Stress and Coping in Psychiatric Nursing

by

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This study identified and examined stressors and modifiers of individual psychiatric staff nurse stress. The exploratory, descriptive participatory study used semi-structured interviews repeated after one month. Information was shared with participants who were invited to comment on analysis of data and conclusions drawn. The sample was 22 female staff registered nurses from nine units in one federal hospital and three private hospitals; they worked in their acute inpatient psychiatric settings from one to five years.

The major source of stress identified was unit staff conflict over working relationships and staff performance (33%). Other sources of stress were conflict with head nurses and supervisors (17%), self (13%), patients (13%), resource shortage (10%), physicians (9%), and the organization (6%).

Typically, unit staff conflicts were not resolved. The head nurse often contributed to staff infighting but helped when other staff were performing inadequately. Outcomes of stressors with head nurses, supervisors and physicians varied. Persistence in dealing with these stressors was most often related to desirable outcomes.

Although patient related stressors were often not resolved, the nurse altered her feelings of distress through lowering her expectations and basing self evaluation on nursing action rather than patient response. Doing one's best and working with others also helped. Stressors with the organization were unresolved but feelings of distress were regulated through alteration of expectations and decreased investment in the organization.

Problem resolution and diminishing distressed feelings occurred regularly with self and resource stressors. Successful strategies with self included identifying the stressor as self and working with self and others to resolve problems and distressed feelings. Successful strategies for dealing with resource shortage included setting priorities, lowering own expectations, and using available help from others.

The most desired outcomes were associated with using problem and emotion focused coping and social support. The more coping strategies used, the more likely was a desired outcome. Implications for nursing education, orientation to service, staff development and organizational change include developing realistic expectations, development of communication and interpersonal skills for staff and head nurses, and organizational change for increased staff nurse participation.

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CHAPTER 1--THE STUDY PROBLEM

Introduction

The process of stress and coping in psychiatric nursing was the focus of this study. Nursing is a high stress profession (Smith, Colligan & Hurrell, 1978). The complex relationships between occupational stressors, mental and physical health, job satisfaction and productivity are discussed by many scientists in theory and documented in research.

The seminal works of Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964) established that stressors such as role ambiguity and role conflict lead to problems at the work site while Caplan, Cobb, French, Harrison and Pinneau (1975) demonstrated differences in stress according to work environment and subsequent effects of stress on physical and mental health. Moos (1973) demonstrated that the social environment and even the physical characteristics of the work environment may influence the worker. The importance of work stressors is demonstrated by the host of consequences which have been studied such as: diminished health (Rosch, 1979; Selye, 1976), job dissatisfaction (Bedeian, Armenakis & Curran, 1981; House & Rizzo, 1972; Schuler, 1979), lowered productivity (Beehr, 1976; Schmidt, 1978; Van Sell, Brief & Schuler, 1981), and economic loss.

Job stress by definition occurs in the work place. For nurses, the workplace is primarily hospitals where nurses work

for and with others. The sources of job stress for nurses employed in hospitals may be personal factors, contextual factors, and/or the interaction of contextual and personal factors. Personal factors include needs and values, abilities and experience, personality and socialization. Contextual factors include organizational structure, policies and procedures, supervisory and co-worker behavior and the behavior of other personnel. When these contextual factors become stressors, the individual nurse may lack control in altering them. These contextual factors also influence the individual nurse's ability to cope with other work stressors such as dealing with clients.

While stressors have some direct effect on outcomes (e.g., health, job satisfaction and productivity), coping also accounts for a portion of the outcome. Many researchers claim that it is not just perception or experience of stress that matters but ability to cope that determines the outcome (Lazarus, 1981).

Just as the organizationally employed nurse may have incomplete control over some stressors, she has incomplete control in coping to alter the stressful situation. Both personal and contextual factors and their interaction influence potential coping efforts by staff nurses. The efforts of individual nurses are not always sufficient to alter or resolve stressful situations in an organizational setting. The outcome

of coping for the individual nurse depends on what she and others in the organization do in response to problems within the constraints of organizational structure, policies and procedures.

The same contextual variables which may be stressors themselves or influence other stressors are also potential and needed sources of support or help. Co-workers, the supervisor, other personnel and organizational structure, policies and procedures may assist the staff nurse in coping with inevitable or occurring stressors or add further to the stress experienced. Therefore, understanding the stress and coping of individual staff nurses depends on understanding contextual factors which interact with the staff nurse to influence stress and coping.

Both stress and coping are processes, not events. Both change over time partly as a result of interaction. In the process of coping, the individual shapes as well as responds to the stressful experience. Coping may change the appraisal of the stressful experience and thereby influences what happens next. Therefore, understanding of stress and coping comes from studying both together over time.

Although stressors have been studied extensively in some areas of nursing (e.g., intensive care units) they have not been studied in psychiatric nursing. Coping has been studied in nursing to a limited extent as an event or a trait but not as a process, not in relationship to the stressors, and not in

relationship to others in the organization involved with the problem.

Research evidence from non-nursing work environments suggests that under conditions of high stress, supervisory support and co-worker support can be important in diminishing perceived stress, buffering the effect of perceived stress on experienced distress, diminishing manifestations of distress, buffering the effect of stress on health, and directly protecting and promoting health, job satisfaction, and productivity. Supervisory and co-worker support may be considered to be one form of help with coping. Whether or not support and other forms of help with coping are important in psychiatric nursing is yet to be determined.

Statement of the Problem

Although nursing has been identified as a high stress profession and job stress is identified as contributing to negative outcomes for nurses, their work, and the organization, specific stressors in psychiatric nursing have not been identified through research. Therefore, the study of the processes and interactions through which psychiatric nurses cope with these stressors has not been possible. The process of stress and coping in psychiatric nursing must be described before systematic intervention can be designed. Intervention includes both prevention and reduction of stress and aid in coping.

Purpose of the Study

The purpose of this study was to discover and examine stressors and modifiers of individual staff nurse stress in psychiatric nursing. The focus was on factors which increase or decrease stress and/or assist staff nurses in coping. This study examined the components of stressors and specific strategies (rather than general supportiveness) from multiple sources within the organization (individual, co-workers, supervisor, other personnel and organizational structure, policies and procedures) to determine effective strategies and sources of help to individual staff nurses in specific situations.

To modify stress in psychiatric nursing we must be able to answer the following questions, what stressors occur and what helps in each of these situations? What can individual nurses, co-workers, supervisors, other personnel and the organization (through structure, policies and procedures) do in response to specific situations to decrease stress and/or aid in coping? What responses are made and how helpful are these different responses as perceived by the recipient? The focus was on stress and coping as processes.

Significance of the Study

The importance of the negatively valued individual and organizational outcomes attributed to stress can be viewed in economic terms. Seventy five percent of heart disease has been

attributed to occupational stress (Lehmann, 1974). The yearly treatment costs for the survivors of heart disease exceed $40 billion per year (Adams, 1981). The cost of lost productivity due to stress-related factors and the cost of replacing human resources has been estimated to exceed $1300 per employed person per year (Adams, 1981). According to Matteson and Ivancevich (1982), former Presidential Science Advisor, Arnold Mitchell, estimated the cost of stress to be in excess of $100 billion annually. These figures document the general economic importance of stress and provide some of the rationale for concern with reducing stress.

Specific health related costs of stress in nursing are not available. However, both nurse's stress and job dissatisfaction have been related to turnover. When one nurse leaves, another must be hired. The average cost of recruiting and orienting a nurse in 1980 was $2,000 (National Association of Nurse Recruiters, 1980). These costs may have increased since then. Patient perception of low quality of care can cost the health care institution its clients. Accidents and nurse errors have economic costs.

The importance of stress in nursing work goes beyond economic considerations. Nursing is concerned with person, environment and health (Fawcett, 1978), the same factors which are important in understanding stress. Understanding health

effects for the nurse in the nursing work environment can contribute to nursing knowledge. Nurses particularly need this knowledge since we use ourselves as the instrument of our care. Manager attention to staff stress and health can aid staff in being better role models and teachers for patients and improving the care given through the use of healthy selves. One could logically assume that improved personal health and the delivery of quality nursing care will increase job satisfaction for many nurses.

This study can help nurses and nursing managers better understand sources of stress and modifiers of individual staff nurse stress in psychiatric nursing. It can help them know what aids in decreasing stress, improving coping, and conveying support to individual psychiatric staff nurses. It identifies what sources and forms of help are useful in particular situations. This study identifies categories of responses to specific situations from individuals, co-workers, supervisors, other personnel and the organization. After validation of these categories and their usefulness in decreasing stress, and/or aid in coping, this information could become the basis for helping nurses and nurse managers to be aware of some variables that nurses perceive as useful in assisting them to cope more effectively with stress in particular situations. This information could also be used in the educational process to help prepare nurses for the reality of their work world.

CHAPTER 2--CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

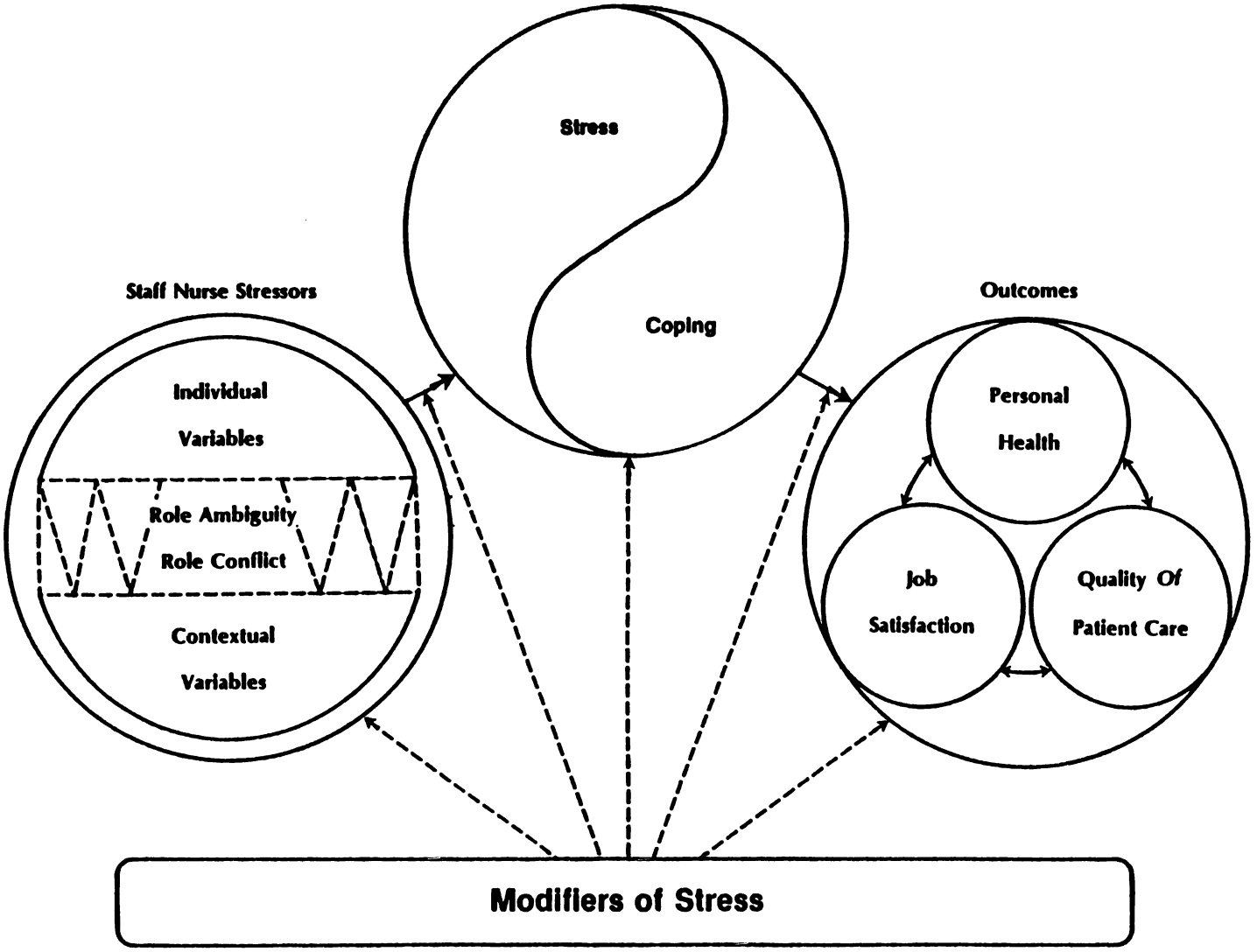
The purpose of this chapter is to describe the conceptual framework for this study and to review literature relevant to this framework. Following this, assumptions of the study are identified, questions for exploration are described and terms used are defined.

Conceptual Framework

In this study stress is conceptualized as a response in the nurse which may be elicited through interaction with a variety of stressors including individual variables (e.g., role skills, socialization), contextual or situational variables (e.g., social environment, job characteristics), and/or the interaction of individual and contextual variables (e.g., role ambiguity, role conflict). The outcomes or consequences of stress in this conceptual framework include diminished personal health, job dissatisfaction, and poor quality of patient care. There is some evidence that the outcome measures may be interactive. Diminished health, job dissatisfaction, and poor quality of patient care may, in turn, become stressors.

The following review of relevant literature is a review of theory and research findings related to this conceptual framework which is depicted in Model I. Model I, gleaned from the literature, is an attempt to identify those elements in a stress model that have been suggested as important. First there is a

Model I: Relationship of stressors, stress/coping and outcomes



brief review of stress theory and research including research findings related to the outcome of personal health. Occupational stressors are defined as a specific source of stress; the relationships of occupational stressors to outcomes of personal health, job satisfaction, and quality of patient care are summarized. This is followed by a discussion of stressors or antecedents to stress; these are related to the outcomes of interest. Finally there is a discussion of social support and other moderators of stress. These moderators may affect the process at any of the five points indicated on the model.

The review of relevant research would logically include a review of research on stress and coping in psychiatric nursing. However, a January 1984 computer search of Medline, ERIC, Mental Health abstracts, and dissertation abstracts reveals the absence of such research. Therefore, relevant research is drawn from the broader area of occupational stress and coping research with research on stress in nonpsychiatric nursing included where available. It should be cautioned, however, that generalizability of findings in occupational stress research outside of nursing to nurses, more than 95% of whom are female (Lysaught, 1981), is open to question. One reason is that there are six times more work stress studies on men than on women. Other studies on work stress have included women but have not analyzed sex differences (Haw, 1982). That men and women may

differ in occupational stress characteristics is indicated by Pearlin and Lieberman's (1979) study reporting that five occupational stressors involving loss and acquisition of jobs and occupational reward deprivation are significantly disproportionately concentrated in women. Working women report more stress than nonworking women (Haynes & Feinleib, 1980).

Review of the Relevant Literature

Stress Theory and Research

Since stress is additive (Selye, 1976), the stress experienced both in the personal life of the nurse and stress at work will become a part of the stress experienced by the nurse at work. Additional stressors experienced at work also become a portion of the total stress experienced by the nurse. Stress theory and research aid in understanding the response of the individual regardless of the sources of stress. Therefore, in the next two sections, certain critical elements of stress theory are presented and discussed. This is followed by a discussion of the more specific concern, occupational stress in nursing.

Stress theory and research have come from such diverse areas as nursing, medical and health science, organizational behavior, personnel psychology, industrial psychology, psychiatry, clinical and social psychology, sociology, and cultural anthropology. A universally accepted definition of stress does not exist within or among these disciplines. In defining and describing stress,

this writer uses the definitions and paradigms of both Selye and Lazarus.

Selye's stress and adaptation theory

According to Selye (1976), stress is the nonspecific response of the body to any demand. This response of the body is elicited by a variety of different agents or by any demand (stressors). Examples of demands may be for a quick response to a crisis situation, dealing with an angry patient or dealing with conflict between staff members.

Stressors elicit the General Adaptation Syndrome (GAS). The GAS is the name given to describe all the nonspecific changes occurring throughout the time of continued exposure to a stressor. It is called general because according to Selye (1976) it is elicited only by agents having a general effect upon large portions of the body, adaptive because it stimulates defenses which help the body adapt, and syndrome because the signs are coordinated and partially dependent on each other.

The fully developed GAS consists of three stages: alarm reaction, the stage of resistance, and the stage of exhaustion. The purpose of alarm is to arouse the body's defenses. When noxious agents continue, there is a fight (resistance) to maintain the homeostatic balance of damaged tissues. Resources are concentrated at the site of the demand. During this time, resistance to the particular agent which produced this stage of

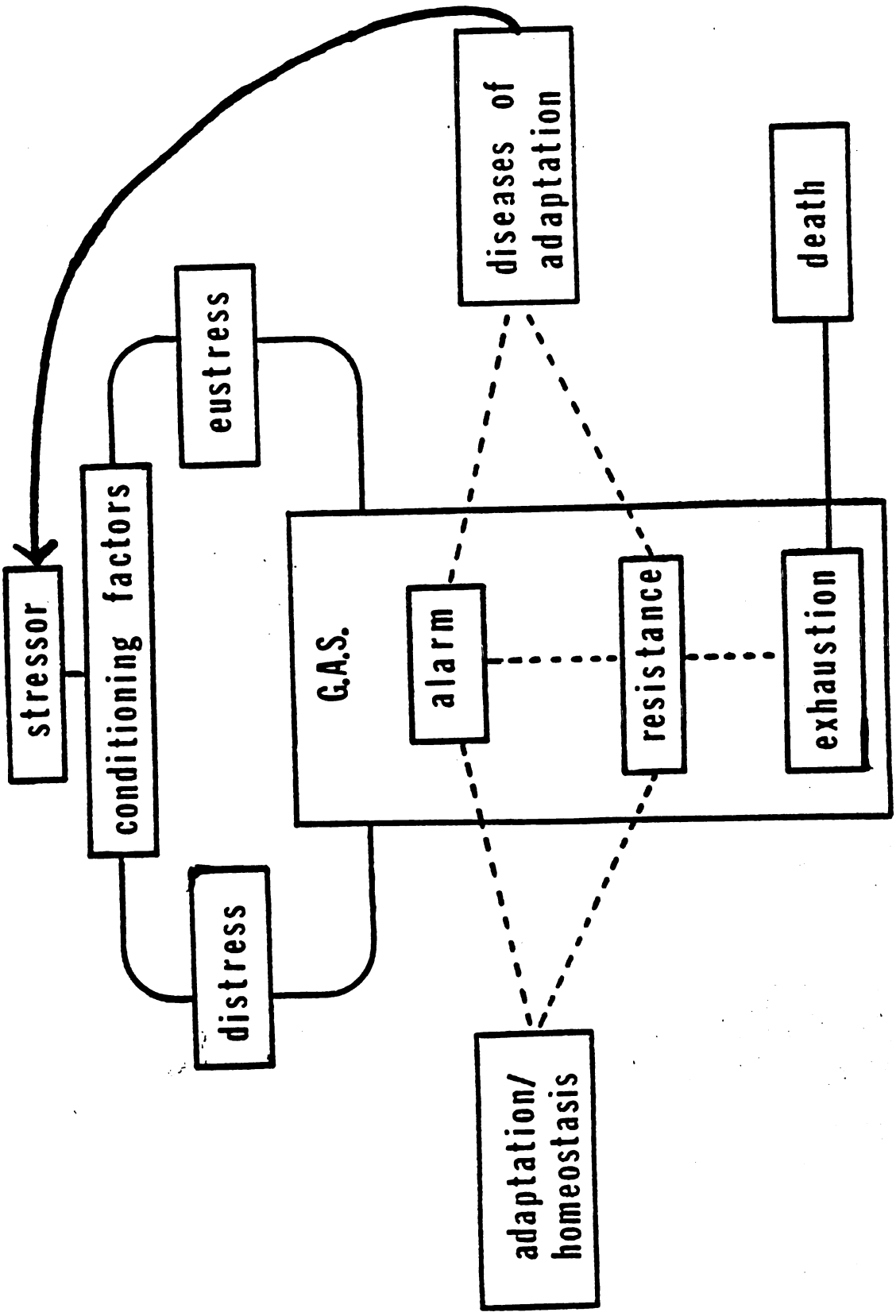
the adaptation syndrome is at its peak but, at the same time, resistance to most other agents falls below normal. If homeostatic balance is not achieved and exposure to noxious agents continues, the body loses its acquired ability to resist and enters the stage of exhaustion. The outcome of the progression of the GAS through the stages of alarm and resistance may be achievement of organic stability (homeostasis), diseases of adaptation, or exhaustion. (Diagram I depicts the writer's concept of Selye's stress and adaptation theory).

There is an element of both stress and adaptation in health and in every disease. While some stress is needed for optimal health, productivity, and morale, excessive stress increases the probability of ill health, low productivity, and low morale. The relationship between stress and health and stress and productivity is curvilinear (Schmidt, 1978; Selye, 1976)

Resistance and adaptation are dependent on the balance of defense and surrender and are influenced by the direct effect of the stressor on the body. The stressor affects the body directly. Some internal responses to the stressor stimulate tissue defense or help destroy damaging substances; other internal responses cause tissue surrender by inhibiting unnecessary or excessive defense. Either excessive defense or an overabundance of submissive bodily reactions will lead to diseases of adaptation. Disease reflects a fight to maintain the

Diagram I

Selye's Stress and Adaptation Theory



homeostatic balance of tissues despite damage. Diseases of adaptation are consequences of the body's inability to meet stressors with adequate adaptive reactions. If the body uses one organ system preferentially to cope with a stressor, disease can result either from the disproportionate, excessive development of the particular system or from its eventual breakdown from wear and tear.

Selye's list of diseases in which maladaptation to stress is a factor include:

> high blood pressure, diseases of the heart and of the blood vessels, diseases of the kidney, eclampsia, rheumatic and rheumatoid arthritis, inflammatory diseases of the skin and eyes, infections, allergic and hypersensitivity diseases, nervous and mental diseases, sexual derangements, digestive diseases, metabolic diseases, cancer and diseases or resistance in general " (Selye, 1976, pp. 169-170).

The relationship between stress and illness in general is further discussed and documented by Pilowsky (1973), Bell (1977), and Pelletier (1977). Dean and Lin (1977) conclude from a review of the stress literature that stressful life events (e.g., bereavement, divorce, job change) are associated with the onset, incidence, and prevalence of a wide range of psychiatric and physical disorders.

Selye's definition of stress as a response of the body does not preclude psychological and behavioral responses; they are simply not his focus. Support for including psychological and behavioral responses in Selye's model is found in Selye's self observable signs of stress which include impulsive behavior, emotional instability, floating anxiety, stuttering and other speech difficulties, increased consumption of alcohol, tobacco and drugs, neurotic behavior, psychosis, and accident proneness (Selye, 1976). Assuming interactive physical, psychological and behavioral dimensions in human beings is consistent with a widely held nursing definition: that man is a biopsychosocial being with the biological, psychological and social or behavioral aspects being interactive and interdependent (San Jose State University, 1979).

Lazarus' stress and coping paradigm

Lazarus' work focuses on psychological aspects of stress with cognitive appraisal determining one's response to a situation. Lazarus defines psychological stress as "demands that tax or exceed the available resources (internal or external) as appraised by the person involved" (Lazarus, 1981, p. 193). Stress is elicited by the transaction between the demand and the individual's cognitive appraisal of the situation.

According to Lazarus' paradigm (Lazarus, Averill & Opton, 1974; Lazarus, 1977; Lazarus & Launier, 1978; Lazarus, 1981)

transactions between person and environment lead to primary appraisal, the judgment that a situation is irrelevant, benign-positive or stressful. If the situation is evaluated as stressful, further appraisal establishes harm/loss (damage has already occurred), threat (future potential for damage exists) or challenge (potential for mastery or gain exists). The assessment of stress leads to both emotion and coping and affects secondary appraisal, the evaluation of available coping options, and resources. Emotion affects both the evaluation of coping options and resources and coping responses. Coping responses affect emotion, reappraisal of the situation as irrelevant, benign-positive or stressful and secondary appraisal as well as the person-environment transaction. The purpose of coping is the alteration of the troubled transaction or self regulation of emotion. Both of these purposes are accomplished through the coping modes of information seeking, direct action, inhibition of action, intrapsychic mechanisms and/or seeking social support. The writer's understanding of this process is illustrated in Diagram II.

The emphasis of Lazarus' model is on stress and coping as processes. Stress appraisal and coping continually interact with each other and with the troubled situation; each factor affects and is affected by the other two factors.

Lazarus Stress and Coping Paradigm

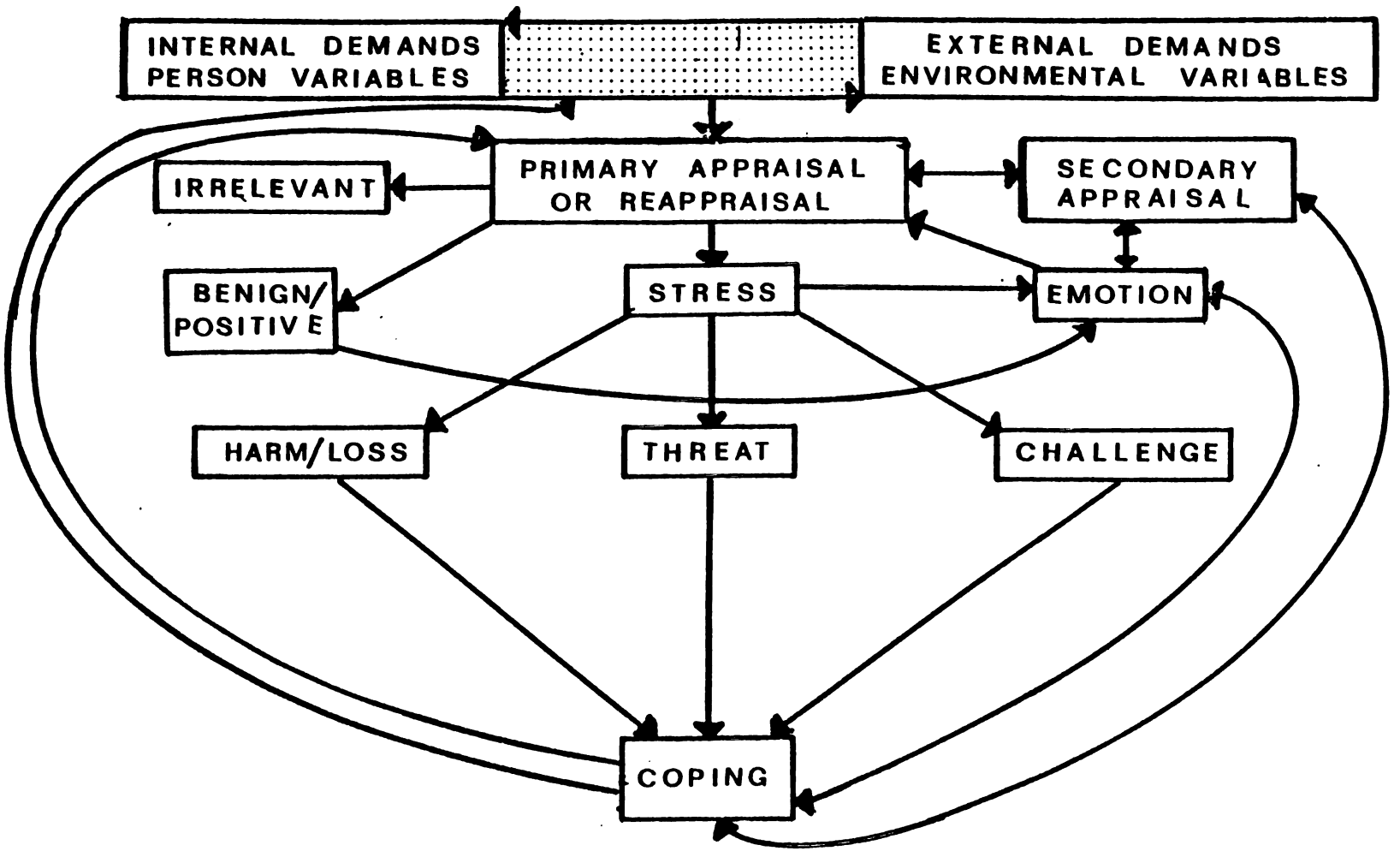


Diagram II

Selye states that any demand will produce a response of the body. Lazarus clarifies that not every event is a demand. As illustrated on Diagram II, all events are appraised and only those perceived as harm/loss, threat or challenge are demands or stressors. In addition, although all demands may produce a response in the body, not all responses are of the same magnitude or duration. There is variation in the intensity of the demand for adaptation or readjustment. The perception of an event as stressful and the magnitude and duration of the response are related not only to what happens but also to the individual to whom it happens. Individual variations have a role in determining the perception of stress, the magnitude and duration of the stress response, and specific coping efforts.

Outcomes of Occupational Stress

Occupational stress is the response of the person to demands experienced in the work place. According to Newman and Beehr (1979) "job stress refers to a situation wherein job related factors interact with the worker to change (i.e., disrupt or enhance) his or her psychological and/or physiological condition such that the person (i.e., mind-body) is forced to deviate from normal functioning" (p. 1). Occupational stress has consequences for worker health, job satisfaction and job performance.

Health Outcomes

Findings that perception of job stress is related to employee health and wellbeing are reported consistently (Beehr, Walsh, & Taber, 1976; Caplan, et al., 1975; Kahn et al., 1964). Measures of poor mental health include anxiety, depression, tension, irritation, and neuroticism. Some of the studies which found that perception of job stress is related to one or more of these include Beehr (1976), Beehr et al., (1976), House and Rizzo (1972), and Pearlin and Lieberman (1979). The psychological consequence of low self esteem has been reported by Beehr (1976) and Margolis, Kroes and Quinn (1974).

Margolis et al. (1974) summarized four health related outcomes of occupational stress: (a) short term subjective states (e.g., anxiety, tension, anger), (b) long term psychological response (e.g., depression, malaise, alienation), (c) transient physiological changes (e.g., levels of catecholamine, blood pressure), and (d) physical health (e.g., gastrointestinal disorders, coronary artery disease, asthmatic attacks). According to Schuler (1980) high blood pressure, cardiovascular disorders and peptic ulcers are the symptoms or diseases more often related to stress in organizations. In a study of 51 female psychiatric nurses, Davenport (1983) found that job stress is one of the indices predicting severity of illness. Other predictors of severity of illness are recent life

changes and social support.

Health and health behavior are conceptualized in several different ways. Laffrey (1983) identifies varied definitions of health as (a) absence of disease, (b) satisfactorily functioning in social roles, (c) being within normal limits, (d) functioning optimally, and (e) attaining an optimal level of well being. Health behavior is described in two paradigms (Loveland-Cherry, Laffrey & Winkler, 1982). In the pathogenic or disease paradigm, health is viewed as diseased oriented; health behavior is conceptualized as treatment or prevention of symptoms or disease. Individuals are viewed as reactive to and manipulated by environmental stimuli. In the health paradigm, self determining individuals interact with their environment so that they both affect and are affected by the environment. The majority of research relating occupational stress and health defines health as the absence of disease and describes health behavior within the disease paradigm.

Job Satisfaction Outcomes

In a review of the literature on job stress, employee health, and organizational effectiveness, Beehr and Newman (1978) report that job dissatisfaction has frequently been studied as a consequence of job stress; consistent findings are that job stress is positively related to job dissatisfaction. Bedeian and Armenakis (1981) examined direct and indirect effects of role

ambiguity and role conflict in a path-analytic study involving 202 respondents from five levels of personnel in a nursing service department including 73 registered nurses. The findings are that while role ambiguity and role conflict are both negatively related to satisfaction, the strength of the relationship of role ambiguity and role conflict to job dissatisfaction is through the path of tension (the intervening variable). Bateman and Strasser (1983) report finding a reciprocal relationship between job tension and overall satisfaction.

