



Rural nurses perceptions of job related stresses and coping methods
by Marie Louise Bunde

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University

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Abstract:

The purpose of this study was to identify the job-related stressors and coping methods of rural nurses. The conceptual basis for the study was based on theories by Selye (1965) on stress and Pearlin (1979) on coping. To identify rural nurses perceptions of stress and coping related to their jobs, the researcher utilized the ethnographic interview technique by Spradley (1979).

The sample consisted of 24 female nurses who lived and worked in four rural settings of central Montana. Their positions ranged from staff to administration with several in mixed roles of administration, staff, and maintenance.

Nurses experience job-related stress in rural areas from an inability to feel self-esteem from their jobs or from relationships between themselves and doctors, the institution, co-workers, other nurses, and the public. Coping methods are predominantly healthy, such as the use of talking, problem-solving, engaging in outside activities, and working as a cohesive group. Exhaustion was alluded to in coping methods such as forgetting and going on and trying to leave work at work.

Data analysis revealed the following themes of stress and coping related to the rural nurses in the study. Stressor themes which were identified included being short staffed, physicians, physical exhaustion, competency, administration of the hospital, coronary care, taking care of friends, the unknown, education, lack of experience, paperwork, equipment, moral issues, anonymity, and could not work in favorite area. Coping themes were talking, leaving work at work, forgetting it and going on, helping one another, using expressions of despair, setting priorities, using assertive skills, doing the best possible, attending educational offerings, solving problems, engaging in outside activities, smoking, drinking alcohol, crying, praying, joking; and practicing patience.

Implications for nursing include the need to re-evaluate nursing education to meet the needs of the rural practitioner and the identification of coping skills to enhance or be taught to assist in coping with job-related stressors. Questions generated by the study for further study include: (1) How do stress and coping methods differ or show similarity between rural and urban nurses? (2) What coping methods are more effective for nurses than others?.

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RURAL NURSES' PERCEPTIONS OF JOB RELATED STRESSES
AND COPING METHODS

by

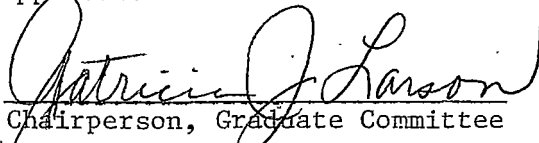
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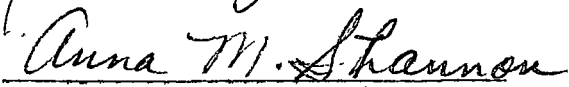
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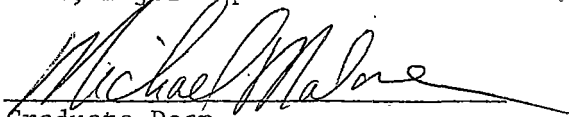
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For the accomplishment of this thesis, I offer thanks

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To my family for their tolerance

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MLB

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ABSTRACT

The purpose of this study was to identify the job-related stressors and coping methods of rural nurses. The conceptual basis for the study was based on theories by Selye (1965) on stress and Pearlin (1979) on coping. To identify rural nurses' perceptions of stress and coping related to their jobs, the researcher utilized the ethnographic interview technique by Spradley (1979).

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Chapter 1

INTRODUCTION

Statement of the Problem

Registered nurses experience stress from their jobs and cope with these stresses by using healthy or unhealthy responses. The work stresses originate from the nurses' feelings about locus of control; about role expectations of nurses by physicians, co-workers, hospital administrators, and patients; about working environment and conditions, and about job dissatisfaction (Claus, 1980; Scully, 1980).

People have choices of the coping methods they use based on past learning experience, personality structure, and social structure in which they live (Burgess, 1978; Johnson, 1978; Kobasa, 1978; Hong, 1979). The method may be effective or ineffective in dealing with the stress and unhealthy or healthy based on the effect on the person using the method (Katz, 1970). Healthy coping responses challenge the nurses to meet the needs of their patients effectively through problem solving, clear communication, maintenance of an attitude of hope, assertive behavior, and change initiation (Scully, 1980). Unhealthy coping responses create negative attitudes toward themselves, toward co-workers, and toward patients and cause internal feelings of powerlessness, hopelessness, and despair (Scully, 1980).

