*). The higher ranked (*more disagreement*) items dealt with teaching and time management. The lowest ranked (*more agreement*) items dealt with feeling exhausted at the end of the day and feeling that the work is never finished. Based on their average responses, the faculty agreed that they find the work unending and exhausting and that they perform job functions they think should be done differently. However, they did not agree that other people expect them to teach in certain ways that are not right for them and that they do not know how to divide their time properly between tasks.

Table 16

Rank Order of Items Related to Role Strain Experienced by Nursing Faculty

Item	M*	SD
I feel that the work is never finished.	1.68	.73
At the end of the workday, I am exhausted.	2.07	.76
I perform job functions that I think should be done differently.	2.23	.67
I was unaware of the multiple expectations of the faculty role.	2.28	.85
I am sometimes confused by conflicting departmental policies.	2.33	.73
I work on things unrelated to my role.	2.33	.72
I sometimes feel caught between students and administration.	2.38	.78
I (do not) have enough time to complete my work.	2.45	.75
My workload is (not) reasonable.	2.47	.73
I am overwhelmed because of being involved in other courses in addition to my primary course.	2.48	.75
I have difficulty handling negative reactions of students.	2.54	.66
I am uncomfortable with the pressure to perform scholarly work.	2.63	.77
Students do not appreciate my efforts on their behalf.	2.65	.86
I (do not) feel certain that I have divided my time properly between the tasks at hand.	2.79	.59
I was uneasy about making the role transition from clinician/nurse to nursing faculty.	2.80	.80
Other people expect me to teach in certain ways that are not right for me or I don't agree.	2.85	.72

* Scale ranges from 1 (*strongly agree*) to 4 (*strongly disagree*).

Findings Related to Research Question 2

To what extent do role ambiguity, interpersonal support, self assessed instructional competency and personal characteristics *separately* explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?

Simple regression analyses were performed to determine the bivariate relationship between the independent (predictor) variables and the extent to which nurse educators

experienced role strain. Table 17 contains the correlation of each predictor with role strain (r), the variance of role strain explained by the predictor (r^2), the tests (t and F) used to determine the significance of the each predictor (p). Role ambiguity, interpersonal support, and self-assessed instructional competency separately predicted role strain and explained a statistically significant proportion of variance in role strain scores. Personal characteristics such as age, years of clinical experience and highest level of education were poor predictors of role strain and they did not explain any significant proportion of the variance in role strain scores.

Table 17

Bivariate Relationships Between Predictor Variables and Role Strain

Predictor	r	r^2	p
Role ambiguity	.66	.44	<.01
Interpersonal support	.59	.34	<.01
Self-assessed instructional competency	.37	.14	<.01
Age	<.01	<.01	.97
Years of clinical experience	.06	<.01	.34
Education	.07	<.01	.31

Findings Related to Research Question 3

To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics jointly explain observed variance in role strain experienced by clinical nurses transitioning to faculty roles?

Multiple regression analysis was performed to determine the multivariate relationship between the independent (predictor) variables and the extent to which nurse educators experienced role strain. A significant equation was created ($F = 61.80, p <.01$). Table 18 presents the results. Four variables explained 52% of the variance of role strain. Role ambiguity provided

the largest proportion (44%), followed by interpersonal support (6%), self-assessed instructional competency (1%), and age (1%). The regression equation can be written as

$$\text{Predicted role strain} = .63 + .39 (\text{role ambiguity}) + .22 (\text{interpersonal support}) \\ + .12 (\text{self-assessed instructional competence}) - .004 (\text{age})$$

Table 18

Significant Variables in the Prediction of Role Strain

	<i>b</i>	β	<i>t</i>	<i>p</i>	<i>R</i> ²
Constant	.63		3.85	<.01	
Role ambiguity	.39	.47	8.18	<.01	.44
Interpersonal support	.22	.26	4.54	<.01	.06
Self-assessed instructional competence	.12	.14	2.75	<.01	.01
Age	-.004	-.09	-2.02	.04	.01
				<i>R</i> ²	.53
				Adj. <i>R</i> ²	.52

Findings Related to Research Question 4 and Research Question 5

To what extent does level of role strain predict satisfaction with transition?

To what extent does level of role strain predict likelihood of continuing in a faculty position?

Simple regression analyses were performed to determine the relationship between the independent variable role strain and two dependent variables—satisfaction with transition and the likelihood of continuing in a faculty position (intent to stay). Table 19 contains the correlation of role strain with each dependent variable (*r*), the variance of each dependent variable explained by role strain (*r*²), the tests (*t* and *F*) used to determine the significance of role strain as a predictor (*p*). Role strain was a significant predictor of each of the dependent variables. Role

strain explained a statistically significant proportion of variance in both role transition and intent to stay.

Table 19

How Role Strain Predicts Role Transition and Intent to Stay

Dependent variable	<i>r</i>	<i>r</i> ²	<i>p</i>	<i>t</i>	<i>F</i>
Role transition	.59	.34	<.01	11.25	126.63
Intent to stay in a faculty position	.33	.11	<.01	5.49	30.12

Findings Related to Research Question 6

How do nurse educators rate the value of selected faculty development topics in assisting nurses transitioning to faculty position?

Table 20 contains the faculty development topics in rank order, from least important to most important. The mean scale ranking and standard deviation for each item are also presented. The two least important topics were writing for publication and conducting nursing research, while the most important items pertained to teaching and students (motivating students, preparing interaction lectures, evaluating students, enhancing student engagement, and developing critical thinking skills in students).

The overwhelming majority of respondents were faculty members who have teaching as a major focus of work. Nursing faculty who conduct research as their primary job focus would most likely have different rankings. The faculty members were focused on improving student learning and improving teaching which are skills that even experienced nurses would not have developed in direct patient care settings. However, the results clearly indicate the value placed on faculty development and continuing education programs. These programs should be geared toward the needs of all faculty members at all levels of nursing education.

Table 20

Rank Order of Items Related to Faculty Development Topics

Item	M*	SD
Writing for publication	2.96	1.18
Conducting nursing research	3.02	1.11
Understanding the accreditation process	3.57	.99
Curriculum writing	3.64	.95
Nursing faculty evaluation	3.76	.91
Preparation for promotion and tenure	3.76	.97
Developing presentations	3.89	.98
Guidelines for student advisement	3.92	.96
Developing course and unit objectives	3.97	.90
Balancing workload	3.99	.92
Maintaining clinical skills	4.07	.86
Time management	4.19	.90
Clinical instruction techniques	4.20	.86
Handling difficult students	4.22	.77
Test writing	4.26	.80
Motivating students	4.29	.79
Preparing a lecture and making it interactive	4.32	.71
Evaluating students in the classroom and in the clinical area	4.34	.76
Using evidence-based practice in the classroom	4.34	.74
Enhancing student engagement	4.35	.71
Teaching strategies	4.36	.73
Developing critical thinking skills in students	4.61	.63

* Scale ranges from 1 (*not important*) to 5 (*extremely important*).

Summary

This chapter presented the findings related to the six research questions associated with this study plus ancillary findings. In summary, the major findings of the research indicates that role strain does exist among nursing faculty with higher agreement scores that feelings of exhaustion, feelings of work being unending, and performing job functions they think should be done differently are major sources of strain. Additionally, role ambiguity is a significant predictor of role strain.

Personal characteristics such as age, education, and years of clinical experience are poor predictors of role strain. Whereas, self-assessed instructional competence is a significant predictor of role strain and role strain is a significant predictor of satisfaction with the role transition and intent to stay.

Nursing faculty agree that faculty development is important to the success of all nursing faculty. Programs they rated as least important were writing for publication and nursing research. Programs they rated as most important were developing critical thinking skills in students and learning teaching strategies. Over half of the respondents had taken classes to prepare themselves for the nurse educator role.

When compensation for the nursing faculty role is questioned, there in an overwhelming majority of nursing faculty who believe that they are grossly underpaid and they either are working or have worked a second job while employed as a nurse faculty member.

CHAPTER V

INTERPRETATION OF FINDINGS

The purpose of this study was to determine the effects of age, gender, education level, and previous experience on the extent of role strain experienced by nursing faculty, and to determine the extent to which role strain predicts perceived satisfaction with the role transition, and intent to stay in academia. A secondary purpose was to determine nursing faculty members' perceived need for professional development. The purpose of this chapter is to interpret the findings of the study. This chapter is divided into four major sections: (a) overview of the study, (b) discussion of findings, (c) implications for practice, and (d) recommendations for future research. The following research questions guided the analysis of the data collected for the study.

1. To what extent did nurse educators experience specific aspects of role strain when transitioning to their faculty roles?
2. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *separately* explain observed variance in role strain experienced by nurse educators transitioning to faculty roles?
3. To what extent do role ambiguity, interpersonal support, self-assessed instructional competency, and personal characteristics *jointly* explain observed variance in role strain experienced by nurse educators transitioning to faculty roles?
4. To what extent does the level of role strain predict satisfaction with transition?
5. To what extent does the level of role strain predict likelihood of continuing in a faculty position?