Job satisfaction is a product of the interaction between the individual and his/her particular work environment. Smith, Kendall and Hulin (1969) define job satisfaction as persistent feelings towards discriminable aspects of the job situation. These feelings are believed to be associated with perceived discrepancies between expectations and experience. Lawler (1973) describes four theories of job satisfaction: (a) fulfillment theory—when the individual's needs are met, job satisfaction occurs, (b) discrepancy theory--satisfaction occurs when what is wanted is consistent with what does occur or is expected to occur, (c) equity theory--satisfaction occurs when the individual perceives a balance between input and output, and (d) two factor theory--intrinsic characteristics (achievement, responsibility, work itself) promote satisfaction while extrinsic characteristics

(e.g., supervision, salary) elicit dissatisfaction.

Many research studies outside of nursing and in nursing have determined factors associated with job satisfaction or dissatisfaction. Caplan et al. (1975) report that job satisfaction is strongly influenced by participation in decision making, social support from immediate supervisor and co-workers and good fit between the job and the worker. In a study of 80 nursing service employees, Slocum, Susman and Sheridan (1972) found a positive relationship between higher position in the organization and greater job satisfaction. In a longitudinal study of 1259 registered nurses, Weisman, Alexander and Chase (1980) found that autonomy was the strongest predictor of job satisfaction. All of these factors (participation in decision making, support from supervisor and co-workers, fit between job and worker, level in organization, and autonomy) have also been studied as stressors.

Quality of Nursing Care

Quality of nursing care is an aspect of job performance. Decreased productivity is reported as a consequence of job stress by Beehr and Newman (1978), Buzzard (1973), Margolis et al. (1974), Schmidt (1978), and Van Sell et al. (1981). Decreased quality of performance is reported by Beehr (1976) and Beehr and Newman (1978). Posner and Randolph (1980) found significant negative correlations between occupational role stress (role

conflict and role ambiguity) and job satisfaction, perception of own individual performance, and unit effectiveness in a study of 124 nurses employed in hospitals.

Stressors in the Work Setting

The important sources affecting job stress include the person, the context, and the interaction between person and contextual variables. The interactions of worker and work place which affect stress are discussed within the framework of role theory. Following this, important individual and contextual variables are identified and discussed.

Interaction of Individual and Contextual Stressors--Stress and Role Theory

Role theory and role characteristics have been used extensively to describe and explain occupational stress since the work of Kahn et al. (1964). Role theory, by relating the properties of the organization and the individual, provides a way of examining the behavior of individuals in organizations (Schuler, Aldag & Brief, 1977). Therefore, in the following section, certain critical elements of role theory are presented and discussed.

Role Theory. According to Sarbin and Allen (1954) proper and convincing role enactment appropriate to one's position is a dependent variable. Psychiatric staff nurse role enactment, the delivery of quality care, is dependent on other variables.

Independent variables which affect role enactment include role expectations, role demands, role location, role skills and role learning, self role congruence, the number of roles and role conflict. Role expectations include the rights, privileges, duties, and obligations associated with a particular social position. This is what others expect from the focal person. Role demands are the implicit demands on the actor for a specific role enactment. Role location is the accuracy with which the actor perceives cues and draws conclusions about the role of the other and thereby locates his/her own position. The ability of the actor to meet the demands associated with a position depends on (a) learning of the role, (b) acquiring cognitive and motoric, general and/or role specific skills, (c) experiencing self-role congruence (agreement between role expectations and concepts of self), and (d) degree of role conflict (incompatible expectations of the person).

Role characteristics are often studied from the interactionist perspective of role theory; this is the perspective of the writer. The interactionist perspective defines role as reciprocal interrelationships in which each individual adjusts her/his reactions and behavior to what s/he thinks others will do. Role is the relationship between what the person does and what others do (Lindesmith & Strauss, 1968). The role of both the staff nurse and head nurse are understood as

role relationships. That is, the role of the psychiatric nurse is a product both of what the nurse does and what others do. The same is true for the head nurse.

This reciprocal relationship view of roles is clearly seen in Pfeffer and Salancik's (1975) study which describes manager behavior as dependent on the social situation and constrained by demands made upon the manager. Kahn et al. (1964) also explain management behavior by its dependence on reciprocal positions in the organization, and note that organizations are composed of interdependent positions and interlocking behaviors. Within this view, persons within an organization occupy positions and are continuously being influenced by persons in interdependent positions. Over time, stable, mutually satisfying interactions would be expected to develop as expectations become known and reciprocal behavior is worked out. When expectations do not become known (ambiguity) and/or reciprocal behavior is not worked out (conflict), the consequence is role stress.

Role Stress. The focus of this study is with those aspects of role which are stressors and result in stress. The terminology used in the role literature is different from that used in the stress literature. In the role literature, stressors are referred to as role stress, and stress responses are called role strain.

Role stress refers to variables which make role enactment more difficult. Role stress is a stressor to the role incumbent. Hardy (1978) defines role stress as a function of the social structure which creates difficult, conflicting or impossible demands for the occupant of a position within the structure.

Role stress includes role ambiguity and role conflict. Role ambiguity is the "degree to which clear information is lacking regarding (a) the expectations associated with a role, (b) methods for fulfilling known role expectations, and/or (c) the consequences of role performance" (Van Sell et al., 1981, p. 14). Contributors to role ambiguity include lack of clear role expectations, role location, role demands, and/or insufficient role skills.

Role conflict is defined as incongruence in the expectations associated with a role. The four identified forms of role conflicts are (a) intrasender role conflict where a single role sender sends incompatible expectations to the person, (b) intersender role conflict where the expectations sent from one role sender are not compatible with those sent by another role sender, (c) person-role conflict where expectations of self held by the role incumbent are incompatible with expectations usually held for the position of the role incumbent, and (d) interrole conflict which occurs when the role demands stemming from one position are not compatible with the role demands arising from

another position.

Since role is an interrelationship, role stress created for the actor in one position may result in discord or role stress for occupants of interdependent positions. This is demonstrated in a study by Moch, Bartunek and Brass (1979). They examined the effect of stressors experienced by supervisors on distress experienced by staff. They concluded that structural and task characteristics of the supervisory position can and do affect stress experienced by staff (but not vice versa).

Both Moch et al. (1979) and Miles (1976) emphasize that different sources of role stressors may be associated with different positions. For instance, the sources of role ambiguity for managers may be very different from the sources of role ambiguity for staff. Further, factors which reduce role stress for one position or role incumbent may not reduce role stress for another; in fact, behavior which reduces role stress for one person may increase the role stress experienced by another.

Denny (1971) found that doctors, social workers, nurse supervisors and nursing assistants perceived and defined the role of the psychiatric nurse differently. The findings suggest that role conflict will occur between the psychiatric nurse and role senders since the psychiatric nurse may define her role one way and each role sender may define the psychiatric nurse's role differently and hold conflicting expectations.

Vredenburgh and Trinkaus (1983) report that more educated nurses experience more role conflict. In examining performance, they found that nurses with low education (diploma or A.A. degree) and lower role conflict performed as well as those with a college degree who reported higher role conflict.

Role Strain. Role stress results in role strain. The effect of role stress is subjective feelings of tension, frustration or anxiety in the role incumbent. These effects or other felt difficulties in fulfilling role obligations are called role strain (Hardy, 1978; Goode, 1960).

According to Goode (1960) role strain is inevitable to some degree. Since each role relationship usually demands several activities or responses, some strain between norms can be expected. In addition, many role relationships are role sets (group of other positions in the organization with which the person interacts in the process of fulfilling her/his organizational role). Each person in the role set sends expectation to the role incumbent. The persons in the role set are thus often referred to as role senders. Goode asserts that total role obligations are over demanding and one role incumbent cannot meet all demands of all role senders to the satisfaction of all persons; therefore, role strain is normal and to be expected.

Arndt and Laeger (1970) looked at the role set of directors of nursing to determine diversity of role set which implies over demanding role obligations and therefore role strain as discussed by Goode. Arndt and Laeger concluded that the role set of directors of nursing was diversified with at least four major classes of role senders. Most nurse managers can also be assumed to have a diversified role set with role senders including nursing and hospital administration, physicians, nursing staff and patients. Staff nurses have a role set which includes nursing and hospital administration, physicians, peers, subordinates, and patients. Role strain can be logically expected because each role set will have somewhat different priorities and expectations.

Consequences of Role Stress. The consequences of role stress are similar to the consequences of other stressors in that role stress affects attitudes, behaviors and physiological conditions. Documentation of dysfunctional outcomes of role stress is broad. According to Van Sell et al.'s (1981) review of role stress literature, the strongest associations with role ambiguity and role conflict are job dissatisfaction and job related tension or anxiety.

Schuler (1979) states that there is adequate research for role ambiguity and role conflict to be assumed to be negatively related to satisfaction and performance. The dissatisfaction is

a result of not knowing what to do, not knowing the extent of authority, and/or experiencing incompatible expectations. Schuler explains that the employee will want to escape these dissatisfying conditions, will seek need satisfaction elsewhere and attempt to maintain self esteem by denying the importance of performing the task involved. This withdrawal results in increased role ambiguity and conflict as the employee is now unable to gain information needed to ameliorate the condition. The opposite cycle is elicited under conditions of low role ambiguity and conflict. Under these conditions, satisfaction and performance improve, the employee is more involved and has greater concern for the task, more information is sought, task improvement occurs, and the result is even less role ambiguity and conflict.

Role ambiguity is also associated with greater concern with one's own performance (versus group performance), less involvement or concern with the group or job, less effort toward quality, less organizational commitment, lower actual and perceived group productivity, lower perception of performance of supervisor and self, unfavorable attitudes towards role senders, depression and resentment, physical symptoms, sense of futility, lower self esteem, less job satisfaction, propensity to leave, and job turnover (Van Sell et al., 1981).

Beehr et al. (1976) reported that role ambiguity was negatively and significantly correlated with effort toward quality and with involvement. In a discussion of these factors Beehr et al. say,

> People experiencing ambiguous role expectations report exerting little effort toward quality in their work. Apparently, concern with the quality of one's work is not maintained if it is unclear what constitutes task success. Not only does the individual suffer from having ambiguous roles, but the organization suffers by having employees who are not concentrating on doing high quality work. Job involvement, the importance of the work role relative to other life roles, is related significantly.@.@.@. People experiencing ambiguous role expectations@.@.@.@feel less involved in their work. (p. 46)

Role conflict correlates with organizationally dysfunctional outcomes including unsatisfactory work group relationships, slower and less accurate group performance, less committment to the organization, lower performance evaluations, less confidence in the organization, unfavorable attitudes toward role senders, perception of inadequate leadership, voluntary termination, and propensity to leave. Personally dysfunctional outcomes associated with role conflict include fatigue, somatic complaints, depression, irritation, increased heart rate, a sense

of futility and lack of happiness (Van Sell et al., 1981).

Rizzo, House and Lirtzman (1970) found documentation in the literature for the following outcomes of role conflict: difficulty with decision making, a tendency to view problems unrealistically and coping behavior which is dysfunctional for the organization. Rizzo et al (1970) quote studies by Perrow (1965) and Zwacki (1963) regarding hospital hierarchies. They conclude that the dual hierarchies in these settings are particularly likely to lead to role conflict for nurses who are expected to respond to both medical and administrative authority. Hostility towards physicians and passive resistance to formal rules are among the results reported by Zwacki.

As was noted earlier, since most of the role stress research has been done outside of nursing and primarily with male subjects, the generalizability of these conclusions to nursing must be questioned. Bedeian et al.'s (1981) research supports the applicability of role stress research in nursing. They have studied 202 respondents from all levels of a hospital's nursing service (nursing assistants, licensed practical nurses, registered nurses, nurse practitioners, and nurse administrators). Both role ambiguity and role conflict were negatively correlated with job satisfaction ($r=-.42$; $r=-.44$) and positively correlated with job tension ($r=.41$; $r=.69$). Both ambiguity and conflict were also related to propensity to leave

but not to performance as measured by supervisory appraisals.

Role stress results from interaction of individual and contextual variables. Both individual and contextual variables also influence occupational stress in general. Therefore, in the next sections, the individual and contextual variable are identified and discussed.

Individual Variables Affecting Stress

Individual differences are important in understanding stress. What elicits stress in one person may not elicit stress in another. What elicits stress in the same person may vary over time. Different individuals have different tolerances for levels of stress. What is experienced as an excessive level of stress for one nurse may be the same level of stress that elicits wellbeing in another. According to Schuler (1980), individual needs and values, abilities and experience, personality and constitutional makeup, and strategies for coping affect perception and the stress an individual experiences in any particular situation.

Needs and values. Needs are defined as physiological and psychological requirements; values are subjective requirements. In a review of the literature Schuler (1980) found that needs and values which are identified or suggested included achievement, feedback, self-control, certainty, predictability, interpersonal recognition and acceptance, fairness and justice, stimulation,

personal space, responsibility and meaningfulness or purpose. Beehr et al. (1976), reported that the negative relationship between role stress and individually valued states is more pronounced for those people who have strong higher order needs according to Maslow's (1943) need hierarchy.

Abilities and experience. Abilities and experience which affect stress are identified by McGrath (1970, 1976). Three factors increase arousal of the body to the demands made: when the demands are perceived to exceed the individual's ability to meet the demands, when there is uncertainty about the rewards or costs involved in meeting the demands, and/or when there is a significant difference in rewards or costs according to whether or not the demands are met. On the other hand, familiarity with the situation, past exposure to the stressor and/or practice or training in dealing with the situation can reduce the perceived threat (McGrath, 1976).

Interpersonal skills and communication are abilities that have been studied in nursing. Dodge (1971) reported finding that all nursing personnel were perceived as ineffective in their interpersonal relationships with other nurses, other disciplines, patients, and their families. Her study examined effective and ineffective behaviors exhibited by psychiatric staff nurses, head nurses, supervisors and directors of nursing service as perceived by 413 peers, subordinates and superiors. In an earlier study by

Whitner (1965) head nurses were perceived by subordinates, peers, and supervisors as ineffective in communicating with co-workers.

Personality and coping strategies. The degree of role stress perceived by an individual is partly a function of personality (Bedeian, Armanakis & Curran, 1980; Organ & Greene, 1974). Bedeian et al.'s (1980) research findings from over 200 respondents in a hospital nursing service support personality as a correlate of role ambiguity. Although the magnitude of relationships was not large, role ambiguity was found to be significantly negatively related to defensiveness (r=-.16), self control (r=-.17), endurance (r=-.12), order (r=-.14), nurturance (r=-.15), and deference (r=-.17) and positively related to autonomy (r=.12), aggression (r=.20), and change (r=.18); all findings were significant at the .01 or .05 level. Bedeian et al. (1980) concluded that personality influences the amount of role ambiguity and role conflict experienced. They suggest that individual's personality dispositions elicit particular responses from surrounding individuals, personality factors often mediate between objective and experienced levels of role stress, and particular personality dispositions lead to more extensive use of some forms of coping behaviors.

Self esteem is another personality variable which may be related to work stress. Mossholder, Bedeian and Armenakis (1982) found evidence to support their hypothesis that self esteem

moderates between co-worker interaction and job stress and work performance. Co-worker interaction had more impact on job stress and work performance for low self esteem subjects than for high self esteem subjects.

Personality affects both the perception of stress and the coping style chosen to deal with the stressor. Much of the work with personality effects has consisted of comparing Type A and Type B personality perception and response. Type A personalities are reported to perceive more stress (Orpen, 1982) and to report a greater relationship between workload and anxiety (Caplan & Jones, 1975). In a study of occupational stress, Type A behavior and physical well being involving 57 nurses, Ivancevich, Matteson and Preston (1982) found that Type A nurses indicate that stressors over which they have the least control cause the most stress. Type A behavior and hostility are independent predictors of coronary heart disease for both men and women (Haynes, Feinleib & Kannel, 1980).

Research in individual coping strategies has looked at internal locus of control versus external locus of control. Given the same stress context, individuals with higher internal locus of control report less stress (Kimmons & Greenhaus, 1976; Organ & Greene, 1974). In a related finding, some individuals are described by Chiriboga and Culter (1980) as "stress prone," that is, they have personal characteristics which predispose them

to stress. These individuals are more likely to experience stress of all kinds. Being stress prone may affect both the situations encountered and coping for stress prone individuals.

Van Sell et al. (1981) assert that individual differences in perception and adaptability can moderate the relationship between objective and experienced levels of ambiguity and conflict. They emphasize that it is important to verify not only that different individuals perceive different amounts of conflict in the same environment, but also to verify the effect of these perceived differences on outcome variables.

To the extent that personality is a factor in role stress, knowledge of personality factors and knowledge of inevitable stress in a particular role could guide matching of person with role. This congruence between role expectations and personality dispositions is considered necessary for performance (Getzels & Guba, 1955).

Socialization of the nurse. One source of individual stress in nurses may be professional socialization. Brief (1976) attributes dissatisfaction and turnover in hospital nurses to expectations fostered by nursing education and unmet in work situations.

Brief, Van Sell, Aldag and Melone (1979) concluded that the type of anticipatory socialization does not influence the activities performed by the RN but does affect her/his

anticipatory definition of role. When this definition is incongruent with the hospital's definition, role stress occurs. In such an instance, role management does not occur as hypothesized.

Each of the individual variables discussed comes to work with the nurse who possesses them. Understanding these specific variables for any individual can help explain the level of stress experienced by the individual.

Contextual Variables Affecting Occupational Stress

Characteristics of the organization, characteristics of the physical and social environment, and characteristics of the job itself are contextual variables which have been documented as contributing to stress. To understand and intervene in the stress of nursing and nursing work, the important contextual variables affecting stress in nursing must be explored.

Organizational characteristics. Characteristics of organizations which have been associated with stress include participation in decision making (Likert, 1967), communication flow, human resource primacy, and level in the organization (Bedeian et al., 1981). In a study of 202 nursing personnel, Bedeian et al. reported finding negative correlations between role ambiguity and role conflict with decision making practices ($r=-.17$; $r=-.31$), communication flow ($r=-.15$; $r=-.38$), and human resource primacy ($r=-.19$; $r=-.35$). The significance of these

correlations range from $p<.05$ to $p<.001$.

Schuler (1980) reviewed findings from multiple studies and concluded that persons who participate in the organization and in decision making experience less stress than those who do not. Jackson (1983) tested a causal model of the effects of participation in decision making with 95 nursing and clerical employees in a hospital outpatient department. After 6 months, participation was shown to have a significant negative effect on role conflict and role ambiguity which were, in turn, positively related to emotional stress. Participation had a positive effect on perceived influence which was, in turn, positively related to job satisfaction.

Organizational structure was examined in magnet hospitals (hospitals with low turnover which are considered by nurses to be a good place to work and practice nursing). In the hospitals studied, the nursing organization is decentralized with a participatory management structure and style facilitating open communication and staff involvement in decision making. These hospitals also have a philosophy of caring for staff as well as patients. This is reflected in flexible work schedules and staff involvement in planning schedules (McClure, Poulin, Sovie & Wandelt, 1983). In a study of 200 workers which included psychiatric nurses, Pines and Maslach (1978) reported that staff who have input into the institution's policies have a more

positive view of themselves, their patients and their work than do those who have no such input.

From a review of the occupational stress literature, Schuler (1980) concluded that, when other organizational qualities are held constant, the most stress occurs for individuals in managerial level positions and those in the health care professions (p. 198). Thus the organizational characteristics described here can be assumed to be among the contextual variables influencing occupational stress in nursing.

Physical and social environment. Physical aspects of the environment which contribute to stress include high levels of noise, light and toxins, lack of space and privacy (Levi, 1981). Nurses in intensive care settings are often exposed to the constant noise of machinery and intense lighting. Exposure to toxic drugs and radiation may also be a physical stressor. Nurses seldom have private space in which to work or rest.

The social environment includes relationships with peers, subordinates, and supervisors. Peer and subordinate relationships are negatively affected by stress. Bedeian et al. (1981) reported negative relationships between role ambiguity and role conflict and work group interaction ($r=-.28$; $r=-.20$) in nursing. These findings are significant at the $p<.01$ level. In the same study negative relationships were found between role stress and supervisory behaviors. Role ambiguity and role

conflict were significantly ($p<.001$) correlated with supervisory goal emphasis ($r=-.36$; $r=-.25$) and supervisory work facilitation ($r=-.33$; $r=-.37$). Supervisory behaviors are discussed more extensively in the section on social support.

In some studies examining interpersonal factors, interpersonal factors are used as correlates of experienced role conflict and ambiguity or moderators of the association between experienced role ambiguity and conflict and the focal person's response. Van Sell et al. (1981) note that the research suggests that structuring and supportive behavior of role senders such as supervisors, frequency of communication between focal persons and role senders and other interpersonal factors do influence the focal person's perceptions of role ambiguity and conflict. Causality between interpersonal factors and focal person's role conflict and ambiguity has not been explicitly examined.

Peer, supervisory, subordinate and physician relationships may also be a source of stress. A variety of studies in nursing report these relationships as stressful. In a 1982 study of 24 neonatal intensive care unit nurses, Gribbins and Marshall found physician relationships to be a source of stress but did not find peer, subordinate or supervisory relationships to be stressful. Welch's study (1975) also reported stress in nurse physician relationships but not other relationships.

Head nurses have long been identified as sources of stress. Discontentment with their relationships with head nurses has been suggested as a reason staff nurses leave their jobs (Diamond & Fox, 1958; Seleh, Lee & Prien, 1965).

Bailey and Bargagliotti (1983) reviewed seven studies of stress in critical care nursing. All identified interpersonal conflict as a source of stress. The sources of conflict varied as did their ranking. This can be noted from a description of findings from four of the seven studies reviewed. Bailey, Steffen & Grout (1980) reported that interpersonal relationships were ranked the number one stressor in a national sample of 566 and second in a regional sample of 1238 intensive care unit nurses. The conflict may be with peers, supervisors, subordinates, administration, other health care providers, patients, and/or patients' families. In a study of sources of tension of the coronary care nurse, Cassem and Hackett (1972) found that conflict with nursing administration was the highest ranked area of conflict. Conflict with other nurses was ranked fifth and conflict with physicians was ranked seventh. Huckabay and Jagla (1979) asked 46 intensive care unit nurses to rank 16 stressors. Those ranked third, fourth, twelfth, and fourteenth respectively were communication problems between staff and nursing office, communication problems between staff and physicians, communication problems between staff members and

communication problems between staff and other departments in the hospital. Jacobson (1978) obtained 220 accounts of stressful experiences from 87 neonatal intensive care unit nurses. Nurse-doctor conflicts were ranked across all quartiles while nurse-nurse conflicts were primarily ranked in the least stressful quartile. Nurses experience problems in working with peers according to Astbury and Yu (1982). They found nurse-nurse problems the most frequent stressor with nurse-doctor conflicts second most frequent. In intensity, nurse-doctor conflicts were ranked first while nurse-nurse problems were second in intensity.

In the study of magnet hospitals, relationships with physicians were described as collaborative. Relationships with peers and supervisors were supportive (McClure et al., 1983).

The importance of the social environment to stress in nursing has been studied by Mohl, Denny, Mote and Coldwater (1982). They comment that studies often focus on primary tasks (the major patient care activities of a particular unit such as intensive care or medicine). The assumption is that primary task is the major determinant of stress. Mohl et al. (1982) suggest the alternative view that social system variables have a major influence on stress and morale. They claim that no empirical research has tested the assumption that primary task rather than social system variables determine staff stress level. Their findings from a study of 68 nurses suggest that social system

variables, particularly supervisory support and encouragement of mutual support (but not primary task definition) affect nurses' stress levels. Social system variables were measured by the Work Environment Scale (discussed in Chapter 3).

Schuler (1980) reviewed studies suggesting that interpersonal conditions are associated with stress in organizations. Schuler assumes that the interpersonal conditions are associated with a person's need for acceptance and interpersonal recognition so when relationships are unsatisfactory stress may result.

> For example, if an individual perceives an unsatisfactory relationship with another (e.g., there is low trust between the two) the individual may withdraw from the relationship and, if there is some task dependency between the two, may find task achievement difficult. This withdrawal and lack of achievement can lead to an intensification of the unsatisfactory condition between the individuals and continued low task achievement. Thus a vicious cycle is created. (Schuler, 1980, p. 199)

Job Characteristics. In a review of stress-related disease incidence according to occupation, Smith et al. (1978) determined that registered nursing is one of 40 occupations with a higher than expected incidence of stress-related disorders. Identified stressors which are characteristic of nursing include ongoing

interaction with ill persons (which can lead to a feeling of being emotionally drained) and responsibility for the wellbeing of patients without the authority to control that wellbeing. In common with their high stress occupations, nursing has the additional stressors of fast-paced work, repetitive job tasks and often, long hours.

Hospital based nurses are among the 25% of working Americans involved in shift work, a job condition associated with lowered performance and increased illness and accidents. In a study of nurses in two Canadian hospitals, rotating shift workers were assessed by supervisors as having less job motivation and providing poorer patient care than fixed shift workers (Jamal & Jamal, 1982).

Tasto and Colligan's (1978) study of rotating shift workers included nurses in the sample. They found that 20% more workers with rotating shifts (as opposed to fixed shifts) reported at least one accident at work in the previous 6 months. Rotating shift workers also reported more fatigue, nervousness and inadequate sleep than fixed shift workers. It has been suggested that weekly shift rotation may be associated with a 5% to 20% shorter life span (Rose, 1984).

To decrease the stress of shift work, rotating to a later shift every third week has been suggested. Czeisler, Moore-Ede and Coleman (1981) demonstrated employee preference, improved

health, and morale from this schedule.

Numerous studies report multiple characteristics of the job which increase stress. Since most of these studies used male non-nurse subjects it is difficult to determine generalizability to nursing. Those characteristics noted by this writer are those which are likely to be applicable to nursing because they are characteristic of nursing work. Schmidt (1978) reported stressful job characteristics including time pressures (always present in the shift work in hospital nursing), insufficient information to make a decision and/or no one best solution to a problem (frequent situations for the bedside nurse) competing loyalties (e.g., to patients, other staff, administration, and physicians) and emotionally charged issues (e.g., abortion, substance abuse). Other contributors to role stress noted by Van Sell et al. (1981) include perceived environmental uncertainty (a current problem in nursing as patient census diminishes and hospital units close) and autonomy (the lack of which has long been identified as a problem in nursing).

Job difficulty factors for 130 nurses and 159 engineers were compared in a study by Ivancevich and Smith (1982). For nurses, overload, conflict, and supervisory practices together explained 63% of common variance. A linear relationship was found between these job difficulty factors and job satisfaction and job tension. Three job difficulty factors also accounted for a

majority of variance for engineers but there was no overlap between the job difficulty factors of nurses and engineers. This lack of overlap underscores the caution necessary in generalizing to nurses from studies of other occupational groups.

After a literature review on occupational stress, Sharit and Salvendy (1982) concluded that uncertainty is the variable which could be singled out as the predominant underlying source of occupational stress. The uncertainty variable includes uncertainty from diverse sources such as task ambiguity, job insecurity or other job anxieties and the effects of lack of feedback about results of the job.

The phenomenon of stress is clearly complex with multiple individual and contextual variables affecting perception, experience and response to work stress. While each of the variables associated with stress can present a problem to the worker and the organization, each also presents a possibility for intervention.

Mediators of Occupational Stress

Identification of the stressors in a particular stressful situation is insufficient for understanding the outcome. There is increasing documentation that stress mediators such as coping strategies play a more important role than frequency and severity of stress episodes in influencing physical and mental health and social functioning (Roskies & Lazarus, 1980). Cohen (1981)

reviewed many studies which show that (a) stressors can influence the central nervous system, hormonal response, autonomic nervous system and immunological process, and (b) mediators may reduce the physiological arousal which occurs in response to stressful events.

Lazarus' transactional model of stress describes the person as shaping as well as responding to stressful experiences. A stressful situation occurs, the person appraises the situation and responds emotionally and behaviorally, the response influences what is happening and what will happen next. The appraisal is both primary, what is happening here (for the event to be appraised as stressful what is happening must be evaluated as important to the person and taxing to her/his resources) and secondary, what personal and environmental resources are available to the person. Thus, the stressful situation is appraised, the appraisal affects the coping responses, the coping responses affect the situation which is then reappraised and so the process continues (Roskies & Lazarus, 1980).

Coping Strategies

One mediator which receives special attention in the Lazarus model has to do with coping behaviors. Coping is broadly defined as the process of managing external and/or internal demands that tax or exceed the resources of the person (Lazarus, 1981). The major functions of coping are managing or altering the problem or

source of stress and regulating the emotional response to the problem. These functions are described by many including Kahn et al. (1964), Murphy and Moriarty (1976), Mechanic (1974), and Pearlin and Schooler (1978). In Lazarus' model the two major functions are described: problem focused coping and emotion focused coping (Folkman and Lazarus, 1980; Lazarus, 1981). More problem focused coping is anticipated in situations in which personal control is possible while more emotion focused coping is anticipated in situations beyond personal control (Folkman, 1982).

Pearlin and Schooler (1978) reported that problem focused coping was infrequently used at work and that problems at work were changed little through coping efforts. Folkman and Lazarus (1980) reported the opposite, that problem focused coping was used more often in work related episodes than in stressful episodes related to family or health. They also found that problem solving responses were more frequent in men than in women, but this conclusion was drawn from work situations which may not be comparable (Folkman & Lazarus, 1980).

Modes of coping include direct action, action inhibition, information seeking, intrapsychic modes (Roskies & Lazarus, 1980), and seeking social support (Lazarus, 1983). These are the functional modes for both problem focused and emotion focused coping.

Evaluation of coping efforts can be according to short-term or long-term outcomes. Short term outcomes are management or mastery of the problem or situation and the regulation of emotion. Long term outcomes include physical and mental health and social functioning (Folkman, 1982).

Studies of coping process are few. Some are in progress (Chiriboga, 1983; Lazarus, 1983) but both theory and research are limited. This is an area in which more knowledge is needed.

Coping is an intrinsic part of the stress process which is recognized as affecting outcome. Social scientists have searched for other factors which mediate stress. In addition to coping, Cohen (1981) lists such mediators of stress as the appraisal of stress, the resources available to deal with the situation and the nature of the surrounding environment including social support.

Social Support

Social support has received the most research interest of the mediators of stress. Social support is believed to modify potentially negative stress effects and to facilitate coping. Research evidence suggests that those with social support have less somatic illness (Cassel, 1976), more positive mental health (Cobb, 1976), and longer life (Berkman & Syme, 1979).

There is no singularly accepted definition of social support. Definitions of support and tools used to measure this

support have been varied.

Schaefer, Coyne and Lazarus (1981) define social support according to its functions: emotional, tangible, and informational support.

> Emotional support includes intimacy and attachment, reassurance and being able to confide in and rely on another--all of which contribute to the feeling that one is loved or cared about, or even that one is a member of the group, not a stranger. Tangible support involves direct aid or services and can include loans, gifts of money or goods and provisions or services such as taking care of needy persons or doing a chore for them. Informational support includes giving information and advice which could help a person solve a problem and providing feedback about how a person is doing. Tangible and informational support may also serve an emotional support function as when they signal caring and are not viewed as resulting from obligation. (Schaefer et al., 1981, pp. 385-386)

Several studies suggest that support from the supervisor is an important variable in manifestations of distress, health and satisfaction outcomes. Research by Likert (1961) and Stogdill and Coons (1957) suggests that non-supportive leadership styles have dysfunctional consequences. High performance is found when managers display supportive behavior and have high goals (Likert,

1967). Kahn and Quinn (1970) propose psychological support in the presence of stress to reduce role stress. House and Rizzo (1972) report that role conflict is strongly related to both supportive leadership and organizational practices with the relationships between supportive leader behavior and satisfaction being consistently higher than the relationship between supportive organizational practices and satisfaction.

House and Wells (1978) report that supervisory support is the only source of support positively correlated with health outcomes. They conclude that existing empirical evidence strongly suggests that supportive relationships with superiors should directly reduce the level of occupational stress for subordinates.