The researcher, from her observation of and interaction with

nurses in intensive care settings, began to question whether their high turnover rate might be because of the intense concentration of stress in that area. Stresses included a high rate of crisis, knowledge demands, irate physicians, and grieving families. Further, she questioned whether the coping methods of forgetting it and going on, of working excessive hours, and of crying were truly effective in managing the stress.

The researcher found that stress and unhealthy coping were not unique to intensive care nurses. From her work in rural settings with police officers and their organizational system, she found that persons in these settings also experienced stress. She also questioned the effectiveness of their coping methods such as excessive drinking and working overtime.

Nurses working in rural hospitals must have a broad repertoire of nursing skills to meet the needs of the geriatric, cardiovascular, obstetrics, emergency, and trauma patients (Shanker, 1980). Hospitals in these areas have low-bed capacity and admit critical patients infrequently. A professional isolation surrounds the rural nurses' practice. Nursing judgments within the rural setting must be frequently based on one's own knowledge and experience. No immediate consultation is available with other nurses or physicians. Further, the nurse in the rural community often knows the patients personally. Such knowledge places a burden on the nurse emotionally and may complicate

her ability to be objective (Shanker, 1980).

Because of the environmental and social circumstances under which the rural nurse works, the researcher questioned what stresses the rural nurse faces and what coping methods she uses. The questions developed were (1) What stresses you in your job? and (2) How do you cope with these stressors?

Purpose of the Study

The purpose of the study was to identify baseline knowledge about the working conditions of rural nurses, about their feelings and interpersonal relationships, and about their professional status through discussion about their job-related stresses and coping methods. This information was to add to the collection of knowledge about rural nursing for the development of a theory of rural nursing. The knowledge could assist in the preparation of rural practitioners. Further, it could identify healthy coping methods to enhance and/or share with other nurses.

The best teachers about a culture, a group of people who live and work together and use a common language, are members of the culture. The richness of a culture emerges from verbatim discussion from these members (Spradley, 1979). The ethnographic research approach which utilized open-ended questions to encourage culture members' discussion in the language of the culture was selected (Spradley,

1979). The researcher believes that the culture of rural nursing can be learned best by exploring the perceptions these nurses have of it. Many areas will require exploration such as patient interactions and relationships with the community. For this study the important areas of stress and coping will be examined.

The conceptual basis for examining these stressors and coping methods is based on the works of Selye and Pearlin. Selye's (1956:5) stress definition, "the nonspecific response of the body to any demand made on it," was used as the conceptual framework for stress. Pearlin (1978:2) defined coping as "the human response to stressors which prevents, avoids, or alters the emotional distress caused by the stressor," which was used as the conceptual framework for coping. These two conceptualizations of stress and coping allow adequate latitude for the researcher to explore rural nurses' perceptions of stress and coping and still keep within the framework of the accepted definitions of these two concepts.

The scope of the study entails discussions in the following chapters, namely, review of the literature and conceptual framework, rural nursing ethnography, cultural inferences about rural nursing, and conclusion, limitations, and recommendations from the study. The definitions of terms conclude this chapter which sets the thought pattern for the literature review.

Definitions of Terms

Cope: A human response allowing the person to prevent, avoid, or control the emotional distress that is caused by the stressor. An example would be the denial of a horrible sight (Pearlin, 1978).

Coping: The ability to deal with stressors in a positive or negative way by using any of the three major categories of coping mechanisms, namely, social resources, psychological resources, or individual personality traits (Pearlin, 1978).

Culture: The knowledge that people acquire to help them interpret experience and generate social interaction (Spradley, 1979).

Ethnographer: One who conducts an ethnographic study of a culture (Spradley, 1979).

Ethnographic interview: An approach using open-ended questions to elicit information from an informant in a culture's language while observing behavior and the use of artifacts (Spradley, 1979).

Nurses: Registered nurses in the State of Montana, educated at the associate degree, diploma, baccalaureate degree, master's degree, or higher degree, who hold a variety of nursing positions in rural Montana.

Rural: Areas with population densities of five or less people per square mile and more than twenty-five miles from a population center of 10,000 or more.

Stress: "The nonspecific response of the body to any demand made upon it" (Selye, 1956:14).

Stressors: External demands placed on the body which cause a stress reaction (Selye, 1956).

