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Parental Support Role Insufficiency as Perceived by Pediatric Intensive Care Unit Nurses

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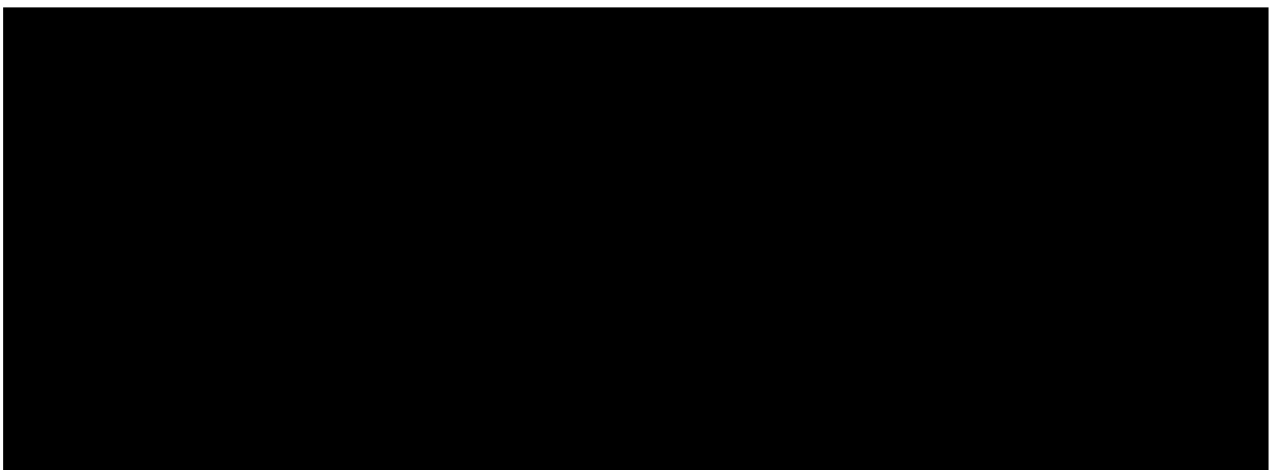

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Parental Support Role Insufficiency As Perceived By Pediatric Intensive Care Unit Nurses

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May 20, 1982

Abstract

The role of the pediatric intensive care unit (PICU) nurse is multifaceted, limiting the ability to enact all role requirements and creating the potential for role insufficiency. This descriptive study was designed to investigate how PICU nurses perceive the parental support role and the factors that hinder or facilitate role enactment.

Sixteen PICU nurses from a single PICU were interviewed using an open-ended, semi-structured guide that was devised for this study. Interview data were grouped into logical categories and summarized numerically. Statistical analysis was not appropriate.

While the primary role of the PICU nurse was identified as patient care, 13 subjects described parental support as a secondary but important role component, and 14 subjects noted difficulty in enacting this role. Parental characteristics were most frequently identified as both hindering or facilitating parental support, and 13 subjects described other staff members as the greatest aid in difficult situations. The provision of support was considered to have both rewards (16 subjects) and costs (11 subjects).

Subjects were determined to be both role insufficient and role sufficient. Variables of role overload, incompetency, motivation, and conflict had the strongest relationship to role insufficiency, and staff support had a strong impact on role sufficiency. Recommendations to facilitate role sufficiency were directed at the work setting and include: educational programs, improved communication between team members, adequate staffing and the availability of support services for both parents and PICU nurses.

Summary

The pediatric intensive care unit (PICU) nurse is a significant person to both the critically ill child and the parents. It is necessary for the nurse to be able to balance many aspects of the nursing role in order to provide care to the child and support to the parents. Since there has been no investigation of the nurse's ability to enact these role components this study was designed to increase knowledge concerning the ability of the PICU nurse to enact the parental support role. Potential variables that influence parental support role insufficiency were identified through the literature. PICU nurses were interviewed concerning their role conception and perceptions of role enactment. Interview data were compared to the conceptual model and the impact of specific variables were identified. Finally recommendations for nursing practice and further research were made.

Acknowledgements

All things being

Interrelated

it becomes Quite Impossible to separate

graduate school/thesis/life

SO-

thanks

mom and dad, friends and siblings, colleagues and cohorts

with special thanks

to special people

Marge, Marylin, and Ann

for: time, interest, humor, support, and wisdom

of inestimable value

to this neophyte

as she spreads her wings

Table of Contents

Table of Contents (continued)

Table of Contents (continued)

List of Tables

List of Figures

Title: Parental Support Role Insufficiency as Perceived by Pediatric Intensive Care Unit Nurses.

CHAPTER I

The Study Problem

Introduction to the Problem

The pediatric intensive care unit (PICU) has been developed over the past decade to provide specialized care and greater surveillance of critically ill children. Nursing staff of these units achieve a high level of clinical expertise and theoretical knowledge in order to provide optimal physical and psychosocial care to patients and families. There are however many demands and time constraints placed upon the PICU nurse. This may result in the exclusion of some role requirements due to an inability to enact all the functions of the nursing role.

Intensive care units (ICU) have been generally described as technical, stressful, and challenging environments in which to work (Hay & Oken, 1977; Jacobson, 1978; Oskins, 1979; Vreeland & Ellis, 1969). Other studies have indicated that ICU nurses may find conflicts between fulfilling both physical care and supportive or psychosocial role requirements (Benner & Kramer, 1972; Lewandowski & Kramer, 1980). The majority of these studies have concerned the adult ICU or combined a sample of adult and pediatric nurses without investigating differences that might exist between them. With the exception of Gilmer (1981), there has been little attempt to investigate either role conception or perception of stress in the PICU nurse.

Although it is infrequently addressed in the literature, the

ability of the PICU nurse to enact both direct patient care and supportive role requirements is especially important due to the unique relationship between parent and child. In pediatric care supporting the parental role and fostering the parent-child bond is of importance because of the child's dependence on the parent for physical and psychological growth and the need and desire of the parent to provide for growth and development. When a child is ill dependence on the parent increases, making the presence of the parent a necessary adjunct to the coping abilities of the child (Mason, 1965; Prugh et al., 1953; Rinkoff, 1980; Vernon et al., 1965). Jay (1977) finds that the parent is impeded in enacting this role because of anxiety over the child's condition, unfamiliar surroundings, and lack of knowledge or skills to provide care. Significant disruption in the parent-child relationship insues, and enactment of the parental role becomes impossible without support and assistance.

The responsibility to provide support to the parent falls primarily to the PICU nurse; however enacting the parental support role is not without difficulty. The investigator noted during her experience as a PICU nurse that direct care and parental support role requirements were valued to different degrees, and that many PICU nurses expressed difficulty in enacting the supportive role. Relevant literature describes the parental support role as an important and integral part of the role of the PICU nurse; however the literature does not address how nurses themselves perceived this role or their ability to enact it (Jay, 1977; May, 1972; Miles, 1979). Furthermore other health care professionals often emphasized other

aspects of the nursing role, for example physical care of the patient. These discrepancies between stated and enacted role, and between the role expectations of significant others led the investigator to believe that role stress was present and might lead to an inability to enact role functions or role insufficiency in the PICU nurse in respect to parental support.

Statement of the Problem

Although parents of children in PICU require support, and parental support has been described as a component of the role of the PICU nurse, there are indications that, for unknown reasons, PICU nurses do not fulfill this role. Furthermore the parental support role of the PICU nurse has been described but not studied, and most significantly PICU nurses have not been questioned as to their perceptions of this role. Therefore it is the intent of this exploratory study to investigate how PICU nurses perceive their enactment of the parental support role. Specific concerns leading to the study revolve around how PICU nurses perceive their role with parents of critically ill children and what factors influence role enactment.

Purpose of the Study

The purpose of this study is twofold: 1) to determine if PICU nurses perceive themselves role insufficient with respect to parental support, and 2) to determine what factors they perceive to influence enactment of the parental support role.

Need for the Study

The ability of parents to support and aid the child during episodes of illness and hospitalization is influenced by their

reaction to the hospital setting and their perception of the condition of the child. Parents of children who are hospitalized, but not critically ill, have been reported to have increased levels of anxiety (Skipper, Leonard, & Rhymes, 1968; Wolfer & Visintainer, 1975a). It can be expected that critical illness of the child would serve to intensify parental anxiety.

Objective data to support this contention is needed; however parental reaction to having a child who is critically ill has been cited in descriptive articles. Rothstein (1980) finds families to be "severely stressed and prone to be disrupted" (p. 614). Initial reactions of shock, disbelief, and helplessness are cited. Self-blame, anticipatory waiting, and mourning follow. Other authors describe parents as anxious, fearful of the death of the child, bewildered, grieving, or in shock (Jay, 1977; Miles, 1979; Soupios, Gallagher, & Orlowski, 1980; Surveyer, 1976a).

The effects of support provided by nursing staff have been studied in non-critical pediatric care areas (Mahaffy, 1965; Skipper et al., 1968; Wolfer & Visintainer, 1975a & b). Wolfer and Visintainer demonstrated that parental anxiety can be reduced through the provision of special psychological preparation and consistent supportive care. Psychological preparation involved identifying the parents' needs and supplying information; whereas supportive care consisted of "offering warm support and reassurance...,answering questions, but neither anticipating concerns nor providing advance information" (1975b, p. 194).

Wolfer and Visintainer (1975b) found that the greatest

reduction of anxiety occurred when interventions took place throughout the hospitalization and especially when instituted before the occurrence of particularly stressful situations, such as blood drawing or the night before surgery. The investigators also demonstrated that combining psychological preparation and consistent emotional support was more effective than emotional support alone. This indicated that the parent had both informational and emotional support needs.

Wolfer and Visintainer (1975a & b) partially replicated and built upon past studies of parental support. The experimental design of their studies lends strong validity to their conclusion that nurses can provide supportive interventions that reduce the untoward effects of hospitalization on both parents and children.

Experimental studies of this nature have not been replicated in critical care area, but the needs of parents for support as provided by nursing staff has been identified in descriptive articles. Surveyer (1976a) views the nurse as the "primary care taker...and in a key position to offer empathy and understanding"; this author further states that "parents depend on the nurses to clarify information" (p. 17). Miles (1979) identifies a key variable affecting the coping abilities of the family to be the way the health care personnel relate to them. This author describes supportive nursing goals to include developing trust, providing information, helping parents cope with feelings, and meeting the basic needs of the parents.

The cited articles have identified that parents of critically ill children require support provided through nursing interventions.

Further investigation of the literature indicates that these interventions are not always carried out. Green (1979), in an editorial comment, characterized parental support in the PICU as "undeveloped and sporadic" in sharp contrast "to the highly sophisticated biomedical care of sick infants and children" (p. 1119). This author calls for both pediatricians and pediatric nurses to be parent specialists as well as child specialists. Miles (1979) notes that parents are often restricted to short visiting periods, and are sometimes subjected to staff who are cool and distant, or to situations in which staffing is so short that nurses have no time to work with parents.

In summary, the literature documents that parents of children in PICUs need both informational and emotional support. The nursing staff has been identified as having the prime responsibility to provide this support and yet in many cases it is not offered. Many authors call for parental support from nurses, others imply what some hinderances might be, yet there are no studies that describe what staff nurses perceive to be the specific factors influencing enactment of the parental support role. This study is designed to address these issues with the nursing staff of a PICU in order to gain an understanding of their perceptions of the parental support role.

Assumptions Underlying the Study

There are three assumptions that underlie this study: 1) that PICU nurses can accurately communicate what factors influence their ability to enact the parental support role, 2) that PICU nurses will honestly tell the investigator what their perceptions are of the

enactment of this role, and 3) that the work environment and potential stressors (i.e., interpersonal relationships, critical nature of patients' illnesses, and technical equipment) of the PICU are similar to those of the adult ICU, enabling the use of background literature from studies of the adult ICU.

Research Questions

The specific questions that the investigator will attempt to answer are the following: 1) do PICU nurses perceive themselves to be role insufficient in respect to parental support, 2) what factors do PICU nurses perceive as to be hindering the enactment of the supportive role, and 3) what factors do PICU nurses perceive as to be facilitating enactment of the supportive role.

Definition of Terms

In order to provide clarity the terms frequently used in this study are defined.

Pediatric intensive care unit (PICU). The PICU is an area designated for the care of critically ill children from infancy through adolescence. It may include neonates but does not include premature infants.