LaRocco, House and French (1980) state that studies prior to theirs provide substantial evidence that social support reduces perceived occupational stressors (e.g., role ambiguity and conflict) and affects some health outcomes. They report Pinneau's (1975, 1976) findings that supervisory and other work related support were associated with lower levels of role conflict and role ambiguity. LaRocco et al. (1980) call their statistical results convincing evidence for the buffering effect of social support between job stressors and mental and physical health variables. Much of the effective support was from supervisory persons.

Social support may benefit the recipient worker through its main effects or through its buffering effects. Main effects are the direct effects of social support which diminish the stressors and/or directly improve health or health indicators. The buffering effects are mediators in the relationship between stressor and stress and between stress and health. House and Wells (1978) identify five possible main effects. First, a supportive relationship with a manager reduces role ambiguity and role conflict. Four other ways in which social support may reduce stress include altering the perception of stress, reducing the importance of perceived stress, producing a general tranquilizing effect on the neuroendocrine system which diminishes the reactivity of individuals to perceived stress, and facilitating positive coping and health promotion behaviors. Hamburg and Killilea (1979) add the idea that social support may have a direct (main) effect on health; the presence or absence of social support itself may be the crucial factor. Hamburg and Killilea (1979) address the buffering effect of support in saying that insufficient social support may exacerbate the impact of life events which are stressful.

Evidence for the main and buffering effects of social support on occupational stress and health is drawn from the following four studies:

1. In a longitudinal study, Cobb and Kasl (1977) compared 100 men who lost their blue collar jobs due to the closing of two places of employment with 74 men who maintained their jobs in four different companies. The two groups were comparable in demographic characteristics, type of work, and rural-urban setting of the plant.

2. House and Wells' (1978) study of occupational stress, support, and health focused on 1,809 men who were hourly workers in a manufacturing plant. Four sources of perceived support were examined in relationship to five health outcomes and seven manifestations of occupational distress.

3. Caplan et al. (1975) studied stress, support and health in over 2,000 male workers from 23 occupations (no nurses) employed by or associated with 67 different organizations. Three sources of support were examined in relationship to five measures of perceived stress, four additional indices of stress, five health outcomes and three job related strain outcomes. Both Pinneau (1975, 1976) and LaRocco et al. (1980) drew from these data in their reports. Many of the conclusions were drawn from a subsample of 636 men.

4. Beehr (1976) looked at the ability of three situational characteristics (one was supervisory support) to modify the relationship between one organizational stressor, role ambiguity, and four stress responses: job dissatisfaction, life

dissatisfaction, low self-esteem and depressed mood. The 651 male and female respondents worked in five different types of organizations, one of which was a hospital.

Support: Evidence for Main Effects. Evidence for the main effect of social support on occupational stress and health is drawn from the first three studies. Cobb and Kasl (1977) reported that social support had a slight direct effect on depression. House and Wells (1978) reported that supervisor support moderately reduced all forms of perceived work stress and, to a lesser extent, reduced symptoms of disease. The reduction in symptoms was considered a result of the reduced stress. From the Caplan et al. (1975) data, Pinneau (1975, 1976) reported that support from the supervisor had an effect on many stress measures. Men with high (supervisory or co-worker) support usually reported low role ambiguity and low role conflict.

Main effects of social relationships are also reported by Berkman and Syme (1979). A social network index was used in a longitudinal study involving a random sample of 6,928 adults studied for 9½ years. An association between social ties and all-cause mortality was found independent of self reported physical health status at the time of the survey, socioeconomic status, health practices and use of preventive health services.

Support: Evidence for Buffering Effects. Evidence for the buffering effects of social support on the relationship between stress and health is drawn from Cobb and Kasl (1977), House and Wells (1978), Caplan et al. (1975) and Beehr (1976). Cobb and Kasl (1977) found that social support successfully buffered workers against the effects of unemployment on work-role deprivations, psychological distress and, to a lesser extent, physical disorders. In reviewing the study, House (1980) concluded that adequate social support buffered the effects of unemployment to the extent that it eliminated the negative effects of unemployment on depression, low self esteem, anomie, anxiety-tension, psychological symptoms, insomnia, suspicion and resentment. In the presence of social support, joint swelling was also reduced.

House and Wells (1978) looked at the capacity of four sources of support to buffer the stress-health relationship. Half of the 35 stress-health relationships were buffered by some source of social support. Supervisory support buffered 9 of the 35 relationships at the .10 level, the authors' criteria for statistical significance. The health outcomes most effectively buffered were ulcers and neurosis.

LaRocco et al. (1980) reported that the data from Caplan et al. (1975) show that support buffers the impact of stress on manifestations of stress, including anxiety, depression and

somatic complaints. House (1980) concluded that 75% of the potential detrimental effects of stress on manifestations of stress were buffered by social support with mental health symptoms being the most affected. In this study, men with low social support reported increased somatic complaints as perceived stress increased. With high support, high perceived stress was not associated with increased somatic complaints. House (1980) concluded that in the case of high perceived stress, high social support could completely eliminate the detrimental impact of stress on health. Beehr (1976) looked at supervisor support as a source of psychological support and found suggestive evidence that when roles are ambiguous, workers with supportive supervisors may not feel as much role stress as workers without supportive supervisors.

Social support may have a buffering effect not only between psychosocial stressors and illness but also between illness onset and illness course. Social support as a factor in illness course was examined by Murawski, Penman and Schmitt (1978) and Lindsey, Norbeck, Carrieri and Perry (1981) among others.

There are multiple studies suggesting that social support may reduce the impact of stress on physical and mental health and moderate the effect of psychological stressors on manifestations of stress. A sampling of these articles includes Cassel (1976), Dean and Lin (1977), Rabkin and Struening (1976), Kaplan, Cassel

and Gore (1977), Medalie and Goldbourt (1976) and Pilusuk and Froland (1978).

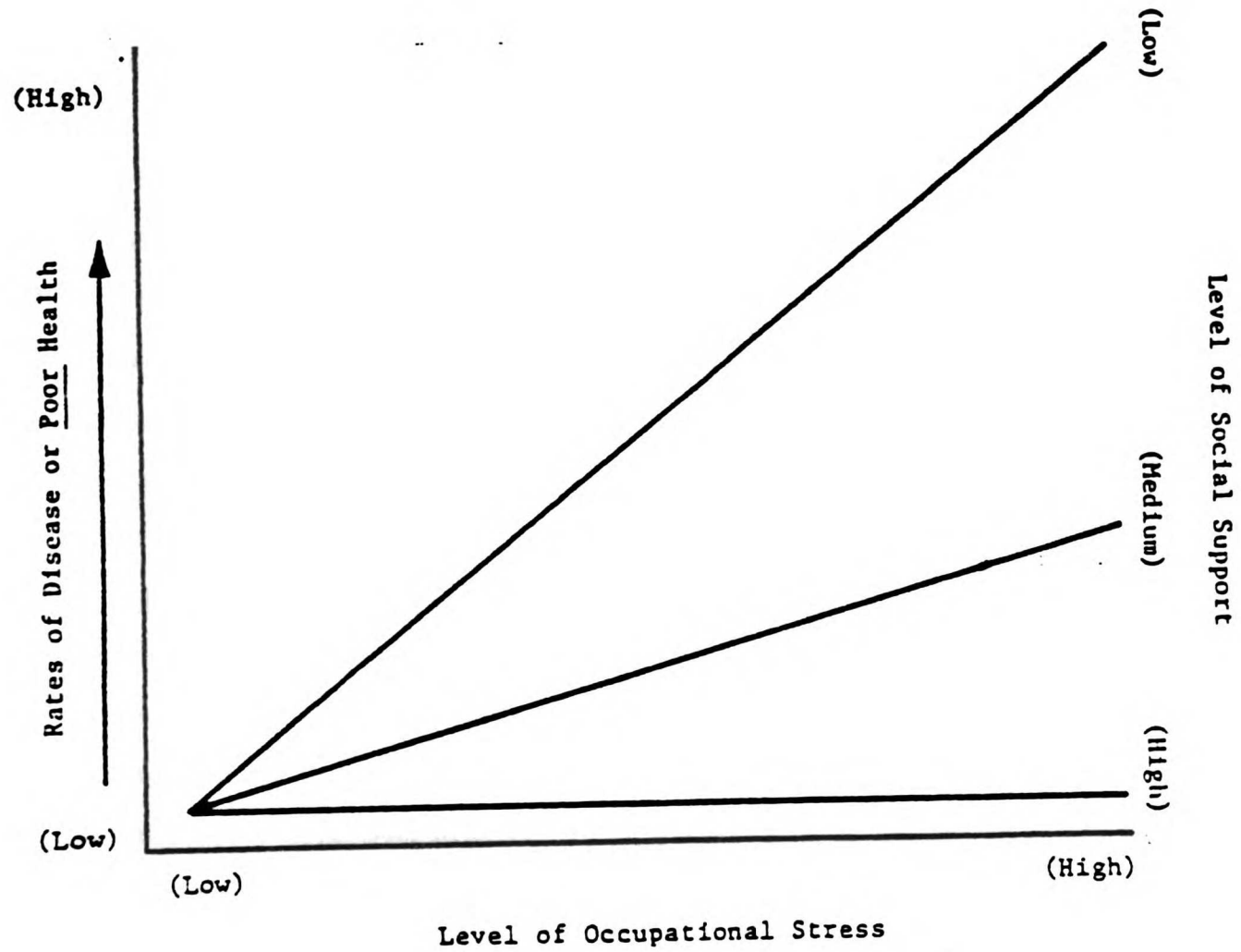
When Support Helps. Support appears to be most effective under conditions of high stress. This has implications for research since it suggests that studies of subjects under low levels of stress may not yield strong results. In the Cobb and Kasl (1977) study, the effect of unemployment on work-role deprivation and depression was markedly higher for those with low social support when compared with those with high social support whether the unemployment was high or low.

House and Wells (1978) found that social support had the greatest ameliorating effect on self reported symptoms of diminished physical and mental health under high stress conditions. As stress increased, those with maximum levels of social support had only slightly increased self-reported ill health. As stress increased for those with minimal levels of social support, a marked increase in symptoms of ill health was reported (see Diagram III). When stress was low, there was essentially no difference in the reported health of those with low versus high support.

LaRocco et al. (1980) note that when stress levels are low, support has little beneficial effect on mental health except as it may contribute to less perceived stress. However, when stressors and stress manifestations are high, support is quite

Diagram III

The "Conditioning" or "Buffering" (i.e., Interactive)
Effect of Social Support on the Relationship
Between Occupational Stress and Health



From: House, J. S. & Wells, J. A. (1978). Occupational stress, social support and health. In A. McLean (Ed.), Reducing Occupational Stress (NIOSH, Publication Number 78-140). Washington D.C.: U.S. Department of Health, Education and Welfare.

protective of mental health. They also note the work related stressors and stress are primarily affected by work-related sources of support.

Nuckolls, Cassel and Kaplan (1972) found that social support made a difference in health when stress was high. When looking at complications of pregnancy, they found that 90% of women with many stressors and low social support developed complications while only one of three women with many stressors and high levels of social support developed complications. Under conditions of low stress, there was little difference in the rate of complications for those with high or low social support. Clearly, social support makes a significant difference under conditions of high stress.

Leadership as a Mediator of Stress

Research documentation exists for several managerial approaches to supportive behavior. Supervisory styles of initiation of task structure and employee consideration (Halpin & Winer, 1957) have been examined in an extensive body of research. The more recent studies have emphasized these two styles as independent but interactive and organizational effectiveness has been predicted on the basis of these styles (Gruenfelt & Kassum, 1973).

Gibb (1965) defines consideration as the extent to which the leader is considerate of subordinates while carrying out leader

functions. Initiating structure is a measure of the leader's organizing and defining the relationship between self and subordinates. Blake and Mouton (1964) claim that both of these styles are needed for optimal effectiveness regardless of situational variations.

House (1971) suggests that under conditions of high ambiguity, leader initiating structure is perceived as instrumental in role clarification and is therefore positively related to satisfaction of subordinates. Initiating structure includes the degree to which the manager assigns tasks, specifies procedures, and schedules subordinate's work. Initiating structure should clarify the probabilities of obtaining rewards. In other words, structure clarifies role ambiguity, makes the attainment of rewards seem more likely, and therefore increases satisfaction with work.

From a study of 82 nursing staff in a pediatric hospital, Gruenfelt and Kassum (1973) concluded that the interactive effects of initiation of structure and consideration are generalizable to the supervision of female nurses. From their study they concluded that higher levels of satisfaction among subordinates and better patient care as seen by other nurses were more likely to be found with supervisors who combined high levels of task and socio-emotional orientation.

Head nurse consideration and initiating structure were studied in relationship to staff nurse burnout and job satisfaction in neonatal intensive care units (Duxbury, Armstrong, Drew & Henly, 1984). They found head nurse consideration to be related to staff nurse satisfaction (r=-.55) and burnout (r=-.29). Structure had an effect in combination with consideration. Low head nurse consideration in combination with high structure was the most detrimental.

Bedeian et al. (1981) found that role conflict and ambiguity were related to supervisory leadership factors including a significantly negative relationship (-.32 $p<.001$) between supervisory support and conflict and ambiguity. They claim that their present findings strongly suggest that role ambiguity and role conflict may be related to supervisory leadership in the area of support.

Recent research documenting the effectiveness of social support from the supervisor has already been discussed. The research includes the studies by Cobb and Kasl (1977), House and Wells (1978), Caplan et al. (1975), and Beehr (1976). Two recent studies in nursing also examined social support. In a study of 68 staff nurses, Mohl et al. (1982) found that supervisory support was central to reducing stress levels for staff nurses. Sheehan, O'Donnell, Fitzgerald, Herbig and Ward (1981) reported that accident and error rates in the intensive care unit were

inversely related to social support.

Role Skills as a Mediator of Stress

Assertiveness is a skill which may be helpful in many roles. Being trained in assertiveness skills increased the interpersonal problem solving ability of high school students (Rotheram & Armstrong, 1980). Assertiveness is generally defined as the ability to express one's self and stand up for one's rights in a way that is respectful of self and other. Assertiveness is contrasted with both passivity (withdrawal) and aggression which inhibit interpersonal conflict resolution and resolution of the individual's feelings of anger or anxiety (Jenkins, 1982). Assertive individuals are more able to express their feelings and elicit respect from others for doing so (Alberti & Emmons, 1970).

Assumptions

The literature reviewed is literature which is relevant to Model I, a model of work stress. Research in stress, occupational stress and stress in nursing was used to identify elements which appear important to work stress in general and nursing work stress in particular. The major elements are stressors, stress/coping, modifiers of stress and outcomes. These major elements have been identified as important in nonpsychiatric nursing stress and in other occupational stress. These same major elements are assumed to be important in psychiatric nursing stress although the specifics of each element

may be very different. Because the model represents those elements important in understanding nonpsychiatric nursing work stress, the same general elements are assumed to be important in psychiatric nursing work stress. Further assumptions are described in this section. These assumptions, derived from the literature, guided the conceptualization and conduct of this study. The questions for exploration guided the study in identifying the specifics of Model I elements. In the next two sections, assumptions and questions for exploration are described.

1. The individual psychiatric staff nurse will perceive some work situations as stressful.

2. Individuals in organizations have incomplete control in reducing stressors and altering stressful situations. This occurs in part because of the existence of the organization and its structure and the roles played by others. These may influence the stress and coping of the individual psychiatric nurse.

3. The individual staff nurse may need help from self, co-workers, the supervisor and perhaps other personnel and the organization in coping with stressors occurring within the organization. The responses which occur may or may not be perceived as helpful.

4. Requesting or accepting social support is a coping

strategy. Supervisory and co-worker support are ways of helping the individual cope with stressors occurring within the context of the organization. The same may be said of help from other personnel and the organizational structure, policies and procedures.

5. Other people and other situations may also influence the stress and coping of the individual staff nurse in psychiatry.

6. The appropriate outcome measure for this study is staff nurse perception of resolution of the problem and/or regulation of the emotional response to the problem. The long term relationship between staff perceived stress and the outcomes of personal health, job satisfaction and productivity are assumed from documentation in the literature.

Questions for Exploration

The purpose of this study was the identification of stressors in psychiatric staff nursing and the description of the effects of coping strategies, others' responses, other mediators of stress, and contextual constraints on the outcome of situations identified as stressful. The following questions guided the study. These questions were not intended to be addressed specifically and discretely in the analytic portion; rather, the questions guided exploration.

1. What stressors do psychiatric nurses perceive in their work? With specific stressors, how do these nurses define:

a. the problem

b. what about the problem was upsetting

c. what was at stake?

2. In a particular problematic or stressful situation, how do the individual, co-workers, supervisor, other personnel, the organization (through structure, policies and procedures) and other persons or situations contribute to perceived stress for the individual nurse: Specifically,

a. In a particular situation perceived as problematic or stressful, what does the individual psychiatric staff nurse do to change the situation, deal with the problem, and/or deal with her feelings?

b. Who and what influences the reactions of the staff nurse and the situation and how do each of these influences affect the stress and coping of the staff nurse?

1. What are the responses of co-workers, supervisors and other personnel in the organization?

2. Does the staff nurse desire and/or request particular responses from co-workers, supervisors and other personnel?

3. How are the responses of the staff nurses and others influenced by organizational structure, policies and procedures?

4. Do other people or situations influence the stress and coping of the staff nurse in this situation?

c. How helpful, hindering or neutral does the staff nurse perceive the responses of self, co-workers, supervisor, other personnel, organizational structure, policies and procedures and other persons or situations in resolving the stressful situation and/or dealing with her feelings about the stressful situation?

d. What was the outcome? Is the stressful situation resolved? Are feelings about the stressful situation resolved?

e. What outcome was desired?

3. Do staff nurses on the same unit perceive the general supportiveness of the work environment similarly or are their views different?

Definition of Terms

Stress: The nonspecific response of the biopsychosocial person to demands made which are perceived as taxing or exceeding the person's resources in a situation important to the person.

Occupational stress: Stress elicited within the work setting.

Stressor: That which elicits stress.

Coping: Interaction of the individual with stressors to resolve problem situations and/or regulate emotional responses to problem

situations.

Problem focused coping: Coping behavior focused on managing or altering the problem or source of stress.

Emotion focused coping: Coping behavior focused on regulating the emotional response to the problem or stressor.

Personal health: In stress research studies, health is generally defined as the absence of symptoms or disease. This is the definition of personal health used in Chapter 2. The researcher defines health as well as wellbeing of the whole person - physical, mental and emotional. This wellbeing is the definition of health used in chapters 4 through 6.

Job satisfaction: Feelings of the individual about aspects of the job situation.

Quality of nursing care: An aspect of productivity which focuses on quality rather than quantity of output. Quality of care is a joint conclusion of patient and nurse.

Psychiatric staff nurse: A registered nurse (RN) prepared through diploma, Associate of Arts or baccalaureate education who engages in patient care and does not have designated administrative responsibilities.

Supervisor: The immediate supervisor of the staff nurse (usually called a head nurse) or a supervisory person hierarchically above the head nurse.

Conflict: Different response tendencies.

CHAPTER 3--METHODOLOGY

Research Design

The research design is an exploratory and descriptive participatory study using semi-structured open ended interview techniques repeated after one month. An exploratory, descriptive study is appropriate when little research has been conducted in an area of interest. No studies of stress and coping in psychiatric nursing have been reported in the literature. Stressors have been studied, particularly in intensive care unit nursing, but the findings are not necessarily generalizable to psychiatric nursing. Research on coping in nursing is very limited; coping has not been studied as a process in relationship to stressors and the context.

An exploratory study is appropriate in the first stage of theory development. According to Dickoff and James (1968) factor isolating theories and factor relating theories are the beginning stages of theory development with situation relating theories and situation producing theories being the successive stages.

Participatory research is also described as new paradigm research, an alternative method of research and cooperative inquiry. New paradigm research focuses on research as a collaborative, experiential, reflexive and action-oriented process (Reason & Rowan, 1981). This contrasts with old paradigm or positivistic research which is concerned with producing

generalizable knowledge based on systematic, comparative, replicative observation and measurement (Morgan, 1983).

According to Morgan (1983) what is studied and what is learned are intimately connected with the mode of engagement adopted. The choice of research method largely determines how the phenomenon studied will be revealed and indirectly, the consequences of the knowledge thus generated. The conduct and consequences of the research are the responsibility of the researcher who is obliged to reflect on the nature of the activity as a means of choosing an appropriate path of action.

In participatory research the researcher and participant develop a collegial relationship with the two together becoming co-producers of learning. The researcher works from the participants' definition of the situation. The participant is viewed as a whole person within a context and the transactions between person and context are studied. The people and processes often cannot be quantified or accurately tested. The participatory researcher values a deep knowledge of the subject under study rather than striving for detachment; real life is not considered a contaminant. Meaning is derived from the phenomenon itself with both complexity and historical roots being explored. Throughout the research cycle, the researcher continues to interact with those from whom the data have come. Information is shared with the participants at all stages and participants are

invited to assent or dissent with conclusions drawn; disagreement elicits a clarification and negotiation process (Reason & Rowan, 1981).

Participatory research is a means of empowering people to take responsibility and control over their lives; it enables them to engage in action consistent with their interests (Morgan, 1983). Therefore the utilization of research findings is valued. It is not sufficient to use findings only to write reports for funding bodies, and/or professional journals (Reason & Rowan, 1981).

Validity is an essential issue in any research. "The primary strength of new paradigm research, its fundamental claim to being a valid process, lies in its emphasis on personal encounter with experience and encounter with persons" (Reason & Rowan, 1981, p. 242). "Validity in new paradigm research lies in the skills and sensitivities of the researcher, in how he or she uses herself as a knower, as an inquirer. Validity is more personal and interpersonal, rather than methodological" (Reason & Rowan, 1981, p. 244). Reason and Rowan (1981) offer the following guidelines for increasing the validity of inquiry:

1. Valid research rests on high quality awareness on the part of co-researchers.

2. A systematic method of personal and interpersonal development is needed.

3. Valid research cannot be conducted alone.

4. Validity is enhanced by the systematic use of feedback loops.

5. Validity involves a subtle interplay between different forms of knowing.

6. Contradiction can be used systematically.

7. Convergent and contextual validity can be used to enhance the validity of any particular piece of data.

8. The research is replicable in some form (pp. 245-250).

The research process is conceptualized as cyclic rather than a linear process. The cycle involves being, thinking, the project (designing a research plan), encounter (doing what is planned), making sense (e.g., content analysis) and communication (Reason & Rowan, 1981). The research process may begin at any point in the cycle. The researcher goes through this research cycle as many times as is necessary or feasible during the research process.

Description of Research Setting

Data were gathered from female RNs working in five inpatient psychiatric units in a federal hospital and four inpatient psychiatric units in three private hospitals. All units involved were for acute adult patients.

The federal hospital has more than 1000 beds with more than half of the beds designated as psychiatric beds. Twelve

participants were employed in this setting. Three RNs worked on a locked unit with 20 beds for acute male patients; some voluntary patients were also admitted. One RN worked on an open research unit with 13 beds for voluntary male patients. Two RNs worked on an open primary care research unit with 22 beds for voluntary male patients. Three RNs worked on a 28 bed unit with acute female patients and subacute male patients who were both voluntary and involuntary; the unit was open or locked as needed. Three RNs worked on a 27 bed unit for acute female patients and subacute male patients who were both voluntary and involuntary; the unit was open or locked as needed. Each unit had a head nurse and four of the five units practiced team nursing; one unit had primary nursing.

Ten participants were employed in three private hospitals. One hospital had a total bed capacity of nearly 500; the RNs involved worked on the 37 bed open unit with male and female patients. Involuntary patients were accepted on this open unit. Three RNs worked on the 18 bed psychiatric unit of an under 200 bed private hospital. This open unit had both male and female patients and also accepted involuntary patients on their own unit. Six RNs worked on two psychiatric units in a 350 plus bed hospital with nearly 100 psychiatric beds divided among four inpatient psychiatric units. Three RNs worked on a 24 bed acute, locked unit with both male and female voluntary and involuntary

patients. Two RNs worked on a 10 bed open unit with male and female patients having both medical and psychiatric problems.

Sample

Human Subject's Assurance

The research proposal was approved by the university's Committee on Human Research and the federal hospital's Committee on Human Research. The proposal was also approved by the directors of nursing at each private hospital.

The research proposal described the risks involved in the research and the anticipated benefits. Two risks were noted: (a) discussing this information could be disturbing; therefore participants had the option of refusing to answer any specific question or of terminating her involvement in the research at any time, and (b) privacy was at stake, so individual interviews were confidential; only the researcher knew the participant's identity. Completed taped interviews were transcribed by the researcher who eliminated all names in the process. Transcribed interviews were coded by number with only the researcher having the list associating numbers with names. This list was destroyed when the research was completed; tapes were erased.

Questions and concerns about the study and participation were encouraged at the outset and at any time in the research process. Participants were also told that they would have input into decisions about dissemination of the findings.

ch participant received an information sheet/consent form
beginning of the first interview. She was asked to sign
y for the researcher and to keep a second copy for herself
pendix E). This form explained the purpose of the study
process involved, reminded them of their rights as
pants and gave the researcher's name, address, and
ne number.

Nature and Size of Sample

ie sample consisted of 22 female registered nurses employed
st half time in psychiatric nursing. These nurses had been
r current jobs for 1 to 4 years, the mean length of time
years. The length of time in psychiatric nursing ranged
years to 32 years with a mean of 6 years. The length of
nursing ranged from $2\frac{1}{2}$ years to 32 years with a mean of
ears.

ie nursing education of these nurses ranged from diploma
is to education at the masters level. Four (18%) of the
held diplomas in nursing, six (27%) held associate of arts
s, ten (46%) had baccalaureate degrees and two (9%) held
s degrees. Four of these nurses were currently enrolled
ers degree programs. In addition, two of the nurses with
te of arts degrees held a bachelors degree in another
ine and two baccalaureate prepared nurses also had earned
laureate degree in another field.

The nurses' ages ranged from 24 to 55 years with a mean age of 38.5 and marital status was single (N=8; 36%), married (N=10; 46%) or divorced (N=4; 18%). None were widowed. Nine of the married nurses and three of the divorced nurses had children who ranged in age from 2 years to adulthood. The number of children ranged from one to four with a mean of 2.2.

The ethnic backgrounds of these nurses varied and four nurses said they did not identify with any ethnic background. In describing the ethnic background with which they identified, four nurses said white anglo-saxon protestant, two said Catholic, two said European, two said Scandanavian, and two said Irish. Russian, Latin, Japanese, Chinese, Jewish and working class ethnic identification were each reported by one nurse.

All of the participants worked either day shift or evening shift. None routinely worked nights or rotating schedules although all of them worked other shifts at times. Fifteen (68%) usually worked days and seven (32%) usually worked evenings. Fifteen (68%) of these nurses worked full time, four (18%) worked 0.8 time and three (14%) worked 0.5. During the time of the study one nurse reduced her time from 0.8 to 0.4 because of school commitments.

Criteria for Sample Selection

The criteria for sample selection were female staff nurses who had been in their present job at least 1 but less than 6

years and worked at least half time. They had no designated administrative responsibilities. Participation was voluntary.

An all female sample was desired to avoid the possible confounding variable of including a few males. Approximately 97% of practicing nurses in the U.S.A. are female (Lysaught, 1981).

The 1 to 6 year period of employment was somewhat arbitrarily selected as a time period when the "honeymoon" period was over, the realities of the work and work setting had become clear, and the RN was not yet firmly entrenched in the job. Some of the stressors of a job may not have been apparent during the first few months of employment and the new employee is also coping with learning the peculiarities of the individual setting during the early month of employment. Talking with nurses employed in the current setting for at least a year diminished the possibility that they were unaware of the stressors within the job and took them past the point of coping with learning the peculiarities of the individual setting. Employees of many years may be motivated to remain in their job because they are close to retirement. The long term employee may also have developed ways of coping unlike those used by newer employees.

The focus of this study was staff nurses, thus those with designated administrative responsibilities were excluded. Almost all of these RNs were sometimes in charge of their unit during their shift but this was not a consistent or designated

responsibility.

Data Collection Methods

Data collection methods were semi-structured interview, the Work Environment Scale by Insel and Moos (1972), and telephone calls for clarification or additions to interview information. Data also came from feedback from individuals and group discussion of the findings; feedback was particularly helpful when discrepancies occurred between researcher and participant conclusions.

The 90-question Work Environment Scale was comprised of ten subscales that measure the social environments of various types of work settings. The relationship dimension was measured by involvement, peer cohesion and supervisor support subscales, the personal growth or goal orientation dimension was measured by autonomy, task orientation and work pressure subscales, and the system maintenance and system change dimensions were measured by the clarity, control, innovation and physical comfort subscales (Form R, measuring perceptions of existing work environments was used).

Norms for the Work Environment Scale were developed from 1607 employees in a variety of health care work groups. Subscale means, standard deviations and standard score conversion tables are provided. Internal consistencies ranged from .69 to .86 (Cronbach's Alpha). Subscale intercorrelations indicated that

the subscales measured distinct aspects of work environments although the aspects were somewhat related (from .36 to .52). Test-retest reliabilities ranged from .69 to .83 after one month. Form R profiles were found to be stable for as long as one year (Moos, 1981).

Procedure

Access was requested through the nursing directors of the private hospitals and the nursing education director in the federal hospital. Head nurses on each unit were then contacted, the study was explained and sample selection criteria were described. Head nurses talked with staff nurses meeting the criteria and gave the names of nurses interested in participating to the researcher. The researcher then contacted each RN to arrange the first interview appointment.

Each of the participating nurses was initially contacted by telephone. The researcher introduced herself as a psychiatric nurse and doctoral student studying stress and coping in psychiatric nursing. The researcher indicated that the name of the RN had been given to the researcher by the RN's head nurse after the head nurse had ascertained that the RN met the sample criteria and had indicated a willingness to discuss participation with the researcher. Information sheets about the study were available on each unit.

The initial interview was arranged at a time and place convenient for the nurse. The interview appointment was reconfirmed the day of the interview with the researcher acknowledging in the original telephone contact that reconfirmation was important because work and personal schedules change and an agreed upon time may become inconvenient or impossible. All federally employed nurses were interviewed at work during work time. All privately employed nurses were interviewed outside of work time; most of these interviews were held in the homes of the participants.

Each participant was interviewed in person for about an hour on two occasions one month apart using a semi-structured interview schedule. The same questions were asked on both occasions with additional questions asked in the second interview (see Schedule I, Appendix A, and Schedule II, Appendix B). During the first interview demographic data were requested (see demographic interview schedule, Appendix C) as well as completion of the Work Environment Scale by Insel and Moos (1982) (Appendix D).

At the beginning of the first interview the researcher reintroduced herself and reviewed the purpose of the study. Researcher expectations of participants were explained: at least two face to face interviews lasting about an hour scheduled approximately one month apart, telephone contact if needed for

ication, completion of the Work Environment Scale, reading
searcher's initial analysis of the data and attending a
session with the researcher and other participants to
s the researcher's analysis and conclusions as well as the
cher's initial theory base, research methodology and future
ination of the findings. This information was summarized
information/consent form. The participant signed one copy
e researcher and kept one copy for herself. The
entiality of the interviews was discussed and the
ipant was encouraged to raise questions or concerns about
entiality or any other aspect of participation at this time
future time. The information/consent form contained the
s and telephone number of the researcher. The ensuing
iew was then tape recorded with the permission of the
ipant and the Work Environment Scale was administered.
he researcher introduced herself as a psychiatric nurse who
en a staff nurse and was currently involved in doctoral
ion. The purpose of emphasizing that the researcher was a
atric nurse was not only for introduction but also to
ish rapport. On the one occasion when the researcher
to introduce herself in this way, there was seemingly a
ence in the openness of the participant. At the end of the
iew the participant asked the profession of the researcher,
when it was explained, then said, "Oh, in that case . . ."

and shared further, more personal work experience and observations. Rapport grew through the two interviews as the researcher indicated commonalities in thoughts, feelings and experiences as psychiatric staff nurses (e.g., a preference for working evenings, frustration with borderline patients and the professional growing pains in learning to base professional self esteem on nursing behavior rather than patient response). The identification of the researcher as a psychiatric nurse also made it unnecessary to explain the legal and technical language involved in psychiatric nursing work.