Chapter 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

The literature review focuses on three main topics: stress (including the stresses and stressors which provoke the stress/coping response), coping, and nurses. The literature review relative to stress includes the subtopics of stress, personality structure and stress, social aspects of stress, and experience with stress. The coping literature is discussed next. The literature review relative to nurses centers on stress and coping. The conceptual frameworks for stress and coping which evolves from the literature review concludes the chapter.

Stress

Life is dependent upon the presence of demands or stressors which cause an organism to react and respond. "Stress is the non-specific response of an organism to any demand made upon it" (Selye, 1956:5). Stress is not simply a nervous feeling or reaction. Stress occurs as the result of any demand whether it is valued positively or negatively by the individual. These demands initiate the stress response of the General Adaptation Syndrome (GAS), described by Selye (1956). Every individual operates at a level of tolerable nonpathologic stress. This state of being contributes to heightened

functioning and performance when the individual maintains a balance between the first two stages of the GAS or the alarm reaction and resistance. When resistance cannot be sustained, stage three of the GAS, or exhaustion, occurs with an altered psychophysiological function as the outcome (Pellitier, 1977; Smith, 1979). At the exhaustion state the organism is experiencing the harmful effect of stress called distress. Complete freedom from stress is death (Selye, 1956).

Distress is inherent in advanced technological society. Positive or negative personal, social, and environmental factors require constant adaptation. Normal life events such as marriage, pregnancy, job change, or geographic relocation can cause exhaustion when all of the events are squeezed into a short time span (Holmes, 1967). Distress results from constant change, economic instability, drug or alcohol addiction, rapid communications, the idolization of youth, devalued spiritual concerns, and value and role confusion (Pellitier, 1977).

Pellitier (1977) believed that job stress was one of the most universal and intense kinds of stress. Job stress can arise from interpersonal conflict with superiors or co-workers, job dissatisfaction, responsibility overload, lack of support, unclear job expectations, and time pressure (Pellitier, 1977). Gerson (1979) proposed a feeling of being overworked as a job stress. Overwork is work which goes beyond one's ability to endure and recover from it; it is most dangerous to those who are self-employed, executives, or professionals.

Real or perceived harassment is yet another job stress. Harassment includes changes in location of the job assignment, humor and teasing, scapegoating, sexual harassment, or name calling (Gerson, 1979).

Symptoms of stress include psychosomatic illness, such as hypertension, insomnia, migraine headaches, asthma, hay fever, peptic ulcer, arthritis, alcoholism, heart disease, and cancer (Pellitier, 1979). Selye contended that humans often can eliminate the distress themselves once they recognize its nature. Therefore, humans can adjust the proportion of body adaptation between active defensive attitudes and measures of surrender in the best interest of keeping a balance (Selye, 1956). Humans can learn to manage the distress and cope.

Personality Structure and Stress

Based on the assumption that life changes may have their most adverse effects on individuals who perceive themselves as having little control over environmental events, a high degree of correlation has been found between life change, depression, and anxiety, and people with an external locus of control orientation (Johnson, 1978). Kobasa (1979) theorized that high stress/low illness executives demonstrated more hardiness as compared to high stress/high illness executives. That is, they showed a stronger commitment to self, an attitude of vigor toward the environment, a sense of meaningfulness, and an

internal locus of control. The executive with low hardiness responded to change with less sense of personal resources, more acquiescence, more meaninglessness, and a conviction that the change has been determined externally with no possibility of control.

Evidence exists that psychological characteristics do influence the occurrence of illness; health is more likely to be impaired by a sustained stress than by a short-term major crisis. Healthy individuals tend to have major life changes of short duration and to avoid the cumulative impact of prolonged life change (Hong, 1979).

Social Aspects of Stress

Social support is defined as human support accessible to individuals, groups, and the community. Lin's preliminary findings suggest strongly "that social support may be just as important as stressful life events, if not more important, in exercising an influence on illness symptoms" (Lin, 1979:116). The greater social support that an individual receives, in the form of close relationships to kin, friends, acquaintances, co-workers, and community, the less likely it is that the individual will experience illness. Social support factors most closely correlated to illness symptoms are neighborhood identification, feeling close to people, frequency of visiting neighbors, and job satisfaction (Lin, 1979). People with personal, familial, and interpersonal resources have significantly less depressive

symptomatology than those without such resources. These findings apply to both the low and the high life-event group (Warheit, 1979).