6. How do nurse educators rate the value of selected faculty development topics in assisting nurses transitioning to a faculty position?

A researcher-designed instrument was developed for implementation as an online survey instrument. The survey was designed to measure the effect of four predictor variables (role ambiguity, self-assessed instructional competence, interpersonal support, and personal characteristics) on role strain and the effect of role strain on intent to stay in nursing academia and satisfaction with role transition. A group of 31 state colleges and universities with nursing programs comprised the study sample. Participants for this study were either nursing faculty from 2-year associate degree nursing programs or 4-year baccalaureate or higher degree nursing programs. The public colleges and universities were selected because they have the same mission and standard guidelines for all nursing faculties. More than 400 nursing faculty ($n = 437$) received invitation letters and a survey link. Responses were received from 262, for a 60% response rate. Of these results, 16 surveys were incomplete and not usable leaving a total number of completed surveys at 246 for a 56% response rate.

Discussion of Findings

The purpose of this study was to determine how nurses transition from clinical practice roles to faculty roles, and to identify factors that contribute to recruitment and successful retention and intent to stay for faculty once they move into higher education. This study examined the extent to which various factors affect role strain in nursing faculty. Additionally, when role strain is present, what effect does it have on the success of nursing faculty transitioning to the role of academician and remaining in academia.

There is a critical shortage of nursing faculty in the United States that has had a domino effect on the profession, resulting in a severe shortage of nurses. According to Barlag (2008), the

role of a nursing faculty member was historically viewed as less physically demanding and it offered other benefits such as holidays, no weekends, summers off, and better hours when compared to clinical practice. However, with the expansion of nursing education programs, schools are competing for the same clinical space and other resources, leading to weekend, night, and year-round options. The loss of these benefits has eliminated what was viewed as positives for choosing higher education as a career choice over clinical practice.

With this realization and the current vacancies in nursing faculty positions, this study attempted to determine what factors contribute to satisfaction and dissatisfaction and what variables predict satisfaction with transition to education with intent to stay. The participants responded to 16 items to determine if role strain was indeed a perceived feeling of nursing faculty members. The items agreed upon most dealt with feelings of exhaustion, the work never finished, job functions unrelated to the job, and lack of awareness of the multiple role expectations. It is important to note that only 6 of the 16 items were above the theoretical midpoint of the scale (2.5) while the other 10 items remained high in terms of agreement. A clear ranking of items emerged, demonstrating the existence of role strain. Analysis of the rank order means indicated that nursing faculty members felt that the job is never completed and they were not prepared for the expectations of the role. Other highly ranked items related to workload, conflicting departmental policies, and feeling caught between students and administration. Responses to open-ended questions also included comments related to workload, workload measurement, inequity in workloads, lack of graduate level classes to prepare them for the educator role, and inadequate time to prepare lectures, and exams.

Nurses with 15 to 25 years of clinical experience describe workload management, and expectations of the role as being very different from the clinical setting. Knowledge in the

clinical realm does not necessarily provide the nurse educator with the confidence to autonomously carry out the many facets of the educator role.

Strikingly enough, areas in which faculty members most highly disagreed were feeling pressure to perform scholarly work, that students do not appreciate their efforts, and that they were uneasy about making the transition from clinical practice to academia. This is contrary to the literature that emphasizes that nursing faculty feels pressure to publish in order to obtain tenure. As a whole, the respondents reported that they felt the transition was a positive move and once in the role, they were appreciated by students. They also disagreed with the statements that addressed their improper division of their time between tasks, and the statement that they are expected to teach in certain ways. Therefore, workload was not due to mismanagement of time on their part.

Regarding role strain, the literature defines role strain as “the felt difficulty in fulfilling role obligations which results in tension and occupational stress” (Goode, 1960, p. 483). Role strain has been described in terms of the stress associated with positions or expected roles. Strain, therefore, is defined as any factor that serves as a source of potential difficulty for the individual in a certain role. As the demands of the job and the complexity of the roles increase, role strain intensifies (Biddle, 1986).

Chang et al. (2005) asserted the fact that the first year is a most important time of transition and it is oftentimes the period when the expert functions as a novice. Competent individuals often begin to feel incompetent when a new role has been assumed, leading to feelings of role strain. Additionally, Sargent and Schlossberg (1988) expounded on the ways adults cope with role change. They believed that adult behavior is determined by transitions in

life and that the more the event alters the individual's roles, routines, assumptions, and relationships, the more the person will be affected by the transition.

Role strain is clearly a factor present as nurses transition to the role of nursing faculty and it tends to remain with individuals if they remain in the job. This is especially true if there is incompatibility with personal values and the role dictates a change in personal behavior. The presence of role strain in the faculty role results in nursing faculty members experiencing more difficulty transitioning or settling into the role of educator. If the level of role strain is not addressed and attempts are not made to reduce it, stress levels increase, feelings of incompetence increase, and the faculty member experiences difficulty in meeting obligations of the job.

When the variables role ambiguity, interpersonal support, and self-assessed instructional competence were measured, each one significantly predicted role strain. Role ambiguity explained 44% of the variance of role strain. Greater levels of role ambiguity alone resulted in greater levels of role strain experienced by nursing faculty. Rizzo et al. (1970) described role ambiguity in terms of lack of information for a given role. The outcome of not providing this needed information results in the employee seeking ways to cope with the situation either positively or negatively in such ways as avoidance or distortion of reality. This often leads to dissatisfaction with the role, anxiety, or decreased performance levels.

Self-assessed instructional competence explained 14% of the variance of role strain and interpersonal support explained 1% of the variance of role strain. Smith (2007) discussed the importance of self-awareness as it relates to job performance. Being aware of self assists the individual to identify strengths and weaknesses as well as areas for development, but it can also lead to role strain. An expert clinician who moves into the role of educator becomes a novice and experiences a work role transition (Chang, Pei-Fan, & Tsay, 2006). This work role change often

results in a decline in competence and results in a high level of anxiety. The role holders' beliefs about their role influence their behavior.

It is during the time as self-assessment that the nurse faculty member needs support from colleagues as college administrators. A perceived lack of support from those individuals who are likely to help the individuals get through the transition coupled with feelings of incompetence increase the level of role strain experienced. The role strain further increases if individuals feel that their capabilities cannot match the responsibilities of the job.

As separate predictors, personal characteristics of age, years of clinical experience, and level of education were poor predictors of role strain, and they did not explain any significant proportion of the variance in role strain scores. However, it is not surprising that personal characteristics were poor predictors given the homogeneity of the sample in terms of race, educational level, years in practice, and age. The participants were 80% Caucasian, 67% held the Masters of Science in nursing and the mean age was 50.6 with a median of 51.5 and a mode of 56.5. More than 50% of the sample was 51 to 72 years of age. Hamric and Taylor (1989) found that those with fewer than 3 years of work experience an orientation phase followed by a frustration phase. The level of frustration did not seem as high in this sample because the majority of the group had moved beyond the 3-year mark into the third phase described by Hamric and Taylor. This is the implementation phase, which involves role modification after interaction with other people. The vast majority of the group, while still experiencing role strain, appeared to have adjusted their role over the years.

Four independent variables were significant predictors of role strain. Jointly they explained more than half (53%) of the variance in role strain. The largest proportion of variance was explained by role ambiguity (44%), followed by interpersonal support (6%), self-assessed

instructional competency (1%), and age (1%). Unclear expectations, lack of support, and feelings of incompetence increase the amount of role strain present in the nursing faculty role. Glen and Waddington (1998) asserted that role ambiguity is caused by a lack of clarity of expectations. Oftentimes, individuals' perceptions of their jobs differ from other members—in this case other faculty members and members of the administration. When certain personal aspects are not reinforced or there appears to be a lack of support and resultant feelings of incompetence, the result is increased stress as the individuals seek to find and define themselves in the organizational context.

Lechuga (2008) describes colleges and universities as complex institutions of which faculty are a part. Faculty work roles and responsibilities are shaped by the culture which is influenced by faculty behavior within the institution. Four subcultures were identified within the academy. They include the culture of: the academic profession, the discipline, the academy as an organization, and the institutional types. Faculty who traverse the educational path and enter academia immediately upon graduation from a doctoral program have a different type of socialization and cultural orientation than the nursing faculty member whose education track exposes them to the culture of healthcare institutions and the culture of the profession of nursing. This makes the academy even more ambiguous and more difficult to transition for the nurse entering the nurse educator role.