The notable disadvantage of the researcher's being a psychiatric nurse and so identifying herself was the possibility of the researcher assuming understanding without validation through asking. The researcher found that it took continual vigilance to ask the meaning of particular experiences for the participant rather than assuming it matched her own.

The researcher began the interview with the statement that she had two areas of interest, (a) the kinds of situations that the participant experienced as stressful, that is, difficult to deal with or requiring a lot of energy, and (b) the in depth exploration of one situation which the participant had found stressful. First, what kinds of events had the participant experienced as stressful in the past month or so at work?

When the participant exhausted her responses to the first question, she was asked to select one situation for in depth exploration. After the situation was described, the participant was asked specifically, how would she define the problem in this situation? And on a scale of one to ten, with ten being equivalent to the most difficult problem she had dealt with in psychiatric nursing, how would she rate this problem? What about the problem was upsetting to her? What was at stake here, that is, what was there to gain or lose or what difference did the outcome make? And on a scale of one to ten, with ten being vital, how important was the stake to her? When the situation was first encountered or recognized as a problem, what did she want the outcome to be? What efforts did she make to achieve that outcome? What feelings did that situation engender in her? What did she do with those feelings? How did that come out? Who else was aware of the situation and how did they respond? In her response, the participant was encouraged to consider and describe the actions of co-worker RNs, other co-workers, the head nurse and supervisor, physicians, patients, other personnel and other persons such as patient families or their own families. They were asked about the influence of the organization, how the structure, policies, and/or procedures of the hospital or their unit influenced the situation and the responses of self and others. When this was exhausted, the participant was asked what

response was most helpful to her of all the various responses she made and others made. Were there any responses which were detrimental? Were any responses desired but not obtained? If so, had she asked for the desired response?

Finally the researcher asked the participant for an update, that is, what was happening now or what was the final outcome. Did this situation and its current status or outcome have any continuing effect on her? Had the situation happened before? If so, how did she deal with it then; did she deal with it differently this time? What else could be said about this situation?

The questions were not always asked in the order described. Sometimes questions were answered without being asked. Additional questions or areas of interest were pursued as they arose in the interview. However, the above information was elicited from each participant.

Demographic questions followed the exploration of one stressful situation. How long had the participant been in nursing, how long in psychiatric nursing, and how long on this job? What percent of time did she work and what shift? What type of unit did she work on (e.g., male, female, locked, open, acute, subacute), and what was the patient capacity for the unit? When she first began her job on that unit, did she receive an orientation? If so, was is sufficient, did it help, how so? Did

she consider this a job or a career? How old was she, what was her marital status and did she identify with any particular ethnic background? Was work the biggest source of stress in her life or were there aspects of her life that were more stressful than work?

After obtaining the demographic information, the researcher acknowledged that she had asked many questions for the past hour and wondered if the participant had questions she wished to ask the researcher. A few participants had no questions; most asked questions about the study, the researcher's work experience and/or the researcher's experience in school. After this the participant often volunteered additional information about herself and her work experience.

As interviews were transcribed by the researcher, missing information and statements needing clarification were discovered. Telephone calls to the participants were used to gather this information. Nearly half of the participants were called for this purpose.

The second interview was scheduled as close as possible to four weeks after the initial interview. The interview time was confirmed the day of the interview. Because of unanticipated changes such as an unusually busy work day, illness or change in schedules, nearly 50% of all interviews had to be rescheduled. The time lapse between first and second interviews was actually

between 2 and 8 weeks.

The second interview contained the same questions as the first about stress and coping. Additional questions were also asked. Each participant was asked to estimate the amount of time usually spent with patients during a work day. Was this their expectation when they started the job or was their experience different from their expectation? If different, what was their expectation in terms of time to be spent with patients? If the participant had all the power, control, and money necessary to make one change on her unit to decrease the stress, what one change would she make? Currently, what was her greatest source of help or support at work? She was then asked to respond to four concepts in terms of her work experience: time, space, money, and energy.

At the end of the second interview participants were asked what, if any, effect they had noticed from their participation in this research project. The most frequent response was that it had been helpful to them to have someone listen and understand; some indicated that it had given them a different perspective on the particular problem and/or their responses. Several nurses indicated that they had elected to talk about situations which were unfinished for them because it helped them further understand what had happened, explore alternatives or move towards resolution within themselves. Participants were also

asked if they had any questions of the researcher. Many asked about findings thus far and these were discussed at the end of the second interview. If this question was asked earlier, the participant was asked to wait for a response until after the second interview. Sometimes the researcher shared preliminary findings that related to the participant to elicit the response of the participant to a particular preliminary finding.

Rapport between researcher and participant grew with the exchange of information and the use of one another as resources. When one participant said she was just beginning an outreach baccalaureate program, and had many unanswered questions, the researcher indicated that she was a mentor for that program and would be willing to discuss her questions and concerns. A participant who was a master's student attending the same university as the researcher asked if time could be allotted at the end of the second interview to discuss her ideas for writing a comprehensive examination. This was done and the researcher shared her collection of books and articles related to the participant's topic. Another participant called the researcher to say her unit was soon to begin primary nursing and the staff wanted to measure staff satisfaction before and after the change. Did the researcher know of tools measuring satisfaction in psychiatric nursing? The researcher shared what she knew and gave the name of a colleague who was studying that topic and had

reviewed many tools for measuring job satisfaction in nursing.

The participants served as resources to the researcher through their participation in the research, in non-research related ways and in discussing preliminary findings brought up by the researcher. The researcher was acutely aware of the gifts of time, interest and information from the participants and expressed her appreciation. When a friend of the researcher asked for a referral to a psychiatrist in a geographical area unfamiliar to the researcher, the researcher called the two participants from that area and obtained appropriate referrals from them. In the preliminary analysis the researcher noticed that master's prepared nurses seemed to spend more time with patients and also to experience more role conflict than nurses with different educations. At the end of second interview the researcher asked master's prepared nurses to respond to the researcher's perception (they validated it) and to discuss how they accounted for this difference.

The mutual give and take and mutual gain described above is one of the aims of participatory research. For the researcher, is was a very satisfying part of the process. This shared relationship is an essential part of what Reason and Rowan (1981) call hermeneutic understanding. "The greatest possible familiarity with the phenomenon in all of its complexity and historical connectedness" (p. 134) is sought. This process is a

part of achieving inter-subject validity.

After 13 participants were interviewed twice the interview process was suspended while an initial analysis of data was completed. This helped to focus on areas of particular interest for the later interviews. The later interviews were also compared with the emerging theory for fit or discrepancy.

The last nine participants interviewed were asked during the first interview if they would like a copy of the interview transcript. Eight requested the transcript which was mailed to them. During the second interview, the researcher's summary of the interview was shared with the participant to obtain their feedback on accuracy and to compare perceptions of what had taken place.

When the interviewing process was nearly completed, participants were sent a letter indicating time and place for the anticipated group session (Appendix F). This letter was sent 2 months ahead of the scheduled session to allow for the requests for days off to be worked into individual schedules.

A cover letter (Appendix G) and a copy of aggregate findings (Chapters 4 and 5) were sent to all participants 2 weeks before the scheduled group session. Participants were asked to read the analysis and make notes of their responses, such as agreement or disagreement with the researchers conclusions, and areas for clarification.

The focus of the group session was the discussion of different responses to obtain a more accurate picture and further understanding and explanation of the major findings. Having participants respond to the data enhanced the constant comparison process and facilitated grounding emerging theory in the data.

The group session was a 6 hour session held in the community. The nurses received 6 hours of continuing education credit for their participation; no fee was charged for the credits (the course outline is given in Appendix H; the continuing education credit certificate is Appendix I). With the permission of the participants, the session was tape recorded and a colleague of the researcher attended as an observer. All others present were participants; nonparticipants were not allowed to attend.

The group meeting was attended by 10 participants. Five others informed the researcher that they would not be able to attend and four of these gave feedback about the analysis of data. The 10 participants attending represented those who did and those who did not identify staff as their greatest source of stress, the continuum of assertiveness within this participant group, all four categories of coping outcomes, and six of the seven classes of stressors. Institutionally, the federal hospital and one private hospital were represented; no one attended from the other two private hospitals.

The day began with introductions and the researcher presented an overview of her theory base and research methodology. The major findings were reviewed and the questions were raised: "How does it come to be that staff are the greatest source of stress?" "How can we understand that and how can we usefully respond?" This discussion lasted most of the day. Many different viewpoints, ideas and experiences were shared. Some of the group agreed and experienced staff as their greatest source of stress. For those who did not experience staff as their greatest source of stress we discussed, "What is different for you?" Areas discussed included education and socialization, unit structure, interactions and leadership behaviors. Interwoven in the discussion were implications and recommendations and ideas for dissemination of information.

At the end of the day participants were asked to categorize according to the researcher's classes of stressors the two stressful episodes which they had described in detail. This was to help the researcher validate her categorization; agreement was 90%. Participants were also asked to rank the seven major categories of stressors according to their experience. Finally, each participant was given the results of their Work Environment Scale with their standard scores graphed so they could compare their own responses to the norm for hospital workers.

A copy of the discussion of the findings and implications for nursing was sent to all participants with a cover letter (Appendix J). Participants were invited to respond by telephone or by letter.

When the researcher's dissertation was completed, participants were sent a thank you letter (Appendix K), and a copy of the dissertation abstract. A copy of the dissertation abstract and a thank you letter (Appendix L) were also sent to unit head nurses and to the directors of nursing who facilitated entree and contact with staff nurses.

Analysis of Data

Each tape recorded interview was transcribed verbatim by the researcher. Each interview was summarized according to the interview questions with theoretical and methodological notes attached.

Interview questions were used first to organize the data. Commonalities and differences were examined within each interview question: What are highly rated problems? What are high stakes? What are the characteristics in a situation where the problem and stakes are rated low? Where the problem is high and the stakes low? Where the problem is low and the stakes high? What does the RN desire in the situation and to what extent is what she desires under her control? What does she do? What are the outcomes? What feelings emerge? How does she cope with these?

What are the outcomes? How do co-workers, the head nurse, supervisors, physicians, other personnel and other people respond? What influence does the organization have? Who or what helps most? What is least helpful? What was wanted that was not obtained? Is this influenced by asking? What one change would the RN most like to make to decrease stress? What is biggest source of support now? What percent of time is spent with patients? How does the RN now relate to time, space, money, energy? What is happening now in relation to stressful situation? Does that have a continuing effect on the RN? Has this type of situation happened before? Is she dealing with it the same or differently from in the past? Also, what is common or different about those in psychiatric nursing less than 2 years? Longer than 10 years? With a master's degree? With a diploma?

The interview questions were used to identify categories of stressors. For instance, all problems and stakes were listed and then sorted into categories of stressors. As categories were developed, commonalities emerged and new categories developed. As problems and stakes were examined, some role enactment problems were noted as stemming from conflict with other staff. The interviews were reread to identify instances of staff-staff conflict as a stressor. The repetitive process of rereading summaries and interviews facilitated developing categories beyond

those identified in the specific questions asked.

The present list of categories of stressors (see Chapter 4) was developed from the interview data and the more than 400 stressors identified by the participants. Twelve categories emerged. After the categories were identified, the list of stressors was reviewed to be sure each stressor identified fit into one of the categories. Sublists and subheadings were extracted through this process. Some recombination and collapse of categories was then possible. Finally, the example situations were classified according to the seven categories.

As stressors were identified the question was asked, what makes these incidents or situations stressful? That is, what is stressful about someone else not meeting their job description? What is it that is stressful about supervisory scheduling or physicians ignoring input and making unilateral decisions or patients having no commitment to change or being unresponsive? Commonalities and differences within and across classes of stressors were examined. From this emerged a list of dimensions which seem to make a situation stressful.

In one situation which most would consider stressful, the RN's perception was that it was not stressful. The question was asked, what are the characteristics of this situation and how do they differ from stressful situations? Can the same dimensions be used to explain the experience of stress or lack of stress?

The same process was used to examine coping. Interview questions were first used to organize the data with new categories emerging from these data.

The development of categories for stressors, dimensions of stress, and categories of coping was not a linear process nor was it as neat as described. All areas were examined simultaneously and discoveries in one area often affected discoveries in another area. Data analysis occurred through the interview process and there was a constant comparison of new data with previously developed categories.

The frequent rereading of the data helped the researcher to become familiar with the data; comments and situations occurring frequently were noticed. A sampling of the themes and questions that emerged included: When does withdrawal happen? What are the effects of self talk, vulnerability, lack of control, perception of injustice or wrongdoing? What do these nurses say about how they survive and what they learn? What happens when the RN feels threatened? What is the effect of longevity or recurrence of the stressor? What interferes with getting the work done? How is staff interaction upsetting? What happens when something is wanted from someone else? Data relevant to these and other questions were listed and sorted into categories.

As categories developed, relationships between categories were sought. Bits and pieces were linked together to form a

coherent whole. These linkages were validated or changed according to incoming data.

The end result of the analysis included responses to the researcher's questions which go beyond a summary of questions asked. The analysis included areas not included in the questions but present in the data. The descriptions represented a compilation of concepts and their linkages as they appeared throughout the data. Validation occurred as an interpersonal process between researcher and participants.

CHAPTER 4--ANALYSIS OF THE DATA: STRESS

Introduction

The purpose of this chapter and the next one is to describe the analysis of the data. This chapter is an analysis of sources of stress or stressors; the following chapter describes coping strategies and outcomes.

This chapter begins with an analysis of the major source of stress identified in this study--staff. This is followed by a discussion of the factors which appear to contribute to stress in any situation. An overview of all identified stressors is then given.

Staff as Stressors

The majority (73%) of these participants identify staff as their major source of stress. This consistent description of staff rather than patients as the major source of stress leads to the question, what goes on in psychiatric inpatient units? How does it happen that co-workers are more stressful to these nurses than the patients with whom they work? This section describes the experience of the 73% of nurses (N=16) who say staff is their major source of stress.

The descriptions of what goes on, and how staff come to be the major source of stress fall into three interrelated categories: (a) staff spend more time with other staff than with patients which provides more opportunity for staff to be

stressors and which itself is a stressor since most RNs do not expect to spend so little time with patients, (b) patient problems and staff problems are dealt with differently, and (c) other staff are often perceived as obstacles to, rather than helpmates in, delivering patient care. As one nurse says, "It is only stressful dealing with patients when there is stress among staff; it has to do with whether or not we are working together."

The Unexpected: More Time and Contact with Staff Than with Patients

Psychiatric nurses are educated to deal with psychiatric patients and they go to work anticipating patient care, that is, "I go to work with energy for patients." Patient care is described as an important source of job satisfaction, even a joy for some. Participants in this study express the continuing expectation that their work is patient care.

At work they find a discrepancy between their expectations and reality. Much of their time at work is spent planning and working with each other. Staff spend more time with staff than they spend with patients. According to Lysaught (1970) "the direct care of patients is the most satisfying single aspect of their profession for a majority of nurses. Nevertheless, the nurse in practice is very apt to find that 50 to 75% of her time is spent in non-nursing functions" (pp. 90-91). Each participant was asked to estimate the percentage of time usually spent with

patients. The average amount of time spent with patients for the entire group is 41%. Those who say that staff is the major source of stress estimated spending 38% of time with patients while those not indentifying staff as the major source of stress estimate spending an average of 47% of their time with patients. The greater amount of time spent with staff and administrative issues versus patient care suggests that there is more opportunity for staff conflict because more time is spent interacting with or in contact with staff.

Fifty nine percent of these nurses say they are surprised by the small amount of time spent with patient care. Many want and expect more, although some say that about 50% of time with patients is all they could tolerate, but few achieved this proportion of time anyway.

These nurses not only spend more time each day with staff than with patients, but they also must deal with the fact that patients come and go while staff tends to remain the same. Conflicts with particular patients have definite time limitations while conflicts with staff may last for a long, indefinite period. This provides more time and opportunity for staff-staff problems to develop. As one nurse explains, "Patients come and go, you have to live with the staff. If you work 40 hours a week, you are with the staff 40 hours a week and they don't get discharged; they are there. You spend more time with them than

you do with family."

Staff also have less control over contact with staff than with patients. It is usually accepted that all staff will not work well with all patients and allowances may be made for this fact. Speaking of another nurse, one nurse describes the process "She has said that she does not have a good relationship with this patient and so she stands back. That is something we do on this ward, if we have a feeling we are not going to be a positive influence for the patient we step back from that patient and let somebody else handle it. If there is a person we can't work with, there is no point in forcing it. It's not going to be good for you, it's not going to be good for the patient so we tend to step back and say, Hey, I can't work with this patient, OK? I can give him his meds or whatever little requests there are but I don't want to be involved in the treatment."

There is seldom allowance for staff who do not work well with each other. Staff are assigned to particular shifts and usually to particular teams. They do not choose their co-workers. There is an assumption that staff will work with whomever is assigned to their work group. At no point during the interviews did participants describe allowances for staff who have difficulty with each other as there are allowances for staff who have difficulty with particular patients.

Differences in Dealing with Patient and Staff Problems

Staff response to problems with patients and problems with staff is very different. Not only do the nurses feel prepared and confident in dealing with patients but there are resources and procedures for dealing with patient problems. This is not true in relationship to staff. The following are four nurses' descriptions of the differences in dealing with patient problems and staff problems:

1. "Patients are stressful, sure patients are stressful, but we have ways that we deal with that. We all sit down and we all problem solve; we all do this, this, and this. There is no way to deal with staff problems."

2. "Patients are not the biggest stressor. We have pretty clearcut things you can do about patients and I think we handle stress with patients pretty well. We meet after a particularly assaultive incident and rehash it and problem solve immediately and give each other feedback right away so that we can think about it right away and also give each other support for what did happen. There are pretty clearcut things that we do like talk to the patient as soon as you can about it, so I don't really carry around too much stress in that area. I'd say it's true that we don't have such effective ways to deal with staff stress."

3. "Basically, if I am dealing with the patient, or patients in general, I am using my own expertise in that area and doing direct patient care is something I am competent in doing and I am dealing with patients who are aggressive or assaultive or you name it. Clinically, if I don't know something, I have the resources available and know where to go to get the information that I need but with staff, there are a lot of issues that are organizational issues or incompetence or laziness or lack of follow through. They have to go through a certain documentation procedure on the job because of the union system, hiring and firing, so a lot of the people who probably shouldn't be there or do not perform the job adequately and know it and administration knows it, we are in the process of doing this documentation thing which takes years. So in that particular situation the staff is, I think, always more stressful. People seem to at least have the goal in mind that patient care should be quality type so they are willing to follow through or at least know that if they don't follow through, there is going to be some documentation in those areas. There is always some controversy in the ways people deal with patients, however, there seems to be a united way of looking at the patient and dealing with the patient. Our patients do fall into a range of behaviors. We have consistent ways of dealing with different types of behaviors in psych. It's not cookbook but there are ways, a routine way,

usually."

4. "You are going to have patients that are out of control or demanding and I particularly have a hard time with borderline patients and some manic patients. But you deal with it. You can separate them, you can ask for help. But I find the working situation, like negotiating the things to be done in a safe and efficient manner, is harder than working with patients."

Problems occur with both patients and staff but patient problems are dealt with more effectively than are problems with staff. Major differences in dealing with patient and staff problems are in the nurse's preparedness to deal with patients' problems, the resources available to deal with these problems, the general recognition that such problems occur and the establishment of procedures or processes for dealing with the problems.

Preparedness is a factor in the nurse's ability to fulfill her role as she discovers it to be in the work world. The psychiatric nurse is educated for patient care. Even more often than she is involved in patient care, she is involved with co-workers. She is not prepared to deal with the inevitable differences of opinion that arise and does not have a general recognition or expectation that different staff will respond in conflict with one another. There may be no recognized procedure or resources for dealing with staff conflict or problems.

The nurse is also unprepared for her role in supervising others. As noted by Lysaught (1981) "though it is not included in the nursing curriculum, registered nurses were expected to supervise and train auxiliary personnel" (pp. 37-38). As one nurse describes it, "I'm aware of the role that has evolved in psych . . . the role has turned into the overseeing of the care by others . . . as far as spending time with patients, I think it is a luxury to have that role anymore." Difficulty in supervising auxiliary staff is frequently described as a stressor.

Staff as Obstacles to Patient Care

Other staff are often perceived as obstacles to patient care because of working relationships and/or the perception that other staff cannot be counted on or are unreliable. Content analysis of reported problems in the working relationships indicate the following general areas: conflict, lack of communication, and attitudes. Problems with ability to rely on other staff stem from perception that staff are unprepared or are not doing their jobs and/or are meeting their personal needs at work.

Stress in Staff Working Relationships

Conflict. There is often conflict over patient care. When dealing with a clearcut medical problem, solutions are usually clear cut and limited. In psychiatric nursing the appropriate procedure is less clear and there may be several useful

approaches. Staff have different belief systems and different ideas about what is good for patients. "I find that in psychiatry the diversity of opinions are much wider than in other areas. You get so many conflicts of opinions and ideals that I sit here and say, This is the first experience that I have had with that many differences of opinion and conflicts of opinions of how to deal with a specific patient."

When differences are accepted and valued, they are not problematic or stressful, rather they are described as helpful. When different response tendencies of staff are discussed, described consequences include learning and arriving at a concensus that all could support.

More often, there is lack of tolerance for differences. In the face of diverse possible approaches, nurses may take an inflexible stance: My way is the only way. As one nurse said to another, "That is not the way I would do it--you are doing it wrong."

When staff take the position that they are right or know best, infighting and power struggles develop. This is described by a number of participants who also describe the effect of the infighting on them and on patient care. "I can honestly say I don't get along as well as I'd like to with the people I work with . . . there isn't the cohesiveness among the nurses in psychiatry." "I'm just not the kind of person that tolerates a

lot of bickering among staff. I like to see a cooperative staff that works together for the benefit of the patient. And it also benefits the staff, I think, When I can work in that sort of situation I am comfortable and I can handle a lot of patient stress but I can't handle patient stress when there is a lot of staff stress." "There is all this undercurrent which takes so much of the energy that should be used on the patients."

The result of the infighting and power struggles is often described as staff being split into waring camps and lack of teamwork with patients. "What ends up happening is one person decides he is going to work with this patient this way and another person decides she is going to work with them this way. There is no treatment plan or treatment planning. So everybody works on whatever they want to work on with the patient; and it's a mess, it's really a mess. . . . They'd rather do their own thing than have a team approach. . . . Patients come up to me and say, I've got eight different people giving me eight different things to do or different advice from all these people and I don't know where to go with it all, I don't know what to do. One says yes do that, another says no, do this and that is real confusing to patients. I don't think it is our job to be giving them all this different advice when they are confused in the first place. Everybody is telling them how to run their lives. And people are coming from their own thing of what people should

do . . . and expecting more out of patients than what they can do. Sometimes I think they (staff) make them worse."

Some of the ways conflict is dealt with and some of the communication patterns of staff make the resolution of any problem more difficult. One nurse describes the three ways that staff-staff conflict is dealt with on her unit: "Tell the head nurse (who listens but doesn't do anything), talk about the problem with others in one's own clique or express resentment to offending staff in an indirect way."

When the conflict is a problem that has happened with patient care, several nurses report that accusations, criticism, blame and scapegoating rather than problem solving is the norm. According to one nurse, "If we do make an error, rather than pointing fingers at each other, we need to really use it as a learning experience and not just accuse and jump on people. That continues to be a problem; they (nursing staff) love to single out one person and say that one person is responsible. This seems to be very rampant among nurses. I don't know if it's in business or other types of jobs but nurses are very quick to jump on each other. I found that when I worked on a medical floor also."

Problems with staff's different response tendencies are not openly recognized or expected and the participants seem unprepared to deal with these differences. In the absence of

procedures or leadership to deal with the different response tendencies, problems come to be expressed in hostility, power struggles, accusations and blame and covert behavior.

Communication. Lack of communication may occur for many reasons including (a) there is not an attempt to communicate, (b) the communication is so indirect it is essentially non-communication, and (c) the person attempting to communicate is not listened to and therefore communication is blocked. This lack of communication both creates and escalates problems.

Some do not attempt communication at all, particularly feedback or discussion. "People are afraid to tell other people things like if you don't like what someone else is doing with the patients; they are afraid of repercussions because they talked to this person. Staff say something to your face and then turn around and say something different."

In describing a problem with another staff member one RN laments ". . . if she had just explained a little more and waited for me to give her a little more feedback." In discussing her communication problems with a co-team leader another RN says, "I feel as if she doesn't talk to me about what she needs to talk to me about. It doesn't make a supportive relationship when she is supposed to be a co-team leader. . . . I'll never know what's going on, it's like there will be all kinds of hidden agendas. . . . I certainly think it affects my performance

because I do depend on her to support me and I do depend on her to give me information I need."

One nurse describes the increasingly indirect communication on her unit: "We have actually gone so far as trying out where you put a little slip of paper in a hat with something that another staff did that you didn't like or you thought was inappropriate, without their names on it, then you pick a slip out and read it." "It strikes me that communication is something we should all be very good at or at least practicing because that's what we are supposed to be teaching."

Listening is a problem identified by many of these staff nurses. One nurse's summary comment is "Nobody is listening to the other. Here we are, psych nurses, and no one is really paying attention to what the other person is saying." Another says, "The frustrating thing is you can say that a million times and they just absolutely don't hear it. I don't know what will make people hear it."

Each time a participant was interviewed, she was asked to describe one stressful situation in detail. Among the questions, each was asked what response from self or others was most helpful in dealing with the problem and what response was least helpful or detrimental in dealing with the problem. Forty-four percent of the time, listening on the part of others is indicated by these participants as most helpful. Sometimes the listening

includes validation, problem solving, understanding or acceptance, other times it is just listening. Twenty eight percent of the time the least helpful response was not listening. These findings underscore the value these nurses place on listening and the distress they experience when listening does not occur.

The problems with listening occur not only with fellow unit staff but also with head nurses, supervisors and physicians, particularly resident physicians. Five of the 42 stressful situations described in detail deal with physicians minimizing or ignoring input from the nurses and making unilateral decisions ignoring this input. Says one nurse, "I find it really frustrating to try to convince the psych resident that we have really important input." The problems with communication indicate a lack of use of skills in listening and feedback. These two skills are not only central to communication but also are central in conflict resolution. The problems with communication and conflict seem interrelated.

Inflexible Attitudes. Resistance or closedmindedness to change was the attitude of other staff most frequently mentioned as stressful to these RNs. One nurse explains "The resistance is very stressful to me and it's irritating to sometimes find a certain group of people who are not open even to trying. . . . Anything you introduce, they (nursing staff) are not very

interested. They are just interested in what they are doing. They are very closed minded and I think that is being perpetuated by supervisors and the whole system itself."

The nurse goes on to explain the other factors (vulnerability and expectations) that increase the stress she experiences with this resistance "the biggest stressor is the staff resistance to change and the lack of administrative support available in making that kind of change and the vulnerability you have in wanting it but being within a group as a staff nurse and not being able to enforce it and running the risk of being excluded from that group if you push too hard . . . people in psychiatric nursing should be more open and more flexible but then I don't find such people. It destroys my expectations of what a nurse should be because most of the people I run into are very rigid and I really look at it as a poor quality. . . . I am more tolerant of the closed mindedness of the patient because of what they are going through . . . but I feel that staff should be more openminded."

Less frequently mentioned but potentially important are several other attitudes which these nurses find stressful and mention as detrimental responses are negativity and futility. "I don't know what will make them (head nurse) hear giving positive reinforcement. It's just negative, negative, negative," says one nurse. A staff member's negative attitude accompanied by

frequent complaining without acting is also bothersome. The combined interactions of inflexible attitudes, conflicting ideas and minimal listening and feedback appear to be the root of the poor working relationships described. The communication skills necessary to resolve problems in these working relationships are those most notably absent.

Perceived Unreliability of Other Staff

On psychiatric units, particularly units with acute and volatile patients, there is a strong perceived need to count on other staff for the number one priority: patient and staff safety. Not feeling able to count on other staff is a frequent stressor for this group of nurses. The primary reasons reported for why nurses feel unable to count on other staff are because staff are not prepared or because staff are not doing their job.

Unprepared Staff. Staff hired from a registry on a per diem basis and staff borrowed ("floated") from other units are often perceived as inadequately trained and lacking in skill and therefore, cannot do their share of the work and cannot be relied upon. Said one nurse, "On call people who don't regularly work here don't function to a full capacity and they are not carrying their own load so you have to go around informing people what to do and it's not at all as comfortable (as having regular staff). Plus, it is stressful for them because if it's busy, I don't have the time to spend to orient them to the extent they need

orienting." Another nurse was more specific in describing the multiple problems: "We just had one person come over who didn't have any training, who cannot accurately report, cannot accurately chart, cannot accurately intervene, needs help in assessment, setting limits and intervening in everything. All of this work is then falling to the staff which ends up falling to the team leaders."

A new staff member may or may not be adequately prepared. Uncertainty about her preparation is a stressor for the other nurses as well as herself. One nurse describes her response to working with a new charge nurse. "When this new charge nurse came on, she was in charge and I was her back up resource person. I felt responsible because I wasn't sure of her skills. One weekend I worked with her; I was so tired. Afterwards, I thought it out. I'm sure I was so tired because I wasn't in charge and yet I was the resource person so I was feeling a lot of stress because I wasn't sure of her skills."

A lack of experience on acute or locked units is particularly stressful when the inexperienced person is designated to be in charge and does not accept input from other staff members. One nurse said, "The problem is very few of the staff have worked on locked units and they don't realize what you have to do when you get an agitated patient. The patient is asking for limits and they are needing limits and more patients

are going to get hurt and more staff are going to get hurt because people are too scared to put these people in restraints. . . . The staff feel sorry for the patient and feel bad about putting them in restraints and that's dangerous. People have gotten hurt before when one RN has been in charge because she doesn't put the limits on. One time we had a patient in restraints and she took them off of her and then the patient went and hurt one of the other staff members. That was ridiculous!"

Staff not doing their job. Other staff not doing their job is the most frequently discussed stressor for this group of nurses. Failure to do their jobs is described for all levels of staff (aides, RNs, head nurses, supervisors and physicians) but is most frequently described for aides and RNs. While the problem occurred more frequently with aides, it is more distressing when it occurs with RNs.

For many participants, other RNs not doing their jobs refers to the fact that they are not doing their share of the work. More specific complaints include not taking orders off or not taking them off correctly, not charting, not doing nursing care plans or histories. Describing another RN, one nurse says, "she hadn't written any care plans in 90 days, hadn't worked with the same patients consistently, was a very poor role model and liked to change policies whenever she didn't like doing something a

certain way." Another nurse says that what is most distressing to her in working with two RNs who are not doing their jobs is that the RNs don't care.

A problem mentioned once but with considerable distress is suspicion that another nurse is taking drugs from the unit. The participant describes an incident where numbered pills were missing. This was particularly distressing because the nurse denied it and very little could be done beyond questioning the other nurses on the unit.

The difficulties described with aides are multiple. Aides are categorized as unreliable when they come to work late, call in sick frequently, leave the unit during work time, do not complete their assignments and/or do not attend to the unit as a whole. Perceived lack of interest and motivation is frequently attributed to aides who are described as engaging in such behaviors as talking on the telephone or doing their nails rather than doing their jobs. These situations seem to be particularly stressful not only because of the aides' behaviors but also because the staff nurse does not expect to have to deal with these problems and feels lacking in skills and/or power to deal with the situations. The following descriptions by nurses reflect their experience with these problems.