Experience with Stress

Examples of how experience with prior stress can be of influence on future stress is worth discussing. Meichenbaum (1975) suggested that the individual experiences a moderate level of arousal when covertly rehearsing the handling of a stressful situation. His contention was that this arousal prompts the emotional inoculation necessary to help the individual cope effectively with the stressor. Averill (1973) believed that even though information about a stressor may have value in helping a person cope with stress, such information may be effective only if it is validated by experience and if such information can be found to be effective in reducing objective worry following reality testing.

Differing types of past stress may have varied effects on individuals. Burgess (1978) pointed out that earlier victimization and chronic life stressors such as economic hardship, lack of social support, and pre-existing biopsychological problems tend to delay a person's recovery from rape. In contrast, family grief stress may act as an energizing coping factor. Coping skills of loss are developed through the grief process; such development serves to enhance the recovery from rape (Burgess, 1978).

Coping

The human response to stressors which prevents, avoids, or controls the emotional distress caused by the stressor is called coping (Pearlin, 1978). Pearlin (1978) proposed that humans have at their disposal major coping mechanisms, namely, social resources, psychological resources, and specific coping responses of the individuals' personalities. Psychological coping mechanisms can have a positive value, such as feelings of self-esteem or mastery, compromising, substituting, intellectualizing, or negative value, such as self-denigration. Other coping resources include denial, escapism, isolationism, and dependency (Pearlin, 1978). Longo (1978) suggested that social resources include interpersonal networks of which the person is a part such as family, friends, fellow workers, neighbors, and voluntary associations. From Goleman's interview of Lazarus (1979), the implication was made that some people's illusion and denial of stress may be essential at times of crisis. For many life stresses, such as surgery, no way exists for the person to change the situation; initially denial is healthy in these instances.

Pearlin (1978) identified three major types of coping responses which can be distinguished from one another by the nature of their functions. The first is a response that changes the situation out of which the stress arises, such as negotiation in marriage,

punitive discipline, and optimistic action. Among the second type are the responses that control the meaning of the stress after it occurs but curtail the emergence of distress. These responses include positive comparisons, selective ignoring, and substitution of rewards. Within the third type are responses that function for the control of the stress after it has emerged. These responses include denial, passive acceptance, withdrawal, magical thinking, blind faith, and worry or tension. Worry is believed to be the same as problem solving by the person using the mechanism (Pearlin, 1978).

Coping methods are uniquely individual; they are related to the individual's personality, to the perceptions of the stressor, and to the confidence in the coping method (Katz, 1970). Many researchers identified the complexities related to selection of coping methods such as personality structure, social structure, or past experience (Meichenbaum, 1975; Burgess, 1978; Hong, 1978; Johnson, 1978; Kobasa, 1979; and Warheit, 1979).

The suggestion was made that individuals differ in the degree to which they perceive environmental reinforcers as being under their personal control. People adhering to the internal control orientation perceive these events as being under their control. Persons with external control orientations perceive reinforcers as being the result of fate, luck, chance, or powerful others (Rotter, 1966). These facts clarify why some people actively or passively react to distress.

Contemporary coping mechanisms include nutritional maneuvers, meditative approaches, visualization, hypnosis, kinesiology, somatic approaches, and bio-feedback (Brown, 1974; Corah, 1979; Sutterly, 1979). As new methods are learned, individuals may use combinations of familiar coping mechanisms and newly acquired methods to deal with stress.

Effective coping is the use of a method that successfully deals with the stressor; through management of the stress the individual is able to accomplish problem-solving or mastery and avoid crisis (Monat, 1977). Pearlin (1978) believed that effective coping modes were unequally distributed in 2300 subjects in Chicago. This population was nearly one-half women and one-half men. Seemingly a pronounced imbalance was evident between the sexes in their possession and use of effective coping mechanisms. Of the women's responses, each of their coping mechanisms entailed selective ignoring which exacerbates stress in some situations. Men used problem-solving and rationalization when dealing with stress. Men appeared to have better coping mechanisms and were at an advantage since their coping repertoires are more potent in dealing with stress. A possible reason for the discrepancy may have been the socialization of the women. Age, however, did not seem to be a factor in whether a person used effective coping mechanisms (Pearlin, 1978).

An individual's coping mechanisms are more effective in

dealing with close interpersonal role areas such as marriage and child-rearing than in dealing with the impersonal problems in occupations (Monat, 1977). Coping failure is the use of a method which does not deal with the stressor or manage the demand; the result is internal distress and anxiety (Monat, 1977). "Coping failures do not necessarily reflect the shortcomings of individuals; in a real sense they may represent the failure of social systems in which the individuals are enmeshed" (Pearlin, 1978:18).