Schriner (2007) found that cultural dissonance created conflict in new faculty as they transition from clinical practice to academe. Schriner also found that this can be improved with formal education. However, 61% of nursing faculty in this study had educational preparation for the role. These participants still identified role strain as being prevalent in role transition. Role strain predicted 34% of the variance of role transition. Transition is ongoing with nursing faculty

because nursing faculties find this role to be very different from their previous positions and many role expectations are unclear. Dempsey (2007) explained how nursing faculty often feel disruption and negative feelings as they strive to transition into the role of academician. Time management and heavy workloads increase stress, which in turn increase role strain levels. These ongoing factors often have an adverse effect upon transition.

Dempsey (2007) also found that nursing faculty expressed far more negative aspects of the faculty role than positive aspects. Feelings experienced by nursing faculty included difficulty coping, anxiety, heavy workloads, and role ambiguity. Garbee and Killackey (2008) attempted to discover a set of predictor variables that best predicted intent to stay for nursing faculty. The goal of the study was to explain more of the variance in intent to stay. The results revealed organizational commitment as the only significant predictor variable explaining 20% of variance in scores for intent to stay 1 year and 21% of the variance scores for intent to stay 5 years. These findings are very similar to the results of this study in which role strain explained 11% of the variance of intent to stay.

While the issues of role strain, adapting to a new role, and transition issues exist, when questioned on intent to stay in nursing academia, 60% answered that they were very likely to remain in academia for the duration of their careers and 23% stated they were quite likely to stay in academia. Intent to stay is inadequately understood in the research and the literature. Nursing faculty tend to stay regardless of role strain. Intent to stay in this study can very likely be attributed to the age of most of the participants or it can be explained by Dempsey's (2007) finding of strong commitment to the organization, which is characteristic of this age group. Many of the participants in this study have taught for a number of years or had been in clinical practice for an average of 16 years, moving them closer to retirement age. If this group of faculty

members is indeed staying until retirement, this poses a threat of “leaving nursing programs without faculty to educate the next generation of nurses” (Falk, 2007, p. 165) once they exit. Garbee and Killacky (2008) found faculty intentions to leave to be most uncertain during the first and third years. In light of this finding, nursing faculty and higher education administrators need to not only recruit new faculty into the pipeline to replace retiring faculty but also strive to develop an implementation plan to retain nursing faculty members. Institutions must be prepared to support the recruits in their new role as well as the current faculty.

Nevertheless, other factors affect intent to stay in academia. One of the ancillary findings was discovery of the major role that compensation plays relative to intent to stay. When asked if they were adequately compensated, 84% of participants felt that they were not adequately compensated for the work done in academia. When asked if they were currently working a second job, 40% responded *yes*. When asked if they had ever worked a second job while employed as a faculty member, 79% responded *yes*. Themes commonly found in the responses to open-ended questions included low pay and poor compensation as major reasons for leaving academia. Those who felt that they were adequately compensated attributed it to merit and cost of living raises that had accompanied longevity in the position. Morris and Nabors (2007) found that salaries for clinical practice nurses with degrees comparable to the majority of the participants revealed an average of \$20,000 more in compensation.

Other perceived needs of nursing faculty included professional development. Faculty development and mentoring have been explored in relation to retention of nursing faculty. Schriener (2007) found those nursing faculties often feel incompetent and ill prepared for the role. In an effort to determine what faculty development programs nurses view as beneficial, a list was provided of faculty development programs that had been cited in the literature as areas of

importance to nursing faculty who are transitioning or have transitioned to the faculty role. The faculty were asked to rate the programs according to importance. The faculty development program rated highest as being extremely important was developing critical thinking skills in students. It was followed by teaching strategies and teaching techniques such as motivating students, preparing interactive lectures, evaluating students, and enhancing student engagement. All of the items highly ranked focused on teaching and student outcomes. The faculty development programs ranked lowest were writing for publication and conducting nursing research. Other lower ranking topics included understanding the accreditation process and curriculum writing.

Findings support the conclusion that nursing faculty members need development programs at the outset of their academic careers beginning with well-planned orientation programs. Faculty development should continue through the socialization process and throughout their academic careers to enhance teaching skills and professional knowledge (Reilly, 1986). These programs must expand to include instructional development, personal development, and organizational development. Wheeler and Schuster (1990) introduced the concept of enhanced faculty development that includes programs that emphasize recognition of opportunities within one's career, development of new career objectives, and integration of strategies that will intertwine professional and personal development. Harrison et al. (2005) described professional learning and development as both a responsibility and an entitlement of all teachers.

Shirey (2006) noted the multiple stressors that nursing faculties face in their work role. Burnout is the term used to describe the results of chronic exposure to job stressors such as high job expectations, heavy workloads, and pressure to maintain clinical competence. Strategies to

prevent burnout include educational approaches to align faculty members with the goals of the organization and to engage them in activities that support their role, such as time management skills and managing workload. These types of opportunities can be included in professional development programs. An added benefit of faculty development programs discovered by Boice (1991) was the fact that teachers who participated in faculty development programs found immediate comfort and success at teaching.

Implications for Practice

The findings of this study have practical implications for academic governing boards such as the University System of Georgia Board of Regents, academic administrators, nursing deans and directors, and inservice coordinators at colleges and universities. The findings also have implications for seasoned nursing faculties who were the majority of respondents in this study. These faculty members have successfully transitioned to the role of nursing faculty and are preparing for retirement. They can assist in recruitment and retention of novice nursing faculty members by helping to reduce the role strain they have identified in the nursing faculty role. These findings have practical implications for budget and finance officers in relation to compensation of nursing faculty, as well as implications for the individuals responsible for hiring and orienting new faculty.

There are a number of significant findings in this study. The findings suggest that role strain is present in nursing faculty to a significant degree. The greater the role strain, the more difficulty the faculty member encounters in transitioning from clinical practice to academia and in establishing and maintaining competence in the role. Factors that significantly affect role strain include role ambiguity, interpersonal support, self-assessed instructional competency of

the faculty member, and specific factors such as workload, exhaustion, feeling overwhelmed, and multiple faculty expectations.

Role ambiguity significantly increases role strain. However, it can be decreased by providing clear guidelines, expectations, and policies that are adhered to by all faculty members. Faculty guidelines should also include an introduction to the multiple expectations of faculty with an explanation of the new and different expectations of academia. New faculty must be given information about the program, the curriculum and the accreditation requirements and standards.

Education of new faculty should begin upon hiring and should continue throughout the tenure of the faculty members. Each year the faculty member should feel more acclimated to the job role and expectations and the world of academia. Administrators and those who mentor faculty must have a clear understanding that this role is very different from the world of clinical practice; thus providing the support nursing faculty need as they continue to make this transition. Nursing faculty need clear explanations of what needs to be done and how they will be evaluated in these areas. Schriener (2007) also emphasized the need to develop a reward structure for nursing faculty based on values inherent in the nursing profession such as clinical expertise and the ability to share this knowledge effectively to improve student outcomes.

Interpersonal support is a key to success in decreasing role strain and thus increasing satisfaction with transitioning to the role and in maintaining nursing faculty in these roles. Faculty members need support from administration, coworkers, and personal support persons, such as family and friends in order to adapt to their environment and the numerous roles in which nursing faculty members are engaged. This type of support must be available throughout the tenure of faculty members. Support includes adequate resources to perform the job and

funding to stay abreast of new changes occurring in the practice of nursing. With the percentage of nurses and nursing faculty being comprised of over 90% female, another significant factor in the literature is the struggle of balancing home with work for women. Flexible schedules, administrative support, and support from family, friends, and other nurses are essential elements for both recruitment and retention of nursing educators. These faculty members also need financial support and workload adjustments in order to continue their education.

Another contributing factor to role strain includes workload. Faculty members find the workload determination to be ambiguous and different in every college of nursing. Nursing faculty expressed feelings of overload, unfair workloads, and workloads that do not accurately reveal the actual number of hours spent in preparation for class, grading both classroom and clinical assignments, and time spent with students outside of class. If the colleges of nursing could identify a standardized method for both assigning workload and capturing all the hours nursing faculty actually spend working, this would help nursing administrators balance the workload; therefore alleviating feelings of being “overworked, not having enough hours in the day,” and “feeling exhausted at the end of the day.” The outcome would be a decrease in the perceived role strain felt by nursing faculties.

Although personal characteristics such as age and level of education achieved were not significant predictors for role strain alone, a combination of these factors—personal characteristics, role ambiguity, self-assessed competence, and interpersonal support—increases the correlation between the variables and role strain. Therefore, the smaller the number of variables that increase role strain, the lower the strain and stress experienced.

If faculty members feel competent to do the job and they feel supported in their position, they experience less role strain. Therefore, in an effort to recruit and retain nursing faculty and

assist them in achieving a positive role transition, administration needs to look at reducing role strain .and increasing feelings of competence and support for the role. The discomfort associated with the transition could be alleviated or at least minimized by formal support structures, adequate preparation for the role, clear information about the demands and expectations of the job, and adequate educational preparation.

A part of feeling competent and supported comes with the provision of a strong mentoring program and a robust faculty education program for nursing faculty. The overwhelming majority of participants answered *yes* to the question of whether or not they felt that a mentor would be helpful for nursing faculty. Several respondents stated a need for “trained mentors.”