Critical illness is any life-threatening pathology.

Support is to assist or to help, to keep from yielding or losing courage, to comfort, to keep going (Websters, 1970). It implies assistance relating to psychological, cognitive, and physical needs.

Parental support is the support given to parents of critically ill children. It includes components relating to psychological, cognitive, and physical needs.

Conception is the process of forming or understanding ideas or abstractions, it is the sum of a person's ideas and beliefs concerning something (Websters, 1970).

Perception is direct or intuitive cognition, the capacity for comprehension (Websters, 1970).

Role is conceived of within the interactionist framework. As such it is considered to be a process that occurs between two people (a dyad), but can be influenced by other significant persons. This is discussed in greater detail in chapter II.

Role insufficiency is "any difficulty in the cognizance and/or performance of a role or of the sentiments and goals associated with the role behavior as perceived by the self or by significant others" (Meleis, 1975, p. 266).

Role motivation is the individual's assessment of the balance between rewards derived and costs incurred from enacting a role (Meleis, 1975).

Role stress is "problematic social conditions resulting in conflicting, confusing, irritating, or impossible role demands" (Hardy, 1978, p. 78). Hardy defines five specific role stress variables, which are listed below.

Role ambiguity is present when expectations are vague, inconsistent, or lack actor agreement.

Role conflict is contradictory or mutually exclusive role expectations.

Role incompetence is present when the actor's resources are inadequate relative to role demands.

Role incongruity occurs when fulfilling role obligations runs counter to self-perception, attitudes, and values.

Role overload is excessive role demands in the time available.

Limitations and Delimitations

This study was limited to the verbal report of PICU nurses concerning role conception and perception of enactment of the parental support role. As such there was no attempt to ascertain the accuracy of these reports by observing subjects or interviewing relevant others in the setting.

A convenience sample of volunteers was interviewed. The participants may have varied from the non-participants. As the investigator has no information about the non-participants the degree of variation is unknown.

The sample was selected from one PICU in one hospital and interviewed over a certain period of time. There may have been factors present in this institution or in that time period that influenced role enactment that would not otherwise be present. Situations that are obviously specific to this hospital, PICU, or time period will be noted in the description of the setting and in the discussion of the data; however since there was no comparison group it will not be possible to indicate any direct relationships to role enactment in other settings. All of these factors will limit the generalizability of this study.

This is an exploratory study in which the goal is to gather more information in an area where little exists, rather than predict outcomes. It is hoped that the results will delineate potential

variables and indicate areas where further research would be indicated.

CHAPTER II

Review of the Relevant Literature

The review of the literature relevant to the study of parental support role insufficiency is divided into two parts. Part I consists of a discussion of current research that addresses parental support role enactment in the PICU and general role enactment in critical care settings. Part II consists of discussion of role theory and the presentation of a conceptual framework in which to study parental support role insufficiency.

Part I: Review of the Relevant Research

Parental Support Role Enactment in the PICU

Green (1979), Jay (1977), Miles (1979), and Surveyer (1976 a &b) have identified the PICU nurse as the appropriate person to provide support to parents of critically ill children, and have described what they view parental support to entail. Miles lists the following as nursing goals for parental support interventions:

> Facilitating the development of trust in the intensive care unit staff, providing information about the child's condition and about the intensive care unit environment, helping parents to cope with feelings engendered by their child's illness, making plans to meet the basic needs of parents, and assisting parents in the re-establishment of their parenting relationship and role (p. 80).

Other authors concur with this description. Jay (1977) emphasizes establishing trust and informing parents of their rights, as well as assisting them to learn how to parent an ill child.

Surveyer (1976a) identifies offering empathy and providing information as important components of the parent support role.

A review of various descriptions of parental support indicates that this role includes all or portions of these three categories of behavior: 1) providing emotional support, 2) providing information about the child's illness, treatments, or the PICU environment, and 3) planning with the parents to meet their basic needs, such as food and rest.

There is evidence that, in some cases, the parental support role is not enacted (Green, 1979; Surveyer, 1976b; Miles, 1979; Waller et al., 1979). A number of factors that might inhibit role enactment have been postulated. These include: lack of time; lack of information on the part of nursing staff; parental expressions of guilt, anger, denial, or grief; subjective responses of the nursing staff that include grief, sorrow, or anxiety; and the availability of supportive services for the nursing staff.

A great deal of investigative work is needed in this area. There has been no attempt to determine if these variables do indeed affect parental support role enactment or if other factors might be present. It is also not known if some of these factors might be stronger inhibitors than others. Finally, factors that might facilitate support role enactment have not been identified.

Due to the lack of literature specific to the role of the PICU nurse the investigator consulted reported research on the adult ICU in order to continue to study role enactment. These studies are valuable and pertinent because of the many similarities between the

PICU and the adult ICU which include: the critical nature of the patients' illnesses, the use of complex and technical equipment, interaction with many other health professionals, and interaction with families that are coping with crisis.

Adult and pediatric ICUs are not interchangeable, however, and differences might affect role conception and role enactment. The emphasis placed on fostering and supporting the parent-child relationship is probably greater than that placed on supporting the family of an adult patient because the need of a child for his parents is perceived of as different from the need of an adult for his family. Of greatest concern to this literature review is that the presence and extent of these variations between adult and pediatric intensive care nurses have not been delineated; therefore it is not known what impact this has on role enactment. The studies on adult ICU are cited with these limitations in mind.

Role Conception in the ICU

Investigations of the ICU that are relevant to study of role enactment have included role conception and perception of stress. Role conception studies concern how the ICU nurse conceives of the many facets of the nursing role. The ICU nurse interacts with many others, including: nursing peers, physicians, other team members, patients and family members. Expectations of both the nurse and the others will vary within each interaction. The extent to which the nurse values and prioritizes each role will influence the time and effort that will be available for other role enactments.

Folk-Lighty and Brennan (1979) attempted to measure role

conceptions of nurses working in adult ICU. A sample of 200 nurses rank-ordered 24 nursing activities with respect to time, importance, and professionalism. The category that most closely corresponded to parental support was referred to as "utilizing family members". This was ranked 17th for time, 13th for importance, and 11th for professionalism, indicating that nursing staff found it to be a moderately important behavior that they devoted little of their time to.

The investigators found significant, positive correlation between the nurses' estimations of the time spent doing an activity and its importance, and also between the importance of an activity and its professionalsim. The correlation between time and professionalism however was significant for nurses holding associate degrees and diplomas, but not for those with the baccalaureate degree.

The Folk-Lighty and Brennan study indicated that the baccalaureate nurse evaluated role functions differently than nursing-peers who were educated differently. Since ICUs (and PICUs) employ nurses educated from three types of programs results may indicate inter-staff conflict over role functions and the potential for sporadic enactment of some role requirements.

The hospitals used for the Folk-Lighty and Brennan (1979) study were randomly sampled in order to limit the affects that specific hospital policies might have on the amount of time spent in an activity; however the nursing sample consisted of volunteers limiting the generalizability of the study.

Benner and Kramer (1972) and Lewandowski and Kramer (1980) have also studied role enactment of critical care nurses. Both of these

studies measured role conceptions in ICU nurses compared to non-ICU nurses, but only in baccalaureate program graduates, limiting the generalizability to one segment of the nursing staff in the ICU.

Benner and Kramer attempted to measure professional, bureaucratic, and integrated role conception. Professional role conception was considered to be commitment to knowledge and nursing practice, and focused on the whole-task system. Bureaucratic role conception was defined as organizational loyalty with focus on the part-task system. Integrated role conception was the ability to enact both of these roles.

The authors compared a sample of 54 registered nurses (all baccalaureate program graduates) who had worked at least nine months in a special care unit (SCU) to 110 nurses who had never worked in a SCU (SCU was defined as any critical care area, 15% of this sample worked in either pediatric or neonatal ICU).

The SCU nurses were found to have a higher integrated role conception score than non-SCU nurses, indicating the SCU nurse's need to adjust to features of both bureaucratic and professional roles to a greater extent. SCU nurses also indicated that they felt able to provide supportive nursing care, but found there were deterrents to fulfilling this role--these deterrents were not listed.

Lewandowski and Kramer (1980) again compared SCU to non-SCU nurses (all baccalaureate graduates). A battery of tests to determine personality attributes and professional, bureaucratic and integrated role conception was administered at six weeks and nine months after beginning work. Data was analyzed based on a four group

ordering by degree of specialization. The four groups, in order of low to high were: general medical-surgical, medical-surgical specialty, parent-child, and SCU (note that the PICU was included in the SCU category, not the parent-child).

The investigators found a significant increase in the bureaucratic and integrated role conception, and a decrease in the professional role conception of the SCU nurses. This indicated that there was a tendency for the new baccalaureate graduate to become more aligned with the bureaucratic structure and the part-task system. SCU nurses also had higher levels of self-esteem, but were less self-actualized, less empathetic, and engaged in less change agent activity.

The cited studies indicate that in the ICU there are conflicts between various role requirements, especially for the BSN graduate, and that the ICU nurses may have more difficulty managing these conflicts than their counterparts in other patient care areas. Technical and physical care skills seem to be emphasized in the initial phases of the development of the role of the ICU nurse. Questions that require further study are: how much variation is there between the baccalaureate graduate and nurses holding other degrees, does role conception change as the nurse continues to work in the ICU, how does previous work experience affect initial role conception, and does the adult ICU nurse perceive the family support role differently than the PICU nurse perceives parental support.

Perception of Stress

A factor that could exert a strong influence on role conception

and role enactment is the ICU nurse's perception of stress. ICUs have been identified as stressful areas in which to work, and studies have indicated that factors from either the environment or the individual nurse may affect role enactment.

Earlier studies (Hay & Oken, 1977; Vreeland & Ellis, 1969) attempted to describe the ICU environment and indicate which aspects of it would be stressful to nursing staff. These included environmental conditions such as noise levels and technical equipment, as well as interpersonal relationships and the severity of illness being treated. Both studies suggested that there was considerable stress on the ICU nurse.

However, as Grout notes in a 1980 review of the nursing stress literature, defining stress as a component of the environment is troublesome since individuals may perceive it differently. This contention is supported by Oskins (1979) who studied perceptions of stress of ICU nurses in a threat versus challenge framework. Many nurses in this sample described intensive care nursing to be challenging, making those studies that have asked nurses to rate perceptions of stress or have used psychological inventories to measure stress more valid.

Gentry, Foster, and Froehling (1972) administered job satisfaction questionnaires and psychologic tests to both ICU and non-ICU nurses (all adult units). They found ICU nurses to rate higher on scales of anxiety, depression, and hostility; although there were no differences in other general personality traits. Based on these results the investigators indicated that the cause of the variation

was due to factors within the ICU, and not the personalities of the nurses themselves. As this was a small (N = 34), self-select sample the study has limited generalizability.

Other studies have had nurses rate their perceptions of stress. Factors that have been identified as contributing to stress include: the ICU environment, interpersonal interactions and communication problems, the critical nature of the patient's illness, and dealing with the family of the patient (Huckabay & Jagla, 1979: Oskins, 1979; Steffen, 1980). Although each of these factors are common in intensive care nursing the studies indicate that not all are stressful to all nurses. The perception of stress is then dependent on the reaction of each individual to a particular situation.

No investigator has attempted to determine if particular factors are perceived as stressors more often in different types of ICUs. For example, is family support a greater or lessor stressor in the adult ICU nurse as compared to the PICU nurse. If stressors are perceived differently then role enactment might vary accordingly.

Grout, Steffen, and Bailey (1981) studied perceptions of stress by having a large sample of 1,238 ICU nurses (predominately from adult ICU) rank-order sources of greatest satisfaction and greatest stress. Patient care and the use of knowledge and skills was found to be satisfying while management of the unit and interpersonal relationships were described as stressful. In this sample, only 2.0% listed patient or family gratitude for care provided and 1.1% listed patient or family teaching as sources of greatest satisfaction. No references to family interaction were made in the discussion of

specific stressors.

The investigators also had nurses answer forced-choice, Likert-type scale questions concerning their perceptions of aspects of the ICU. Of note to this study is that 43.4% found that time occasionally prevented them from giving emotional support to families, 26.0% were frequently prevented, 6.2% almost always prevented, and 21.8% were rarely prevented from giving emotional support to families. In wording the question the investigators made time the variable that family support was dependent on, it is unknown if other factors might also inhibit the provision of support.