Folkman (198) found in a study of 100 forty- to sixty-year-olds that problem-solving type coping was the most effective in work settings. She further found that situations in which hope existed for change were conducive to problem-solving methods, whereas situations which have to be accepted were conducive to emotion-focused coping. The men in the study (N=48) used more problem-solving than the women (N=52) at work, in situations that had to be accepted, and in situations that required additional information.

Rural Nursing

Wickham (1980) identified the following stresses and coping mechanisms of rural nurses. The stresses identified are life threatening and critical situations, too much to do and not enough time or staff, conflict with other people, death and dying, administration's decisions, moral and value conflicts, nursing decisions and assessment,

mechanical and technical problems, chronic and elderly patients, and work hours and environment. Coping methods which were able to relieve stress were physical exercise, emotional expression, talking, religious practices, reassessment and setting priorities, withdrawal, relaxation, doing something different, drinking alcohol, coffee, and other beverages, using drugs, smoking cigarettes, and joking (Wickham, 1980).

Though many attitude changes have taken place, rural women continue to be stereotyped especially by nonrural dwellers. Rural women are viewed as ignorant, barefoot, and pregnant, or, in contrast, as strong, resistant, and self-reliant. The rural woman is viewed primarily within the context of the family and, more specifically, in relation to "her man" (LaGodna, 1981:18).

Rural communities tend to have working group characteristics. Whenever new members enter the community, group resistance has to be resolved, trust has to be established, and the power struggle has to be resolved. Finally, the individual who is now a member took on the focus of the group. Other characteristics of the working group include the use of disclosure, honesty, spontaneity, acceptance, cohesion, and responsibility (Corey, 1977).

The literature review provides a broad spectrum from which to assess the stresses and coping mechanisms of rural nurses. Community characteristics influence how these situations and behaviors are perceived and dealt with.

Nurses, Stresses, and Coping

Stress reactions and psychological burnout are, in all probability, one and the same. The nursing literature contains references to both subjects along with coping methods. Psychological burnout, a progression to disillusionment in the job, is one of the hazards of the nursing profession (Shubin, 1978). Nurses, doctors, social workers, and other helping professionals who are busy helping others tend to neglect their own needs. Balance in the nurse/patient relationship is critical for the prevention of distress. This ideal balance means that the helper retains objectivity and distance from the situation without losing the concern for the client (Shubin, 1978).

Storlie believed that burnout is "a highly personal happening inside the nurse; it is the literal collapse of the human spirit" (Storlie, 1979:2108). Nurses bring ideals and beliefs to the work setting; these constitute their internal reality. Situations can be tolerated so long as the most special ideals are compatible with work. Storlie lists ten nursing ideals, which, if they are compatible with work, would constitute utopia. They are having a voice in making or approving policies affecting nursing practice; having strong, consistent nursing service support; having comparable pay to other professions; having choice of shifts; having a variety of educational experiences; having to float but seldom to other areas; having the

respect of physicians; having the technological ability to give high quality care; having ample staff with whom to work; and having a reporting mechanism for physician problems or incompetencies (Storlie, 1979). Burnout is the resignation or surrender to the external forces of the job and to the lack of power; in other words, burnout is a giving up (Storlie, 1979).

Some situations nurses face are so common and so inherently threatening to the professional ideals of nursing that stress is the logical outcome. Such situations include the inability to give supportive care to patients, the inability to perform skills proficiently, and the inability to feel personally and professionally satisfied with the nursing care given. Since nurses function interdependently, what affects one nurse affects the group with whom they are working and the group coming on to work the next shift (Scully, 1980).

The socialization of the nurses mandates that certain behaviors are unacceptable to a professional nurse such as criticizing a patient, judging another's behavior, being disappointed, crying, showing anger, or admitting not knowing the answer to a question. Good nurses remain silent, accept everyone and everything, and ignore behavior. Continued tolerance of what nurses see as intolerable will result in physical and emotional depletion on the part of the nurse. Such attitudes fragment the self in such a way that the nurses' personal strengths no longer sustain them (Storlie, 1979; Scully, 1980). Stein (1968) tells about

the doctor-nurse game where the nurse is found in the mediator role in many situations.