There were also high rankings for faculty development programs to improve teaching techniques and provide assistance with the student evaluation process. These are oftentimes skills that must be acquired and improved upon through experiential learning as well as formal education programs which connect practice and education. Programs to help develop online teaching strategies and to provide support groups for networking and the exchange of ideas were rated highest. This information sets the foundation for a faculty development model. A formal faculty development program for the University System in the form of a nursing faculty teaching institute can be proposed. Funding can be sought to sponsor annual 2-week institutes that include many of the topics included in the questionnaire. This would be open to all nursing faculty across the state and it would be designed to meet the needs of any nursing faculty–novice or seasoned. It would provide a time for networking and an exchange of ideas and best practices. The institute could be developed as a multidisciplinary program that would include nursing faculty as well as other health care disciplines. There could be a sharing of resources, knowledge, and expertise.

Faculty development and early socialization are factors which increase self-confidence, allow faculty an opportunity for personal growth and development and thus decrease the amount of role strain perceived.

Garbee and Killacky (2008) found that faculty who work 40 hours a week score much higher in intent to stay than faculty working 60 hours a week. Shirey (2006) found that nurses leave academia because of the stresses and high expectations associated with an academic career. Overwhelming workload and unfamiliarity with the university and college culture were identified as major stressors. Faculty development programs would provide a conduit for sharing time management strategies, workload management, and teaching strategies and at the same time serve as support groups.

Nursing faculty ranked scholarly activities lowest of all professional development topics. This could be related to feelings describing the work as never being done or the heavy workload. However, nursing research, writing for publication, and faculty evaluation are essential elements of the promotion and tenure process, another professional develop activity ranked low. This brings into question the nursing faculty members' reasons for the ratings. Are they able to perform these roles at a satisfactory level or is this an area for further development? Do members of the nursing faculty understand that although teaching strategies and getting through the day are important, a large part of being a successful academician includes learning the culture of the institution and the business of being a part of the academic environment?

The mean age of the faculty in this study was 51. Therefore, this group has 10 to 15 more working years. This presents another challenge of retaining and using aging nursing faculty effectively (Falk, 2007). In support of aging nursing faculty, nursing administrators should include strategic planning for construction of desirable work environments that meet the needs of

this age group. Workplace flexibility options and revised policies for retirement are possible considerations.

Recommendations for Further Research

This quantitative study provides the basics for understanding the nursing faculty role. It is a foundational piece of a larger puzzle concerning recruitment, retention, and transition of nursing faculty. Further research is definitely mandated through continued investigation of the findings of this study or by approaching the research from a different perspective. There are a number of avenues for future research.

1. Generalization of the findings of this study might be limited because of the sample population selected, which only included nursing faculty from one state. One suggestion for future research is to repeat the study with a national random sample of nursing faculty.

2. Another suggestion for future research relates to the participants. This study could be replicated to address younger faculty with less clinical and teaching experience. Personal and educational demographic information did not significantly affect role strain in this study because the majority of participants fell in the same age group, same race, and same educational level. A younger, more diverse group might provide different results.

3. Qualitative research might also be used to gain further insight into the reasons faculty members feel they experience role strain and difficulty transitioning to the role of nursing. Qualitative research conducted on more seasoned faculties might add to the body of knowledge relating to retention, methods for improving the attractiveness of the nursing faculty role, and insights into increasing longevity among this group of professionals.

4. Further research is warranted to examine nursing salaries and ways to improve compensation for nursing faculty that is competitive with clinical practice. Further research is

also needed to examine the outcomes of faculty development on the amount of role strain experienced by nursing faculty members.

5. The instrument should be administered to particular sectors such as faculty across major research universities. This would likely yield different responses especially in the faculty development rankings. Research and publication were two low ranking faculty development topics that would probably assume a higher priority and greater importance.

6. Ninety-eight percent of nursing faculty viewed a formal mentoring process as positive toward successful nurse faculty transition. Research into the types of mentoring programs currently being utilized including criteria for becoming a mentor and the success of these programs could be explored.

Summary

Healthcare reform in the United States cannot occur without reversing the current nursing shortage. This shortage is expected to worsen as baby boomers continue to age and require more care for chronic illnesses. The shortage of nurses is driven by a shortage of nursing faculty to expand programs and provide education for 50,000 or more qualified applicants who are turned away from nursing program each year. Supply has not kept up with demand for nurses and nursing faculty. Nursing faculty tends to enter academia late in their careers and they retire at a relatively young age—62 years of age on average. The average age of the clinical practice nurse is 45 years of age and the average age of a nursing faculty member is 51 years of age. These nurses will soon retire leaving a pipeline that is sorely lacking in numbers (Bartfay & Howse, 2007).

Nursing academia is very different from nursing clinical practice. To make a career move from practice to academia is a major transition and requires a change in role. If this is not a

smooth transition, it can lead to increased stress and dissatisfaction with the role change.

Gormley (2003) studied various factors affecting job satisfaction in nursing faculty and found that organizational characteristics were poor predictors of satisfaction but role conflict and role ambiguity were strong predictors of satisfaction.

Nursing needs strong highly motivated nursing educators. Therefore, administration and governing boards need to be educated on factors causing role strain in this group such as workload, role ambiguity, lack of interpersonal support, and feelings of incompetence. It is of dire necessity that changes are implemented to make the role of nursing faculty more palatable. This will be a major issue in resolving the nurse shortage and improving the impending labor crisis in healthcare.

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APPENDICES

Appendix A: Pilot Survey

Thank you for your interest in participating in this important study about nursing faculty transition. Your answers to this survey will help researchers understand how nursing faculty think about their role, competence, job satisfaction, and intent to stay in nursing academia.

Your participation is strictly voluntary. Data will be treated as confidential; however, internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, once the materials are received by the researcher, standard confidentiality procedures will be employed.

The survey will take approximately 15 minutes and you may decide not to participate at any point. If you have any questions or experience technical difficulties please contact the researcher by email at j_cranford@gdn.edu or call 678-359-5085(D) or 404-505-8472(E).

Are you willing to participate in this study?

- Yes
- No

Are you currently a nurse educator?

- Yes
- No

To what extent do you agree with each of the following statements?

	Strongly Disagree	Disagree	Agree	Strongly Agree	
	1	2	3	4	
1. I have enough time to complete my work.					1 2 3 4
2. I have adjusted to my role as nursing educator with little difficulty. n					1 2 3 4
3. I am sometimes confused by conflicting departmental policies.					1 2 3 4
4. I perform job functions that I think should be done differently.					1 2 3 4
5. My workload is reasonable.					1 2 3 4
6. I sometimes feel caught between students and administration. n					1 2 3 4
7. At the end of the workday, I am exhausted.					1 2 3 4
8. I feel that the work is never finished. 9. I work on things unrelated to my role.					1 2 3 4
10. I am overwhelmed because of being involved in other courses in addition to my primary course.					1 2 3 4
11. I feel certain that I do a good job of dividing my time properly between the tasks at hand.					1 2 3 4
12. I am unable to view my role change in a more positive light.					1 2 3 4
13. I am uncomfortable with the pressure to perform scholarly work.					1 2 3 4
14. Other people expect me to teach in certain ways that are not right for me or I don't agree.					1 2 3 4
15. I found the transition from clinical practice to academician to be a positive move.					1 2 3 4
16. There is a lack of policies and guidelines to help me in my faculty position.					1 2 3 4
17. I was uneasy about making the role transition from clinician/nurse to nursing educator.					1 2 3 4
18. Students do not appreciate my efforts on their behalf.					1 2 3 4
19. I'm unsure about how much authority I have as a nursing educator.					1 2 3 4
20. It bothers me that all faculty do not adhere to policies.					1 2 3 4
21. Sometimes I have to feel my way in performing my duties.					1 2 3 4
22. I understand how I will be evaluated for a raise or promotion.					1 2 3 4
23. I know exactly what is expected of me.					1 2 3 4
24. I receive feedback on how well I am doing my job.					1 2 3 4
25. I receive clear explanations of what has to be done.					1 2 3 4
26. I am fully qualified to handle the work of a nursing faculty member. N					1 2 3 4
27. I feel confident enough about the nursing program requirements to advise students in future course selections.					1 2 3 4
28. I have difficulty handling negative reactions of students. N					1 2 3 4
29. I do not know if I will be able to answer the student's questions in class and/or clinical.					1 2 3 4
30. I find it difficult to write exam questions.					1 2 3 4
31. I worry about my teaching ability affecting students' performance.					1 2 3 4
32. I receive assignments that are within my educational capabilities.					1 2 3 4
33. Previous education and clinical experience were adequate to prepare me for the nurse faculty role.					1 2 3 4
34. I was unaware of the multiple expectations of the faculty role.					1 2 3 4
35. I receive support from my colleagues at the college.					1 2 3 4
36. Administrators provide me with the support I need to do this job.					1 2 3 4
37. Family is supportive of my work role change.					1 2 3 4
38. I receive support from my friends for my work role change. n					1 2 3 4
39. I receive support for my work role change from other nurses I know.					1 2 3 4
40. I bring confidence to my role.					1 2 3 4

To what extent do you agree or disagree with the importance of the following Faculty Development Programs to the success of nursing faculty?