As the Grout et al. study indicated, nurses find that enacting certain behaviors can be both satisfying or stressful. The provision of support has been identified as exacting an emotional drain on the nurse (Jones, 1962; Micheals, 1971). Holsclaw (1965) identified "high emotional risk" areas which included the ICU. This author found that working in areas where cure or restoration of health was frequently not possible served to diminish the self-concept of the nursing staff. Surveyer (1976b) describes nurses that care for comatose children as experiencing feelings of vulnerability, anger, frustration, guilt, sorrow, and anxiety. If enacting the supportive role exacts an emotional toll it might come to be perceived as a stressor to the nurse.

Other ICU studies which have included the ranking of family support in respect to perceived level of stress have been reported by Jacobson (1978), Huckabay & Jagla (1979), and Steffen (1980). Jacobson's work was done with neonatal ICU nurses, the other two

with adult units. Differences in content categories and scales make comparisons difficult, but all three studies found working with the families to be stressful. The degree of stress varied from high to low. In these studies factors that might affect the perception of stress were not delineated, making it difficult to determine if working with families was always stressful, or just in certain situations (i.e., when staffing was short or the family denied the critical nature of the patient's illness).

Gilmer (1981) provided needed depth and detail to the understanding of the relationship between interactions with families and the perception of stress in the PICU. This investigator categorized stressful situations into patient-induced, family-induced, and environment-induced and devised questions specific to each heading. The presence, frequency, and intensity of stress within each specific situation was ranked by 46 PICU nurses.

Potential scores for each question ranged from 0-6, with six being highest in both intensity and frequency. Scores for each question, total score for categories, means, and standard deviations were computed.

Because the patient-induced category contained 50% of the questions, mean scores were more useful in making comparisons. Environment-induced stress was perceived as highest, but all categories were found to be stress provoking and mean scores covered a narrow range: environment 3.03, patient 2.86, and family 2.55.

The author ranked situations within each category as to high, medium, and low stress based on natural gaps in scores. Highest

family-induced stress occurred when families were: noncaring toward the child, demanding and controlling, never present, always present, grieving, or noncommunicative. Medium stress was found in families that watched every thing the nurse did, were frightened, guilt-ridden, submissive, talkative, or in cases where the nurse felt unknowledgable about how to interact. Low stress was seen when interacting with upper-class, lower-class or single parent families.

This was the first study to identify how the PICU nurse perceived stress and to attempt to delineate particular factors that contributed to the perception of stress. The presentation of specific factors in respect to family-induced stress is especially relevant to this study. Although the investigator achieved a 100% return rate of the questionnaires the sample was drawn from only one PICU. Replication of this study with other groups of PICU nurses is warranted and would be useful in providing generalizability in order to better understand stress in the PICU.

The studies cited indicate that both adult and pediatric ICUs are stressful areas in which to work, but that individuals may perceive this stress in a different manner. Studies to date have measured the perceptions, attitudes, and personality traits of nurses, but have not directly related these measurements to behavior. It has also not been determined if feeling challenged rather than stressed has an impact on physiological and behavioral responses. There has been no differentiation between nurses working in adult ICU compared to PICU so that it is unknown how applicable studies of the adult ICU are to the PICU. A single study concerning the PICU

indicates factors from the patient, the environment and the family lead to the perception of stress in nurses. Further investigation is needed to determine the affects of stress on role enactment.

In summary, the parental support role of the PICU nurse is considered to include three components: emotional support, provision of information, and attendance to the basic needs of the parent. Authors cited indicated that this role is not always enacted. Reasons for the lack of role enactment have been postulated, but not studied.

Because the parental support role of the PICU nurse has not been formally studied it was necessary to investigate related areas of research. Studies of role conception and perception of stress in nurses working in adult and pediatric ICU have provided clues to the factors that might influence enactment of the nursing role generally and the parental support role specifically.

Educational background, degree of specialization and perception of stress and emotional drain are all factors that seem to have the potential to influence the role enactment of the ICU nurse. More study is needed to determine direct relationships, and to determine differences between specific nursing care areas.

Studies of the adult ICU were reviewed for discussions of family support, since this was considered comparable to parental support in the PICU. Overall, ICU nurses found deterrents to providing family support, but there was little attempt to delineate these factors. One study identified time as a variable, and others found that family support was perceived as stressful. A study specific to stress in

PICU nurses identified a number of family-induced stress factors; this study requires replication with other samples of PICU nurses.

Since parental support is conceived of as a role of the PICU nurse, study of the theory and practice of role enactment is indicated. In the following section role theory is discussed and a conceptual framework for studying parental support role insufficiency is presented.

Part II: Conceptual Framework

This section addresses the theoretical basis of the study of problems in parental support role enactment. Interactionist role theory is presented as a broad perspective in which to view the nursing role; while the role insufficiency framework is introduced as a particular way in which to study the problem.

Interactionist Role Theory

The term role was first used in the theater to denote the combined characteristics and actions of an actor's part. It was borrowed by scientists of sociology and psychology to describe the position and behavior of individuals in relation to others. This field of study has been termed role theory.

Role theory is a broad area of study in which there exists much diversity--concerning even the concept of role itself. Thomas and Biddle (1962) note that role has been viewed as "prescription, description, evaluation, or action" (p. 29). An important theoretical perpsective is referred to as interactionist theory. In this framework roles are perceived of as constellations of behavior that are subject to modification (Turner, 1956).

Interactionist role theory has been identified as appropriate to the study of nursing and nursing problems (Conway, 1978; Hadley, 1967; Meleis, 1975). The role of the nurse is dynamic, it is influenced by both the qualities of the individual and properties or people within the environment. Enactment of the nursing role is a process subject to change as the individual learns about himself and others. Interactionist theory is useful because these components are incorporated into the role analysis.

Role, in the interactionist framework, is viewed in terms of behavior rather than position, so that a role is enacted rather than occupied (Turner, 1956). Role players are described as actors who devise a performance. A specific role is conceptualized as a collection or pattern of behaviors for which there are common goals or sentiments (Turner, 1956; Hadley, 1967).

Although it is conceptualized in behavioral terms, role does continue to have normative properties. These are viewed as a set of expectations for a given role (Turner, 1956). The person is expected to enact a given role within this set of related directives. Norms provide a framework for consistency of role enactment and role analysis.

The basic unit of role analysis is the self-other dyad. A role only exists as it relates to at least one relevant other role. Turner (1962) describes this as poles on an axis. There are an infinite number of placements of this axis in space, but at each defined placement a boundary for the identification of the other exists. This boundary directs the self to devise a role by

considering or taking the role of the other.

Role-taking is a fundamental process in the interactionist concept of role. Turner describes it as an "imaginative construction of the other's role" (1956, p. 317). As such it is a mental process in which the self conceives of and evaluates the other role, attributing some purpose or sentiment to the other's behavior. It is related to empathy in that both the tendency and/or ability to empathize may influence the accuracy of construction of the other's role, but the process of role-taking itself is the same whether the individual empathizes accurately or not (Turner, 1956).

The self uses the information he has obtained to devise a performance. This becomes a creative process as the role is revised and modified. It is termed role-making, and it too is cognitive. The behavioral result of these two processes is role-playing, which is the overt enactment of the role.

Role-making is influenced by the other of a specific interaction and the relevant others with which the self interacts within this role. For example, a person may enact the role of the PICU nurse with a number of others, such as: physicians, patients, parents, and other nurses. In each of these interactions the expectations of the others for the PICU nurse would vary. The physician might expect the nurse to rapidly carry out orders without question, while the parent might expect the nurse to provide information on the reason for each treatment. The nurse will also have expectations within each of these relationships. The nurse attempts to devise an enactment that maintains consistency between each specific

interaction and the general constellation of goals and sentiments (Turner, 1956). The person that perceives the nursing role as one of an equal partner in patient care would relate differently to the physician and parent than one who views the nursing role as a subservient one.

A final component in role-making is the reference group. The reference group is a broad concept related to a generalized other that is relevant to the self (Turner, 1956). The self derives his perspective or values from the reference group and uses this in devising a performance. Generally the self is considered to relate to the reference group in one of three ways: specific norms or values are derived from the group, role enactment is judged or evaluated based on group standards, or basic values are attributed to the group and the self attempts to behave in a manner appropriate to these values (Lum, 1978). These three categories lie on a continuum from the high conformity/low individuality of role construction in the first situation to low conformity/high individuality of the third.

In summary, interactionist role theory is an appropriate framework in which to study enactment of the nursing role because it is a process that is subject to change and modification and that is sensitive to the many relevant others that the nurse interacts with. There are three primary components to role enactment: the self, the other, and the reference group; and three processes: role-taking, role-making, and role-playing. A given individual enacts many roles and each role will influence enactment of others by influencing both

time and energy available for role enactment and the individual's general conception of the self.

Role Insufficiency

Since the self, the other, and the reference group are components of role enactment they can also be sources for disruption of the role. Examples of this include: 1) the other sending conflicting messages that diminish the self's ability to devise a role, 2) the reference group imposing role expectations that the self feels unable to meet, and 3) change and instability in the general environment requiring the self to make frequent modifications in the role enactment. In order to understand the difficulty of the PICU nurse in providing parental support literature concerning problematic role enactments was reviewed.

Meleis (1975), conceiving of roles in the interactionist perspective, described a concept related to problematic role enactments termed role insufficiency, which was defined as "any difficulty in the cognizance and/or performance of a role or the sentiments and goals associated with role behavior as perceived by the self or by significant others" (1975, p. 266). This concept relates to both perceptions of the actor and of those relevant others that are involved in definition of the role, allowing for both involuntary and voluntary components.

To differentiate voluntary from involuntary role insufficiency a comparison could be made between a PICU nurse that desires to provide parental support but is impeded by some factor from doing so and the PICU nurse that does not provide support because of the lack of

desire. Because parental support is a behavior that is expected of a PICU nurse both individuals would be considered role insufficient.

Meleis finds voluntary role insufficiency to be related to role motivation and assessment of rewards and costs. It may or may not have disruptive effects, depending on how the other reacts or alters his own expectations. Involuntary role insufficiency can be more detrimental to the individual. Subjective feelings of anxiety, depression, apathy, frustration, grief, powerlessness, unhappiness and/or aggression may occur (Meleis, 1975, p. 267).

Figure 2-1 is Meleis' diagram for role insufficiency. It demonstrates that general factors listed as predisposing conditions and quality and quantity of roles influence role insufficiency. A major portion of the framework is devoted to a method to relieve role insufficiency and enable the actor to master role enactment. This is termed role supplementation, which may be both preventative or therapeutic, depending on whether it is implemented as the actor is attempting to develop a new role or after role insufficiency has been identified.