Claus and Bailey (1980) documented the situational stressors and coping methods used by intensive care unit (ICU) nurses. Six situations were identified as being most stressful: presence of poor staffing patterns; need for an ICU nurse to work with a high percentage of inexperienced "floating" or medical pool personnel in a unit; families threatening to sue the hospital and staff; need for the uninformed family of a dying patient to be counseled by the busy ICU nurse; presence of a congested, busy, noisy ICU environment; and the ICU nurse with a personal crisis being required to work (Claus, 1980). Anderson (1981) suggested the death of a young adult, the doctor not available when an emergency arises, and working with a demanding physician as highly stressful situations.

Professional nurses' frustration that their formal education is underutilized on the job also was found to be a stressor (Kramer, 1974). Student nurses are socialized to expect that their roles as practicing nurses will include a variety of professionally valued demands, such as patient instruction and counseling and the planning and coordination of patient care. The general hospital, a most common employer of nurses, defines the nurses' roles as serving the system. The differences between the nurses' anticipation of their roles and the hospital's definition lead to the nurses' experiencing stress (Brief,

1979).

Nurses' symptoms of ineffective coping, as described by Shubin (1978), include distancing, such as spending as little time as possible with patients and referring to patients by their symptoms. Nurses work overly long hours and do not go home because there is too much to do; they begin to practice rigidly. Feeling physically and emotionally exhausted; developing negative, cynical, dehumanizing attitudes about the people with whom they work; feeling negatively about patients and guilty for feeling that way; and, finally, total disgust are prevailing thoughts of exhaustion. These feelings occur among staff and administrative nurses when they are exhausted.

Scully (1980) observed individual signs of distress. First to appear are the physiological indicators such as, anorexia, uncontrolled eating, urinary frequency, insomnia, lethargy, muscular tension, rashes, diarrhea, headaches, tachycardia, palpitations, tenseness, high blood pressure, trembling, nausea, increased perspiration and hyperactivity. Psychologically, one can feel disoriented, disorganized, angry, frustrated, depressed, apathetic, helpless, indecisive, afraid, irritable, withdrawn, or unable to concentrate. When allowed to continue, these persistent feelings can internalize into ulcers, myocardial infarctions, asthmatic attacks, depression, addiction, or psychoses (Scully, 1980).

Groups can exhibit signs of distress, too. These behaviors

include: scapegoating, argumentation, responding with sullenness or silence, exhibiting busy behavior, and intolerance of others' ideas or behaviors. Trends one sees in job behavior include absenteeism, commission of errors, inefficiency, and rapid staff turnover. When not recognized and dealt with, these behaviors deteriorate to poor morale, uncooperative behavior, apathy and paranoia; the result is a totally dysfunctional system (Scully, 1980).

Shubin (1979) recommended that nurses develop interests outside the profession to prevent professional burnout. Open, honest relations with colleagues are essential. Changing jobs may be the option. Most important is that the nurses believe in themselves and cling to those cherished ideals. Inner strength will withstand the forces of external reality; a good nurse can change the system (Storlie, 1979).

Scully (1980) offered a positive viewpoint by stating that nurses needed to learn to help stress work for them rather than against them. First, persons must recognize that they are stressed and become knowledgeable about the feeling. Next, they should observe when these experiences occur. After recognition of the feeling, control can begin. Controlling methods include relaxation exercises to drain off consciously the energy with a "decompensation routine," such as time out somewhere or exercising. Utilizing assertiveness skills, such as expressing feelings clearly and directly in a nondefensive way, is a great tension reliever. One can minimize stress production by

accentuating the positives, recognizing talents, cultivating meaningful relationships, and engaging in recreational activities (Scully, 1980).

Scully (1980) identified ten sources of stress for nurses, namely, group membership; losses from or additions to the group membership; conflict in goals; lack of staff; physician interaction; administration; less than supportive support services; caring for patients; perfectionistic expectations of self; and believing life is the only goal of nursing care.

Conceptual Framework

Stress, coping, and the culture of rural nursing provide the conceptual basis of the study. Stress, as defined by Selye (1956:5), "the nonspecific response of the body to any demand made upon it," indicated that the demands placed upon nurses in their job setting could be equated to stressors which cause stress to be experienced by individual nurses and nurses as a group. These stressors and the resulting stress mandate that nurses develop coping responses that effectively help them to manage their job situation. Pearlin's interpretation of coping--individual responses to stressors by preventing stress, avoiding the stressors, or avoiding the emotional stress caused by the stressor (Pearlin, 1978)--best fits the way that the researcher perceives how nurses cope with stress which results from

the stressors in job situations.