	Strongly Disagree	Disagree	Agree	Strongly Agree
	1	2	3	4
41. Balancing workload				1 2 3 4
42. Teaching strategies				1 2 3 4
43. Developing presentations				1 2 3 4
44. Enhancing student engagement n				1 2 3 4
45. Developing course and unit objectives				1 2 3 4
46. Test construction				1 2 3 4
47. Clinical instruction techniques				1 2 3 4 n
48. Conducting nursing research				1 2 3 4
49. Understanding the accreditation process (AACN, NLN, BON)				1 2 3 4
50. Nursing faculty evaluation				1 2 3 4
51. Curriculum writing				1 2 3 4
52. Guidelines for student advisement				1 2 3 4
53. Preparation for promotion and tenure				1 2 3 4
54. Preparing a lecture and making it interactive				1 2 3 4
55. Evaluating students in the classroom and in the clinical area				1 2 3 4
56. Time management				1 2 3 4
57. Maintaining clinical skills				1 2 3 4
58. Writing for publication				1 2 3 4
59. Motivating students				1 2 3 4
60. Developing critical thinking skills in students				1 2 3 4
61. Using evidence based practice in the classroom				1 2 3 4
62. Handling difficult students				1 2 3 4

Please add any other faculty development programs that you feel would contribute to your success as a nurse educator.

1. Approximately how many years have you worked as a nurse in a clinical setting minus the time spent supervising students in the clinical area?

2. What is your area of specialty?

3. In what type of nursing program are you currently employed? (check all that apply)

ASN

BSN

MSN

DNP

PHD

Other (please specify) _____

4. Are you currently or have you ever worked as a nurse while employed as a nurse educator?

Yes

No

5. Did you take classes or courses to prepare you to be a nurse educator?

Yes

No

6. How likely is it that you will remain in nursing education for the duration of your career?

Not likely

Somewhat Likely

Quite Likely

Very Likely

7. What year were you born? _____

8. What is your race/ethnicity? _____

9. What is the highest level of education that you attained?

BSN

MSN

PhD (Nursing)

PhD (Other)

DNP

EdD

DNSc

10. How satisfied are you with the compensation you receive for the work that you do as a nursing faculty member?

Not satisfied

Somewhat satisfied

Satisfied

Very satisfied

We appreciate your time and help with this important study.

Appendix B: Full Survey

Thank you for your interest in participating in this important study about nursing faculty transition. Your answers to this survey will help researchers understand how nursing faculty think about their role, competence, job satisfaction, and intent to stay in nursing academia.

Your participation is strictly voluntary. Data will be treated as confidential; however, internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, once the materials are received by the researcher, standard confidentiality procedures will be employed.

The survey will take approximately 15 minutes and you may decide not to participate at any point. If you have any questions or experience technical difficulties please contact the researcher by email at j_cranford@gdn.edu or call 678-359-5085(D) or 404-505-8472(E).

1. Are you willing to participate in this study?

1. Welcome

Yes

No

2. Are you currently a nurse educator?

2. Nursing Faculty Survey

Yes

No

Role Ambiguity, Role Strain, and Satisfaction Among Nursing Faculty

To what extent do you agree or disagree with the following in terms of the job functions you normally carry out at your institution?

	1	2	3	4	
	Strongly agree	Agree	Disagree	Strongly disagree	
3. I have enough time to complete my work.					1 2 3 4
4. I have adjusted to my role as nursing educator with little difficulty.					1 2 3 4
5. I am sometimes confused by conflicting departmental policies.					1 2 3 4
6. I perform job functions that I think should be done differently.					1 2 3 4
7. My workload is reasonable.					1 2 3 4
8. I sometimes feel caught between students and administration.					1 2 3 4
9. At the end of the workday, I am exhausted.					1 2 3 4
10. I feel that the work is never finished.					1 2 3 4
11. I work on things unrelated to my role.					1 2 3 4
12. I am overwhelmed because of being involved in other courses in addition to my primary course.					1 2 3 4
13. I feel certain that I do a good job of dividing my time properly between the tasks at hand.					1 2 3 4
14. I am unable to view my role change in a more positive light.					1 2 3 4
15. I am uncomfortable with the pressure to perform scholarly work.					1 2 3 4
16. Other people expect me to teach in certain ways that are not right for me or I don't agree.					1 2 3 4
17. I found the transition from clinical practice to academician to be a positive move.					1 2 3 4
18. There is a lack of policies and guidelines to help me in my faculty position.					1 2 3 4
19. I was uneasy about making the role transition from clinician/nurse to nursing faculty.					1 2 3 4
20. Students do not appreciate my efforts on their behalf.					1 2 3 4
21. I'm unsure about how much authority I have as a nursing educator.					1 2 3 4
22. It bothers me that all faculty do not adhere to policies.					1 2 3 4
23. Sometimes I have to feel my way in performing my duties.					1 2 3 4
24. I understand how I will be evaluated for a raise or promotion.					1 2 3 4
25. I know exactly what is expected of me.					1 2 3 4
26. I receive feedback on how well I am doing my job.					1 2 3 4
27. I receive clear explanations of what has to be done.					1 2 3 4
28. I am fully qualified to handle the work of a nursing faculty member.					1 2 3 4
29. I feel confident enough about the nursing program requirements to advise students in future course selections.					1 2 3 4
30. I have difficulty handling negative reactions of students.					1 2 3 4
31. I do not know if I will be able to answer the student's questions in class and/or clinical.					1 2 3 4
32. I find it difficult to write exam questions.					1 2 3 4
33. I worry about my teaching ability affecting students' performance.					1 2 3 4
34. I receive assignments that are within my educational capabilities.					1 2 3 4
35. Previous education and clinical experience were adequate to prepare me for the nurse faculty role.					1 2 3 4
36. I was unaware of the multiple expectations of the faculty role.					1 2 3 4
37. I receive support from my colleagues at the college/university.					1 2 3 4
38. Administrators provide me with the support I need to do this job.					1 2 3 4
39. Family is supportive of my work role change.					1 2 3 4
40. I receive support from my friends for my work role change.					1 2 3 4
41. I receive support for my work role change from other nurses that I know.					1 2 3 4

The following items list possible topics for faculty development programs for nurses making the transition from working nurse to nursing faculty member. Please rate the importance of the each topic to the success of nursing faculty.

	1	2	3	4	5
	Not important	Somewhat important	Quite important	Very important	Extremely important
42. Balancing workload					1 2 3 4 5
43. Teaching strategies					1 2 3 4 5
44. Developing presentations					1 2 3 4 5
45. Enhancing student engagement					1 2 3 4 5
46. Developing course and unit objectives					1 2 3 4 5
47. Test writing					1 2 3 4 5
48. Clinical instruction techniques					1 2 3 4 5
49. Conducting nursing research					1 2 3 4 5
50. Understanding the accreditation process (AACN, NLN, BON)					1 2 3 4 5
51. Nursing faculty evaluation					1 2 3 4 5
52. Curriculum writing					1 2 3 4 5
53. Guidelines for student advisement					1 2 3 4 5
54. Preparation for promotion and tenure					1 2 3 4 5
55. Preparing a lecture and making it interactive					1 2 3 4 5
56. Evaluating students in the classroom and in the clinical area					1 2 3 4 5
57. Time management					1 2 3 4 5
58. Maintaining clinical skills					1 2 3 4 5
59. Writing for publication					1 2 3 4 5
60. Motivating students					1 2 3 4 5
61. Developing critical thinking skills in students					1 2 3 4 5
62. Using evidence based practice in the classroom					1 2 3 4 5
63. Handling difficult students					1 2 3 4 5

64. Do you believe a formal mentoring process would help nurses make a successful transition to nursing faculty?

- Yes
- No

Why or why not?

65. Please add any other faculty development programs that you feel would contribute to your success as a nurse educator.