"Some of these people (staff) are just not aware. You could get report from the day shift that someone is running down the

hall naked and threatening to hit so and so over the head and these people will still sit and talk on the phone all night and not be aware of what is happening with patients. They come into report late so they don't even hear this stuff and it's ridiculous. They are not doing their job."

"One LVN spends probably 30% of her time on the phone and I think that is a lot of time on the phone. I am not the charge nurse there and the charge nurse tolerates it, I don't know why."

"My time is not utilized well because I end up spending a lot of time with staff instead of patients and spend a lot of time trying to get staff to do their job (aides, not RNs)."

"I prefer going in and dealing with patients and doing my job. I really don't like to tell other people how to do their job. Yet I feel there are people there who are, as somebody says, here for the beer. There are people who will slide and will leave early if they can. . . . I get tired of it."

"If you have to start controlling staff as well as patients, we have enough control jobs with patients; I just don't want to be bothered with it. It's frustrating because I'm not in a position to control that much."

Staff are also perceived as unreliable when they bring personal needs to work or respond more to self than the work needs. Says one nurse, "Some people come to work to meet their social needs." Says another, "Some staff have a lot of personal

problems that they bring to work. I guess because they are in an environment with psych nurses they expect a lot of support from them. Some people really come to work needing a lot of support and it makes it really hard. I can see once in a while if you are having some personal problems, but all the time some seem to need support." This nurse says she has found herself being a nurse to the staff rather than to the patients. Other responses of RNs which these nurses find distressing are an RN who becomes more agitated as patients become more agitated and a moody RN who complains about her job in front of patients.

Other staff non-performance of duties is a perception of the participant. This situation can also be described as conflict or different response tendencies. It has already been noted that communication skills needed for conflict resolution are infrequently visible. Insufficient communication may well compound the problems of varied performance expectations and behavior.

The stressfulness of staff is underscored when participants are asked what one change they would make if they could make one change on their unit to make it a less stressful place for them to work. Ninety one percent of participants say they would make changes in the staff. One third of these changes could be accomplished with existing staff; two thirds of these desired changes would require replacing existing staff with new staff.

Changes involving existing staff include staff meetings with more RN input, staff support groups, more staff education, more teamwork, more open communication and more accountability of and better supervision of resident physicians. Changes involving new staff include replacing head nurses, supervisors, physicians, RNs, LVNs, technicians and aides. Others want all RN staff, hand picked staff and more regular staff to eliminate the need for borrowing staff from other units or hiring per diem staff from a registry service. One nurse wants to restructure unit staff to eliminate the need for a charge nurse and increase the team relationship between physician and nurse.

Components of a Stressful Situation

What is it about these situations with staff that make them stressful? And what is it about the many other situations described by these nurses but not yet discussed that make them stressful? How does a stressful situation differ from a non-stressful situation?

From the study of various aspects of each situation described and a comparison of aspects across situations, a picture emerges. The situation or event matters, but it matters within a larger context. The event or situation itself takes place within an organizational context which influences the situation. Other people are present and/or influence the situation. The event or situation is experienced by a person

with their own individual perspective or perception, expectations and history. In interacting with the situation, the individual may or may not have influence or control over the situation. As the individual interacts with the situation she will have a personal emotional response and usually a behavioral response which may increase or decrease her discomfort. The outcome or consequences of stressful situations are very varied and may or may not have been influenced by the individual interacting with the situation. These aspects of situations seem to make the difference in whether or not a situation is experienced as stressful and, if stressful, how stressful. Therefore, each aspect is discussed with attention to the properties of that aspect which make it stressful. Examples from stressful situations with staff demonstrate some of these properties.

Organizational Context

The organizational context of the situation provides a social climate and the organizational (unit or hospital) structure, policies and/or procedures provide the constraints. Stress is more likely when the organizational climate is experienced negatively (particularly devaluing or exploiting) and when the constraints are seen as negatively or undesirably influencing the situations.

When one participant nurse describes a situation where RNs are performing at less than minimal standards, and she describes

the organizational policy as contributing to the problem. Within this organization, problem employees can be shifted from one nursing unit to another. Both RNs described by the participant as performing at less than minimal standards have been transferred from another unit to her unit after unsatisfactory performances on the first unit.

In 70% of the situations reported by respondents, the organization is described as a major contributor to or negative influence on the problem. The organization is considered a positive influence about 10% of the time and has no influence another 20% of the time.

The organization contributes to the problems described through its policies, procedures or structure, its philosophy and through the structure and practices of other departments. Hiring and scheduling policies are described as particularly problematic. Lack of policy (e.g., lack of policy about the role of the resident physician) is frequently a negative influence. Conflicts between policies such as those between treatment and research create problems and the organization is sometimes described as meeting census needs as a priority; in these situations, inappropriate patients may be admitted to a unit to keep the census high. Units are twice described as hiring or promoting to a charge position nurses familiar with hospital policy but unfamiliar with psychiatric patient care.

Administration's valuing familiarity with hospital policy over competence in patient care is problematic to nurses who find themselves taking direction from other nurses who are versed in policy but not safe psychiatric patient care.

Lack of structure in nurses' roles is seen as creating ambiguity and conflict and lack of structure for staff meetings and a low priority for staff meetings is described as creating a communication gap. A philosophy of status quo is frustrating to nurses who are interested in new approaches to patient care. The structure and practices of other departments may interfere with nursing efficiency. The most frequent examples of this are from pharmacy. Pharmacy procedures of individually packaging unit doses and using childproof caps on medication bottles means extra time for nurses pouring medications.

Responses and Influence of Others

Responses of other persons may increase or decrease the stress experienced in a stressful situation. The stress may be increased when other staff fail to validate the importance of the situation, do not listen, do not help or respond or behave in nonhelpful ways. Through these behaviors the threat may be heightened and/or a new threat may be introduced. An example of stress being increased by the response of a staff member is contained in the following description from a participant.

When the participant was in charge, an aide came to work late and amongst other omissions, did not do the diabetic urine testing ordered on one of her assigned patients. The nurse expressed her feelings to another staff member and said she was considering reporting the aide's behavior to the supervisor. The other staff member reminded the participant of the unit ethic that staff members do not get one another in trouble.

In this situation, the other staff member invalidated the importance of the aide's behavior and introduced a new threat: violating group norms. This interaction increased the participant's feeling of vulnerability, the incident went unreported, the problem was not resolved and the participant experienced an increase in felt distress.

The stress experienced in a situation may be decreased when other staff validate the importance of the situation, listen, help or respond as requested. One example of experienced stress decreased by the response of other staff comes from the participant who assessed a co-worker RN as performing below minimal standards. The participant describes talking with her head nurse who listened with interest, checked out the situation herself, talked with other staff and the problem RN and gave feedback to the participant. The participant did not continue feeling distressed until the problem RN was terminated; rather, the participant's experienced distress was reduced when she felt

heard, validated, and assured that action would be taken. At this point the participant did not feel a need to do anything further; the situation would be resolved and the experienced distress was already lessened.

Perception

Individual perception or perspective appears to influence all that is described by the individual and shows enormous variation. Within this study seemingly similar situations were perceived very differently. Perception or perspective establishes "reality" for each individual.

The same work units are described by nurses who work on them with wide variations on the Work Environment Scale (WES). Scores for this scale are converted to standard scores. It is common to find differences of 20 points between nurses on one unit on the same subscale. Even differences of 40 points occur with surprising frequency. That is, one nurse on the unit might perceive very low peer cohesion while another perceived high peer cohesion. These differences appear on all ten subscales, even the most concrete of the subscales, physical comfort. However, differences are most frequently found in perception of supervisory support and next most frequently in peer cohesion and autonomy.

It is of note that nurses on only one unit score within 20 points of each other on all WES subscales. Additionally, each of

these nurses say that staff are not their biggest source of stress. This elicits the question, does similarity of perception alone assist staff in being able to work together? Or is the importance in what they perceive?

On this unit, peer cohesion, supervisory support, autonomy, involvement and innovation are rated above the mean by all nurses. This is generally true of all the nurses who do not perceive staff as the biggest source of stress. This entire group rates peer cohesion, supervisory support and autonomy above the mean; all but one nurse in this group rates involvement and innovation above the mean.

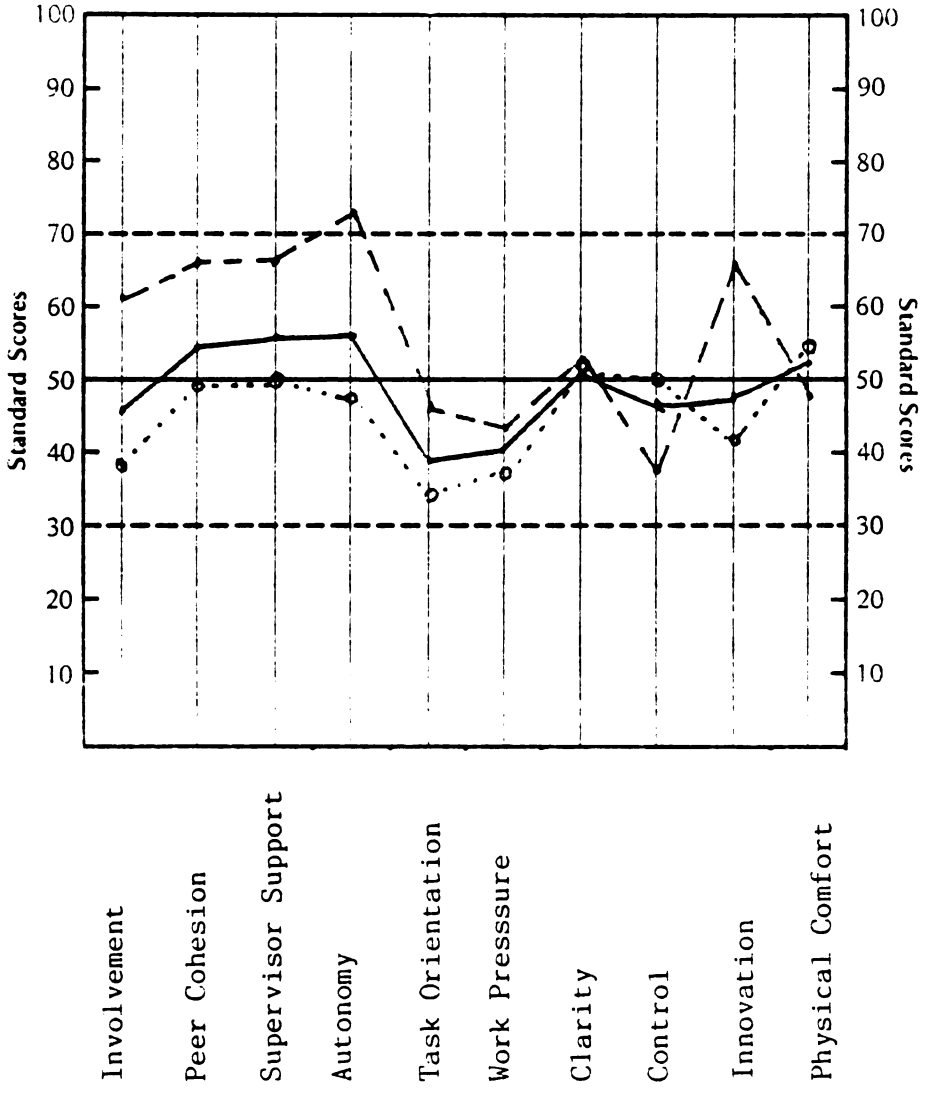
The WES shows a different pattern for those who say staff are their biggest source of stress. For this group, half rate peer cohesion, supervisory support and autonomy below the mean and two thirds rate involvement and innovation below the mean.

Mean scores on the WES are summarized in Chart I. The solid line represents mean scores for the entire group, the broken line represents mean scores for the 23% who do not identify staff as their major source of stress, the dotted line indicates mean scores for the 73% who say staff is their greatest source of stress.

Perception of vulnerability of self or patient, wrongdoing by omission or commission or injustice including fault, blame and diminished altruism are likely to make a situation stressful. At

Chart I

Social Climate Scale Profile



least one of these perceptions (vulnerability, wrongdoing or injustice) is involved in every described situation where staff is a stressor. Perception of high vulnerability and/or wrongdoing were particularly stressful. In one situation the participant believes the physician had inaccurately assessed the potential violence of a patient. The perception of extreme vulnerability for patients and staff led the participant to follow her own judgment against the wishes of the physician. Another participant describes a situation where another RN frequently got upset and angry with the participant for her individual approach to problems. The co-worker RN's anger was particularly stressful to the participant because she perceived the anger and the co-worker RN as being unfair.

In most of the situations described, the perception of what is at stake is more stressful than the situation itself. For each situation described, the participant was asked to identify the specific problem and rate it from one to ten with ten being equivalent to the most difficult problem they had experienced in psychiatric nursing. They were also asked what was at stake, that is, what was there to gain or lose or what difference did the outcome make. The stake is rated on a scale of one to ten with ten being absolutely vital. The mean for all problems is 6.9 on a scale of 10 while the mean for all stakes is 8.9. This suggests that the stress is in the meaning or perspective more

than in the situation. Therefore, understanding what is stressful to a nurse requires more than knowing or seeing the situation; understanding the meaning of the situation to the individual nurse is what explains the experienced stress.

Perception of one's role with patients is an important determinant of whether or not stress is experienced with patients who do not get better. This is illustrated by statements from two nurses: "The difference the outcome makes is the gain or loss of a human life. Obviously, it's her (the patient) problem." "Sometimes it makes me feel guilty that they (patients) are not achieving what I want them to achieve or that I haven't achieved what I think I should with them."

Help or support in a stressful situation is perceived help or support. The social support literature points out that support offered may not be support received. This is clearly indicated in one participant's statement: "I didn't get much help or support but that was more because of my . . . problem than actually their not offering the help. When they would offer to help, then it was very irritating because she (the patient) would respond to them in a much more positive way than she would to me and I'd say, so, damn, why is she doing this to them and that to me?"

Expectations

Expectations are what the individual thinks should be. When what happens is different from and particularly when it is less desirable than what is expected, the nurse usually experiences discomfort or distress. Unmet expectations are present in every stressful situation described in detail. The nurse may try to change the situation to meet her expectations or she may revise her expectations to be more in line with experienced reality.

One participant's experience reflects all of the above. On her unit, an evening shift duty is to assign patients to rooms; each contact staff person is responsible for helping her/his patients with bed and locker arrangements. When the night report indicated that some patients had not been assigned and others needed reassignment, the nurse expected the evening shift to respond to the verbal and written reports and take care of the problem. On one occasion, when this did not happen, the participant assigned the job to particular staff members who did not do it. She felt disappointed and angry, said her expectations of staff were dropping lower and lower and resolved to take care of the reassignment of patients herself.

Expectations certainly play a role in staff experiencing other staff as stressors. Two nurses who do not experience staff as their major source of stress describe their expectations and experience.

"We do sometimes get on each other's nerves and we sit down and talk about it, that's all. We can't afford to be at each other, there is too much work to get done out there to allow us to stress each other that way. . . . It may take some time but eventually we hammer out some sort of acceptance of each other's point of view and unify in a way. We may not agree 100% with each other but we'll hammer out something that will be presented as a united front to the patient."

"I can't say we always work real well together but most of the time we do. . . . I see staff splitting but staff can usually talk about it and discuss it. . . . With all the different personalities there is no way that anybody could make any kind of changes that would make it utopia. There are always such different personalities and different things happening day to day. I couldn't imagine everything going smoothly all the time. I think in any work situation, I can't imagine working with people and not having things to always work on and strive for. . . . I think people work very hard to have a cohesive unit and respect each other. I think its partially intelligence and caring about one another and considering their jobs as more than a job and really trying to get the most out of it and give the most. If people do have some kind of misunderstanding, problems, they try to work them out themselves. . . . People are really motivated and there is a lot of humor and a lot of kidding and

also a genuine concern for people."

The expectation that differences will occur and the expectation (and historical experience) that these differences will be resolved diminish the potential stress in the above situations which describe interpersonal differences which are resolved.

Prior Experience With Stress Context

The nurse's past experience or history with another individual, the situation, or both influence her perception and expectations as well as her behavior. When a nurse has had past conflict with a particular staff member, the nurse more readily perceives conflict in the present. If past conflict has been unresolved, the nurse seems to expect that current conflict will remain unresolved. When conflict is perceived and expected to be unresolved, the nurse seems less likely to attempt resolution. One participant has had previous exposure to an unreliable staff member who used poor judgment and did not follow established procedures. When the unit was very short staffed the staff member asked to leave early, the RN said no, the staff member then left the unit anyway for about 45 minutes. History contributed to the participant's conclusions that "she is going to try to get away with murder unless I clamp down" and to her conclusion that she will have to watch the staff member more closely in the future because that staff member cannot be

trusted.

Influence or Control

Influence or control over the situation depends only in part on the nurses' behavior. This behavior is heavily influenced by history, expectations and perception of self and others. It is interesting to note that these participants never had total individual control over getting what they wanted in the stressful situations described. In nearly half of the situations, what was wanted was under another individual's control (they wanted someone else to respond in a specific way). In the remaining situations what was desired was controlled by a group or the organization. Ivancevich, Matteson and Preston (1982) found that type A nurses experienced the most stress when they had the least control over the stressor. Lack of control seemed an important component in all stressful situations described by participants in this study.

Because these nurses never have control over the situations they describe, they must turn to influence to affect a situation. This reality explains why the refusal of someone to listen is so stressful to these nurses. They cannot influence another staff member's behavior if that other staff member refuses to listen or discounts the input given.

One participant expects that the charge nurse be in control of what is going on in the unit. In one situation, she perceived

that a patient was becoming agitated beyond the patient's ability for self control. The participant made successive recommendations for taking the patient to the patient's room, getting more medication for the patient and later for seclusion and restraint as the patient's agitation increased. The charge nurse ignored the input of the participant. The participant reminded herself that this had happened before, said to herself, "here we go again," "washed her hands of it" and went to lead her group therapy session saying to herself, its the charge nurse's problem now. This example demonstrates the stress experienced by the nurse when she is not heard and the frustration, anger and withdrawal often described when attempted influence (input) failed.

Closely related to influence or control is the perception that something useful has been learned in the situation. This learning is often perceived as learning that will assist the nurse to influence or control of future situations. In the situation where the nurse believed the physician had inaccurately assessed the potential for violence by the patient, the finding of knives hidden by the patient on the unit reinforced the nurse's belief that nurses need to attend to and respond to their own observations of patient behavior more than to the opinions of others.

Outcome

Negative or undesired outcomes typically perpetuate distress while desired outcomes typically reduce distress. The reduction in distress or satisfaction experienced is also influenced by the nurse's perception of whether or not the problem is resolved or only this situational example of the problem is resolved. Satisfaction is lessened when the problem is expected to recur. In one situation the day shift inaccurately accused the evening shift of inadequately assessing and intervening with a patient problem. After the two shifts jointly assessed the patient and reviewed the care given, all agreed that no problem existed. For the participant, the stress is "the consistency with which it (quick accusations and blame) keeps happening, it gets frustrating and people don't seem to learn anything from it."

The validity of these aspects and properties as determinants of stress comes in part from the examples of stressful situations in this study. It also comes from an example where minimal distress is experienced when the description of these aspects is different from or the opposite of what creates stress.

Imbalance of human resources and demands is frequently described as a stressor in this study. Most nurses consider a double assignment of patients stressful. One participant described a situation where she was responsible for her own and another staff member's full assignment of patients for over a

month because the staff member had been transferred and another had not yet been hired. This participant did not consider this a particularly stressful experience; she rated it a 2 or 3 on a scale of 1 to 10 with 10 the most stressful. Her perception was that the transfer of a staff member was within the normal course of events within an organization and was to be expected periodically. She did not perceive any real vulnerability for herself or patients, no injustice and no wrongdoing. It had happened before and from that she had learned better skills for setting priorities, completing paperwork and revising and lowering expectations of herself to be realistic or in keeping with caring for a double load of patients. She experienced no need to control the situation beyond this. She believed all that could be done was being done to hire a new staff person. The head nurse, other staff and patients were all aware of the situation and all helped when she needed help. She believed the situation was time limited and nearing resolution. There were no important negative consequences noted although she said that she was perhaps a little more tired than usual at the end of a month.

Other Sources of Stress

Thus far the writer has described the staff as the biggest source of stress for the majority of these nurses, described the categories of staff stress with examples, examined aspects and properties which make any situation stressful and given examples

of the properties from situations participants found stressful.

Staff stress was certainly not the only source of stress for the participants in this study. The following is a list of classes of all sources of stress and their categories drawn from the situational descriptions in the 42 interviews and the 399 other stressors that these nurses identified. Frequencies are indicated in parentheses.

Classes of Stressors

1. Unit staff - 33% (N=145)
    A. Staff working relationships - 20% (87)
        1. Communication process (15)
            a. lack of, insufficient - (7)
            b. not listening, defensive, ignore input - (5)
            c. indirect: not deal openly with person having problems with; passive-aggressive - (3)
        2. Infighting (between individuals or groups e.g., evenings; new/old) (62)
            a. disagreement (usually over patient care) intolerance of differences, conflict, power struggles - (34)
            b. bickering, backbiting, friction, accusations, blame, criticism, scapegoating, complaining, gossip, distortion - (21)
            c. disrespect, lack of trust, tense environment with

poor IPR - 7

3. Resistance to change - (10)

B. Staff performance - 13% (58)

1. Non performance of job description - (25)

2. Other staff not meeting RNs expectations of their work - (16)

3. Unskilled, unprepared, unfamiliar or new staff who lack psych skills and cannot function to full capacity - (17)

2. Head nurse and supervisory attitudes and practices - 17% (N=75)

A. Scheduling - (28)

B. Lack of input into decisions; decisions unilateral - (17)

C. Lack of positive reinforcement or support for staff - (6)

D. Lack of information - (4)

E. Lack of expertise clinically or administratively or lack of availability or responsiveness - (14)

F. Other behavior (e.g., favoritism, rigidity) - (6)

3. Problems with physicians - 9% (N=41)

A. Ignoring, blocking or minimizing RN input, making unilateral decisions - (16)

B. Not available for or insufficient, inappropriate medical care - (11)

C. Dealing with patients individually in conflict with unit

structure - (5)

D. Not communicating plans for patients to RNs, poor IPR with RNs - (4)

E. Not fulfilling job description (5)

4. Problems with resources - 10% (N=45)

A. Lack of resources - (20)

B. Lack of time - (18)

C. Lack of material resources - (4)

D. Space: physical and personal (includes noise) - (3)

5. Problems with patients - 13% (N=56)

A. Danger to self or others - (11)

B. Chronicity, nonresponsiveness, negativity, no committment to change, lack of improvement - (18)

C. Demanding, needy, self centered, verbally abusive patients & families - (18)

D. Acuity and complexity - (9)

6. Problems with self - 13% (N=59)

A. Self role conflict - (8)

B. Feelings about self, especially self doubt, self image, concern about consequences - (8)

C. Vulnerability and fear; concern for own safety - (5)

D. Not performing at own optimum - (3)

E. Role change (e.g., from staff to charge) and multiple roles - (8)

F. Difficulty with role particularly being in charge, responsibilities - (8)

G. Personal stressor - (16)

H. Lack of satisfaction - (3)

7. Organizational practices - 6% (N=26)

A. Inappropriate patients admitted to unit to maintain census - (3)

B. Policies and organization needs valued over nurses and nursing care; feel devalued - (9)

C. Procedures that are not helpful to nurse - (9)

D. No input, resistance to change - (3)

E. Poor relationships with other departments - (2)

Summary

This chapter began with a discussion of the major source of stress identified in this study--staff. There is more time and opportunity for staff to develop conflict with other staff rather than patients. When patient problems are encountered, they are dealt with openly, resources are available and there are established procedures for dealing with patient problems. Staff problems are generally not acknowledged openly as problems important to be dealt with and there are minimal if any resources or established procedures for dealing with staff-staff problems. Both because of the poor relationships and the perception that staff are unprepared or unwilling to fulfill their job, staff are

often seen as obstacles to rather than helpmates in patient care.

Not every problem or encounter is identified as stressful. Whether or not a situation is appraised as stressful depends in part on the organizational context, the responses of others, the perception and expectations and prior experience of the RN, the influence or control of the RN in the situation and the outcome of the situation.

These factors influence not only staff-staff problems but also influence the other categories of stressors: head nurse and supervisory attitudes and practices, problems with physicians, problems with resources, problems with patients, problems with self, and problems with organizational practices.

CHAPTER 5--ANALYSIS OF THE DATA: COPING

Introduction

The analysis of data thus far has dealt with stress. As noted before, the experience of distress is not just in the stressful situation. The experience of distress is heavily influenced by responses of self and others. Thus the focus now turns to coping.

This chapter describes coping strategies and outcomes of stress and coping episodes. This chapter begins with a general description of participant's behavioral and emotional responses to stressful situations and a discussion of what helps and what hinders generally in resolving problems and/or diminishing the distress experienced. Outcomes of stress and coping episodes are categorized and described. Specific coping behaviors and outcomes are then described in relation to each of the major categories of stressors identified in Chapter 4. Finally, assertive behavior and other patterns of coping useful across situations are described. The findings regarding coping behavior and outcome are then summarized.

Behavioral and Emotional Responses

In each interview, participants were asked to describe in detail one stress and coping episode. The participants described responding to their perceived problem situations in many ways. They assessed the situation and acted, they dealt with the

problem, they attempted to hold their position, and they used avoidance and withdrawal. They gave input and feedback, they requested responses from other staff and they supported other staff. They changed their own behavior, they wished things were different and they altered their own expectations.

The emotions elicited in the stressful situations were varied. The initial emotions experienced were all emotions that are considered negative or distressing. The following is a list of emotions participants said they experienced during stress and coping episodes; frequencies are given in parentheses: anger (21), frustration (11), anxiety (5), impotence or helplessness (5), fear (4), "bad" (4), "here we go again" (3), tired (2), pressured (2), guilty (2), concerned (2), disappointed (2). The following feelings were identified once each: defeated, sad, devalued, betrayed, trampled, scapegoated, ashamed, appalled, disgusted, overwhelmed, unwilling, exposed, judged, inadequate, discomfort, and indifference.

The participants also responded to their feelings in a variety of ways. They sought more information, they focused on dealing with the problem and took care of the patient. They expressed their feelings to the person who had elicited the feelings, they requested responses from other staff, they talked with other staff and their head nurses. They also talked to themselves, engaged in self examination and resolved to behave

differently in the future. They used techniques for personal stress management, particularly exercise, relaxation and meditation, and they talked with friends and husbands. They also grumbled and complained, they ate, experienced nausea and vomiting, they withdrew and they thought about quitting their jobs. Some of them said they did nothing to manage their feelings.

These varied responses elicit the question: "What helps, what hinders (what decreases or increases distress) in general and in particular situations?"

What Helps, What Hinders in General

The writer has noted that few situations described by these nurses as stressful are under the individual control of the RN. Despite this, these RNs most frequently (31% of the time) identified their own responses as the most helpful on the detailed descriptions of stressful situations. These self responses fall into three categories described in order of frequency: (a) self talk, mental work with own expectations and perception, (b) taking an active role, doing something behaviorally, and (c) talking to others which may or may not include asking for their help.

Other sources of most helpful responses and the percentage of time these sources were identified are as follows: head nurse (20%), other RNs (18%), ward chief (9%), patients (5%), all unit

staff (4%), clinical specialist (4%), psychologist (4%), co-workers who were not RNs (2%), resident (2%), and husband/boyfriend (2%).

Categories of most helpful responses from others were listening and help. Listening included listening only, listening with validation, problem solving/discussion, understanding and/or acceptance. Help included someone else doing what needed to be done, working together and role modeling. On two occasions the participant stated that no response from self or others was helpful.

Sources of least helpful or detrimental responses and the percentage of time these sources were identified are as follows: RNs (42%), head nurses (16%), residents (13%), non-RN staff (13%), staff MD (6%), self (6%), psychologist (3%).

Categories of detrimental responses listed according to frequency include not listening, not responding as desired, accusations/blame/scapegoating, conflicting behaviors, expression of negative feelings, and complaining without acting. Twenty percent of the time the participant said no detrimental or unhelpful responses occurred.

Participants were also asked to identify their greatest source of support at work. This was a general question, not the kind of question about a specific situation that was described on the previous pages. These sources of greatest support and the

percentage of time they were identified are co-workers, either RNs or RNs and non-RN staff (42%), head nurse (27%), self (8%), clinical specialist (8%), psychologist (8%), and ward chief (8%). It is of note that in the specific stressful situations described, the head nurse and RN co-workers were about equally likely to be identified as most helpful in that situation (p. 143). However, in response to a general question about sources of greatest support, co-workers were far more likely than head nurses to be identified as the source of greatest support.

It is notable that other RNs and head nurses appear at the top of the list for most helpful, most supportive and most detrimental or least helpful. The conclusion drawn from this is that other RNs and the head nurse are the most influential others in the work world of the RN. It has already been mentioned that difficulties in nurse-nurse or staff nurse-head nurse relationships and ability to work together are the most important determinants of the work stress experienced by these psychiatric staff nurses. Positive relationships with other co-workers are also a major source of satisfaction to many of these nurses.

What helped most was for a problem which was perceived as a single incident to be resolved to their satisfaction. However, few of the problem situations described were considered single incidents; rather, they were often described as a single example of a continuing or recurrent problem. Even the successful

resolution of such an incident was minimally satisfying because it was considered to be part of a chronic problem which was not resolved.

These nurses considered coping ineffective when it did not alter the perceived problem or the feelings engendered by the problem. They may have done something, but the something did not help.

Hindering or detrimental responses were those which the nurse described as causing or aggravating the problem and/or the feelings accompanying the problem. Helpful, ineffective and hindering responses came from both self and others.

Outcomes of Coping

During both interviews the participant was asked to describe one stress and coping episode in depth. The 22 participants described 42 stress and coping episodes. From these 42 situational examples, outcomes of coping have been divided into four groups: (I) those (N=13) who perceive a positive resolution or improvement in the problem, are pleased with the outcome, do not expect it to continue and feel less stress, (II) those (N=10) who perceive and are pleased with a positive resolution or improvement in the specific incident and feel less stress but expect the problem to continue, (III) those (N=13) who are dissatisfied with the outcome but feel less stress and (IV) those (N=6) who are dissatisfied with the outcome and experience the

same amount or more stress.

Each of the four outcomes reveals a different pattern of coping. Those in group I tended to use problem focused coping, emotion focused coping, and social support (77%). Two (15%) used problem and emotion focused coping and one (8%) used problem focused coping and social support. Twelve of the 13 (92%) talked about the problem with at least one other person; the thirteenth person resolved the problem with the patient during the time limited incident. Nine of the 13 (69%) considered and revised their expectations. Four of the 13 said that although it was not a chronic problem, it could recur. If the problem occurred again, they anticipated dealing with it in the same way. None of the 13 mentioned withdrawal or burnout in their discussion of the problem.

Those in group II were less likely than those in group I to use problem and emotion focused coping and social support. Sixty percent used problem and emotion focused coping and social support, 20% used problem and emotion focused coping only, and 20% used problem focused coping and social support. Eighty percent talked about the problem with at least one other person; 20% did not talk about the problem. Fifty percent considered and revised their expectations; 50% did not. Of the eight individuals involved in these ten incidents, four persons (50%) talked about withdrawal and the possibility of leaving their jobs; the other four talked about the discomfort of the continuing stress.

Of those in group III, 62% (8) used problem and emotion focused coping and social support, 31% (4) used problem and emotion focused coping and 8% (1) used problem focused coping and social support. Seventy seven percent talked about the problem with at least one other person. Sixty two percent considered and revised their own expectations. Forty six percent described withdrawal as part of their response to the situation.