The role insufficiency framework addresses the major dimensions considered to be pertinent to this problem, making it very applicable to the study of the parental support role. Components of this framework that are important to the study problem include: 1) the voluntary and involuntary aspects of role insufficiency, 2) conception of role enactment as being influenced by factors from the self, the relevant others, and the general environment, 3) assessment of role enactment that is derived from both the self and relevant others, and

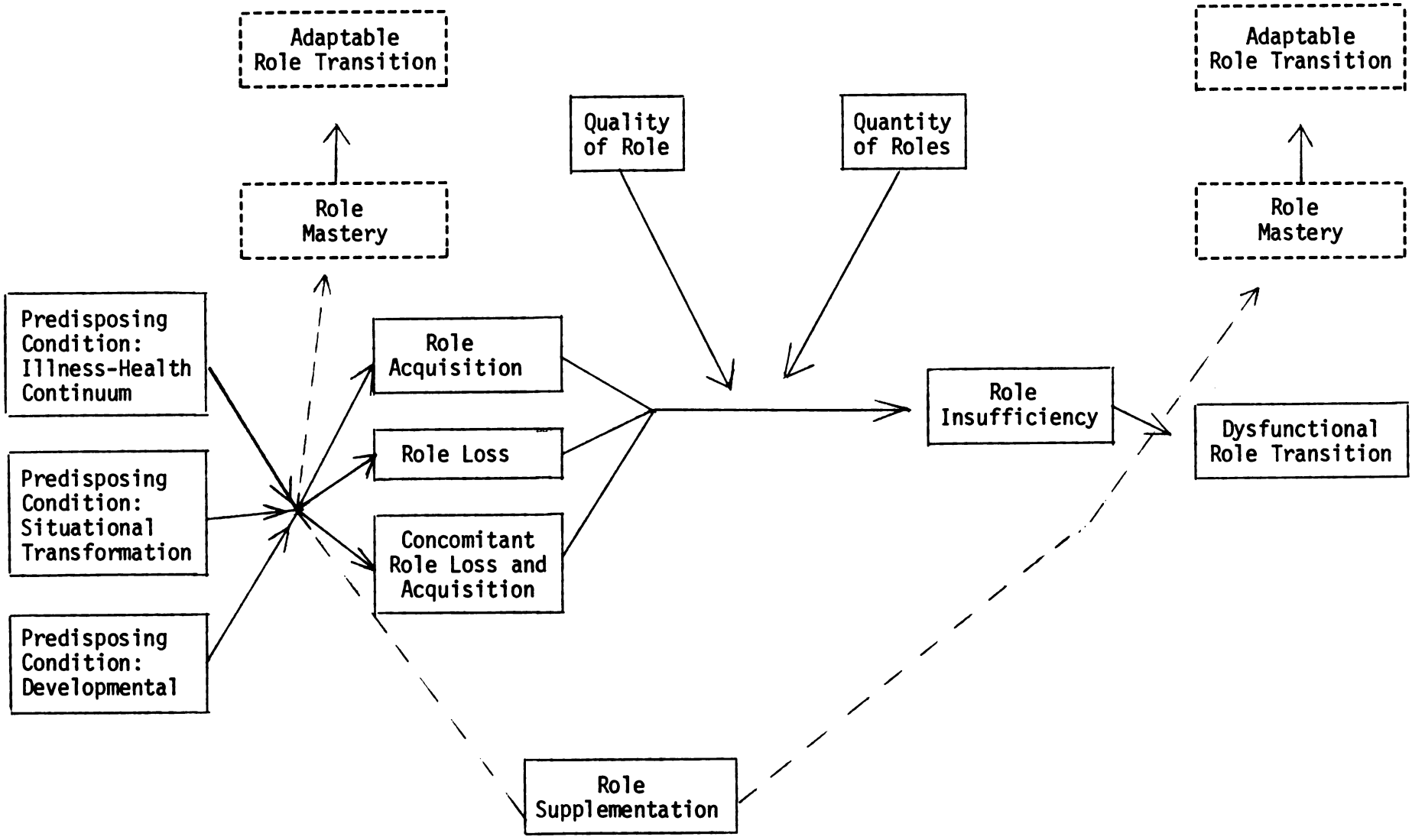

Figure 2-1. A portion of the role insufficiency and role supplementation framework as diagrammed by Meleis. (Meleis, 1975, p. 271)

4) and avenue for further investigation is provided in the role supplementation component of the framework.

The framework, however, does not provide direction for looking at specific factors that lead to role insufficiency. In order to determine what factors might hinder or facilitate the enactment of the parental support role by PICU nurses the investigator needed to learn what specific components existed within the broad categories of predisposing conditions and quality and quantity of roles (Hardy, 1978) was found to supplement the work of Meleis by identifying many factores that influence role enactments.

Specific Conditions Leading to Role Insufficiency

Hardy (1978) described a concept similar to role insufficiency which is termed role strain. Role strain is a "subjective state of distress" (Hardy, 1978, p. 76) and consists of feelings of "anxiety, tension, frustration, apathy, and futility" (Hardy, 1978, p. 92), a description that corresponds closely to that of involuntary role insufficiency. Factors that led to role strain were investigated as potential factors of role insufficiency.

Hardy groups the factors or conditions that led to role strain into two sequential categories: conditions that predispose individuals to difficult role enactments, and role stress. Predisposing conditions result in a climate in which role stress is likely to occur. Role stress in turn leads to role strain. Figure 2-2 is a diagram of the interaction between predisposing conditions, role stress and role strain. Specific factors in each category are discussed in the following section.

Figure 2-2. Interaction of components leading to role strain

Predisposing conditions. Hardy (1978) includes socialization deficits, increasing rate of social change, and advances in technology as conditions that predispose to role stress. This author finds that these conditions result in new and different role obligations, and in increasing numbers of relevant others with which to interact in situations where there is little guidance or supplementation of role acquisition.

To the PICU nurse this involves understanding and using new, technical equipment; relating to growing numbers of health professionals; and gaining increased responsibility for the assessment and management of the patient and family. Often there is no assistance in learning how to enact this expanding role. ICUs have been identified as work areas that are stressful (Gentry et al., 1972; Gilmer, 1981; Hay & Oken, 1977; Huckabay & Jagla, 1978; Oskins, 1979; Steffen, 1980), and as areas in which the transition to the nursing role may be prolonged as compared to other patient care areas (Lewandowski & Kramer, 1980). These are the specific conditions that predispose the PICU nurse to role stress.

Role Stress. Hardy (1978) defines role stress as "a social structural condition in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet" (p. 76). There are

five types of role stress; role conflict, role ambiguity, role incongruity, role overload, and role incompetence. Each type will be discussed as it relates to the parental support role.

Role conflict is a situation in which role expectations are at variance. Relevant others in a setting are making demands on the nurse to enact behaviors that do not concur with the nurse's role conception. The nurse finds it difficult to maintain consistency between each role enactment and the general constellation of goals and sentiments that unify role enactment. An example of this would be a PICU nurse who puts a high priority on supporting parents interacting with a nursing supervisor who views nurses as having responsibility only for patient care.

Research studies have indicated that the potential for role conflict frequently exists in the ICU setting. Factors which have been identified include: differing educational background of the nursing staff (Folk-Lighty & Brennan, 1979), institutional versus professional goals (Benner & Kramer, 1972; Lewandowski & Kramer, 1980), disagreement over role obligations between nurses and physicians (Jacobson, 1978; Grout et al., 1980; Huckabay & Jagla, 1979), and disagreement between nursing staff and nursing supervision (Jacobson, 1978).

Role overload is a condition of excessive role demands. As the nurse interacts with greater and greater numbers of people it becomes more difficult to have adequate time and energy to put into each role enactment. Figure 2-3 displays the various others and reference groups with which the PICU interacts. Those within circles interact

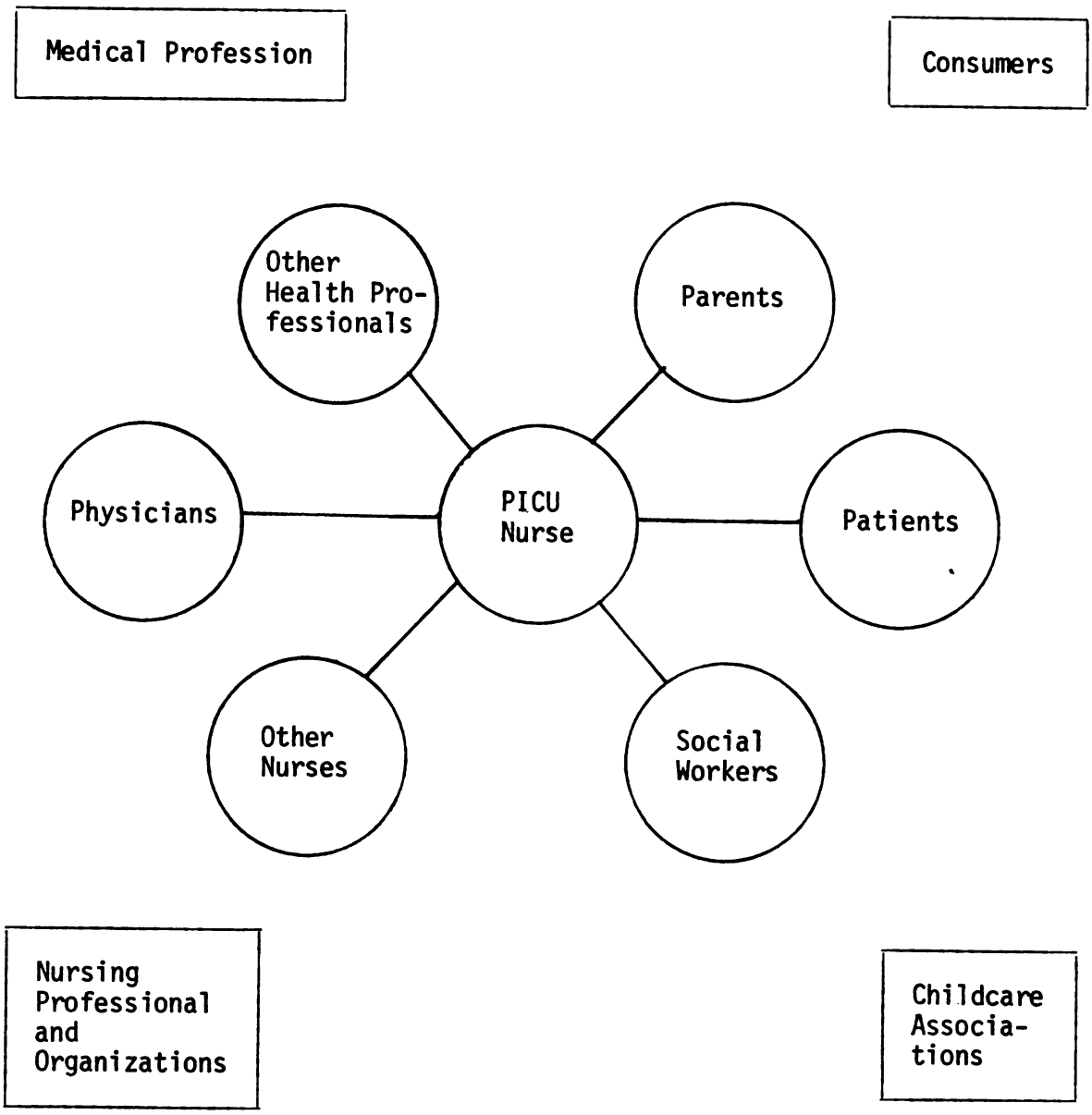

Figure 2-3. Relevant others and reference groups of the PICU nurse.

with the nurse directly, on a daily basis, while those on the periphery are groups that impact on nursing roles indirectly.

Role overload, as it relates to the PICU nurse, has been identified in two specific conditions. Benner and Kramer (1972) and Lewandowski and Kramer (1980) indicate that ICU nurses must learn to balance role demands to a greater extent than nurses in less specialized patient care areas. Miles (1979) finds situations of short staffing to impede parental support, in that the PICU nurse does not have the time to enact the role with both critically ill children and the parents.

Role ambiguity results from poor definition or lack of clarity in a given role. This concerns both the actor's understanding of the role expectations and the ability to interpret the other's behavior. Role ambiguity is then related to previous study and preparation in the role to be enacted, as well as the ability to accurately receive cues.

Factors that might produce role ambiguity in the PICU nurse include: inadequate preparation or instruction in the role (Folk-Lighty & Brennan, 1979; Hardy, 1978), the inability of parents to send accurate cues due to stress reactions (Gilmer, 1981; Jay, 1977; Miles, 1979; Rothstein, 1980; Soupious et al., 1980; Surveyer, 1976a); and the inability of the nurse to perceive cues accurately due to anxiety states (Bugen, 1980).

Role incongruity exists when the actor finds a discrepancy between role expectations and self-perception. For example, a PICU nurse who considers himself to be supportive, but finds that relevant

others do not have this expectation of his role will be role incongruent. Role incongruency can be conceived of as an inner turmoil. Jacobson (1978) identified its presence in philosophical or ethical dilemmas such as ambivalence toward abusive parents and providing aggressive care for hopeless cases.

Role incompetence is related to role skill and the person's ability to enact role behaviors. If a nurse has not mastered the skills necessary to provide support it will not be possible to enact the supportive role. Examples of support role incompetence include the nurse who is: inexperienced and unable to provide accurate information about the child's condition or treatments, deficient in role-taking skills and not correctly assessing the needs of the parent, or one that is lacking in knowledge of crisis interventions and unable to deal with the emotional state of the parent. Gilmer (1981) indicated that PICU nurses perceived not knowing how to interact with families as stressful.

This concludes a discussion of the types of role stress and how each relates to the parental support role of the PICU nurse. The factors discussed have been identified through the investigation of various studies and no direct relationships have, as of yet, been shown. Other factors that have not been described might also exist. In the following section it will be demonstrated how the role stress variables have been applied to the role insufficiency framework.