66. Approximately how many years have you worked as a nurse in a clinical setting (do not count the years spent as a nursing instructor in a clinical setting)? _____ years

67. What degrees are offered by the nursing program in which you currently teach? (*Choose all that apply*)

- ASN
- ADN
- BSN
- MSN
- DNP
- PhD
- DScN

68. What is your area of specialty? Choose all that apply.

- Adult Health
- Pediatrics
- Geriatrics
- Maternal-Child
- Critical Care
- Women's Health
- Oncology
- Rehabilitation
- Mental Health
- Other (please specify) _____

69. Are you currently working as a nurse in addition to your job as nursing faculty member?

- Yes
- No

70. Have you ever worked as nurse while employed as a member of a nursing faculty?

- Yes
- No

71. Did you take classes or courses to prepare you to become a nursing faculty member?

- Yes
- No

72. How likely is it that you will remain in nursing education for the duration of your career?

73. Do you believe that you are adequately compensated (monetarily) for your work as a nursing faculty member?

- Yes
- No

74. What year were you born? _____

75. What is your race/ethnicity? _____

76. What is the highest level of education that you attained?

- BSN
- MSN
- PhD (Nursing)
- PhD (Other)
- DNP
- DScN (DSN)
- EdD
- Other (please specify) _____

77. Please feel free to make additional comments in the box below.

Thank you very much for helping with this important research project.

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Joan Sistrunk Cranford

Permission is granted for use of survey by writing j_cranford@gdn.edu or contacting the author at
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678-359-5085

Appendix C: Participating University System Schools

PARENT INSTITUTION	ADMINISTRATION	AD	BSN	RN/ BSN ONLY	MS	PHD	SATELLI TE	APPROV AL
Abraham Baldwin Agricultural College Division of Nursing and Health Services 2802 Moore Hwy. Tifton, Georgia 31794-2601 (229) 391-5020 Fax (229) 391-6862 wgolden@abac.edu	Dr. David Bridges, President Dr. Niles Reddick, VP & Academic Dean Wanda Golden, RN, MSN, Chairman www.abac.edu/nursing	X						FULL
Albany State University College of Sciences and Health Professions 504 College Drive Albany, Georgia 31705 (229) 430-4724 Fax (229) 430-3937 joyce.johnson@asurams.edu	Dr. Everette Freeman, Ed.D., President Dr. Abiodun Ojemakinde, Vice President for Academic Affairs Joyce Johnson, RN, Ph.D., Dean Linda Grimsley, RN, DSN, Chairman, Dept. of Nursing www.asurams.edu		X		X			FULL
Armstrong Atlantic State University Dept. of Nursing 11935 Abercorn Street Savannah, Georgia 31419-1997 (912) 344-2575 Fax (912) 344-3481 camille.payne@armstrong.edu	Dr. Thomas Jones, Ph.D., President Dr. Ellen Whitford, Ed.D., Vice President and Dean of Faculty Dr. Shelly Conroy, Ph.D., Dean, School of Health Professions Dr. Camille Payne, RN, Ph.D., Head www.nursing.armstrong.edu		X		X			FULL
Augusta State University Department of Nursing 2500 Walton Way Augusta, Georgia 30904 (706) 737-1725 Fax (706) 737-1726 cprice@aug.edu	Dr. William A. Bloodworth, Jr., President Dr. Samuel Sullivan, Vice President Dr. Robert Parham, Dean, School of Arts and Sciences Charlotte Price, RN, Ed.D., Chairman www.aug.edu	X						FULL
Bainbridge College Associate Degree Nursing Program 2500 Shotwell Street Bainbridge, Georgia 39818-0990 (229) 248-2850 fgarrett@bainbridge.edu	Dr. Thomas Wilkerson, President Dr. Miriam Dittman, Ph.D., Vice President for Academic Affairs Mr. James Hylton, Chairman, Division of Technical Studies Faith Garrett, RN, MSN, Director www.bainbridge.edu	X						INITIAL
Clayton State University School of Nursing 2000 Clayton State Blvd. Morrow, Georgia 30260-0285 (678) 466-4959 sueodom@clayton.edu	Dr. Thomas Harden, President Dr. Sharon E. Hoffman, Vice President for Academic Affairs Dr. Lisa Eichelberger, RN, DSN, Dean, School of Nursing Dr. Sue Odom, RN, DSN, Assoc. Dean, School of Nursing www.clayton.edu		X		X			FULL

PARENT INSTITUTION	ADMINISTRATION	AD	BSN	RN/ BSN ONLY	MS	PHD	SATELLI TE	APPROV AL
College of Coastal Georgia Nursing Program 3700 Alameda Ave. Brunswick, Georgia 31520-3644 (912) 279-5860 Fax (912) 262-3283 jgift@ccga.edu	Dr. Valerie Hepburn, Ph.D., Interim President Dr. Wesley Payne, Vice President for Academic Affairs Judith Gift, RN, MSN, Chairman, Div. of Health Sciences, Nursing Program Director www.ccca.edu	X					Savannah	FULL
Columbus State University Department of Nursing 4225 University Ave. Columbus, Georgia 31907-5645 (706) 565-3649 Fax (706) 569-3101 Goyne_June@colstate.edu	Dr. Timothy Mescon, Ph.D., President Dr. George Stanton, Vice President for Academic Affairs Dr. Glen Stokes, Dean, College of Science Dr. June Goyne, RN, Ed.D., Chairman - Dept. of Nursing & Director of BSN Program www.colstate.edu		X					FULL
Dalton State College School of Nursing 650 College Drive Dalton, Georgia 30720 (706) 272-4463 Fax (706) 272-2533 cstarling@daltonstate.edu	Dr. John Schwenn, Ph.D., President Dr. John Hutchenson, Academic Dean Cordia Starling, RN, Ed.D., Dean www.daltonstate.edu	X						FULL
Darton College Division of Nursing 2400 Gillionville Road Albany, Georgia 31707 (229) 317-6557 Fax (229) 317-6671 epsey.bryant@darton.edu	Dr. Peter Sireno, President Dr. Joan Darden, RN, Ph.D., Vice President for Academic Affairs Epsey Bryant, RN, MSN, Interim Dean of Nursing www.darton.edu	X					Colquitt Cordele Swainsboro Thomasville	FULL
Georgia College & State University School of Health Sciences 231 W. Hancock St. CPO 064 Milledgeville, Georgia 31061 (478) 445-2633 Fax (478) 445-1913 cheryl.kish@gcsu.edu	Dr. Dorothy Leland, Ph.D., President Dr. Robert Haney, Interim Vice President Dr. Sandra Gangstead, Ph.D., Dean, School of Health Sciences Cheryl Kish, RN, Ed.D., Associate Dean School of Health Sciences, Director, Division of Professional Nursing www.gcsu.edu		X		X		Macon Through 2008	FULL
Georgia Highlands College Division of Nursing Education 3175 Cedartown Hwy., SE Rome, Georgia 30161 (706) 295-6321 Fax (706) 295-6732 brees@highlands.edu	Dr. J. Randy Pierce, Ph.D., President Dr. Renva Watterson, Vice President for Academic Affairs Dr. Barbara Rees, RN, DSN, Chairman, Health Sciences Division and Nursing Program Director www.highlands.edu	X					Cartersville Marietta	FULL

PARENT INSTITUTION	ADMINISTRATION	AD	BSN	RN/ BSN ONLY	MS	PHD	SATELLI TE	APPROV AL
Georgia Perimeter College AD Nursing Program 555 North Indian Creek Drive Clarkston, GA 30021-2396 (678) 891-3845 diane.white@gpc.edu	Anthony Tricoli, President Dr. Virginia Michelich, Vice President for Academic Affairs Diane White, RN, Ph.D., Chairman, Nursing Dept. www.gpc.edu	X					Dunwoody Lawrenceville	FULL
Georgia Southern University School of Nursing P.O. Box 8158 Statesboro, Georgia 30460-8158 (912) 478-3955 Fax (912) 478-0536 jbartels@Georgiasouthern.edu www.georgiasouthern.edu	Dr. Bruce F. Grube, President Dr. Linda Bleicken, VPAA Dr. Frederick Whitt, Dean, College of Health & Professional Studies Dr. Jean Bartels, RN, Ph.D., Chairman, School of Nursing Dr. June Alberto, Director, RN/BSN Program Dr. Danette Wood, RN, Ed.D., Director, BSN Program Dr. Donna Hodnicki, RN, Ph.D., Director, MSN Program		X		X			FULL
Georgia Southwestern State University School of Nursing 800 Wheatley St. Americus, Georgia 31709 (229) 931-2280 Fax (229) 931-2288 sdd@canes.gsw.edu	Dr. Kendall Blanchard, Ph.D., President Dr. Brian Adler, Vice President for Academic Affairs Dr. Sandra Daniel, RN, Ph.D., CPNP, Dean, School of Nursing Dr. Leisa Easom, RN, Ph.D., Chairman, School of Nursing www.gsw.edu		X					FULL
Georgia State University Byrdine F. Lewis School of Nursing P.O. Box 4019 Atlanta, Georgia 30302-4019 (404) 413-1201 Fax (404) 413-1203 bwoodring@gsu.edu kmeinersmenn@gsu.edu www.chhsweb.gsu.edu/nursing/index/asp	Dr. Carl V. Patton, President Dr. Ronald J. Henry, Ph.D., Provost & VP for Academic Affairs Dr. Susan Kelley, Ph.D., Dean, College of Health and Human Sciences Dr. Barbara Woodring, RN, Ed.D., CPN, Director, School of Nursing Dr. Cece Grindel, RN, Ph.D., FAAN, Associate Director, Graduate Program Dr. Krista Meinersmann, RN, Ph.D., Associate Director, Undergraduate Program		X		X	X		FULL
Gordon College Division of Nursing & Health Sciences 419 College Drive Barnesville, Georgia 30204 (678) 359-5197 Fax (770) 358-5064 j_cranford@gdn.edu	Dr. Lawrence Weill, President Dr. Ed Wheeler, VPAA Joan Cranford, RN, MSN, Chairman www.gdn.edu	X						FULL