Of those in group IV, 33% (2) used problem and emotional focused coping and social support, 17% (1) used problem and emotion focused coping, 33% (2) used problem focused coping only and 17% (1) reported no coping efforts. Sixty six percent did talk about the problem with at least one other person although half of these talked minimally. Expectations were minimally discussed (17%) and never revised. Of the four persons involved in the six situations, all have described themselves as burned out; withdrawal was used in 5 of the 6 instances. Table 1 gives a summary of strategies of coping according to the four coping groups.

The contrast between coping behaviors in coping groups I and IV is remarkable. Those in coping group IV used less coping of all kinds than those in group I. Group IV individuals were less persistent in problem solving and exercised fewer options. They talked less to others, seldom considered and never revised their expectations. They all considered and frequently engaged in

Table 1

Strategies of Coping by Outcome Group

Coping Strategies	Outcome Group I	II	III	IV
used problem and emotion focused coping and social support	77%	60%	62%	33%
used problem and emotion focused coping	15%	20%	31%	17%
used problem focused coping and social support	8%	20%	8%	0
used problem focused coping	0	0	0	33%
No coping efforts	0	0	0	17%
talked about the problem with at least one other person	92%	80%	77%	66%
considered and revised own expectations	69%	50%	62%	0
talked about withdrawal and/or burnout	0	50%	46%	100%
used withdrawal as part of coping	0	0	46%	83%

withdrawal. Perhaps the amount of coping activity is related to outcome. In studying behaviors of college educated women coping with role conflict, Hall (1972) found that some coping behavior was more strongly related to satisfaction than the specific coping strategy used. The important difference was between one coping response and no coping strategies.

Pearlin and Schooler (1978) report that problem focused coping is infrequently used at work and that problems at work are changed little through coping efforts. Folkman and Lazarus (1980) report the opposite, that problem focused coping is used more often in work related episodes than in stressful episodes related to family or health. In this study, the majority of participants with the most desired coping outcome (group I) used problem focused coping in conjunction with emotion focused coping and social support. All other outcome categories were associated with less use of all three strategies combined. The use of problem focused coping only was found in the least desired coping outcome (group IV) but not in the other groups.

Sources of stress by outcome groups are summarized in Table 2.

Table 2

Source of Stress by Outcome Group*

Outcome Group	Sources of Stress						
	unit staff	head nurse/ supervisor	MD	resources	patients	self	organ-ization
I	1	2	2	3	1	4	0
II	3	4	2	1	0	0	0
III	6	0	1	0	5	0	1
IV	3	2	1	0	0	0	0

*Numbers in Table 2 reflect stress and coping episodes, not individual participants.

In examining the coping strategies employed when dealing with unit staff, the most desirable outcome occurs least often. Only one of the 13 outcomes from unit staff conflict episodes is in group I and this outcome was not solely a result of the individual nurse's efforts. Her efforts to cope with the problem had made no difference in the behavior of her co-worker. The individual staff nurse had then talked with her head nurse and felt resolution, pleased, and less stress when the head nurse informed her that the problem was being resolved.

Almost half of the outcomes involving unit staff (46%) were in outcome group III: The individual nurse was able to reduce the stress she experienced but was dissatisfied with the outcome of the problem. The remaining incidents were equally divided (23% each) between outcome group II, feeling less stress and some satisfaction in the outcome of the incident but with satisfaction diminished by the perception that the problem persists chronically, and outcome group IV, feeling dissatisfied with the outcome and continuation or exacerbation of the stress. This lack of desirable outcomes from coping may explain further why unit staff is so stressful. Not only does interaction among staff lead to stressful situations, the problems are not resolved.

Coping with Specific Stressors

The coping behaviors and their evaluation of helpfulness or non-helpfulness occurred in relation to specific situations. Coping and its helpfulness can best be understood and discussed in relation to the problem to which the coping was a response. This section focuses on the way the nurses coped with specific situations, the ways they sought to alter the perceived problem and to alter the engendered feelings of distress. The responses of others are also discussed. Some of the responses of self and others are described by the nurses as helpful, some ineffective and some hindering in the alteration of the perceived problem and

the felt distress.

Stressors with Unit Staff

Forty two of the forty four interviews involved indepth discussion of one stressful experience guided by the questions for exploration. Of the 42 stressful situations, 13 dealt with problems with unit staff (five with staff friction or infighting and eight with non-performance of duties). The biggest stressor identified by the majority of these nurses frequently provided the example chosen by participants for indepth discussion.

Stress in Staff Working Relationships

In dealing with the problem of staff friction and infighting and the attendant feelings, all five nurses who reported this type of problem talked directly with staff member(s) involved, four also talked with other staff and three talked with their head nurses. Two of the five also expressed their feelings to the staff member(s) involved. In the five specific incidents, the problem and attendant feelings were once resolved, once improved and unchanged in three instances. However, all five escribe the underlying problem as unresolved and therefore the tress was minimally diminished. The residual effects of this nresolved stress are continued efforts by two nurses to deal th the problem particularly by altering their own behavior, thdrawal of investment from the unit by another nurse and nsideration of transfer to another unit or project by the

remaining two nurses.

Head nurse responses were important in these situations of staff conflict. In three situations, the most detrimental responses came from the head nurses. In one situation the head nurse joined other unit staff in making inaccurate accusations, in the second situation, the head nurse gave tacit approval for the distressing behavior of the problem RN and in the third situation the head nurse was not perceived as supportive: "The head nurse wants me to stick up for myself, not whine or complain; I did not feel supported by the head nurse at all." The responses these three nurses wanted were also all from the head nurse. These responses desired were for an apology, for the head nurse to talk with the problem RN and for support and structure. None of these responses were requested directly or offered by the head nurse.

It is worth emphasizing that the head nurses were perceived as so very detrimental to the coping efforts of RNs dealing with staff conflict. These RNs are having difficulty with interpersonal conflict resolution and experience their head nurses as contributing to the problem and hindering rather than facilitating resolution.

on Performance of Duties

In dealing with staff non-performance of duties, what was desired by the eight who reported this problem was for staff to

do their job. All talked directly with the staff person involved and considered this strategy ineffective since staff behavior typically did not change as a result of this approach.

Other coping efforts by these nurses and responses from others did sometimes result in the perceived problem being diminished or resolved. The nurses felt better when this occurred; they did not experience a reduction of distressing feelings when the problem remained unchanged.

Talking with and getting help from the head nurse was reported to make the biggest difference in resolution of the stressful problem and feelings. When talking with the problem staff person did not have the desired effect, three of the nurses talked to their head nurse. In two situations, the problem staff members have been terminated; in the third situation, the staff member has been counseled and her behavior is being documented.

When staff did not perform duties assigned to their shift, one nurse took the next step of assigning the task to specific staff members the next day but these staff also did not do what was assigned. The nurse decided to resolve the problem by doing herself the next day. Also, she was documenting the problem to the head nurse and said she would bring it up in the next staff meeting. Another nurse considered talking with her supervisor, but was dissuaded by another staff member reminding her it was a "unit ethic" not to get co-workers in trouble. Two

situations were singular incidents which ended at the expense of the patient. In one situation the patient had to be physically subdued, restrained and medicated after no intervention was made in earlier agitated behavior; in the second situation the incident ended with patient injury and transfer off the unit. These situations were not discussed with the head nurse during or after the incident. The head nurse was not present at the time these incidents took place.

Help from others in these situations was quite variable. In three instances, all levels of staff were concerned, responded and gave input. In four other situations there was no help. In the other situation, the responses of staff were considered detrimental (blaming and scapegoating).

Feelings were expressed to the problem staff by four of the eight nurses; this was not perceived as helpful in resolving the problem but was somewhat helpful in diminishing feelings of distress. Four of the nurses talked about the problems with other staff which did not help in resolving the problem but did provide a feeling of support. Four of the nurses now feel better about the problem. One felt better after the head nurse resolved the problem through termination, one felt better after validation from other RNs and the head nurse, one felt better after she cared for the injured patient, assessed herself as not 100% responsible, spoke to the administrator and resolved to behave

differently in the future. One nurse felt better after she suppressed her feelings and focused on patient care and four did not feel better about the problem situation.

Two of the nurses report some positive continuing effects from their own learning. One has a shorter response time and takes more immediate action herself; the second would handle the same situation differently next time.

Five nurses report continuing negative effects. One nurse fears recurrence of the problem and one does not trust the problem staff member. One says this is only one example of a continuing problem with no end in sight and says the problem is burning her out. Even the termination of inadequate employees brings minimal comfort. One says organizational policy allowing the shifting of inadequate employees from one unit to another will create the problem again and another has unresolved concerns about hiring and orienting procedures for the unit.

Dealing with staff non-performance of duties seems to be an area over which the individual RN has little influence even with direct confrontation and nominal authority. It seems necessary to involve the head nurse for resolution. Attempts to deal with staff non-performance of duties seem to be a particularly negative experience.

This discussion of coping with staff problems sheds further light on why they are stressful. Not only is the situation

itself stressful but individual nurse coping efforts are generally ineffective. Responses of others and the organizational constraints seem hindering as often or more often than they are perceived as helpful or supportive.

Stressors with Head Nurses, Supervisors and Physicians

There are wide variations in both coping efforts and outcomes in dealing with problems with head nurses and supervisors and physicians. However, these nurses described more success in dealing with head nurse and supervisory problems and problems with physicians than in dealing with problems with unit staff.

Scheduling

Four of the eight problems with head nurses/supervisors involved scheduling. Three were distressed by being assigned to rotating shifts and/or being sent to another unit for a shift; one was distressed when she was unable to get requested time off. All talked to the head nurse about the problem. All got something that they wanted in the specific situation but three of the four remained distressed by the expectation that the problem will occur again. Only one believes the situation is resolved.

One participant was sent to another unit for weekend coverage while a nurse not regularly assigned to the participant's unit was sent to the participant's unit for weekend

coverage the same weekend. This participant talked with her head nurse both before and after the weekend; the head nurse listened but took no action. The participant resolved this instance by requesting a trade with the nurse assigned to the unit for the day.

Another participant was sent to a different unit for part of a shift to give medications. Her distress was not so much in being sent as in not finding needed medications on the unit and not being able to identify patients; a second staff member had to be involved for patient identification. When the participant nurse returned to her own unit she described the problem to her head nurse who discussed it with the supervisor who decided RNs would not be sent from one unit to another to give medications.

A third participant was assigned to rotating shifts after taff vacancies occurred on the night shift. Her first response as to make the most of being off during unaccustomed hours. Her istress began when hiring of new staff did not occur after a ouple of months. She talked with the head nurse but felt no tisfaction. She then allied herself with other RNs for creased power and they increased the pressure on the head nurse hire new staff and be more flexible in hiring staff (e.g., ept part time staff). The hiring of new staff resolved this ident but she believes it will happen whenever staff leave.

The fourth nurse wanted to take a class in a particular subject. Through persistence in requests and changing her request to different times and days when different courses were offered, she did get time off for a class she wanted. She described the resolution process as unsatisfactory and believes the situation will recur. The meaning of the situation to her is that she has no power or control over her own life.

The feelings engendered in these situations were primarily anger and frustration. The anger and frustration were softened through ventilation of feelings and personal stress management techniques. Continuing frustration is present for those who expect the problem to recur. All of those nurses with continuing frustration talked about the possibility of leaving their jobs as a result. None of them talked about revising their expectations. Scheduling was the only retention issue which emerged in this study. Their discussion of the possibility of quitting is perhaps both an indicator of the distress experienced and the only possibility the participants see for gaining personal control.

In the scheduling problem situations these participants all made individual efforts to resolve the problem. While these efforts could resolve a specific instance, they could not resolve the larger problem. The head nurse's response or behavior makes significant difference in outcome.

Other Head Nurse/Supervisory Problems

The four descriptions of coping with other head nurse/supervisory problems also disclosed wide variations. In one situation the head nurse listened to a staff member complain about the participant without sending the staff member to the participant as was desired. The participant did not talk with the head nurse. This nurse did talk with the other staff member and asked for discussion between the two of them when friction occurs, but she does not believe it will happen. She further believes that continuing conflict will negatively affect her own performance. She did not talk with anyone else and did not do anything to manage her feelings. She described herself as tired, not confident or hopeful. She said no responses of self or others were helpful. She considers the situation unresolved and distressing.

In a second situation the staff nurse represented her acationing head nurse in a problem solving session with other ead nurses. She wanted rational problem solving but assessed e other head nurses as responding emotionally and unfairly. e believed that offering alternative solutions would be used ainst her and chose to focus on "holding my own ground" which did successfully but distress continues because she believes issues with those head nurses will surface again. She ressed her feelings to other staff and from this and success

in "holding her own" did feel better.

The remaining two incidents are particularly interesting in that the situations are very similar but the coping efforts and outcomes are quite different. In both situations the nurse was told by the supervisory person to do something the nurse did not believe was appropriate.

In one situation the nurse put in a call to the head nurse, got input from other staff, collected more information and did not take any action until she could discuss the issue with the head nurse. The participant felt very vulnerable and the head nurse was angry that the participant did not carry out the order. However, the participant felt her own integrity and staff morale were maintained. She was satisfied by her own behavior and felt the conflict with the head nurse was mostly resolved in later discussion. She also felt better when another RN who is frequently in charge said she would do the same thing.

The second nurse perceived no options and did as she was old. This nurse felt quite vulnerable with the supervisor and elieved her behavior protected her from feeling further lnerability. The participant did not talk with anyone else out the situation or her feelings of helplessness and anger. did resist in her own mind, thought a lot about the uation, swore about it and "made the problem worse for elf." She said no responses of self or other were helpful.

The situation ended with greater distress than was present initially.

In these situations of problems with supervisory persons the nurses' perception of power made important differences. Their coping efforts were based on perceived alternatives which were based on perception of personal power or vulnerability.

Stressors with Physicians

Six participants described stressful situations involving physicians. Three of the nurses wanted the resident physician to order medications, the fourth wanted the resident physician to follow up with a patient and the fifth wanted the resident physician to complete the legal paperwork for which the resident was responsible. The sixth nurse believed the attending physician had inaccurately assessed his patient's potential for violence.

For the first five, the key coping behaviors were persistence and eliciting the aid of the senior physician. Four of the five eventually got what they wanted through these behaviors. The fifth was less persistent and did not get what she wanted.

In coping with these problems the first five all talked with the resident, four very directly and one indirectly. One sought input and help from the head nurse and unit chief, another sought help from the unit chief. Responses of others ranged from

detrimental to none to very helpful. These did not usually have an important effect on the outcome but had an important effect on how the RN felt. The exception was the nurse who went to the unit chief who wrote the desired order. The most helpful responses were those behaviors that contributed to some resolution; sources were self or others, behaviors included support and direct action.

The key coping behavior of the sixth nurse was relying and acting on her own judgment. She continued to do what she thought best despite the physician's objections; she did talk with him and expressed her feelings to him. She also sought and obtained support from the head nurse and unit chief.

Feelings were resolved only if/when the problem was resolved. The first five all felt angry; four felt less angry when they got what they wanted in the specific situation. The fifth nurse also felt impotent and examined her own role and communication. She did not get what she wanted. While the other four all wanted specific orders, she wanted to feel heard and have discussion with the resident. This participant still feels frustrated.

The sixth nurse felt fear which was diminished when she confiscated knives from the patient. She felt resolution when her behavior was acknowledge as maintaining safety on the unit.

Organizational policy was perceived as a negative influence in all six of these situations. This occurred through lack of policy about resident physicians' role, lack of clear policy about transferring dangerous patients and the established procedure of using new resident physicians educated outside the United States to rotate through the officer of the day schedule with no back up resource available in the hospital even after the residents have demonstrated inability to function independently. The negative influence also occurred through mandatory rotation of interns through psychiatric units they do not wish to experience and as a result of conflict between admissions and research. All patients admitted to the research unit are withdrawn from medications even when the patient will not be appropriate for research. Research accuses nursing of disinterest in research when nursing concern for patient medication conflicts with maintaining a patient as a research candidate (drug free).

The continuing effects of the situations are varied. Four express continuing negative feelings towards the residents involved. These negative feelings came from non-resolution and the expectation that the problems will recur. One is particularly frustrated that the resident has to be reminded by nurses to complete the resident's legal obligations. The nurse believes the resident's supervision is inadequate. The

participant's complaining through the appropriate channels (to her head nurse who went to the unit chief) has had no effect thus far.

Two nurses say the continued effect is reinforcement of what they already knew. For one nurse the experience reinforces the need for staff to talk; for another it reinforces the need for nurses to attend to and respond to patient behavior more than others' opinion.

Stressors with Resource Shortage

A more positive picture emerges when these nurses talk about coping with lack of resources. Detailed situational descriptions three times focused on lack of human resources and once focused on insufficient time to complete the work. Because of similarities in both coping and outcomes, the two resource problems are discussed together.

The coping efforts of all four nurses included assessing overall needs, setting priorities, focusing on the priorities and using the help of available others. All four nurses felt that the situations had been acceptably resolved through their efforts. Two also talked about a sense of pride in their achievement. Feelings of distress were resolved through taking care of the situation and by revising expectations of self to reflect resource constraints rather than maintaining more idealistic expectations.

The continuing effects of having dealt with these resource problems are primarily positive. Noted continuing effects include professional growth, learning better skills for doing the amount of work and setting realistic expectations for self, learning to use others and learning to focus on priorities instead of getting disconcerted and angry at everything and trying to make changes.

In these situations the nurses were pleased with the results of their own coping and the fact that their own coping efforts did make a difference. The ability to set priorities and revise expectations of self seem most helpful. The role of others seems important but not most important; it is nicer when others are helpful but help from some seems to suffice even if all are not helpful. Valued learning from these stressful experiences is worth noting.

Stressors with Patients

Six participants identified problems with patients (non-responsive to nurse and/or therapy goals) in their detailed description of a stressful situation. In each instance the nurse felt she did all that she could with/for the patient. In one instance this was all that was needed; the problem was resolved.

In the remaining five situations all of the nurses talked with other staff about the ongoing problem. In the four instances where help from other staff was desired, help was

received. The only detrimental response was a physician's questioning the nurse's input regarding a patient's hostile sexual behavior.

Talking with others was perceived as at least somewhat helpful in working toward resolution or control of the problem in four instances but the outcome the RN desired was never achieved. The nurses had attempted to influence patient response in each of these situations with some, but limited, success. The perceived problem remained.

In many previously discussed situations, the nurses' feelings were resolved only if/when the problem was resolved. In these situations the nurses' feelings were less attached to problem resolution and this seemed a deliberate and effective coping strategy. One nurse talked about learning to back off and give herself space; another talked about learning to separate her own actions from patient actions to determine her own impact. This diminished her distressing feelings.

The art of dealing with feelings when patients do not respond as nurses hope for and work for is well described by a psychiatric nurse of many years: "As a younger nurse I guess I thought if I had done something differently the results would have been different. Now my attitude is, I did what I could do with the best skills that I have and the outcome probably would not have changed no matter what I did. I don't have to feel that

I am somehow responsible for that life being ended because I know that I have done the best I can with my skills as a practitioner which I consider quite good. Therefore I have to let go and say, OK, we lost that one. . . although the feelings are still there, they are not overpowering in the same way."

Another nurse describes a superficially similar strategy: "It used to frustrate me terrifically when I first came over to psychiatry. I was always in a state of frustration. Now I realize that I can't personally control it. There is nothing I can do that is going to stop this process from going on but it still causes me frustration. I wish there was something more I could do. It is a survival response. I say to myself, OK, you have documented what you can, you have done everything you can, when you can do no more, forget it. You still have a job and you still have a paycheck coming in and you still have a family. Find other interests outside the hospital, which I do."

The important difference between the above two strategies is in effect on self. In the first situation the nurse makes herself more comfortable while maintaining her strong connection to patient and to the unit. In the second situation, comfort is achieved at the price of connectedness.

The key coping strategies in dealing with non-responsive patients appears to be working with other staff with the patient and working with self with expectations. This need for staff to

work together with the patients gives one more indication of why staff can be stressors.

Self as Stressor

In four situational descriptions nurses focused on problems where their own response was the stressor. When this happened, the focus was on dealing with self. The nurse's willingness to see the problem as her own and work on it with self and others was important. One nurse considered her own participation in creating the problem and said she had learned how to prevent its recurrence. Three of the nurses talked with others. To the extent that others responded, the responses were perceived as helpful. Feelings were primarily resolved through this talking with others and seeking help. The feelings resolved as the problem resolved. The perceived problem and attendant feelings were diminished in all four situations but it took time for this to occur.

Organization as Stressor

On one occasion the situation described in detail focused on problems with the organization. The situation was conflict between organizational policy and individual desire for flexible work time. Coping efforts have involved talking with unit staff at all levels, assertive behavior, presenting plans to the head nurse and requesting a conflict resolution session with unit chief. These coping efforts have not had an effect on the

perceived problem. Personal optimism, continued assertive behavior, clarification of personal goals, interest of co-workers and limited investment in the organization have been helpful in limiting and reducing the accompanying feelings of distress.

Section Summary

In summary, different coping strategies seem most helpful in response to different stressful situations for these psychiatric nurses. In situations of staff friction and infighting and staff non-performance of duties, no individual strategies were described which resolved the basic problem and coping behaviors seldom affected even the example incident. Head nurses were often described as contributing to staff friction and infighting and hindering rather than facilitating resolution. On the other hand, help from the head nurse made a salient difference in resolving problems with staff non-performance of duties.

The individual nurse's talking with head nurses, supervisors and physicians about problems with them was more effective than talking with unit staff about problems with them. The underlying problem often remained but at least specific incidents were often resolved. Persistence, perception of power and vulnerability and help from others were sometimes important factors here.

By contrast, the nurse's individual efforts were successful in resolving problems of resource shortage. Successful strategies were a combination of assessing overall needs, setting

and focusing on priorities, revising expectations of self to reflect constraints of the situation and using the help of available others. Not only were these problems resolved but also valued learning occurred for these nurses.

These nurses described strategies effective in coping with the stress of patient problems involving non-responsiveness or lack of improvement. The effective combination was doing one's best with the patient and working with other staff with the patient while revising one's own expectations of self and separating good nursing care from desired patient outcome. Evaluating self on the basis of nursing behavior rather than patient behavior allowed for resolution of distressing feelings even when the perceived problem remained.

Effective coping strategies were also described when the nurse's own response was the stressor. Effective coping involved seeing the problem as her own and being willing to work with self and others to resolve both problems and feelings.

No strategies were effective in resolving problems between the individual and the organization. However, coping behaviors and limiting personal investment in the organization did affect the distress experienced.

Simply talking with others seldom had much effect on the outcome of the above situations. However, talking was often described as a valued strategy with all of the stressful

situations because it made the nurse feel better.

Assertiveness: A Coping Trait Helpful Across Situations

The foregoing has examined coping strategies effective in specific situations. It is also possible that coping strategies which are traits for individual nurses may be helpful across situations. From the data one trait emerged which seemed generally helpful--assertiveness.

Assertiveness is generally defined as ability to express self to others while showing respect for self and others. From their descriptions of themselves these nurses were classified into there groups: least assertive, moderately assertive, and most assertive. After classification into these groups, the high and low group were compared as to frequency of expression of thoughts and feelings to involved person and other for validation of the classifications. The most assertive nurses expressed their thoughts to the involved person 100% of the time compared to 83% of the time for least assertive nurses. Most assertive nurses expressed self to others 93% of the time as compared to 67% of the time for the least assertive nurses. The most assertive nurses expressed their feelings to those involved 71% of the time compared to 25% of the time for the least assertive nurses. The most assertive nurses expressed their feelings to others 73% of the time compared to 58% of the time for least assertive nurses.

Assertiveness seemed to aid coping in three ways: assertive nurses felt less vulnerable, were better able to revise their expectations and obtained more help. The perception of personal vulnerability increases the stress experienced in a situation but more importantly affects the nurse's perception of appropriate or possible behavior in coping. The nurse who feels vulnerable is seldom willing to increase her vulnerability through risk taking. Sixty percent of the most assertive nurses expressed personal vulnerability in the stressful situations described in detail while 100% of the moderately and least assertive nurses expressed personal vulnerability. The following is one most assertive nurse's understanding of the relationship between assertiveness and vulnerability: "For me there is a relationship because I don't look at it from a personal standpoint. I look at it from a professional standpoint and why it's important to me is making sure quality care is given and the reasons behind it and there is rationale to the nursing care as it is given. . . . I don't feel afraid and it's because I can make my point, get my point across and the only way that I think that you can do that is by being assertive. I think of situations where other nurses back down or why they do that and I wonder if it's because they are not assertive. Is it because they are afraid of what might happen to them in the long run? I'm saying I'm not afraid of what might happen in the long run because I'm basing it on professional

standards and not personal like fearing looking stupid or whatever else."

Most assertive nurses revised their expectations as situations changed 25% of the time compared to 14% of the time for least assertive nurses. Letting go of more idealistic expectations may be related both to separation of the personal and professional and to the ability to respond to a situation by making oneself heard.

The most assertive nurses elicited help 38% of the time while the least assertive nurses elicited help 0% of the time. Asking for help in a way that can be heard and responded to seems related both to the ability to express oneself and not perceiving personal vulnerability in saying one needs help.

It is interesting to note that the most assertive nurses do not have fewer problems with their own unit staff. In fact, the opposite is true. In this study 57% of those who are moderately and least assertive see staff as the biggest problem while 88% of those who are highly assertive see staff as the biggest problem. At the moment this is without explanation. One possibility is that more assertive nurses are more aware of or simply report more staff problems. Another possibility is that more assertive nurses experience more problems with those who speak up less clearly or frequently or that in trying to accomplish something they are more likely to encounter opposition. A third

possibility is that assertive nurses engage in more problem situations or more problem solving behavior.

Coping Across Situations

Patterns also emerge in looking at coping across situations. Many of the stressful situations described in detail were said to be examples of recurrent or ongoing situations. These nurses described four strategies they used in dealing with these situations. These strategies were (a) "not taking it in," (b) reinterpretation, (c) acknowledgment of what is and change of focus for the nurse's efforts, and (d) continuing to work on the problem in different ways.

One nurse compares herself to a duck in "not taking it in." "I have taken the stance in life that you have to be a duck and let the water run off your feathers because if you let the water go in, then you are never going to be able to accomplish what you came here to do. It is a theme in my life, you have to play duck every once in a while when it is necessary and I have had to really think it through and tell myself, Today you are a duck because of the heavy rainfall." Another said, "I take that job with, not a grain of salt, but very eased. I don't really let a whole lot bother me because I have so much else going on. I think that is one of the secrets to being in psych nursing; I don't bring it home with me."

Reinterpretation is a deliberate effort to alter one's perception. One nurse describes receiving very negative feedback when she objected to a consequence as punitive rather than productive for her patient: "It was very negative. I don't consider myself a weak person but that was seen as a weakness so I had to interpret it as strength so I could go on."

Several nurses describe the value they experienced in first acknowledging "what is" then deliberately changing their focus. "If you can't do something about something, there is no point dwelling on it, I don't think. . . . I go on to something that is going to be constructive and that I can see that I can do." "I stopped complaining, it's not worth it; I'll just do my job and not try to change anything and now things are better." "We have all pretty much given up on the system. We look for our own rewards. It is the only thing we have control over. There is no control over the other."

One nurse describes her strategy for change as being a role model and giving the staff time to develop trust and acceptance. Another says "sometimes I just do it gradually to win the staff's appreciation and to make the resistance less, just introducing them to it gradually."

The commonality of these strategies is that they offer hope and some sense of personal power in the situation. When hope is lost and powerlessness is experienced, withdrawal and burnout are

described.

The withdrawal described is psychological. According to one nurse, "When you can't do something about something, you develop an attitude of So what?" Another says, "Over the last month nothing seems important; I don't care anymore. . . . It's easier just to pull back and say It's a job; you don't get hurt as much that way."

This psychological withdrawal is sometimes accompanied by thoughts of physical withdrawal. "I just don't want to put up with that and I don't have to put up with that and I won't. . . . I can always move," and "The whole situation, the way hospitals are run, I'm ready to get out of nursing."

In this sample, psychological withdrawal does not lead to actual physical withdrawal or termination of employment. A major reason for this may be the lack of available jobs as nursing has experienced surplus rather than shortage of workers. Increased numbers of psychologically withdrawn nurses may increase the stress for all staff and decrease nursing productivity.

A second pattern which emerges across situations is the effect of coping with anger. As noted earlier, anger is the feeling most frequently described by this group of nurses in response to the stressful situations described in detail. Regardless of the outcome of the situation, dealing with anger in some way helped reduce the distress; not coping with the anger

took a toll on the nurse. This is evident from the following descriptions from two nurses: "I was just plain angry. I let them know it. I really do. I don't carry that stuff around a long time. I think that if they have earned it, they need to hear it. . . . It doesn't linger because I deal with it." "I was angry. I was probably real ineffective. I let a lot of anger build up inside me then I will start taking it out on other people; I don't deal with that person particularly. I'm displacing a lot of my anger all over the place, everybody, if they look at me the wrong way and it really has nothing to do with them, it's just, I'm frustrated."

Dealing with anger with staff seems particularly difficult. One nurse explains, "You can get angry with the patient and you can go into your little office and you can say, that patient is a pain in the neck. If a staff angers you, you don't dare say something like that because you don't want to start a fight. So you just suppress it because you are not allowed to do that or maybe you could do it but then that would bring up a lot more; that would be like a volcano until it erupted so you try to overlook it. And you hate to say to another co-worker when they are driving you crazy, you know I want to slap them upside the face because then you are putting your feelings about somebody else on somebody else so you just don't say anything. Then you come home and tell your lover or your roommate or whoever, it's

getting rough at work, they are about to drive me crazy. And it's really the staff because you don't have an outlet for it, but you have an outlet with the patients. We have treatment conferences all the time to deal with patient problems. So what ends up not being dealt with are the staff problems. We do have a staff meeting once a week, but you'll notice that nothing is said of great importance; it's all superficial."

Both stressors experienced and coping strategies were examined according to demographic variables, educational variables and employment variables (e.g., type of unit, length of time in psychiatric nursing and length of time in this job, shift worked). No association was apparent.

Summary

The varied stressful situations described in Chapter 4 elicit a variety of behavioral and emotional responses, coping efforts and outcomes. The stress described by these participants is primarily interpersonal and complex. Understanding the stressor is possible only by understanding both the meaning and the context of the situation from the viewpoint of the participant.

Problems with self and resources have the most positive outcomes in terms of both problem resolution and diminishing of distressed feelings. Successful strategies for resolving problems with self include identifying the problem as one with

self and working with self and others to resolve both problems and distressed feelings. Successful strategies for dealing with resource shortage include setting priorities, revising own expectations and using available help from others.

Although patient problems were often not resolved satisfactorily, the nurse was able to alter her feelings of distress. This was achieved through revision of expectations and basing self evaluation on nursing action rather than patient response in combination with working with other staff and doing one's best with/for the patients. Problems with the organization were also unresolved but again feelings of distress were successfully regulated through examination and alteration of expectations and investment in the situation.

Outcomes of problems with head nurses, supervisors and physicians were quite varied. Persistence in dealing with the problem was the strategy most often related to desirable outcome.

Problems with unit staff were most frequent and had the least desirable outcomes. Both problems and distressing feelings were often unresolved. The role of the head nurse in these problems seemed pivotal. The head nurse often contributed to staff infighting but made an important difference when other staff were not performing adequately.

Assertiveness was a behavior identified as helpful across situations. Compared to the less assertive nurses, more

assertive nurses expressed themselves more often, felt less vulnerable, obtained help more often and revised their own expectations more often. The ability to revise own perception, refocus and then persist in working on problems and the ability to deal with anger are also noted as helpful across situations.