Conceptual Framework for Parental Support Role Insufficiency

For the purpose of this study the concepts presented by Meleis and Hardy were integrated. This was necessary because both brought

important components to the study. Meleis provided an overall structure while Hardy added needed detail. Combination of these two authors was possible because of the similarity between the concepts of role strain and role insufficiency, and because of their shared basis in interactionist role theory. Meleis (1981) found the combination to be appropriate. Figure 2-4 is a model of the framework that will guide this investigation.

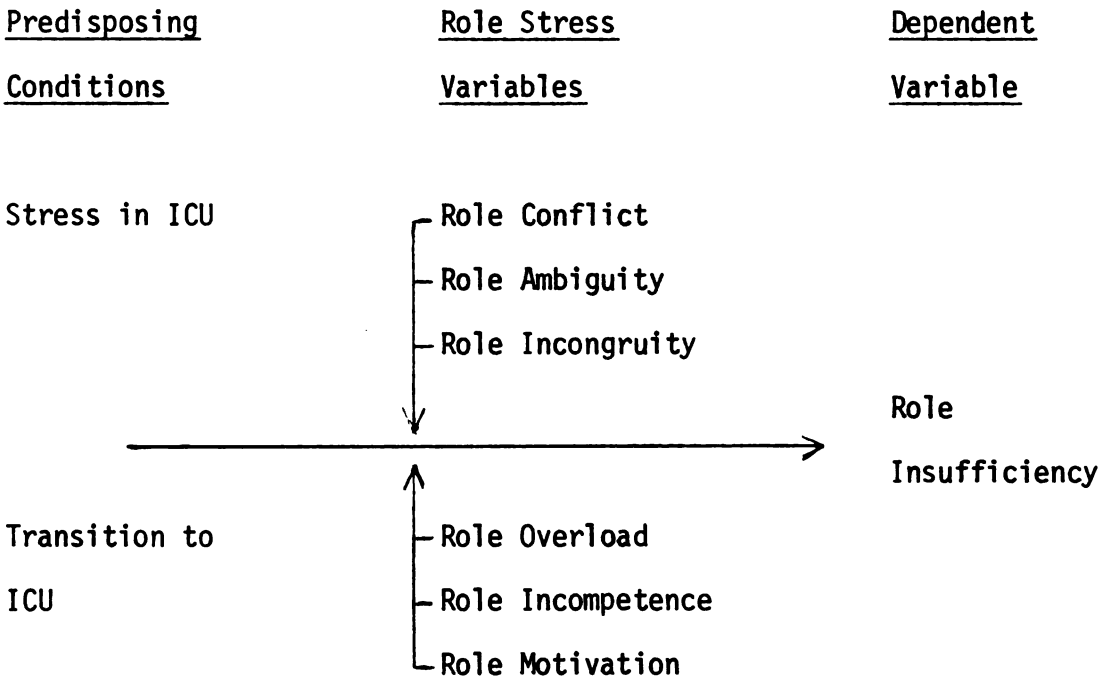

Figure 2-4. Adaptation of the role insufficiency framework

It should be noted that role motivation has been added to the role stress variables. This is to preserve the voluntary component of role insufficiency. Role motivation is related to the desire to enact a role. Individuals that interact with the PICU nurse can offer rewards for behavior they consider valuable. Examples include:

praise, attention or promotions. Based on the attitudes and values of the PICU nurse certain rewards will provide more satisfaction than others. For example, the PICU nurse that derives personal pleasure from assisting parents to cope with critical illness would be more likely to enact the supportive role than a nurse who gains self-esteem by complements from physicians regarding functional skills.

Studies that have addressed either motivation to provide support or rewards from enactment of the supportive role offer conflicting data. While Grout et al. (1981) found family support to be a low level satisfied, Gilmer (1981), Jacobson (1978), Huckabay and Jagla (1979) and Steffen (1980) all found it to be a potential stressor. Others have described providing support as exacting an emotional toll (Holsclaw, 1965; Jones, 1962; Micheals, 1971; Surveyer, 1976b).

The adapted role insufficiency model results in a number of strengths for this study. Predisposing conditions of role stress variables in place of the quality and quantity of roles provides needed detail in the delineation of factors that influence role insufficiency. Finally, the addition of role motivation to the role stress variables preserves the voluntary and involuntary components of role insufficiency.

Conclusion

In conclusion, chapter II has consisted of discussion of: research relevant to parental support and role enactment in intensive care settings, interactionist role theory, and a conceptual framework in which to study parental support role insufficiency.

There exists a lack of objective data concerning role enactment

in the ICU generally, and the parental support role of the PICU nurse specifically. Many factors--including time, staffing ratios, educational background, perception of stress, and desirability of the role--have been postulated, but no study of these potential variables has been attempted with PICU nurses. Indeed, with the notable exception of Gilmer (1981), few studies make reference to either parental support or family support in intensive care areas.

Interactionist role theory was identified as an appropriate theoretical perspective in which to study this problem because it incorporates properties of both the individual, relevant others and the general environment into role analysis as well as viewing roles as constellations of behavior that can be modified.

A framework in which to study the parental support role was developed by combining the role insufficiency framework with role stress variables. Similar definition of concepts and a shared basis in interactionist theory allowed for this combination. The framework serves to guide the investigator in the delineation of variables which have the potential to influence the parental support role of the PICU nurse.

CHAPTER III

Methodology

Research Method

An exploratory study was conducted to investigate how PICU nurses perceived the enactment of the parental support role. A semi-structured, open-ended interview guide was used to obtain descriptive data that would validate the presence of literature based variables, of other variables that have previously not been documented, and to examine relationships between these variables.

Analysis of the data was descriptive. Statistical methods were not considered appropriate due to the sample size, method of subject selection, and the exploratory nature of the study. Responses to questions were inspected for key themes, organized into content areas and summarized both numerically and by written description.

Setting

The subjects were selected from the nursing staff of a 16-bed PICU in a large children's hospital within a metropolitan community. This hospital is affiliated with a large university medical school and provides training for pediatric residents.

The PICU in this institution is designated as a regional center and critically ill children from both the community and the surrounding area are transported there. Types of diagnosis include critical post-operative patients, such as open heart patients, and critical medical emergencies, such as trauma, meningitis, or near-drowning. The children range in age from infancy to sixteen. Premature infants are not cared for in this unit.

The care of critically ill children in this unit involves constant monitoring and frequent assessment of physiological function, administration of treatments and procedures to arrest disease or improve functioning, and use of sophisticated equipment such as pulmonary artery pressure catheters or intracranial pressure monitors.

Data were collected over a three month period in the fall of 1981. At the end of data collection the head nurse of the unit was interviewed to determine if anything unusual had occurred during this time period. The Head Nurse reported normal census. They had cared for a slightly higher number of oncology patients due to a new treatment protocol for leukemic patients that required close monitoring--the unit continued to have the same mix of other patients.

The Head Nurse also indicated that new attending physicians had joined the medical staff. Initially this resulted in some difficulty between the new physicians and the nursing staff concerning treatment regimens and interpersonal relations. The attending staff and nurses had met to discuss these issues approximately one month before the first interview, and the Head Nurse felt issues were being resolved.

Sample

The subjects for this study were selected from the registered nurse (RN) staff of the PICU--which consists of 73 full-time and part-time people. The original sample consisted of 17 volunteers, one of which later decided not to participate, resulting in a sample size of 16.

Criteria for sample selection. There were four selection criteria: 1) the nurse must be an RN, 2) the RN must be a permanent

employee of the PICU staff (eliminating float or nursing registry personnel), 3) the RN must be engaged in patient care activities at least 50% of the time, and 4) the RN must have worked in the PICU for more than three months (eliminating staff members that were still undergoing orientation).

Human subjects assurance. In order to protect the subject's anonymity and confidentiality, interview forms were assigned code numbers. The investigator also emphasized that participation (or refusal to do so) would have no bearing on employment status. The subjects were informed that they could withdraw at any time. This study was reviewed and approved by the University of California, San Francisco, Human Subjects Committee. Refer to Appendix A to review the consent form.

Demographic data. Personal information that was felt to be pertinent to the study of parental support was obtained from each subject. Subjects were questioned regarding their basic and current nursing education, other education, years of nursing experience, types of nursing experiences, and number of years as a nurse in PICU. This information was tabulated into percentage calculations and is contained in table 3-1. Percentages of type of nursing experience are greater than 100 because many nurses had more than one experience.

Techniques of Data Collection

Recruitment of subjects. Nurses were recruited into the sample by three means: 1) RNs who were interested after the investigator presented the study at a staff meeting left their names on a sign-up sheet, 2) the Head Nurse of the PICU individually recruited

Table 3-1

Demographic Data of Education and Experience of Subjects

Variable	Range and Mean	Response	No. of Subjects	Approximate Percentage
1. Basic education		Diploma	6	.37
		Associate	4	.25
		Baccalaureate	6	.37
2. Current education		Diploma	5	.31
		Associate	4	.25
		Baccalaureate	5	.31
		Masters	2	.12
3. Other education		General college credits	7	.44
		Other degrees	1	.06
		Current further nursing education	4	.25
		None	5	.31
4. Length of experience				
a. As a nurse	2-12.5 yrs.	1-2	1	.06
		2-3	2	.12
	3 yrs. 7 mos.	3-5	3	.19
		5-10	9	.56
		10	1	.06
b. In a PICU	7 mos.-22 yrs.	1	2	.12
		1-2	3	.19
	6 yrs. 9 mos.	2-3	2	.12
		3-5	4	.25
		5-10	5	.31
5. Type of previous experience		Adult (non-critical)	4	.25*
		Adult (critical)	1	.06
		Pediatric (non-critical)	9	.56
		Neonatal ICU	3	.19
		Obstetrics	1	.06
		None	4	.25
		Other	1	.06

* Subjects listed more than one type of experience

participants, and 3) the investigator asked initial participants to request others to participate.

Compensation to subjects. As compensation for the subject's time and inconvenience the investigator offered to send a summary of the results of the study to each participant. The investigator also offered to present her findings to the staff of the PICU, with protection of the confidentiality of the subjects.

Protocol. Each subject participated in one interview. This was approximately one hour in length, and took place during non-work time. Most of the interviews occurred in either the subject's home or in a non-patient care area of the children's hospital. The choice of the location depended on what was feasible for the investigator and convenient for the subject. Nine interviews were done in homes, five in the hospital, and two at other sites.

The instrument. The investigator used a semi-structured, open-ended interview guide that was developed for this study (see Appendix B). It consisted of 22 questions that dealt with demographic data, the subject's conception of the nursing role and the parental support role, and the subject's perception of factors that influence parental support role enactment. The interview guide was reviewed by experienced researchers and pilot tested before initiating interviews. Pilot testing resulted in rewording of questions to clarify intent, and the inclusion of additional questions.

Validity, reliability, utility. Interview questions were generated from the investigator's experience as a PICU nurse, conversations with other PICU nurses, and role theory literature.

Literature-based validity in this instrument was assured by developing the interview items from general role theory literature, the Meleis (1975) role insufficiency framework and the adapted role insufficiency model. Pilot testing of the interview guide insured that questions posed elicited responses pertaining to content areas.

The reliability of this tool is related to the consistency with which it measures the perception of the parental support role, determination of which will require further usage and analysis over time.

The utility of this instrument concerns its efficiency and accuracy in gathering data about the perception of the parental support role, which will be addressed in chapter V.

CHAPTER IV

Results

Chapter IV consists of tabulation and description of the data from interviews of 16 PICU nurses concerning parental support role enactment. The results are presented as they relate to the research questions. Data from interview questions concerned with role conception, the presence of role insufficiency, factors that hinder or facilitate role enactment, and subject identification of recommended changes to facilitate parental support are discussed.

Research Question #1: Do PICU nurses perceive themselves to be role insufficient in respect to parental support?

Interview questions which addressed this research question focused upon conception of the total nursing role and the parental support role, identification of factors that led to role conception, identification of agreement between role concept of the subject and relevant others in the setting, and estimation of the ability to enact the parental support role.