PARENT INSTITUTION	ADMINISTRATION	AD	BSN	RN/ BSN ONLY	MS	PHD	SATELLI TE	APPROV AL
Kennesaw State University Wellstar School of Nursing 1000 Chastain Road, MB #1601 Kennesaw, Georgia 30144-5591 (770) 499-3080 Fax (770) 423-6870 www.kennesaw.edu/chhs/schoolofnursing	Dr. Dan Papp, President Dr. Lendley C. Black, Ph.D., Vice President Dr. Richard Sowell, RN, Ph.D., FAAN, Dean of Wellstar College of Health & Human Services Dr. Mary de Chesnay, RN, DSN, CS, FAAN, Director, Wellstar School of Nursing		X		X		Rome Jasper	FULL
Macon State College Division of Nursing 100 College Station Drive Macon, Georgia 31206-5145 (478) 471-2761 Fax (478) 471-2983 rebeccacorvey@maconstate.edu	Dr. David Arnold Bell, President Barbara J. Frizzell, Ed.D., VPAA Dr. Rebecca Corvey, RN, Ed.D., Dean, School of Nursing & Health Sciences Vivian Austin, RN, MSN, Interim Dir. Nursing Programs www.maconstate.edu	X		X			Warner Robins	FULL AD RN/BSN
Medical College of Georgia School of Nursing (EG-103) 987 St. Sebastian Way Augusta, Georgia 30912-4200 (706) 721-2787 Fax (706) 721-1878 lumarion@mcg.edu jaheath@mcg.edu	Dr. Dan Rahn, President Dr. Barry Goldstein, Provost Dr. Lucy Marion, RN, Ph.D., FAAN, Dean Dr. Janie Heath, RN, Ph.D., FAAN, Assoc. Dean Rebecca Rule, RN, MN, MPH, Director, Undergraduate www.mcg.edu		X		X	X	Barnesville (BSN) Athens (BSN) Columbus (MSN)	FULL BSN MSN (CNL)
Middle Georgia College Department of Nursing 1100 Second Street, S.E. Cochran, Georgia 31014-1599 (478) 934-3057 Fax (478) 934-3148 jjackson@mgc.edu	Dr. Michael Stoy, Ph.D., President Dr. Mary Ellen Wilson, Ph.D., VPAA Jo Anne Jackson, RN, MSN, Ed.D., Chairman, Division of Allied Health & Director, Nursing Dept. www.mgc.edu	X					Dublin	FULL
North Georgia College & State University Department of Nursing Highway 60 South Dahlonega, Georgia 30597 (706) 864-1935 Fax (706) 864-1845 tbarnett@ngcsu.edu	Dr. David Potter, President Dr. Linda Roberts-Betsch, Vice President for Academic Affairs Dr. Mike Bodri, D.V.M, Dean, Natural & Health Sciences Dr. Toni Barnett, RN, Ph.D., Head, Dept. of Nursing www.ngcsu.edu	X		X	X		Cumming Gainesville	FULL AD RN/BSN
South Georgia College Division of Nursing 100 W. College Park Drive Douglas, Georgia 31533-5098 (912) 389-4503 Fax (912) 389-4631 mpeacock@sgc.edu	Dr. Virginia Carson, Interim President Dr. Carl McDonald, Vice President for Academic Affairs Melissa Peacock, RN, MSN, Dean www.sgc.edu	X					Waycross	FULL

PARENT INSTITUTION	ADMINISTRATION	AD	BSN	RN/ BSN ONLY	MS	PHD	SATELLI TE	APPROV AL
University of West Georgia Department of Nursing 1601 Maple Street Carrollton, Georgia 30118-5180 (678) 839-6552 Fax (770) 836-4409 kgrams@westga.edu	Dr. Beheruz Sethna, Ph.D., President Dr. Thomas Hynes, Ph.D., Vice President for Academic Affairs Donadrian Rice, Ph.D., Interim Dean, Arts & Sciences Kathryn Grams, RN, Ph.D., Chairman www.westga.edu/nurs		X		X		Newnan Rome Dalton	FULL
Valdosta State University College of Nursing 1300 N. Patterson Street Valdosta, Georgia 31698-0130 (229) 333-5959 Fax (229)333-7300 ahufft@valdosta.edu	Dr. Patrick Schloss, Ph.D., President Dr. Louis Levy, Vice President for Academic Affairs Dr. Anita Hufft, RN, Ph.D., Dean Dr. Jean Temple, RN, DSN, Associate Dean for Graduate Programs, Research & Evaluation www.valdosta.edu/nursing		X		X			FULL

Appendix D: Letter to Potential Respondents



The University of Georgia®

Dear Nurse Educator:

I am a nursing faculty member in the state of Georgia and I have been in the profession for over thirty years. I am very concerned about the current nursing shortage and how it will affect the profession and the health care consumer. There are a number of plausible explanations for the shortage but there is one cause that has become a more critical realization over the past decade. The nursing shortage is inextricably linked to the nursing faculty shortage. There are predictions which paint a very glum picture of the future of nursing and the increased shortage of nursing faculties.

Nursing faculty members are most often recruited from clinical practice, and the transition from practice to academia is not an easy task. I am soliciting input from those directly involved in and affected by the faculty shortage. Therefore, I am asking professional nursing faculty members to participate in this survey that will hopefully identify issues surrounding the transition from clinical nurse to nurse faculty and ultimately develop a retention plan and a faculty development model. I am eager to learn the views of all nursing faculty – both novice and experienced.

As part of my doctoral studies at the University of Georgia, I am currently conducting a brief survey about the transition from practice to nurse education. I would greatly appreciate it if you could take a few moments to complete it. By doing so you will help ensure that we have the best information possible. Your experiences, perspectives, and opinions will make a valuable contribution to the profession. Completing the survey should take no more than 15 minutes.

All responses will be held in strictest confidence and at no time will respondents be identified by name. Only aggregated data are reported, no individual responses or contacts are shared with any other organization nor are they used for any other purpose. There are no known risks associated with participation. Only the researcher will have access to the data. When the study is completed, I will be happy to share the results with you because I believe that all nursing programs can benefit from these results.

Please click the link below to begin the survey. This link is uniquely tied to this survey and your email address. Please do not forward this message.

If you have any questions, please feel free to contact Joan Cranford at Gordon College at 678-359-5085 or by email at j_cranford@gdn.edu.

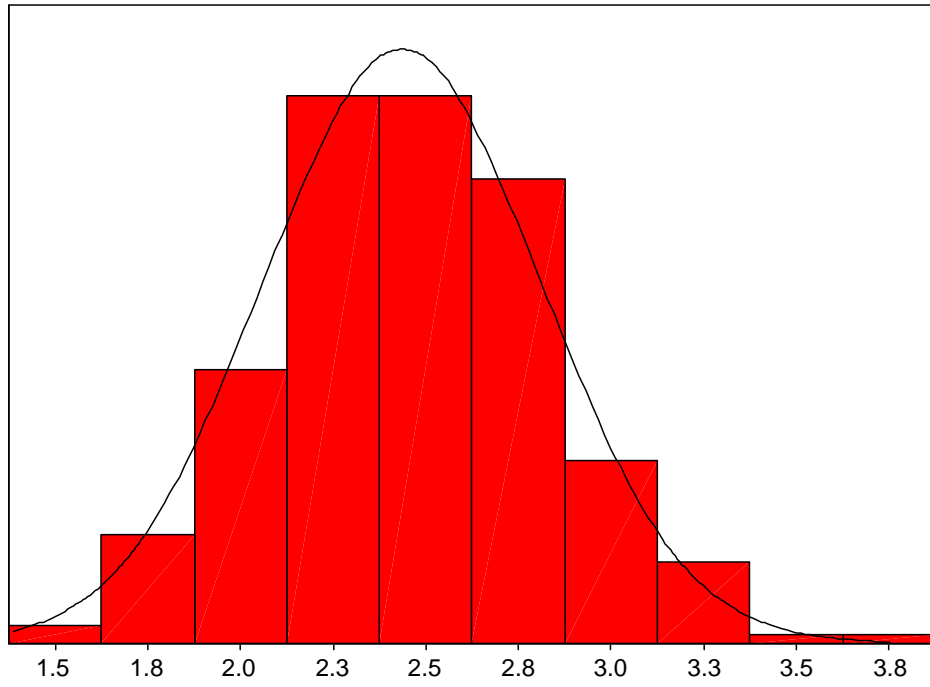
Thank you in advance for helping with this important study.