CHAPTER 6--DISCUSSION AND IMPLICATIONS

In this chapter, the findings of this study of stress and coping in psychiatric nursing are presented. The discussion focuses on one finding, that having to do with the major role of unit staff conflict. This finding seems to be one of the most useful contributions of the study and is therefore discussed in detail in the first section. In the following sections the larger context of unit staff stress is discussed, the general significance of the study is reviewed, implications for nursing are discussed, limitations of the study are noted and possibilities for future research are described.

A Model to Illustrate Unit Staff Conflict

One finding from this study stands out as most in need of explanation: That for inpatient psychiatric staff nurses, the unit staff is the most frequent source of stress with predominately unsuccessful or limited success outcomes. One of every three stressors encountered by these participants involves conflict with peer or subordinate unit staff. An additional 17% of stress involves conflict with the head nurse/supervisor making 50% of reported stress a result of conflict with unit staff, head nurse, co-worker RNs and ancillary nursing staff. Not only is unit staff the most frequent source of stress, the outcomes of coping with unit staff conflict are less desirable than outcomes of coping with most other stressors. Patient care and

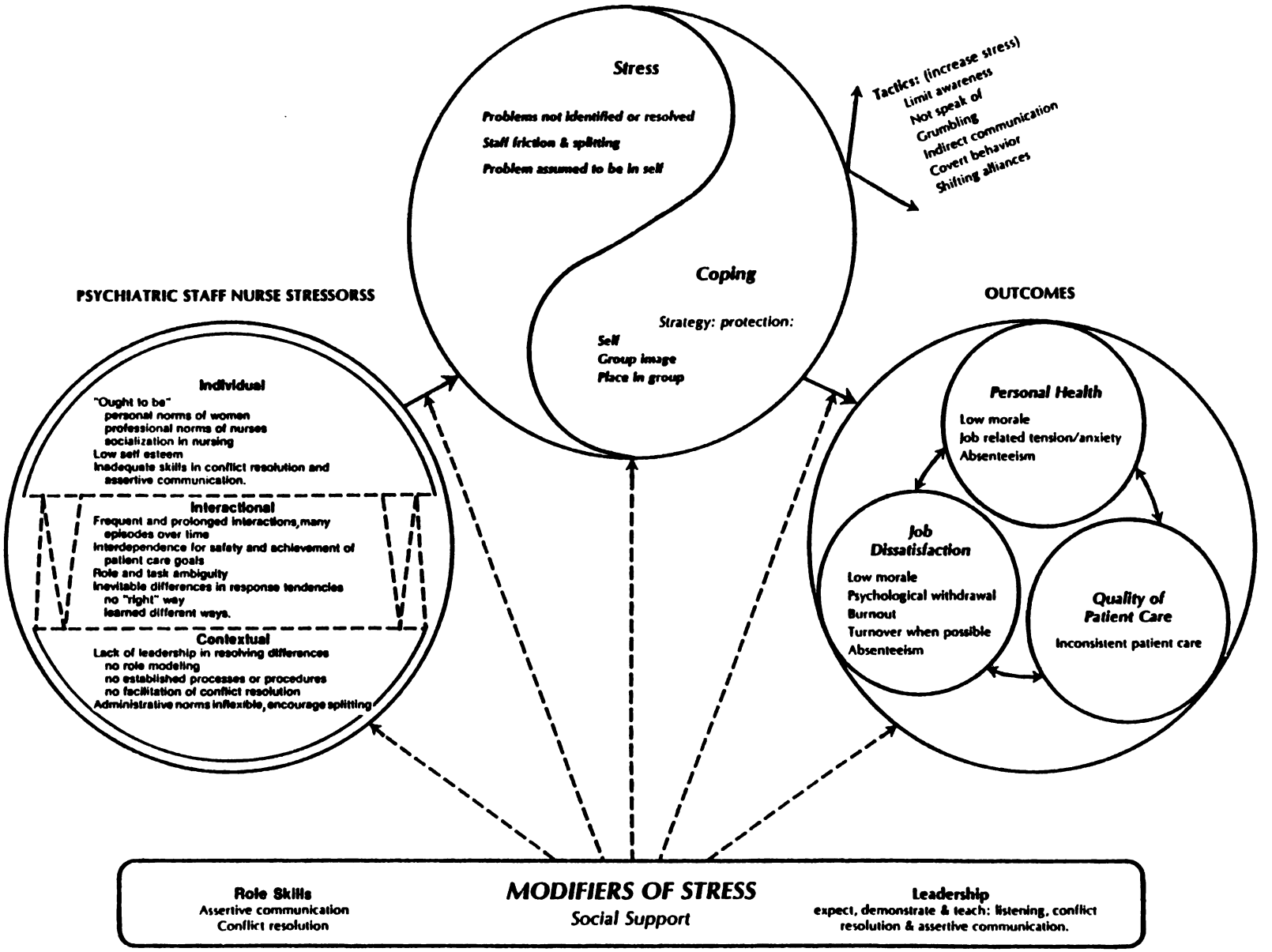
technological problems may be resolved but the human factor remains an enigma. How can it be explained that staff have so many problems with each other and that these problems are not discussed and resolved?

The author's Model I is used as the organizing framework for discussing unit staff conflict. Model I was developed from elements noted in the literature as important in a stress model. This same model can be used to discuss any of the findings since it provides a framework of elements helpful in understanding stress as a multifaceted process.

The writer's visualization of the process of staff conflict is depicted in Model II. According to Model I (p. 9), understanding and explanation of stress and outcomes of stress come from examining personal and contextual factors interacting with the situation, coping and other modifiers of stress. Model II is the specific application of Model I to the process of staff conflict. Model II emerged from and is grounded in the data. Each identified factor is described in some detail.

By way of overview, the relationship between the individual staff nurse and the situation is characterized by (a) frequent interactions of staff with many episodes over time, and (b) interdependence of staff in providing for safety and achievement of patient care goals. The psychiatric unit is characterized by ambiguity. The staff face many different approaches to the

Model II: Application of Model I to Unit Staff Conflict



patient problems. From educational differences with different therapeutic "schools," from different experiences and from holding different values, individual staff have different response tendencies to patients and to each other. These differences emerge as conflict when there is uncertainty about what to do, how to do it, and who is to do what. This conflict is aggravated by individual and contextual factors, and coping strategies. Individual factors are personal and professional norms and professional socialization, low self esteem and inadequate skills in conflict resolution and assertive communication. Contextual factors include lack of leadership in resolving differences and administrative norms.

These staff conflicts are neither openly identified nor resolved but are perceived as threatening (to self, group image, and self within group) and elicit a coping strategy of protection. The tactics used in protection interfere with resolution of the conflict. In the absence of conflict resolution, the stress is expressed as staff friction and splitting and many individual nurses assume the problem to be in themselves. The unit staff conflict is influenced not only by coping but also by social support, leadership, and role skills. Social support, particular leadership behaviors and role skills in assertiveness may have helped to resolve the interrole conflict and/or diminish the distress experienced by the nurse

experiencing interrole conflict.

Interaction of Individual and Contextual Factors

In psychiatric nursing there is a high need for staff to work together to do the job. One staff member cannot achieve unit safety alone and usually cannot achieve a patient care goal alone. Safety and achieving goals with patients depend on staff working together and maintaining consistency from person to person and shift to shift.

Nurses know that nursing involves working together; interdependence is often discussed in the interviews. The nurses frequently reflect concern about individual versus group and us versus them attitudes. Having staff work together is considered positive; the consequences for not working together are negative sanctions. The nurses in this study say that going against the group is extremely risky. According to one nurse, "there is a sense of groupness on most units. When we and I are opposite, it's hell."

Psychological consequences are described for those who transgress group norms: exclusion, isolation, and lack of support. Examples given of the consequences of going against the group include: "if you bring something up in a meeting, no one responds," "all that you suggest is torn down," "you have no power, you are outside of the group and can never be a change agent," "you are not acknowledged and not supported." According

to one nurse, "You are afraid not to show loyalty and you want to present a united front to all outside of unit staff." In other words, nurses pretend that the unity that ought to be actually exists.

This need to be part of the group and stay within professional norms and present a united front leads to suppression of conflict, making it more likely to be enacted in behavior rather than resolved in words. As one nurse explains, "working with each other is like a marriage only the stakes are higher--you'll sell your soul to keep the peace." Says another, "passive aggressive behavior is the only way to survive in this system."

Nurses come through a primarily physiological education of specifics, certainty and right/wrong and should/oughts into a psychiatric work world of uncertainty and ambiguity. There is uncertainty about what is to be done, who is to do it, and how it is to be done. Generally there are two or more possible ways of approaching a problem. These different ways of doing things reflect different therapeutic "schools" which are seldom right or wrong but merely different. Evaluation of observed or actual effects is the basis for continuation or change of interventions rather than predetermined "rightness." As one nurse explained, "In medical surgical nursing you may work together to turn a patient and do a bath; in psychiatric nursing you work together

with a schizophrenic patient with family problems." There is no universally accepted way to do this or to determine who will do what. Also, approaches to different patients may vary. In medicine, surgery or intensive care units, once a specific procedure is seen as most reasonable, carrying out the procedure is relatively clearcut; everyone knows what to do and can function as a team. Carrying out work with a schizophrenic patient and his family is not so clearcut.

Not only is the role of the psychiatric nurse uncertain and different from setting to setting, but also, the role of the psychiatric nurse overlaps in areas with the roles of ancillary staff, social workers, psychologists and psychiatrists. According to Denny (1971) nurses and other professionals vary in their definition of the psychiatric nurse's role. Differences in understanding and expectations will inevitably lead to some conflict.

Psychiatric nurses are often not prepared for the ambiguity encountered in roles and tasks and may attempt to impose certainty and "should" on the situation. Each nurse may have learned a different way of providing care to psychiatric patients with the same diagnosis and thus nurses have different response tendencies, a definition of conflict. This conflict is experienced as stressful. According to one participant, "the stress for me, when I'm in charge, is asking other people to do

things and meeting resistance and having other people's ideas of the job very different from mine." In the face of ambiguity the nurses have only their own ideas to which they become more attached as right/certain, a position which promotes conflict. This may be particularly true for those whose education focused on what and how rather than why, what and how; nurses who have learned only what and how have little basis for understanding differences or changing their own ideas. In discussing the rigid attachment of each nurse to her own ideas, one nurse said simply, "staff lack tolerance for each other. Each says, so much needs to be done, but it must be done within my understanding. In psych we have to allow for individual differences in patients but we don't allow for flexibility in us."

In the job stress research literature, uncertainty by a worker about what is to be done and how to do it is called role ambiguity; competing role expectations or different desired response tendencies from workers in response to a task is called role conflict. Role ambiguity and role conflict have been studied extensively as stressors outside of nursing. Both ambiguity and conflict are demonstrated to be associated with job dissatisfaction, job related tension and anxiety (Van Sell, et al., 1981) and performance (Schuler, 1979). Bedeian et al. (1981) found that role ambiguity and conflict are correlated with job tension and job dissatisfaction in hospital nursing service

personnel. Participants in this study seem to experience tension with role ambiguity and conflict which interferes with interdependent performance and satisfaction with performance.

Both role ambiguity and role conflict have been associated with unfavorable attitudes towards role senders and role ambiguity has been associated with lower self esteem (Van Sell et al., 1981). The negative relationship between role ambiguity and conflict and co-worker interaction in nursing is supported by the research of Bedeian et al. (1981). Unfavorable attitudes towards role senders and low self esteem are evident in these participants who do experience role ambiguity. Causality is uncertain but association is clearly present. Attitudes toward self and co-workers and role ambiguity appear interactive. Schuler (1980) describes the vicious cycle of interdependence coupled with unsatisfactory relationships leading to withdrawal from the unsatisfactory relationships causing further difficulty with task achievement. The pattern Schuler describes is evident in this study.

Thus it can be seen that ambiguity and conflict over potential treatment approaches and the high need of psychiatric staff nurses to interact with each other, the patient, the family, physicians, and other clinicians increases the possibility of conflicting ideas over treatment. Yet these professionals seem intolerant of differences and professional

ideals and norms prohibit overt conflict so when conflict occurs, it is pushed from awareness and not dealt with openly.

Individual Factors Contributing to Staff Conflict

Professional norms and socialization are among the individual factors which contribute to the lack of resolution of staff conflict. Other individual factors which contribute to staff conflict are personal socialization, low self esteem, inadequate communication and interpersonal skills and coping response. Each of these factors is now discussed.

Norms and Socialization

Since 97% of practicing nurses are women, most nurses have been socialized as women. This has historically included the learned expectations and behaviors of passiveness and submissiveness. This personal socialization joins professional socialization in contributing to problems with unit staff conflict.

Professional socialization may contribute to unit staff problems in two ways: (a) concern with "what ought to be," and (b) professional norms and taboos. Concern with ideal states, the "ought to be" condition, is prevalent in nursing and emphasized by nursing theorists. Stevens (1979) discusses the two types of nursing theories: those which focused on describing "what is" and those concerned with "what ought to be." According to Stevens, "nursing (for most theorists) is a mentally

constructed world rather than the real world of nursing practice. . . . The nursing discipline usually is located in a mental construct of 'ought to be'" (p. 7). This concern with ideal over real is reflected in professional norms and taboos.

Professional norms include the definition of professional behavior and the expectation that nurses work together. Professional may be contrasted with personal. Professional behavior in nursing means a selfless helping of others. The professional nurse is admonished to leave personal problems and concerns at home and come to work as if this part of her/his personhood can be voluntarily separated from any other part. The nurse's own values, attitudes, feelings, and responses are expected to be held in abeyance; the nurse "ought not" to have personal responses which could interfere with patient care or detract from the task at hand. This depersonalization of the nurse presents an impossible paradox in a psychiatric setting where the self is the only tool for working with patients. Nursing calls this process the "therapeutic use" of self yet insists on suppression of the self and disowning of the only tool for work: the self. Jacobson (1983) notes the paradox "that (ICU) nurses are expected to be objective and firm while simultaneously emanating warmth and feeling" (p. 34). This paradox centers on the potential conflict between the personal needs of the nurse, the needs of the patient, and the needs of

the organization.

In attempting to be professional, nurses attempt to limit their awareness of personal feelings and responses and feel badly when they are unable to do this. There are consequences to this limiting of awareness. "In the process of focusing away from selves, helpers may end up denying the very humanness he/she needs in order to have a positive impact on the patient" (Cleve, 1979, p. 16).

That nurses work together interdependently is assumed as a part of what "ought to be." When interpersonal problems are experienced, they are both unacceptable and unspeakable because they are recognized as what "should not be."

Even within the professional nursing literature intra-staff conflict appears unspeakable. Staff-staff conflict is infrequently mentioned; since it "ought not" occur it is not looked for or seen. Interpersonal conflict between nurses does not fit the professional image of what ought to be. However, probably a lot of interpersonal conflict (with patients, with medical staff, and administrators as well) does not fit the professional image. When experience with other staff fails to meet the ideal, the problem is assumed to be in the self: "There is something wrong with me." Because it is unacceptable (taboo) to have personal problems, awareness is limited and problems are not discussed openly, so how could they be resolved? Further,

attention to resolving the problem would be meeting personal needs, another taboo. Yet the distress remains and so becomes expressed covertly in behavior.

In discussing barriers to work-site interventions in stress, Baldwin and Bailey (1980) identify two beliefs which hinder interventions: "1) the belief that experiencing work stress in nursing is a sign of personal weakness and 2) the belief that the individual nurse must handle work stress alone" (p. 52). These beliefs are particularly relevant when the work stress is interpersonal conflict with unit staff. Nurses are socialized to expect to work together for the benefit of the patient. When reality does not meet expectations, the nurse assumes it reflects her individual weakness and she "should" be able to handle it alone. Yet the lack of training in how to deal with each other leaves the nurse without skills for resolving conflict.

These stressful effects of professional socialization are consistent with the role stress described by Brief et al. (1979) as occurring when anticipatory socialization (during the educational phase) is incongruent with actual experience in the nurse's role. Brief et al. (1979) note that this anticipatory socialization affects the expected role of the nurse but does not influence the actual activities performed by the nurse. Brief (1976) attributes dissatisfaction and turnover in hospital nurses to expectations fostered in nursing education and unmet in work

situations.

Low Self Esteem

Low self esteem seems to be an individual characteristic of many nurses in this study. Low self esteem is both identified verbally and expressed in behavior. Low self esteem is associated with role ambiguity (Mossholder et al., 1982) and is, no doubt, promoted by cultural norms of submissiveness for women and by nursing socialization. The message that nurses are not important may begin with faculty's demeaning responses to nursing students. The message is continued by physicians and head nurses who do not listen to staff nurses' input. The nurse's perceived message of devaluation could come from many sources. In this study, examples are frequent: in one case, unit nurses remembered and acknowledge the unit physician's birthday but nurses' birthdays went unnoticed. In another example, head nurses asked staff nurses to plan a "nurse appreciation day" for themselves, then the supervisor asked the staff nurses to contribute $5.00 each to pay for nurse appreciation day. One organizational policy decision was that staff nurses on locked units should not possess unit keys. Instead, these units' nurses must ring the doorbell to enter and sign out a key for each day's use. This was in contrast to employees from other departments (e.g., engineers, physicians, pharmacists) who retained their personal keys to the same unit.

Peters and Waterman (1982) say that self esteem is related to positive reinforcement. The lack of positive reinforcement, particularly from head nurses, is a frequent complaint from these nurses. Mossholder et al. (1982) report that co-worker interaction has more impact on job stress and work performance for low self esteem subjects than for high self esteem subjects.

Low self esteem may lead to lack of conflict resolution even if there is awareness/acknowledgment of staff conflict and possession of communication and interpersonal skills. To spend time and energy resolving problems, the nurse has to value self and feel worthy of resolution. Valuing self and feeling worthy is the opposite of low self esteem.

The existence of low self esteem may be self perpetuating. If nurses are devalued by others, nurses are likely to devalue themselves and to devalue other nurses. Indeed, these nurses often do not listen to or respect one another. Stevens (1980) describes that as the "casual disrespect" (p. 10) that nurses have for each other. Weiss (1981) notes nurses' invalidation of nurses' expertise, another example of disrespect of one nurse for another.

Inadequate Communication and Interpersonal Skills

The third individual factor identified by nurses in this study explains further why conflict is kept out of awareness, not acknowledged, and not discussed: Nurses often lack the skills to

resolve conflict. Even if the problem of conflict is identified and acknowledged, these nurses often lack the skills needed for conflict resolution. Indeed, these participants often talked with staff with whom conflict occurred but the conflict was not resolved.

Sarbin and Allen (1954) note that the ability of the individual to meet the demands of a position depend in part on learning role specific skills. Given the ambiguity, conflict and interdependence in psychiatric nursing, assertive communication skills seem essential. Assertive communication includes expressing feelings, needs and ideas and standing up for one's own rights in a way which respects the rights of others. Cultural norms for women have historically included passivity and submissiveness. Neither cultural norms for women nor socialization in nursing encourage awareness and expression of feelings. Assertive communication is often neither taught nor role modeled in nursing. Several nurses describe learning communication skills from nursing instructors who are themselves inept or passive aggressive (perhaps to be expected since they come through the same education and socialization process).

When ignoring one's own feelings, needs, ideas and rights becomes unacceptable to women/nurses, aggressive behavior is often the response. The attempt is to dominate others to get one's own way. This aggressiveness is reflected in the power

struggles described by participants in the study. The focus with different responses is on whose way is right or will dominate rather than how can we work together.

The ineffectiveness of nurses in communication and interpersonal skills has been demonstrated in Dodge's (1971) research. The study examined effective and ineffective behaviors exhibited by psychiatric staff nurses, head nurses, supervisors, and directors of nursing. Peers, subordinates, and superiors perceived these nurses as ineffective in interpersonal relationships with other nurses, other disciplines, patients, and their families.

Coping Responses

The coping responses described by these nurses also aggravate staff conflict. The overall coping strategy appears to be protection: protection of the group image, protection of self image, and protection of the individual's place within the group. The consequences of this protective strategy lead to inhibition of awareness and inhibition of active coping strategies. Since the problem and distress are present, but not acknowledged, the problem and distress are expressed covertly. Coping tactics include complaining, withdrawal, passive resistance, and joining forces with staff who agree on a particular issue. These tactics perpetuate staff distress but do nothing to resolve the underlying conflict.

Contextual Factors Contributing to Staff Conflict

Contextual factors also contribute to staff conflict and inhibit resolution. The important contextual factors to be discussed are nursing leadership and hospital administration policies and practices.

Nursing Leadership

Nursing leadership, particularly the head nurse, may further contribute to lack of resolution of conflict and lack of support among staff nurses. Head nurses are often weak in communication and interpersonal skills (Ferguson, 1971; Whitner, 1974). They have had the same education and socialization as staff nurses. As head nurses make the transition from staff nurse to head nurse, they are often given no aid or education to help them acquire the skills they need for effective leadership (Hardy, 1978). The nurse's position has changed but the skills have not.

Nurses in this study who do not find staff their greatest source of stress often describe some leadership patterns of their head nurse as a possible stress alleviator. Putting together their comments, the optimal leadership pattern of head nurses would appear to be a willingness and ability to listen to anger and disagreement; expecting their staff to do the same; encouraging staff to work out differences; and facilitating this process when help is needed. The stress-reducing head nurses are likely to assume that problems between nursing staff arise from

misperception and miscommunication and both initiate and facilitate those involved talking together to resolve problems. Where the stress alleviating head nurse leadership pattern is described, unit staff are not described as the greatest source of stress. Rather, staff are described as doing things in a variety of different ways; there is tolerance for these differences and when discomfort or disagreement occurs, the disagreements are resolved openly and staff are supportive to one another. This pattern is consistent with the findings of Bowers and Seashore (1966) that supportive leadership is the best predictor of peer support. On units where head nurses do not role model and facilitate assertiveness and conflict resolution skills, continuing conflict is more likely and peer support less likely.

Hospital Administration Policies and Practices

Participants suggest that hospital administration may contribute to lack of resolution of unit staff problems. Because hospital administration is able to exert more power when staff is divided, administration has a stake in maintaining the split in all levels of nursing rather than promoting unity. An example of this seen in hospitals is the enforced splitting off of leaders from staff nurses in negotiations with the employer. Hospital administration considers head nurses part of management and head nurses are frequently forbidden to attend staff nurse meetings where negotiation issues are being discussed. Thus the natural

leaders are split off from the rest of nursing staff and the groups are pitted against one another. An alternative to the concept of divide and rule is the concept that joint efforts of organization and staff are better for both organization and staff. The rationale for this viewpoint comes from the work of McClure et al. (1983) and Peters and Waterman (1982) which is discussed in the next section, Stressors: the larger context. The dialectical process, discussed on page 212, is one approach to achieving joint efforts.

Consequences of Staff Conflict

Not acknowledging and inhibiting overt conflict protects the notion of "what ought to be" at the expense of dealing with "what is." Meanwhile, "what is" (unit staff conflict) exerts a continual pressure relieved but not resolved through covert behavior and indirect expression. The consequences of this covert behavior and indirect expression are reflected in staff splitting--friction and shifting alliances. Occasionally, open fighting erupts but it is covered over as soon as possible. The major consequence of this covert pattern is that problems are not clearly identified nor resolved. As one nurse explained, "the problem with indirect communication is, you don't know what the problem is." Thus the attempt to maintain the appearance of "what ought to be" (professionals working together) prevents the achievement of nurses working together.

Hillier (1981) described some of this process. She identified nursing culture as emphasizing tasks while minimizing personal reactions to stress. How nurses should react to difficulties is determined by senior staff's "unspoken consensus" or what Glaser and Strauss (1968) call the ward's "sentimental orders." Social control to remain within this standard is achieved through fear of ridicule or shame. Hillier (1981) noted that this culture does not allow for working out role relationships which "appear to be a serious source of stress for nurses" (p. 28). In keeping with the "unspoken consensus" the difficulties in role relationships are seldom overtly expressed in verbal conflict or anger. Rather they are covertly expressed in gossip, looks, gestures, tone of voice, and shifting alliances, a pattern which does not allow for resolution. Thus the suppression of overt conflict inhibits the development of close personal supportive relationships and may lead to apathy.

Until recently interpersonal problems in inpatient nursing could be dealt with through turnover. Nurses changed positions instead of changing their relationships. As nursing experiences a shortage of jobs instead of a shortage of nurses, nurses are less likely to leave their jobs. With the pattern of decreased turnover, an increase in nurse-nurse problems can be expected.

Stressors: The Larger Context

Thus far the discussion has focused on explanation of unit staff conflict, the source of one third of the stress identified by inpatient psychiatric staff nurses. Unit staff conflict has been partially explained by examining its antecedents and process. However, the situation of unit staff conflict exists within a larger context. Other findings of note in this study have to do with this larger context.

Unit staff conflict is problematic not only because it exists but also because it is not expected, not acknowledged, and not resolved. The same may be said of conflict between the individual staff nurse and the organization's structure, policies, and procedures. Different response tendencies by individual staff nurses and hospital organizations are inevitable because of different goals. The usual goal of the staff nurse it to give quality patient care while the goal of any organization is to stay in business.

These variant goals will inevitably bring different response tendencies. The different response tendencies per se are not necessarily problematic. In fact, the organization's attention to staying in business guards the individual nurse's arena for providing quality patient care while meeting some of the nurse's individual basic needs through employment. At the same time, the nurse's focus on patient care meets the need of the organization

to provide a service which will keep the organization in business. However, the handling of the different response tendencies appears to make the conflict problematic. Like unit staff conflict, individual staff nurse and organizational conflict is not expected or acknowledged and not resolved. For the most part, organizational structure described by these nurses was hierarchical, autocratic, and conflicting. The problems generated by this structure of hospitals have been noted by many researchers including Perrow (1965) and Zwacki (1963). Decisions are made at the top and passed down with little opportunity for input from workers affected by the decision. Open communication does not exist. There is no forum for the discussion of different response tendencies. Rather, a right way is determined by the organization and the individual staff nurse can either adapt or leave. This same process of intolerance of differences and arbitrary, unilateral decision making is demonstrated in the unit staff conflict described.

Intolerance of differences, blocked communication and unilateral decision making can be seen throughout the hospital setting between and among various working groups. The handling of conflict is similar between administrator-staff nurse, physician-staff nurse, head nurse-staff nurse and unit staff-unit staff (and perhaps staff nurse-patient). In all of these situations, power is unequal, input is unequal, and the decisions

made are likely to be mostly or totally unilateral. Differences are not valued or incorporated in the decision process. Thus conflict becomes a process of meeting the needs of one organism at the expense of the other. The powerless objection of the "loser" in these win-lose situations is then expressed in passive resistance through behavior. The passive resistance may then be identified as a problem rather than a reflection of a problem.

The importance of open communication, worker input in decision making, and dealing with differences has been examined from different points of view. The magnet hospital study (McClure et al., 1983) identified desired outcomes: hospitals with low turnover considered by nurses to be a good place to work and practice nursing. Hospitals with these characteristics were then studied. Peters and Waterman (1982) conducted a similar study of business organizations. Desired outcomes were identified: large, profitable companies with a strong history of economic health and growth. Worker satisfaction was not a criteria but was uniformly found in these companies when 62 were studied. The results of the two studies have many similarities. Specifically, characteristics of magnet hospitals and profitable companies included: (a) communication which goes up, down, and laterally with listening being characteristic of management, (b) workers affected by decisions have input into the decisions because they are considered a valued source of input, and (c)

differences are a valued source of creativity and innovation. The presence of these characteristics apparently facilitates the goals of both worker and organization and satisfies both.

The present study of stress and coping in psychiatric nursing is consistent with the many studies which show that the absence of the above three characteristics is associated with stress, lower productivity, job dissatisfaction, and diminished personal health. A sampling of existing documentation is given here. The effects of closed communication are documented by Bedeian et al. (1981), McClure, Poulin, Sovie and Wandelt (1983) and Van Sell et al. (1981). The stress associated with lack of input into decisions by which one is affected is documented by Caplan et al. (1975), Likert (1967), and Jackson (1983). The effects of valuing differences are described by Peters and Waterman (1982).

Unit staff conflict can be partially explained by examining unit staff conflict alone but unit staff conflict also exists within a larger context and reflects this larger context. The unit staff conflict takes place within an organizational context which influences the situation by creating structure and policies and setting norms and precedents. The norm is to not acknowledge or resolve different response tendencies but rather to block communication and make unilateral decisions. Other staff work within the same organizational context and experience the same

norms and precedents. These are reflected in behavior. The outcomes of dealing with unit staff conflict are predominately discouraging. So are the outcomes of dealing with staff nurse-organizational conflict.

The significance of this study and its implications for nursing center on identification of the problem of unresolved unit staff conflict. Understanding of unit staff conflict is greatly enhanced by understanding this conflict as typical and reflective of conflict within hospital organizations. Implications for change necessarily focus on both the identified problem of unit staff conflict and the organizational context of this problem.

Significance of the Study and Implications for Nursing

The significance of this study lies in its ability to ascertain, from interview and participatory approaches, what psychiatric nurses themselves perceive to be the problems and problem solving issues in their profession. The consensus obtained from the participants indicates validity of the findings. Previous work on stress in nursing has often relied on more structured techniques that may miss entire elements like unit staff conflict as the prime stressor.

Stressors, patterns of coping and their outcomes have been identified for psychiatric nurses working on acute inpatient

units. Until stressors and coping patterns were identified, it was not possible to identify possibilities for alteration of the stressor or alteration of coping patterns to deal with stressors.

On the basis of stressors identified in this study, a stressor inventory could be constructed for psychiatric nursing. With the addition of "other" to each major category, the outline on pages 136-139 could be used as the first draft of the stress inventory. This inventory could be used as an assessment guide by individual psychiatric nurses and/or work groups to determine and rank order their own sources of stress. Rank orders for individuals and work groups could be compared with this and future studies. Prominent sources of stress for the individual or work group could be used to guide interventions.

The most prominent sources of stress in psychiatric nursing (unit staff and head nurse and supervisory practices) appear to arise from within nursing. In a study of the effects of nurse beliefs and behaviors on the development of collegial relations, Weiss (1981) also found "that while forces external to the nursing profession have contributed substantially to the current status of nursing, the most destructive forces may well be the attitudes and behaviors of nurses themselves" (p. 2).

Awareness and acknowledgment of staff conflict as a source of stress is the first step towards alteration. The participants in this study were surprised but agreed with the finding that

unit staff is the most frequent source of stress. The effect of this explicit recognition on them was initially (a) validation (I'm not strange and feel less ashamed that I have these problems), and (b) motivation to understand and deal with these issues more directly. Hopefully, dissemination of these findings will have similar effects on other psychiatric nurses.

The fact that the major stressors arise within nursing is encouraging in that this is the area over which we as nurses have the most collective input and control. Identifying the problems as arising within nursing is not meant to imply "blame the victim." Awareness is a source of possible change and empowerment.

The focus for the first section of this chapter was on why staff have so many problems with each other and why these problems are not discussed and resolved. The findings in Chapters Four and Five and the explanation in this chapter describe and explain staff stress and lead to implications for nursing education, orientation to service settings, inservice education/staff development in the service setting, and organizational practices.

Each problem suggests a potential intervention. Socialization and professional norms, low self esteem and minimal role skills are individual variables contributing to staff conflict. Awareness of socialization, alteration of

socialization, support for self esteem and improved role skills are obvious interventions. Administrative norms, lack of input and leadership behaviors are contextual factors that contribute to staff conflict. Revision of administrative norms and processes and improved leadership skills for head nurses are obvious interventions. Frequent, prolonged interaction with staff and interdependence with staff are characteristic of interaction in the inpatient psychiatric unit as are ambiguity and conflict. These, too, contribute to staff conflict. Clarification to improve understanding and processes to deal with the inevitable conflict are obvious possibilities for intervention. Stress is increased in staff conflict by coping tactics, lack of support and lack of skills. Teaching and encouraging more adaptive coping tactics, and role skills and encouraging leader and staff support are obvious possible interventions.