Conception of the nursing role. Findings related to conception of the nursing role revealed that major components of the role are patient care, interactions with the family, and interstaff relations (refer to Table 4-1). Patient care was identified by the entire sample and ranked as having the highest priority. Thirteen subjects identified interactions with the family as one component of the role, and eleven identified interstaff relations.

The majority of the sample indicated that nursing care of the patient was first priority and alternated second priority between

Table 4-1

The Identification and Prioritization of Role Components of the PICU Nurse (N = 16)

Role Components	Frequency of Responses by Priority 1st	2nd	3rd	Total Responses
Nursing care of the patient	12.5	3.5	-	16
Interactions with the family	.5*	6.5	6.0	13
Interstaff relations	3.0	5.0	3.0	11

* decimals resulted when subjects ranked priorities equally between two role components

interactions with the family and interstaff relations. In light of these findings a comparison was made between those subjects that identified family interactions as a higher priority and those that identified interstaff relations.

Seven subjects indicated that parental interactions were either a higher priority or did not include interstaff relations in the nursing role. These nurses tended to have less than three years of experience in the PICU and in nursing, more previous experiences with pediatric or neonatal patients, diploma degrees, and to be involved in further nursing education to obtain the baccalaureate degree.

Eight nurses identified interstaff relations as the higher priority. These subjects tended to have more than three years of experience in the PICU and in nursing, more previous experience with

adult patients, and held the baccalaureate or masters degree. Four of these nurses noted that interstaff relations were a factor in their decision to continue to work as a PICU nurse.

Three subjects did not include family interactions as a component of the role of the PICU nurse. These subjects did however describe the importance of family interaction in other parts of their interviews, and one indicated that family interactions was a factor in the decision to continue to work in the PICU.

Conception of the parental support role. The subjects delineated and prioritized the components of the parental support role, as they conceived it. Responses were grouped into three categories which are contained in Table 4-2. Fifteen subjects included all three categories as components of their parental support role.

Table 4-2

Identification and Prioritization of the Components of the Parental Support Role (N = 16)

Parental Support Role Components	Frequency of Responses by Priority			Total Responses
	1st	2nd	3rd	
Provision of information	7.5*	7.5	1.0	16
Emotional support	6.0	6.0	2.0	16
Attention to the basic needs of the parent	2.0	1.0	12.0	15
Other	-	1.0	-	1

* decimals resulted when subjects ranked priorities equally between two role components

The subjects frequently expressed difficulty in separating and prioritizing parental support role functions. Many described an interrelationship between the provision of information and emotional support. For example one nurse stated "I alleviate anxiety by teaching" and another noted that "teaching and support go hand in hand". Interview data also indicate that provision of information and emotional support are closely related. Although provision of support was ranked slightly higher in priority, a first priority of 7.5 compared to 6.0, the difference was not great.

Variation between subjects, based on the order in which they prioritized provision of information and emotional support, was demonstrated. Five nurses ranked provision of information as more important. This group tended to have greater than three years of experience in PICU and were graduates of diploma, baccalaureate or masters programs. Three subjects ranked emotional support as highest priority. This group tended to have less PICU experience, and were graduates of associate or diploma degree programs; two of the three were currently enrolled in a baccalaureate degree program.

Attention to the basic needs of the parent was a lower priority. Of the 15 subjects that included as a role component 12 ranked it as third. Furthermore many subjects included it only after the investigator asked if they considered it to be a role function; while informational and emotional support components were offered without probing.

Description of the enactment of the parental support role. The subjects described the ways in which they enacted each component of

the parental support role. When providing information the subjects described treatments and equipment (6 responses), offered explanations of the child's pathology and prognosis (4), and reinforced what the physicians had told the parents (2). One nurses stated "I demystify the unit" and many thought the parents did not "hear" everything they were told the first time and needed follow-up explanations.

When providing emotional support the subjects stated that they assessed the anxiety level and coping mechanisms of the parents, and intervened. Interventions identified were: helping the parents to feel comfortable in the PICU (4 responses), easing anxiety (4), demonstrating a caring attitude (4), and building trust (2).

Rest was identified as the parental need that most required nursing intervention (12 responses). Subjects indicated that they encouraged the parents to "take breaks" from the unit, but perceived their role to be that of making recommendations rather than forcing parents to perform a behavior.

Factors that influenced parental support role conception. Role conception is influenced by both past experiences and relevant others in the setting. Nurses were asked what led to their conception of the parental support role and which professional groups in the setting agreed with their role conception.

Subjects identified four factors that led to their present conception of the parental support role: nursing experience, personal traits, nursing education, and nursing colleagues (see Table 4-3). Nursing experience was identified by the majority of the sample

Table 4-3

Factors That Influenced the Conception of the Parental Support Role (N = 16)

Factors	Number of Responses
Nursing experience	10
Personal traits	5
Nursing education	4
Nursing colleagues	1

(10 responses). One-half of the sample described it as the single factor influencing role conception and two others identified it in conjunction with another factor.

Five subjects stated that their own personal characteristics or traits influenced role conception and four found education to be a factor. Education was never identified as a single factor. Experience and personal traits were never indicated by the same respondent. Nurses with the diploma degree tended to identify experience as most influential. Nurses who identified education as a factor held the baccalaureate or masters degree or were currently enrolled in a baccalaureate degree program.

The subjects were asked to indicate which groups or relevant others in their setting agreed with their role conception. Eleven subjects named other nurses, eleven named other health team members

(excluding physicians), ten named physicians, one named parents, and four stated that every one agreed. When asked who disagreed with role conception six subjects stated that no one did.

The ten subjects who did describe some disagreement with role conception identified subcategories within the groups of nurses and physicians. Five subjects described other nurses as disagreeing with their role conception. These other nurses were either new to the PICU and unable to enact all aspects of the role, or uncomfortable with parental support. Physicians were identified by seven subjects. Those physicians who disagreed with the role concept were specialists in cardiology and oncology, doctors who admitted to the PICU infrequently, and those from outlying areas where the nurses went to transport critically ill children to the PICU.

Estimation of the extent of role enactment. The subjects were asked to estimate the extent to which they were able to enact the parental support role as described by them. Responses were tabulated in Table 4-4. Subjects expressed that it was difficult to estimate

Table 4-4

Subject's Estimation of the Extent To Which She Is Able To Enact the Parental Support Role (N = 16)

Extent of Role Enactment	Number of Responses
Completely	2
Partially	8
With difficulty	6

overall role enactment because cases could vary a great deal. Those nurses that found role enactment to be most difficult had less experience, the baccalaureate degree, and no other education.

Research Question #2: What factors do PICU nurses perceive to be hindering the enactment of the parental support role?

Interview items which addressed this question focused on identification of specific factors, description of difficult situations, estimation of the costs to providing support, and comparison of the PICU to other patient care areas in respect to the provision of parental support.

Identification and description of factors that hinder parental support The subjects discussed factors they perceived to hinder parental support and then described specific situations in which parental support role enactment was perceived as difficult. Responses to these two questions were grouped into categories and are contained in Table 4-5.

Parental characteristics were noted by ten subjects as the factor with the highest priority to potentially hinder parental support and by 14 subjects as a situational factor that had created difficulty. Specific characteristics that were noted most frequently were: interfamily conflict (8 responses), language barriers (5), ethnic or cultural differences (4), hostility toward staff (4), and lack of trust in the health care system (3). Other parental characteristics noted less often included: parental responsibility for the child's condition (2), unrealistic expectations of the patient's prognosis (1), and over-involvement in the care of the child (1).

Table 4-5

Identification and Prioritization of Factors That Hinder Parental Support and Identification of Factors From Specific Situations in Which Parental Support Was Difficult (N = 16)

Factors Hindering Parental Support	Factory Priority 1st	2nd	3rd	Situational Factors That Created Difficulty
Parental characteristics	10.0	1.5*	0.5	14
Patient characteristics	2.0	5.0	-	4
Interstaff relations	1.0	2.0	1.0	3
Personal characteristics	1.0	1.0	-	1
PICU environment	2.0	0.5	1.5	-

* decimals occurred when subjects ranks priorities equally between two factors

Other categories of factors that hindered parental support included patient characteristics, interstaff relations, personal characteristics, and the PICU environment, all of which were identified less frequently than parental characteristics. The characteristics of the patient had the second strongest impact on parental support. Seven nurses identified it as first or second priority and four nurses described it as a situational factor. Support was perceived as more difficult when the patient was dying or had a poor prognosis (7 responses), very unstable or worsening (4), or was in

some way similar to the subject's own children (1).

Physicians were identified as the staff members who were most likely to hinder support role enactment. This occurred when the medical plan was not adequately communicated (3 responses), physicians were not honest with the family (3), or were rude (1), and cases in which the nurses were not involved in decision making (1) or did not agree with the medical plan (1).

Personal characteristics that hindered support were identified by three subjects (who noted more than one characteristic). These included: lack of knowledge about the patient's illness or treatments (2 responses), physical energy (2), inexperience (1), and emotional states (1). Support was also hindered by aspects of the PICU environment such as lack of privacy in which to converse with the family (1), or lack of facilities where the parents could rest and remain near to the child (1).

Perception of costs to providing support. Eleven of the 14 subjects who answered this question identified costs associated with providing support to parents. Parental support was described as being emotionally draining by nine subjects. Specific responses included: feelings of hurt or loss for a family whose child died (2), frustration (2), depression (1), feeling ungratified (1) or as if one had failed (1).

Two subjects found costs of parental support to result in physical symptoms of fatigue or loss of appetite. One subject noted that parental support increased the work load and was time consuming.

Comparison of the PICU to other clinical areas. Aspects of the

PICU that detracted from the provision of parental support and were not perceived to be present in other patient care areas were identified (see Table 4-6). The PICU environment was described as distracting and lacking in privacy. Patients were identified as requiring much time due to acuity of illness, and parental characteristics of shock and increased anxiety served to hinder the provision of support.

Table 4-6

Identification of Parental Support Detractors and Facilitators of the PICU Compared to Other Clinical Areas (N = 16)

Factor Category	Frequency of Responses Indicating Detractor	Frequency of Responses Indicating Facilitator
PICU environment	9	2
Staff characteristics	-	8
Patient condition	6	2
Parental characteristics	4	5
Interstaff relations	-	2
Other	-	1
None	2	1

Research Question #3: What factors do PICU nurses perceive to be facilitating the parental support role?

Six interview items addressed this question. These concerned:

identification of specific factors, descriptions of situations in which support role enactment was perceived as less difficult, estimation of the rewards gained by providing support and identification of factors that attracted the nurse to the PICU, identification of factors that aided the nurse in difficult situations, and comparison of the PICU to other patient care areas in respect to parental support.

Identification and description of the factors that facilitate parental support. Subjects discussed the specific factors they perceived to facilitate parental support and described specific situations in which parental support was less difficult. Responses to these two questions were grouped into categories and are contained in Table 4-7.

Parental characteristics were noted by 14 subjects as the situational factor that facilitated support. It was also ranked first in priority by four subjects. Specific characteristics that were noted as facilitators were: receptiveness to support (14 responses); being interested in the child, his treatments, and disease pathology (3); having a similar ethnic or cultural background (3); being verbal (2), educational level similar to that of the nurse (2), seeming to like the nursing staff (1), and having a cohesive family unit (1).

Patient characteristics and personal characteristics occurred next in frequency after parental characteristics. Patient characteristics received a higher first priority ranking (4.3 compared to 3.7) but both were indicated by four subjects as situational factors. Patient characteristics included: a good prognosis (7), stable

Table 4-7

Identification and Prioritization of Factors That Facilitate Parental Support and Identification of Factors From Specific Situations In Which Parental Support Was Less Difficult (N = 16)

Factors acilitating Parental upport	Factory Priority 1st	2nd	3rd	Situational Factor That Facilitated Support
Parental characteristic	4.0	4.5*	1.0	14
Patient characteristic	4.3+	2.3	.3	4
Personal characteristics	3.8o	0.8	0.3	4
Interstaff relations	1.3	2.3	2.3	1
PICU environment	1.5	1.5	1.0	-
Other	1.0	-	-	2
None	-	-	-	1

* decimals of .5 occurred when subjects ranked priorities equally between two factors.

+ decimals of .3 occurred when subjects ranked priorities equally between three factors.

o decimals of .8 occurred when some subjects ranked priorities equally between two factors and others ranked equal priorities between three factors for the same question.

condition (3), or improving condition (1). Subjects own characteristics which aided them included: knowledge of the patient's pathology and treatment (6), self-confidence (3), the ability to empathize (1),

and being a parent (1).