Sincerely,

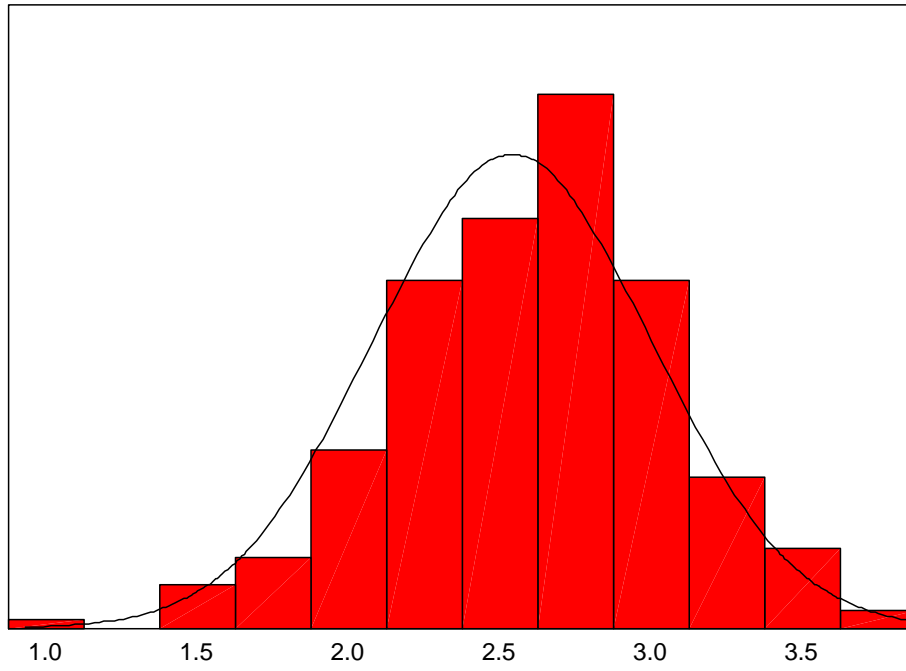
Joan S. Cranford, MSN, RN
Division Chair

Appendix E: Histograms of Variables of Interest

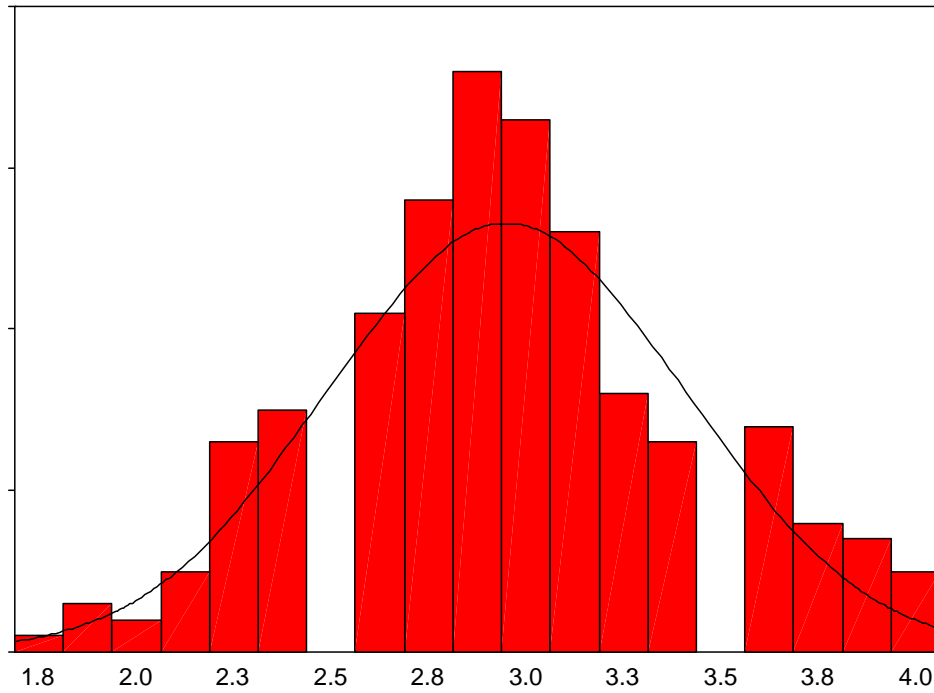
Role Strain



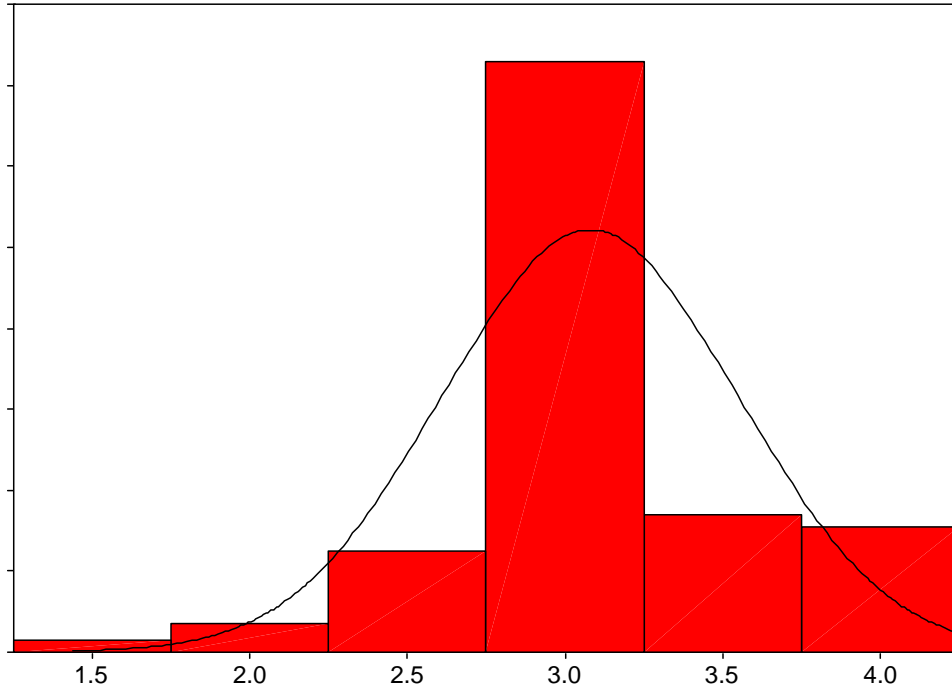
Role Ambiguity



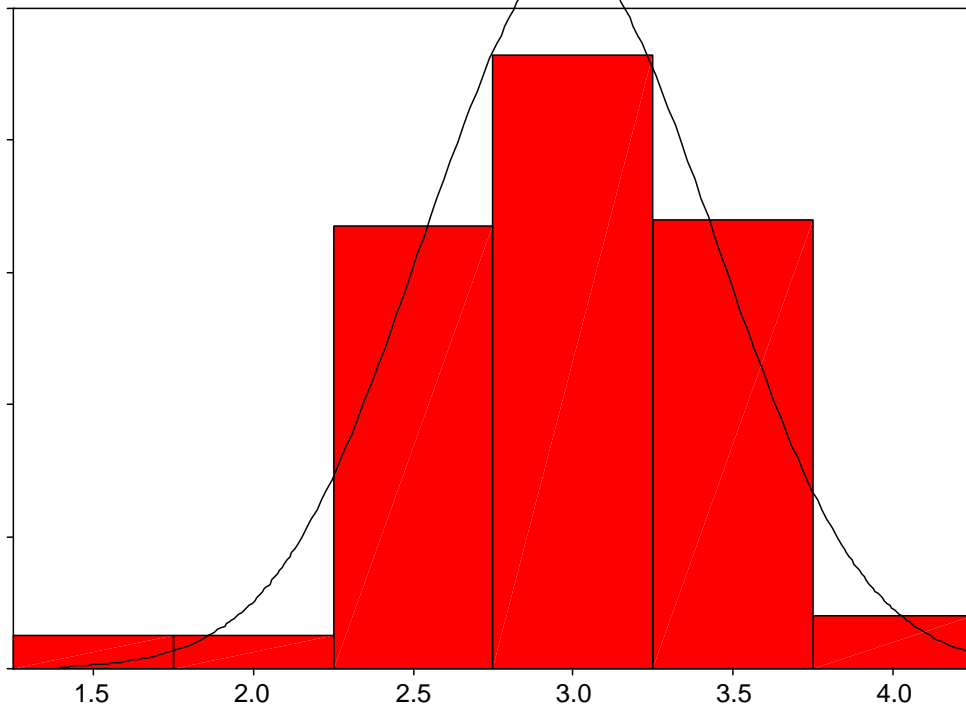
Self-Assessed Personal Competence



Interpersonal Support



Role Transition



Intent to Stay