The intervention possibilities identified are sorted into the following four areas for potential change: (a) acknowledgment of what is and developing realistic expectations, (b) development of communication and interpersonal skills, (c) organizational change for increased staff nurse participation, and (d) development of personal power through awareness.

Acknowledgment of What Is and Developing Realistic Expectations

In psychiatric nursing work there is a gap between "what is" and "what ought to be." Psychiatric nurses are different people with different educational backgrounds working in interdependent ambiguous relationships. Under these conditions, different response tendencies are inevitable and do occur. Differences and conflict are part of "what is." Nurses have ignored the discrepancy between the real and the ideal in terms of working together. By ignoring this split and pretending that what ought to be exists, the possibility of attaining the ideal is blocked. What ought to be could be redefined as a goal. To achieve the goal of working together, it is necessary to address what is, what is desired, and what must happen to move from what is to the goal.

Conflict could be viewed as an asset, a source of creativity. One process through which differences could become assets and sources of creativity is dialectical thinking, a process of development through the stages of thesis, antithesis, and synthesis. In this Hegelian change process a "concept or its realization passes over into and is preserved and fulfilled by its opposite"(Webster's New Collegiate Dictionary, 1980, p. 311). Dialectical thinking could help us move from our present position: That either (a) nurses' needs are met (thesis) or (b)

patient needs are met (antithesis) to (c) both personal and patient needs are important (synthesis). The realization of each is fulfilled through the realization of both. Nurses are persons who learn to use themselves to help others. Enhanced development of the nurse's interpersonal skills could lead to both reduction of staff-staff conflict and more therapeutic use of self with patients. Thus nurses' needs and patients' needs would both be met.

It would be helpful for education to provide a more accurate description of the work role of the staff psychiatric nurse. This would include knowing that only half the job is working with patients, understanding why conflict is inevitable within staff, and developing the expectation of experiencing and resolving conflict. The influence of the organization needs to be described so that this, too, becomes part of realistic expectations.

Orientations to service settings could reinforce expectations learned in the basic educational process. A discussion of expectations and clarification of realities could help the new psychiatric staff nurse to enter the world of "what is" instead of the nonexistent world of what "ought to be." Unmet expectations are frequently a source of stress and disappointment and, to the nurses in this study, sometimes a source of shame. More realistic expectations would help avoid this problem.

Developing Communication and Interpersonal Skills

Ineffective communication and interpersonal skills found in the nurses in this study suggest that basic education curriculums need to emphasize these skills to a greater extent. Assertive communication skills need to be taught during the basic educational process by teachers who role model as well as teach. Communication skills are taught in most nursing education programs but the focus is commonly on listening to and understanding the patient. The emphasis needs to be expanded to communication with other staff and include assertive strategies. Practice is an essential component of learning communication skills; role playing is one important aspect of practice. Role play situations should include peer relationships as well as nurse-patient relationships. The rationale for teaching assertiveness needs to include the inevitability of conflict in psychiatric nursing work. Open acknowledgment and acceptance of this inevitability and practical skills for dealing with it could move nursing from suppression of self and covert expression of conflict to active identification and resolution of conflict and to the development of more supportive relationships.

Assertiveness training involves not only clear and direct expression of self but also valuation and respect for self and other. It is the combination of valuation of self and other and learning to express self overtly and clearly and receive the same

from others that is essential. Assertive behavior can be contrasted with the passive behavior that is often encouraged and rewarded in students and graduate nurses. New behavioral responses would be required from faculty and nurse leaders as students and staff learn these behaviors.

Assertiveness also needs to be included in orientation to service settings and inservice education/staff development programs. Orientation would be a good time to review communication and interpersonal skills, particularly listening skills, assertiveness, and conflict resolution. This would no doubt be new material for some and a review for others. Either way, focusing on communication and interpersonal skills in orientation would underscore their importance.

Alteration in the time structure of orientation would allow for relevant practice and assistance with the skills. Designated orientation time is usually completed before service time begins. Saving two days of orientation time to be used in 2 to 4 hour segments throughout the first 6 to 12 months would allow "orientation" to address actual problems encountered in the work setting and assist with their resolution.

Staff development/inservice education is needed by both staff and head nurses. This study clearly described inadequate communication and interpersonal skills by both staff and head nurses. This note of inadequacy is also an identification of

learning needs. Listening skills, assertiveness, conflict resolution skills, and understanding of group process could be most helpful in promoting effective unit staff relationships. Working with the work group with these skills would expose all staff to the same learning and provide a safe environment for practice with the individuals with whom they will continue to interact.

With particular leadership skills and abilities head nurses could positively influence 50% of stress experienced by psychiatric staff nurses. One third of the stress of individual staff nurses comes from unit staff and another 17% from interaction with the head nurse. If the head nurse could help staff in dealing with each other and herself, the head nurse could help reduce the source of half of the reported stress. This is worth doing from a humanistic point of view, for benefit of staff, patients and health care organization.

The head nurse's ability to assist staff in dealing with herself and each other would require skill development for most head nurses. Hardy (1978) has noted that role skill building does not often accompany transition to the head nurse role. Part of the problem may be with identification of skills needed. This study suggests skills needed for clear assertive communication and conflict resolution within an atmosphere of realistic expectations. The head nurse also needs to learn to give

positive reinforcement to bolster nurses' self esteem.

The development of support skills for head nurses is also indicated. The participants in this study frequently described head nurses as nonsupportive. Support from the supervisor has an effect on many stress measures (Pinneau, 1975; 1976). House (1980) states that 75% of the potential detrimental effects of stress are buffered by support. In instances of high perceived stress, high social support could completely eliminate the detrimental impact of stress on health (House, 1980). Mohl et al. (1982) report that supervisory support is central to reducing stress levels for staff nurses.

The role of the clinical specialist has been developed to be an expert resource in patient care. This same concept could be applied to staff needs and problems. Having staff choose a resource person could meet the need for an expert resource in staff relations, a staff advocate or agency ombudsman. This resource person could work with individual staff nurses and small groups of staff who are having difficulties with each other. This assistance could also be provided through regularly scheduled staff meetings or support groups. In any event, a process needs to be established for dealing with staff-staff problems. It is not sufficient to acknowledge that staff conflict occurs. A recognized process for conflict resolution is also needed. Whether the established procedure is formal or

informal, nurses need to know that conflict resolution is valued and that help is available.

Staff and head nurses with strong communication and interpersonal skills could also be used as resources for each other. For instance, more assertive staff nurses could work with less assertive staff nurses; nurses working on units where interpersonal problems are openly resolved could work with nurses on units which have not developed this pattern; head nurses who facilitate conflict resolution could work with head nurses who have not facilitated conflict resolution. This is not only a practical use of resources, it is a way of acknowledging and valuing the skills within the work group. It may be a way of breaking the cycle of "casual disrespect" described by Stevens (1980, p. 10) to promote valuation and self esteem.

Organizational Change for Increased Staff Nurse Participation

Changes in some organizational procedures could greatly assist in improving staff working relationships. Staff/staff relationships might be improved by staff choosing the staff with whom they will work. The selection of new unit staff members would systematically include having the applicant meet with current staff and current staff having input into the selection of new staff members.

Staff/head nurse/supervisory relationships could be improved through an increase in two way communication. One way communication involves the imparting of information or directives from one person to another. Two way communication allows for the response, questions and suggestions of the listener. The result is a dialogue rather than a monologue. A dialogue suggests that the response and input of the listener are valued and respected and increases the commitment of the listener to decisions and courses of action.

One modality for increasing two way communication is through two way evaluations. Not only would head nurses evaluate and give feedback to staff about perceived strengths and areas where growth was needed, but also staff would evaluate head nurses and give feedback about perceived strengths and areas where growth was needed. The issue is not only individual abilities but also goodness of fit interpersonally and individual adjustments to improve this fit.

Increased visibility and accessibility is needed for supervisors making decisions affecting the work role of the RN. The conflict experienced by staff nurses with supervisors is often that supervisors make decisions actually advocated as part of participative management. For example, a nurse may be sent to another unit according to needs the supervisor perceives unilaterally without any input from staff nurses. The

opportunity for dialogue may bring consensus from initially opposing response tendencies.

The suggested organizational changes are second order changes, that is, the system rather than the individual is the point of change (Archer, Kelly & Bisch, 1984). Many of the stressors and coping patterns discussed in this study focus on first order change. That is, the individual learns to alter her own behavior within the existing system. But the stressful situations and coping responses occur within the larger context of the hospital; hospital policies and procedures are identified as sometimes causing but often aggravating other stressors and hindering coping. In these situations, individual or first order change is not enough. A change in the system is needed.

Developing Personal Power Through Awareness

A secondary gain from this participatory research was assisting the individual participant to examine and alter her own stress and coping. This was not a goal of the researcher but was an outcome described by the participants. When participants were asked what effect, if any, participation in this research had had on them, the most frequent responses were (a) that it was nice to have a non-judgmental listener, and (b) that the process of identifying and describing the stressful situation and their coping responses had allowed them to see changes they could make for themselves. In describing possible interventions for nursing

work stress, Baldwin and Bailey (1980) suggested debriefing of the event. Participatory research seemed to fill this function. Many participants said they chose to describe a situation which felt "unfinished" to them. That is, the participants experienced incomplete understanding of the situation or unfinished resolution of the problem or feelings. According to participants, discussion of the situation facilitated participant's understanding and resolution.

After participants met to discuss preliminary findings they were asked if there were any changes they planned to make as a result of their participation. Eighty percent of this group said they planned to deliberately develop more effective support networks for themselves and/or develop their assertiveness skills. Apparently enhanced awareness helped these participants to identify individual needs and make plans for meeting these needs. It is appropriate in adult education that the learner identify own needs and take responsibility for meeting them (Knowles, 1975).

Thus it appears that further participatory research could be of assistance in two ways. First, the process of participating in the research seemed useful to participants in enhancing awareness and recognizing coping options for themselves. Second, additional participatory research can contribute to the general purpose of nursing research: expanding nursing knowledge to

improve nursing practice.

This section has described the significance of this study and implications for nursing education and nursing practice. The following is a summary of the recommendations for nursing education and nursing practice:

Recommendations for Nursing Education

1. Introduce dialectical thinking.
2. Provide an accurate description of the work role of the psychiatric staff nurse and the influence of the organization.
3. Teach and practice assertive communication skills to be used with staff as well as patients.

Recommendations for Nursing Practice

1. Utilize dialectical thinking and process.
2. During orientation, reinforce realistic expectations about the actual work role of the psychiatric staff nurse and the constraints of the organization.
3. During orientation, review essential communication and interpersonal skills (e.g., active listening, assertive communication, conflict resolution and group process); provide inservice education to teach these skills to nurses who are deficient in these skills.
4. "Save" 2 days of orientation time to be used in 2 to 4 hour segments throughout the first 6 to 12 months of employment to

address actual problems encountered in the work setting and assist with their resolution.

5. Provide skill development for head nurses so that head nurses could assist in conflict resolution, provide the support which is linked to stress reduction and learn positive reinforcement as an enhancer of motivation and self esteem.
6. Establish a procedure for staff conflict resolution.
7. Provide a staff-selected resource person to assist in problem solving/conflict resolution between staff.
8. Use existing staff with strong communication and conflict resolution skills to work with same level staff in developing these skills.
9. Develop a systematic process for current staff to have input into the hiring of new staff.
10. Increase two way communication between staff and head nurse. One example would be two way evaluations.
11. Increase visibility and accessibility of supervisors to staff and provide for staff input into decisions directly affecting staff.
12. Seek input of staff into organizational policies and procedures which affect staff.
13. Continue participatory research in stress and coping to function as debriefing for staff nurses, assist them in identifying changes they can make for themselves and to

expand nursing knowledge.

Limitations of the Study and Alternative Explanations

The fact that this study was based solely on perception might be raised as a limitation of the design. However, the degree of consensus obtained from participants reduces this possible limitation.

Another limitation might stem from assuming that the explanations given here are the only explanations. For example, there are at least two alternative explanations regarding the finding that psychiatric unit staff is the nurse's biggest source of stress. Perhaps what is described is not the problem itself but a reflection of the problem of burnout. Signs and symptoms of burnout include personal and interpersonal withdrawal, rigidity, blame and resentment, cynicism and griping, apathy, and task avoidance (Cleve, 1979). This list is very similar to the stressors attributed to unit staff. Additionally, some of these nurses describe themselves as burned out.

A second possible alternative explanation is that problems with unit staff are a displacement of feelings elicited from other situations. The researcher considered and the participants discussed the possibility that conflict with unit staff is a displacement of feelings about others, particularly physicians and administrative practices. The possibility was considered that it is "safer" to take these feelings out on each other than

on the offending party. Also, unit staff may represent a more available target.

In the case of physicians, participants disagree that displacement is a factor. Participants agree that the patient is most often the "loser" in nurse-physician conflict and that anger over these conflicts is not displaced to each other. In fact, in this study nurses were more likely to express anger to and conflict with physicians than to peers.

Participants did consider that the administrative practice of sending nurses to other units may be a source of staff-staff conflict. Participants explain that most nurses are uncomfortable with and dislike being sent to other units. Being sent to another floor underscores the nurse's lack of control over her own work. When they arrive on a unit, these nurses often feel discomfort, are hypervigilant and are not a part of the group. These feelings about being sent to other units may make it more difficult to work with colleagues on the new floor. However, this explanation of nurse-nurse conflict as displacement does not apply to staff-staff conflict within one's own unit.

A third limitation of the study may be the exclusion of male nurses. It is possible that male nurses may not perceive the same stressors described in this study or they may respond differently to the same perceived stressor.

Finally, this study is limited to psychiatric staff nurses

in acute inpatient settings. The study would be strengthened by comparative analysis with psychiatric nurses in other settings and with nurses working in other specialty areas. While generalizability is not an issue in qualitative research, questions can and should be raised. Are the same stressors found in other psychiatric settings and in other areas of nursing? For instance, is unit staff conflict a major source of stress in long term psychiatric settings or in medical-surgical units or home care agencies? Is coping behavior similar or different? How do the organizational structure and leadership styles influence coping and outcomes? Exploring the nature of staff interactions in other settings would add depth to these findings.

Future Research

The first suggestion for future research is to extend the findings of the present study through comparative analysis. Male nurses in acute psychiatric settings, nurses in psychiatric settings other than acute inpatient units and nurses in other specialty areas would be asked questions similar to those asked in this study with particular emphasis placed on describing the nature of staff interactions. Similarities and differences in staff conflict and coping with staff conflict would be described.

Another question to be answered through comparative analysis is, to what extent are the stressors described problems of the helping professions? Do other helping professionals have the

same stressors? Do they identify the same stressors? If so, how do they cope with these stressors? Pines and Maslach (1976) suggest similarities in stress and coping across the helping professions. The findings of this study could be compared with a similar study of other helping professions such as social workers, firefighters or psychologists.

Evaluation research would be appropriate where recommendations are implemented. It is important to establish whether or not staff stress could be reduced and coping improved through some of the recommended changes. (Acknowledgment of what is and the development of realistic expectations, improved communication and interpersonal skills, increased participation by the staff nurse in her work setting and increased awareness of stress and coping.) For instance, this study suggests that assertiveness training could be helpful to nurses who experience unit staff conflict as a primary source of stress. A group of nurses meeting this criteria could be identified, half of the group could be trained in assertiveness and then differences between the two groups could be studied.

A third area for study is further descriptive research focused on units where nurses do not identify staff as their greatest source of stress. The research question is: What are the conditions, interactions, and strategies that have consequences of staff working comfortably and effectively

together? From a study of what does work could come greater understanding both of what is (for some nurses) and what could be for nurses whose goal is to reduce staff stress and work together more comfortably.

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Appendix A

Interview Guide

1. Stressors in the past month
2. Describe one experience
3. Specifically, what was problem? 1-10 (10 worst)
4. What about problem was upsetting?
5. What was at stake? How important was the stake 1-10 (10 vital)
6. Desired outcome?
7. Your efforts to change situation or deal with problem
8. Outcome of your efforts (detrimental - extremely helpful)
9. Feelings experienced.
10. Efforts to deal with feelings?
11. Outcome of efforts to deal with feelings?
12. Then what happened with outcome-change situation, problem or feelings

    Co-workers

    Supervisor

    Other personnel

    Organization--structure, policy, procedures

    Responses offered or requested

    Responses helpful, neutral or detrimental
13. Anyone or any other situation influence outcome?
14. Wanted help not received? Job title? Wanted...? Asked...?

15. Outcome now--resolution or something still going on? Changed situation, dealt with problem or feelings. If unresolved, effect on you?

16. Most helpful, most detrimental response?

17. History of problem--happened before, you did. . ., outcome?

Appendix B

Interview Guide

Questions added during the second interview:

1. What percent of time and energy is spent with staff; with patients? Was this your expectation when you took the job? If not, what was your expectation?
2. Response to time, space, money, and energy in relationship to work.
3. Given all needed power and control, what one change would you make to decrease stress, make your place of work more nourishing?
4. What is your greatest source of support or help at work now?
5. What effect, if any, does participating in this research have on you?

Appendix C

Demographic Data

1. How long have you worked in psychiatric nursing?
2. How long in nursing?
3. How long on this job?
4. What type of orientation did you have to this unit and how long was the orientation?
5. Type of unit (e.g., voluntary, involuntary)?
6. Size of unit?
7. Do you consider this a job or a career?
8. Educational level?
9. Age?
10. Marital status?
11. Ethnic background?
12. Are there aspects of your life more stressful than work? If work stress equals 100, what number would you assign to your areas of non work stress?

Appendix D

Work Environment Scale, Form R

Instructions

There are 90 statements in this booklet. They are statements about the place in which you work. The statements are intended to apply to all work environments. However, some words may not be quite suitable for your work environment. For example, the term supervisor is meant to refer to the boss, manager, department head, or the person or persons to whom an employee reports.

You are to decide which statements are true of your work environment and which are false. Make all your marks on the separate answer sheet.

If you think the statement is TRUE or mostly TRUE of your work environment, make an X in the box labeled T (true).

If you think the statement is FALSE or mostly FALSE of your work environment, make an X in the box labeled F (false).

Please be sure to answer every statement.

1. The work is really challenging.
2. People go out of their way to help a new employee feel comfortable.
3. Supervisors tend to talk down to employees.
4. Few employees have any important responsibilities.
5. People pay a lot of attention to getting work done.
6. There is constant pressure to keep working.

7. Things are sometimes pretty disorganized.
8. There's a strict emphasis on following policies and regulations.
9. Doing things is a different way is valued.
10. It sometimes gets too hot.
11. There's not much group spirit.
12. The atmosphere is somewhat impersonal.
13. Supervisors usually compliment an employee who does something well.
14. Employees have a great deal of freedom to do as they like.
15. There's a lot of time wasted because of inefficiencies.
16. There always seems to be an urgency about everything.
17. Activities are well-planned.
18. People can wear wild looking clothing while on the job if they want.
19. New and different ideas are always being tried out.
20. The lighting is extremely good.
21. A lot of people seem to be just putting in time.
22. People take a personal interest in each other.
23. Supervisors tend to discourage criticisms from employees.
24. Employees are encouraged to make their own decisions.
25. Things rarely get "put off till tomorrow."
26. People cannot afford to relax.
27. Rules and regulations are somewhat vague and ambiguous.

28. People are expected to follow set rules in doing their work.
29. This place would be one of the first to try out a new idea.
30. Work space is awfully crowded.
31. People seem to take pride in the organization.
32. Employees rarely do things together after work.
33. Supervisors usually give full credit to ideas contributed by employees.
34. People can use their own initiative to do things.
35. This is a highly efficient, work-oriented place.
36. Nobody works too hard.
37. The responsibilities of supervisors are clearly defined.
38. Supervisors keep a rather close watch on employees.
39. Variety and change are not particularly important.
40. This place has a stylish and modern appearance.
41. People put quite a lot of effort into what they do.
42. People are generally frank about how they feel.
43. Supervisors often criticize employees over minor things.
44. Supervisors encourage employees to rely on themselves when a problem arises.
45. Getting a lot of work done is important to people.
46. There is no time pressure.
47. The details of assigned jobs are generally explained to employees.
48. Rules and regulations are pretty well enforced.

49. The same methods have been used for quite a long time.
50. The place could stand some new interior decorations.
51. Few people ever volunteer.
52. Employees often eat lunch together.
53. Employees generally feel free to ask for a raise.
54. Employees generally do not try to be unique and different.
55. There's an emphasis on "work before play."
56. It is very hard to keep up with your work load.
57. Employees are often confused about exactly what they are supposed to do.
58. Supervisors are always checking on employees and supervise them very closely.
59. New approaches to things are rarely tried.
60. The colors and decorations make the place warm and cheerful to work in.
61. It is quite a lively place.
62. Employees who differ greatly from the others in the organization don't get on well.
63. Supervisors expect far too much from employees.
64. Employees are encouraged to learn things even if they are not directly related to the job.
65. Employees work very hard.
66. You can take it easy and still get your work done.
67. Fringe benefits are fully explained to employees.

68. Supervisors do not often give in to employee pressure.
69. Things tend to stay just about the same.
70. It is rather drafty at times.
71. It's hard to get people to do any extra work.
72. Employees often talk to each other about their personal problems.
73. Employees discuss their personal problems with supervisors.
74. Employees function fairly independently of supervisors.
75. People seem to be quite inefficient.
76. There are always deadlines to be met.
77. Rules and policies are constantly changing.
78. Employees are expected to conform rather strictly to the rules and customs.
79. There is a fresh, novel atmosphere about the place.
80. The furniture is usually well-arranged.
81. The work is usually very interesting.
82. Often people make trouble by talking behind other's backs.
83. Supervisors really stand up for their people.
84. Supervisors meet with employees regularly to discuss their future work goals.
85. There's a tendency for people to come to work late.
86. People often have to work overtime to get their work done.
87. Supervisors encourage employees to be neat and orderly.

88. If an employee comes in late, he can make it up by staying late.
89. Things always seem to be changing.
90. The rooms are well ventilated.

Appendix E

Stress and Coping in Psychiatric Nursing

Information Sheet/Consent Form

The purpose of this study is to clarify stressors in psychiatric nursing, the coping strategies used by individual nurses and the help they receive from others in the organization. These questions are part of a study for a doctoral dissertation by Louise Trygstad, a psychiatric nurse and doctoral candidate at the University of California, San Francisco School of Nursing. It is hoped that the resulting information can help nurses and nursing managers know what helps decrease stress, improve coping and convey support to individual staff nurses.

Louise would like to talk with you two or three times for about an hour each time about difficult or upsetting experiences you encounter in psychiatric nursing and what you and others in your organization do in response to these situations. During the first session she would also like to ask a few questions about yourself and your nursing background and have you complete the Psychiatric Work Environment Scale. She will talk with you at a time and place you designate as convenient. After all data are analyzed you will be asked to read the analysis of the group data and provide clarifying or corrective feedback.

Louise would like to tape record these interviews which she will transcribe omitting any names. The tapes will be erased and

the typewritten interview will be identified only by number. Any reports or publications resulting from this study will report on the interviewed group as a whole, not individual participants. If anecdotal information is used, anonymity will be preserved.

After completion of the study, you will be invited to a workshop for continuing education credit to learn about the theory and previous research upon which this study was based, study results and practical applications for what has been learned.

If you have any questions about this study or your participation, please call Louise at (408) 659-3828 or write her at 630 Country Club Drive, Carmel Valley, CA 93924. Or questions can be addressed to the Human and Environmental Protection Committees office, Room Clinics 116, University of California, San Francisco, California 94143, telephone (415) 666-1814 from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Your participation is completely voluntary. If you agree to participate, you have the option of refusing to answer any specific question or terminating your involvement in the research at any time.

I have been told all of the above and agree to be interviewed, complete the questionnaire and review the analysis of the data.

_____ _____

Signature Date

Appendix F

630 Country Club Drive
Carmel Valley CA. 93924
January 20, 1984

Dear Colleagues,

I am looking forward to our session together discussing "Stress and Coping in Psychiatric Nursing." At the moment I am immersed in the analysis the the data and plan to have a completed draft in the mail to you on March 23.

I have arranged for us top meet in the kitchen meeting room of the Palo Alto Cultural Center on Thursday April 5 from 10:00 a.m. to 4:30 p.m. The address is 1313 Newell Road. Exit on Embarcadero from Highway 101. The cultural center fronts on Embarcadero. You can park on Embarcadero or turn right on Newell and park in either lot.

As I have previously indicated, you will receive 6 hours of continuing education credit for your participation. I will explain the theory base from which the research was designed and describe the research methodology. We will then discuss our different responses to my analysis of the data to arrive at conclusions which are valid for the group as a whole. We will also discuss possible uses for these conclusions and ways in which you would like the information to be disseminated.

With your permission, I would like to bring my colleague, Andrea Renwanz, to our group session. I am concerned about missing something important and would value having a participant/observer to assist with my recall and understanding. Please let me know if you have any concerns or objections to my bringing Andrea.

Confidentiality is a concern to all of us. I want to remind you that only those who participated in the research will be present. Even within the group and the written analysis of the data, individual identity will not be exposed. I will not ask you to "own" any piece of data nor to discuss anything you do not wish to discuss. If you have questions or concerns about confidentiality, please let me know.

I find that I need one more piece of data from some of you. Many of you have indicated that it is staff rather than patients who are stressful to you. For those who feel this way, I would greatly

appreciate a few sentences explaining in what ways staff are more stressful and your explanation of why staff are more stressful than patients.

I would also appreciate knowing if you are planning to attend the group session. I hope to see you all.

Sincerely,

Louise Trygstad

Appendix G

630 Country Club Drive
Carmel Valley CA. 93924
March 23, 1984

Dear Colleagues,

Please note CHANGE IN MEETING PLACE for April 5. Instead of meeting at the Palo Alto Cultural Center we will meet in the Mercury Room at Mercury Savings and Loan in Mountain View--same time, 10:00 a.m. to 4:30 p.m. Mercury Savings and Loan is located at 350 Showers Drive in the San Antonio Mall next to Mervyns (phone: 941-9100). The Mall is on El Camino.

Enclosed please find the first draft of my analysis of the data. I look forward to hearing your responses, additions, agreements and disagreements. I want to know where this does and does not reflect your experience and hear your ideas. And I look forward to discussing recommendations with you. Feel free to make your comments on the text or write them on a separate page if you prefer to keep the paper.

As has been true throughout this study, I am particularly concerned with maintaining confidentiality. I have used experiences and quotations from all of you in telling your story. I believe I have altered any identifying data so that only someone with whom you have already discussed an incident would recognize an experience or quotation as coming from you. If this is not the case, I wish it to be so. This is not a public document--it will be read only by you, the participants, and the colleagues/faculty who are working with me at U.C. Any threat to confidentiality will be altered from your feedback before my dissertation is completed.

I eagerly anticipate meeting with all of you who will be able to attend. For those who have said they will not be able to attend, I will try to reach you on April 3 or 4 so your input can be included in our discussion. Feel free to call if you have questions (415) 731-8792 Tuesday through Friday or (408) 659-3828 Friday through Monday.

Sincerely,

Louise Trygstad

Appendix H

Workshop for Stress and Coping in Psychiatric Nursing

April 5, 1984

Workshop Description

This workshop is a meeting of participants involved in participatory, exploratory research focused on stress and coping in psychiatric nursing. The purpose of this session is to discuss the findings, draw conclusions and develop recommendations and discuss the dissemination of this information. We will also discuss the previously developed theory and research which influenced this study and the methodology of this study.

Objectives

During the course of this workshop the participant will:

1. Discuss theory and research which influenced this study and the methodology used in this study.
2. Discuss the analysis of data as reflective of or discrepant from the participant's experience and point of view.
3. Generate and discuss conclusions which can be drawn from this data.
4. Discuss dissemination of these findings, conclusions and recommendations.

Content Outline

General responses to the data analysis
Methodology of this study
Previous theory and research related to this study
Discussion of the findings--areas of agreement and disagreement; alternative viewpoints
Conclusions from the data
Recommendations from the data
Dissemination of information
Other agendas of the participants

Teaching Methodology

Written analysis of data distributed to and read by participants prior to meeting
Discussion
Minilecture

Evaluation

Of participant learning: self assessment and participation in workshop.
Of workshop: Written and verbal feedback.

Louise Trygstad RN, CS, MSN

Appendix I

CALIFORNIA R.N. LICENSE # _____ HAS EARNED 6 HOURS OF CONTINUING EDUCATION CREDIT BY PARTICIPATING IN THE RESEARCH PROCESS AND SEMINAR, "STRESS AND COPING IN PSYCHIATRIC NURSING." SEMINAR DATE: APRIL 5, 1984, MOUNTAIN VIEW, CALIFORNIA.

LOUISE TRYGSTAD

This certificate must be retained by the licensee for a period of four years after the course concludes.

This course has been approved by the California Board of Registered Nursing, B.R.N. Provider Number 04515.

Appendix J

630 Country Club Drive
Carmel Valley CA. 93924
May 25, 1984

Dear Colleagues,

I am writing to you for two reasons. First, I am enclosing the first draft of my final dissertation chapter, discussion of the findings and recommendations. This is, of course, drawn from the data and from our meeting together on April 5. I would very much appreciate your feedback: areas of agreement, disagreement, questions, comments, additions, alterations--I would like to hear whatever response you have. Also attached are additions to the analysis of the data chapter which you received. I have divided the analysis into two chapters, added an introduction and summary for each, added a section on coping outcomes and made a table of the stressors experienced. Again, I solicit your feedback.

The second reason for writing is to say I have been asked to present my research to the nursing executive committee at the Palo Alto V.A. Hospital on July 3. The presentation will include an overview of the research methodology; the substance will be drawn from what is enclosed in this packet (rather than the more detailed descriptions of the analysis of data). Please let me know if you have any concerns or questions about my presentation of this material--my continuing concern is for your confidentiality.

You can contact me during the week in San Francisco (415-731-8792), in Carmel Valley on the weekends or any time to leave a message (408-659-3828) or write to me at the above address.

Sincerely,

Louise Trygstad

Appendix K

630 Country Club Drive
Carmel Valley CA. 93924
July 13, 1984

Dear Colleagues,

The research is completed and the dissertation has been written and successfully defended--all that remains is to say a heartfelt thank you. I enjoyed working with each of you.

I have been particularly pleased with my experience of participatory research--sharing information and gathering feedback from you at multiple points in the research cycle. The validity of the research rests with your consensus that the analysis of the data and conclusions drawn describe your work world.

I have enclosed the abstract of the dissertation as it will be submitted to Dissertation Abstracts International. I also want to enclose it with my thank you letters to your head nurses and the administrative person in your hospital who facilitated my access to you. As always, my concern for your confidentiality is priority one. I will not mail the abstracts for two weeks after this letter is postmarked. This allows time for you to tell me if your confidentiality is threatened. I will alter the abstract to preserve your confidentiality if that is in any way a concern to you.

The presentation at V.A. Hospital, Palo Alto, was extremely well received. They were particularly interested in recommendations for change.

If you are interested in reading the completed dissertation, it will be available in the U.C.S.F library after December, 1984. I also have a copy which I am willing to lend to you.

Together we have produced nursing knowledge. I hope the collaboration has been as gratifying to you as it has to me.

Sincerely,

Louise Trygstad

Appendix L

630 Country Club Drive
Carmel Valley CA. 93924
July 30, 1984

Dear

I am writing to thank you for your help in facilitating my research study of stress and coping in psychiatric nursing. Without your help in contacting participants, I could not have conducted the study.

I have enclosed the study abstract for your information. If you have any questions or would like to discuss it, please write or call me at (415) 731-8792 Tuesday through Friday or (408) 659-3828 Mondays or anytime to leave a message.

Sincerely,

Louise Trygstad
Doctoral Candidate
University of California
San Francisco