The effect of other staff members was a lower priority but was identified as having a positive impact. Other nurses were noted by five subjects as facilitating by supporting subjects and assisting with planning and implementation of care. Two subjects identified physicians that maintained good communication, two identified the chaplain, and one identified the social worker. Finally support was facilitated when the bedside was clean (1), numbers of people at the bedside were decreased (1), and when parents were stimulated to ask questions based on what they saw in the environment (1).

Perception of rewards. All subjects stated that there were some rewards to providing parental support and eight volunteered that there were more rewards than costs. Fifteen subjects described feelings of personal satisfaction such as accomplishment, competency, being respected, and being "able to make a difference". Eight subjects identified positive feedback from the parents in the form of verbal expressions of gratitude, written notes, or gifts of food or candy to the unit. Three nurses identified other nurses as verbalizing positive feedback.

Another way in which to view the perception of rewards is to determine what the individual perceives to be an incentive to come to or remain in the work place. Subjects were questioned as to why they initially chose to work in the PICU and why they continued to do so. Subject responses were grouped into five categories: critical care, pediatric patient population, interstaff relations, family interactions, staffing, and other.

In describing initial attractors categories that were identified as either first or second priority were critical care (12 responses), pediatric patient population (6), and other (5). First or second priority for continuing attractors were: critical care (10), inter-staff relations (7), and staffing (4). Family interaction was a low priority, it attracted one nurse to the PICU and was a factor for three nurses to remain.

Facilitation of support in difficult situations. As previously described, the subjects identified situations in which they found the enactment of the parental support role to be difficult. They also identified factors that aided them in these situations, which are tabulated in Table 4-8.

Table 4-8

Factors That Aided Subjects in Difficult Situations of Parental Support (N = 16)

Factor	Number of Responses
Interstaff relationships	13
Personal characteristic	7
Parental characteristic	3
Other	2
Patient characteristic	1

Interstaff relationships were identified by the majority of the sample (13) as facilitating enactment of the support role in these situations. Relevant others served as a means for the subject to ventilate emotions and express concerns (7), to assist in the provision of support (4), and to clarify interactions and plans (1). Other nursing staff were identified most often (4), but social workers (3), physicians (1), and the chaplain (1), were also reported.

Personal characteristics that included: getting away from the unit (2), the ability to be realistic (1), and empathetic (1), plus past experience (1), and knowing that she had helped (1) were mentioned. Parents that were willing to reconcile after a disagreement (1), or open to support (3) were also helpful, and one nurse described a patient with a good prognosis as a help to her.

Comparison of the PICU to other clinical areas. Aspects of the PICU that facilitated the provision of parental support and were not perceived to be present in other patient care areas were identified. This information is contained in Table 4-6 which was presented previously.

Characteristics of the PICU staff were noted most frequently (8 responses) as a facilitator not present in other patient areas. All of the eight described the nurse:patient ratio as a facilitator; while two included the supportive nature of the nursing staff and two others noted the constant presence of a nurse served to make the parents more comfortable. PICU parents were thought to be more vulnerable and open to support (5), and there was noted to be support for both nurse and family from other non-nursing staff (2).

Subject Identification of Changes to Facilitate Parental Support

At the conclusion of the interview the subjects were asked what changes, if any, they would make in themselves or the PICU to facilitate the enactment of the parental support role (see Table 4-9). A variety of changes in six major areas were identified.

Table 4-9

Recommendations For Changes To Facilitate Support (N = 16)

Recommended Changes	Frequency of Responses
Support for the nursing staff	6
PICU environment	6
Improved communication	5
Staffing	5
Education	4
Other	3
Personal changes	1

Changes noted most often were in categories of support for the nursing staff (6 responses) and the PICU environment (6). Four nurses recommended the continuation of a current chaplain-led support group, and two others suggested more sharing and supporting of each other informally. Changes in the PICU environment included: lounge area or private room for parents (5), better housing or sleeping

areas (3), more space at the bedside (1), and a lounge area for staff (1).

Subjects also described changes to improve communication (5) and changes directed at staffing (5). Three nurses felt improvement of nurse physician communication was needed, and two others suggested more frequent group meetings or health team rounds to improve communication among all staff. Changes in the areas of staffing included: increased number of staff (3), an all RN staff (1), establishing of a clinical ladder for promotion (1).

Four subjects suggested educational changes such as: classes on cultural awareness (2) and parental needs (2). One nurse suggested she would make personal changes to increase her knowledge and experience. Also suggested were more rapid administrative response to unit needs (2) and establishment of a parent support group (1).

Summary

Chapter IV has consisted of a summary of the data from interviews of 16 PICU nurses regarding enactment of the parental support role. Data obtained included demographic variables, subject conception of the nursing role and the parental support role, and subject's perception of the factors that hinder and facilitate parental support role enactment. The chapter concluded with subjects' recommendations for changes in the PICU. A discussion of these findings will be presented in chapter V.

CHAPTER V

Summary and Conclusions

Chapter V includes a discussion of the research findings and their application to the study problem. The presence of parental support role insufficiency in PICU nurses and factors that hinder or facilitate role enactment in relation to the role stress variables will be identified. The limitations and implications for nursing practice of this study will be delineated, and recommendations for further research will be made.

Discussion of the Data

The perception of parental support role insufficiency. Role insufficiency can exist in either a voluntary or involuntary mode. Voluntary role insufficiency assumes that the actor is aware of role functions and declines to enact them. It is determined by comparison of the actor's role conception to that of a broad reference group or to relevant others in the setting. Involuntary role insufficiency exists when the actor is either unaware of role functions or percevies himself to be unable to enact a desired role.

In this study the reference group of the PICU nurse was defined as those authors that discussed parental support in the PICU. It was determined that the parental support role was a function within the larger role of the PICU nurse, and specific components of the support role were: provision of information, emotional support, and attendance to the basic needs of the parents. There was consistency between the reference group and the individual nurse as indicated by 1) subject identification of the parental support role as a component

of the total nursing role and, 2) subject identification of the three components of parental support.

Voluntary role insufficiency is also related to the amount of agreement between the actor and relevant others in the setting with respect to role conception and role enactment. This can be determined by comparison of the actor's role conception to the role conception of relevant others and to the actor's perception of the role concept of relevant others. In this study these aspects of voluntary role insufficiency were only partially explored in that role conception of relevant others was obtained through the perception of the subjects.

Subjects described consistency between themselves and groups of relevant others; while any disagreement that existed occurred between role conception of some relevant others and the reference group. Therefore, voluntary role insufficiency, based on comparison of subjects to the reference group and relevant others, did not exist in the majority of the sample.

Determination of involuntary role insufficiency involes both the actor's perception of the ability to enact a role and the identification of subjective states that are consistent with role insufficiency. Subjects indicated that they were at times not able to enact the parental support role. This was related to both caring for particular patients or families and to individual traits of the subjects. Subjects also identified subjective feelings of frustration, depression, and anxiety which are associated with the responses to involuntary role insufficiency. Based on this data involuntary role insufficiency did occur in this sample of PICU nurses.

Factors that hinder the provision of parental support. Six role stress variables were identified as having the potential to influence parental support role insufficiency (refer to figure 2-4). The data support the presence of all six factors although some had greater influence on subjects than others. Role stress variables that had the greatest impact on parental support and will be discussed first are: role overload, incompetency, motivation, and conflict.

Role overload exists when the number of role functions excede the individual's ability to enact them. The subjects identified the role of the PICU nurse to contain three components: patient care, parental support, and interstaff relations. Of these patient care was described as the highest priority. Increased demand in the patient care role function would then take precedence and decrease the ability to enact other role functions.

Role overload was potentially influenced by patient characteristics and staffing patterns. Caring for a number of patients or a patient that was very unstable required so much of the nurse's time and attention that the provision of parental support was greatly reduced. In this study the subjects rarely identified nurse:patient ratio as hindering their support role, which may reflect staffing patterns in this PICU. Subjects indicated more frequently that the condition of the patient had an effect on role enactment. This effect was perceived as strongest for the inexperienced nurse.

The effect of role overload on the inexperienced PICU nurse was related to role incompetence by the subjects (most of whom were

experienced PICU nurses). Nurses that were developing their roles were described as initially concentrating on the primary role function of patient care. Until they had adequately developed skill competence and knowledge in the patient care role requirement they were unable to enact the parental support role.

Role incompetency also worked in conjunction with role motivation to influence role insufficiency in the general sample. This was apparent in descriptions of cases in which parental support was hindered by specific parental characteristics such as: interfamily conflict, language barriers, ethnic or cultural differences, hostility toward staff or lack of trust in the health care system.

Parental support is more difficult to provide in these cases because parents do not send standard cues as to their state of well-being. This occurs for two reasons, parents either can not (language barriers) or will not (hostility, lack of trust) verbalize needs, or their behavior may not be easily interpretable (cultural dissimilarity, interfamily conflict). In such cases the nurse must rely on increased skills in recognizing and assessing coping mechanisms and in planning interventions in order to effectively support these parents. If these skills are absent the nurse is role incompetent.

Effective parental support role enactment resulted in feelings of personal satisfaction and competency. The nurse derived these feelings or rewards from assessment of the outcome of interventions and the impact on the family. This positive appraisal motivated the nurse to enact the role with other families; however when parental characteristics hindered support these rewards were not present.

The nurse was unable to derive positive feelings from these interactions because parental response did not coincide with what was previously established as an expected outcome.

Without the buffer of rewards the nurse becomes more vulnerable to the attendant costs of enacting the parental support role; which are both emotionally and physically draining. Emotional states such as depression and frustration, as well as physical fatigue will serve to decrease the nurse's motivation to enact the support role and often require a period of time for recovery.

Feelings associated with a particular case also had the potential to influence future situations that were in some way similar. Subjects made this apparent by identifying categories of parental characteristics that always made role enactment more difficult, and by identifying experience as the major factor leading to conception of the parental support role.

The relationship between role incompetency and motivation is demonstrated in Figure 5-1. There are some parental characteristics that require greater degrees of role competency than others. When this competency does not exist the nurse gains little reward from role enactment and perceives the effects of physical and emotional drain. Since role motivation is related to the balance of rewards and costs it is decreased and the incidence of parental support role insufficiency rises.

Role conflict had a strong potential influence on role insufficiency that was described in actual incidences of conflict as well as through statements that emphasized the importance of a lack of

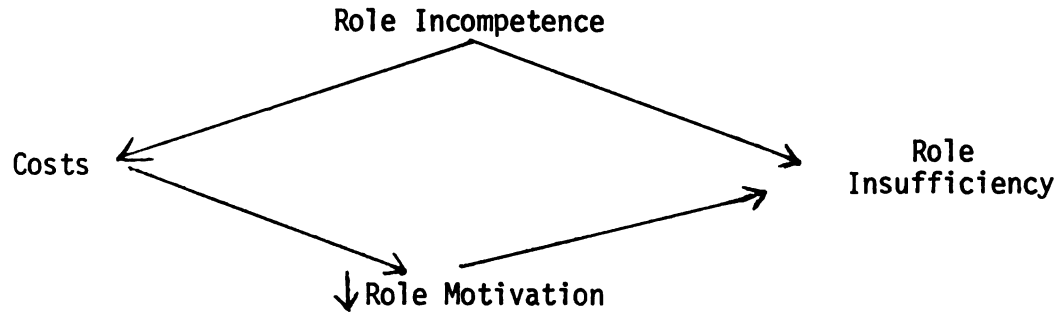

Figure 5-1. Interrelationship between role incompetence and role motivation.

conflict. Conflict among staff members was rare, but did occur between subjects and other nurses or physicians.

Physicians had the greatest impact on the subjects' ability to enact the support role due to two conditions. Nurses who disagreed with the subjects were fewer in number (allowing the subject to obtain support for herself from others), and they did not prevent the nurse from enacting her own role as she wished. Physicians, however, were more problematic because the nurse had to work with specific physicians when caring for patients and because these physicians enacted behaviors such as failure to communicate the medical plan to the nursing staff or were rude to parents directly affecting parental support.

The subjects often identified the support provided to them by other staff members as valuable. Interpersonal relations had a very positive effect on role enactment. This would not have existed had there been a great deal of role conflict in the setting.

Role ambiguity and role incongruity had less impact on this

sample of PICU nurses. The agreement between role conception of the subjects, relevant others, and the reference group demonstrated little role ambiguity; however this variable is also related to perception of parental needs during role enactment, which was not measured in this study. Perceptions can be influenced by anxiety and stress in both the nurse and the parent, which subjects indicated did exist.

Subjects identified a few other nurses in the setting as not desiring to enact the parental support role. These nurses would be considered role incongruent as they do not enact a required role function. Since subjects indicated that there were a small number of these individuals they would have a small impact on parent support over all, but a larger impact in particular cases.

Variables of motivation, incompetence and overload had the most direct influence on role insufficiency in this sample, while role conflict demonstrated a strong potential effect. The variables acted singly and in conjunction to decrease the ability of the nurse to provide parental support. Factors that facilitate role enactment are discussed in the following section.

Factors that facilitate the provision of parental support. Facilitation of parental support role enactment occurred both before and after role insufficiency was evident. This led to a categorization of these factors into those that prevented role insufficiency and those that relieved it. The adapted role insufficiency model (see figure 2-4) was deficient in directing the analysis of this data due to its focus on states of role insufficiency with no provision for cases in which this did not occur.

The original role insufficiency framework (Meleis, 1975) was reviewed again and factors that aided support role enactment were found to be comparable to preventative and therapeutic role supplementation. Meleis (1975) describes this process as an intervention which "prevents, decreases, or ameliorates" role insufficiency (p. 267).

Preventative role supplementation aides the nurse in devising an effective role enactment. Factors described by the sample which fall into this category include: knowledge of patient diagnosis and treatment, experience, self-confidence, understanding of parental characteristics (such as anxiety states, cultural beliefs), and adequate facilities.

Those factors that prevent role insufficiency are related to one's ability to enact a role or role competency. Nurses that have the necessary knowledge and skills are better able to care for critically ill children and support parents; however this expertise must be developed and role competency might exist in some situations but not others. Subjects noted that they felt better able to support parents with particular characteristics and that they gained experience or knowledge from one situation that could be applied to another.

Factors that aided subjects when role insufficiency existed are comparable to therapeutic role supplementation. The majority indicated that therapeutic role supplementation occurred through the intervention of another staff member; which often consisted of listening to the nurse or providing some degree of emotional support.

Since therapeutic role supplementation is tied to actions of staff members it is related to the absence of conflict and clarity of role purpose within the PICU. Support and assistance are offered because parental support is considered to be important by relevant others as well as by the individual nurse. The focus on interstaff agreement also provides motivation toward role enactment because the support for this role is evidenced.

PICU nurses displayed competencies and dysfunctions in parental support role enactment, demonstrating that they were both role insufficient and role sufficient. The adapted role insufficiency model (figure 2-4) provided delineation of factors that were shown to influence problems in role enactment; however, this model provided little direction for the understanding of role sufficiency. This is due to the nature of the role stress variables which are largely negative, with the exception of role motivation. In order to view role enactment in the perspective of both sufficiency and insufficiency opposing variables are presented. This relationship is diagrammed in Figure 5-2.

When conditions of role agreement, clarity, congruity, manageable load, competence and motivation exist there is strong potential for the nurse to be role sufficient, enabling the enactment of the parental support role. In the remaining portion of this chapter the limitations of this study will be discussed and recommendations for nursing practice and research based on this discussion will be made.

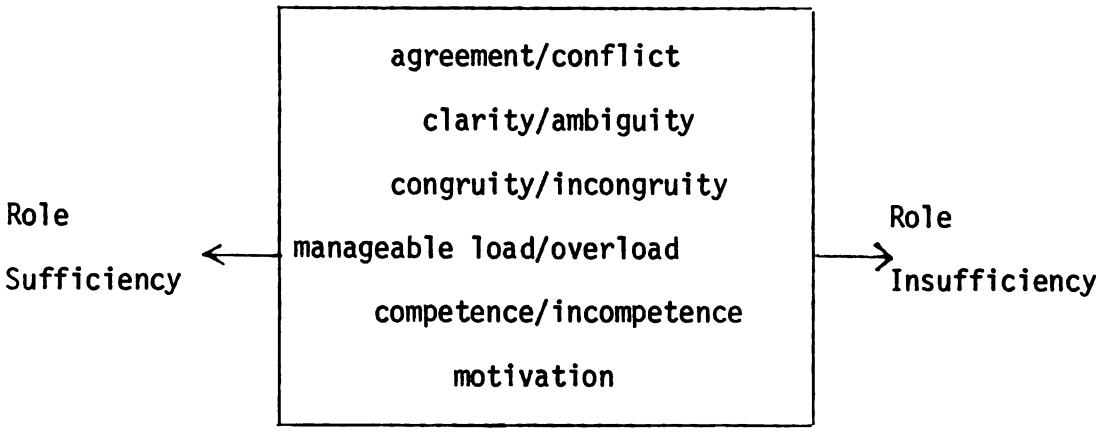

Figure 5-2. Role insufficiency and role sufficiency

Limitations of the Study

This study has limited generalizability due to sample size, composition, method of selection, and use of a single setting from which to draw the subjects. The data were not statistically analyzed due to these factors and the qualitative nature of the critical variables. Information from this study does provide delineation of potential variables and data for comparison to further investigation.

The interview guide for this study was open-ended and semi-structured. This was useful in gaining subject's perceptions of an area in which little was known, but responses relied heavily on memory and recall; which could have been affected by recent events and emotional status. Consistency was not determined by test-retest. Internal validity between some items was demonstrated by similar responses to similar questions (for example identifying what made it harder to support parents and describing difficult situations). The tool was also informally reported to be nonthreatening to the

subjects.

Recommendations for Nursing Practice

This study indicated that, although educational background had some impact, role conception is largely developed through experience. Nursing staff develop role conception through experience, perception of others in the setting, and perception of their own individual traits. Therefore interventions to modify role conception and facilitate role sufficiency should be directed at the work setting.

Because patient care is the primary role of the PICU nurse role overload can have a strong impact on parental support. Recommendations to prevent or relieve role overload include: 1) educational programs to improve patient care knowledge and skills, thereby allowing the nurse to develop secondary role requirements, 2) adequate staffing, and 3) the availability of other personnel assist with provision of parental support when patient care requirements are high.

The competency of the PICU nurse to provide support can be facilitated by increasing knowledge and developing skills. Methods to achieve this include: 1) educational programs on stress, crisis intervention, and cultural awareness, and 2) staff discussions to plan strategies and interventions and evaluate outcomes.

Motivation to provide parental support can be increased by: 1) instituting measures to improve competency, 2) providing positive feedback on successful interventions, 3) demonstrating support for the parental support role generally, and 4) providing for period of recovery when role enactment has been difficult (such as a lighter

clinical load, assignment to a more rewarding patient, or time away from the unit).

The effects of role insufficiency can also be lessened by an active support network which is maintained by open communication, congruent care philosophies, and a lack of interstaff conflict. Recommendations to achieve this include: 1) care conferences, 2) nurse-physician dialogues, 3) health team rounds, 4) role-modeling of supportive behavior, and 5) existence of a formal staff support group.

Recommendations for Further Research

Modification of the design of this study and research into areas of parental support and role enactment is recommended. Changes that will increase the ability to investigate direct relationships between variables and role enactment should be made. This would entail methods to increase the significance and generalizability such as: increasing the number of subjects, sampling more than one PICU, and stratified sampling to assure the inclusion of critical variables of experience and educational background.

To replicate this study with a larger sample a questionnaire should be substituted for the semi-structured interview guide. Response categories could be reduced in number by merging similar questions, such as those concerning what made it harder to support parents and difficult situations. In light of the relationship Gilmer (1981) found between age and perception of stress the variable of ego should be included.

This study demonstrated that it is both feasible and desirable

to obtain information from staff nurses. The subjects were not only willing to share their perceptions with the investigator, but also had considered valuable ways in which to supplement role enactment, enabling the investigator to gain useful information concerning both role conception and role enactment.

Further research could be conducted in many related areas. These include: 1) comparison between adult and pediatric nurses in respect to family support, 2) comparison between the perceptions of staff nurses and relevant others (in the setting) regarding role enactment, 3) investigation of the three components of parental support to determine relative difficulty or ease of enactment, 4) investigation of the transition of the inexperienced nurse to the PICU and its influence on role enactment, and 5) determination of the effects of a nursing support group on parental support role enactment.

Conclusion

Parental support role enactment was investigated with a sample of 16 PICU nurses, and voluntary role insufficiency was found to occur in varying degrees. Because the primary role of the PICU nurse was patient care role overload had the greatest potential for leading to role insufficiency; however role incompetency, motivation, and conflict were also strongly indicated.

A state of accurate role enactment, or role sufficiency, was postulated to describe situations in which PICU nurses demonstrated the ability to support parents. This state occurred when conditions opposite to those of the role stress variables existed such as:

role competency, motivation, clarity, congruency, absence of conflict, and manageable load.

Although the study had little generalizability, it contributed to knowledge of parental support role of the PICU nurse by delineating variables, describing their potential effects, and demonstrating that degrees of role enactment can exist. The data led to recommendations for specific measures to prevent or relieve role insufficiency that can be instituted within the work setting and for further research in related areas.

Appendix A

University of California, San Francisco

Consent To Be A Research Subject

Maura Fitzgerald, R.N., is a graduate student at UCSF, School of Nursing. She is interested in identifying 1) what pediatric intensive care unit nurses perceive to be their role in supporting parents, and 2) what factors hinder or facilitate them in enacting this role. She has invited me to participate in this study because I am an R.N. working in a pediatric intensive care unit.

If I agree my participation will consist of one interview of approximately 1 hour in length. Ms. Fitzgerald will meet with me in my home, or another place that we agree upon. Participation will not infringe upon my work time. The interview will consist of questions concerning my perceptions about supporting parents of critically ill children. If I agree the interview will be taped.

If I agree to participate in this study there is the risk of loss of my privacy. The investigator will keep coded personal information separate from the interview, and data will not be kept in the hospital where I am employed, so that my confidentiality will be protected as much as possible.

There will be no direct benefit to me in participating. The investigator hopes to improve our understanding of the perceptions of pediatric intensive care unit nurses concerning their role in supporting parents.

I have discussed this study with Maura Fitzgerald. If I have any further questions I can call her at (415) 387-1708. In addition, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the committee office by calling: (415) 666-1814 from 8:00 AM to 5:00 PM, Monday to Friday, or by writing to the Committee on Human Research, University of California, San Francisco, CA 94143.

Participation in this study is voluntary. I have the right to refuse to participate, to refuse to answer any question(s), or to withdraw at any time without any danger to my employment. If I would like a brief summary of the findings of this study, Ms. Fitzgerald will send this to me when it is completed.

_____ _____

Date Subject Signature

_____

Subject's Address (necessary only if a summary is desired)

8/18/81

Appendix B

Interview Guide

I. Demographic Data

A. Amount of time the nurse has worked in PICU

B. Previous nursing experience

C. Reason for choosing PICU (prioritized)

D. Reason for studying in PICU (prioritized)

E. Type of nursing education

F. Other education (non-nursing degrees, college credits, other experiences)

II. Perceptions of role

A. What do you consider to be your role in PICU? Can you prioritize those roles?

B. What do you consider to be your role in interactions with parents? Can you prioritize those?

C. What led you to perceive these activities as part of your role?

D. Generally, what people seem to agree with your perception of your role?

E. Generally, what people seem to disagree with your perception of your role?

III. Perceptions of Role

A. To what extent do you feel able to carry out these activities with parents?

B. What makes it easier for you to interact with parents? Please prioritize.

C. What (if any) rewards do you perceive you gain from interactions with parents?

D. What makes it more difficult for you to interact with parents? Please prioritize.

E. What costs (if any) are there to you when interacting with parents?

F. Do you find anything about the ICU that makes it more difficult to interact with parents compared to other patient care areas? Please explain.

G. Do you find anything about the PICU that makes it easier to interact with parents compared to other patient care areas?

H. Would you describe any situations in which you found it especially difficult to interact with parents.

I. What helped you in these situations?

J. Can you describe any situations in which interacting with parents was easier?

K. What changes would you make in your PICU to help you to better carry out your role with parents?

L. Is there anything else you would like to tell me?

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