The nature of nursing practice leads one to believe that the stressors from the job situation are as varied as the job situations themselves. For this study the focus is on the rural nurse and the stressors and coping responses associated with the particular situation of being a rural hospital nurse. Little, if anything, is known about rural nurses' stressors and coping methods; therefore, to identify the stressors and corresponding coping methods associated with this specific culture of nurses is necessary.

Culture, as defined by Spradley (1979), is a group of people who have acquired knowledge and experience which then generated social behavior. The knowledge is shared through the developed cultural language. The researcher believes that by defining rural nursing as a distinct culture, one can obtain, via ethnography, insight into those stressors which evolve from the rural hospital situation. Further, the belief is held that by exploring the culture of rural nursing from the nurses' perspectives, one also can gain insight into the coping responses which help the alleviation of the resulting stress.

Chapter 3

METHODOLOGY

To gain information about the culture of rural nursing specific to the stressors associated with the job and the responses utilized to cope with these stressors, several topics were addressed. Baseline information about the rural nursing culture was needed for the formation of a rural nursing theory. Topics for exploration of the culture included the scope of rural nursing practice, patient population served, community medical complement, and job stresses and coping mechanisms of the nurses. To gain rural nurses' perceptions of job-related stresses and coping methods, the researcher selected the ethnographic research method as described by Spradley (1979).

Ethnography

Thoroughly enculturated members--ones who no longer have to think about being in the culture--had been members of the culture full time for twelve consecutive months or part time for three years, according to Spradley (1979). Current cultural involvement allowed the members to use the knowledge system to assess how new events were interpreted and how knowledge was applied to daily problem-solving and to review what is known. Members had a relatively narrow age span. That the researcher, ethnographer not be a member of the culture being studied was considered best (Spradley, 1979).

Open-ended questions were formulated to capture the richness of the cultural meaning systems. Descriptive questions elicited cultural language from the informant; as, "Can you describe . . . ?" Structural questions helped the researcher discover cultural domains, as, "What stresses you in your job?" Contrast questions helped the researcher to arrive at meanings, as, "What is the difference between . . . ?" (Spradley, 1979).

The ethnographic interview had three elements, namely, its explicit purpose, ethnographic explanations, and ethnographic questions. The researcher clearly stated the purpose as the interview proceeded and throughout any succeeding interviews. Ethnographic explanations included a clarification of the study, method of recording, and reasons for seeking answers in the informants' own words.

Ideally, several interviews were conducted with each informant to validate their meanings of the language, actions, and artifacts. It was preferred that the informants not answer questions in ways they believed they should answer; rather their answers flowed spontaneously in the cultural language. Verbatim recordings were made on magnetic tape or on paper as the informant spoke, with notations of behavior or use of artifacts collected as the informant talked (Spradley, 1979).

The written report of the ethnographic research, an ethnography, contained the researcher's prepared translation of the cultural meaning systems, behavior, and artifacts into the language of the

report's recipient audience. Data analysis involved the discovery of central themes, the identification of the specific use of symbols or words, and the formulation of inferences about the relationships of these items. Verbatim language recording, along with general observations about social, geographic, and psychological environments of the culture, were included in the analysis. Specific inferences about the cultural meaning systems were concluded finally (Spradley, 1979).

An assumption made by the ethnographic method was that cultural members consistently will use words in the same manner. Consequently, small numbers of informants are acceptable for research with this method. The phenomenon of repeated answers between informants is observable in as small a sample as five to ten informants who are fully enculturated.

A limitation to the method is the amount of time required to conduct the interviews. Persons should feel comfortable and free during the interaction, thus mandating that a block of time be dedicated to the activity. The researcher needs to enter the cultural environment; this entrance can mean additional time for travel as well as additional monetary expenditures.

Another limitation is the researcher's diminished objectivity when he/she was a member of the culture that was being studied. Assumptions about words are made more easily with missed inferences occurring when one is a member of the cultural group.

The focus of the study was maintained by asking each of the twenty-four informants these two descriptive questions: (1) "What stresses you in your job?" and (2) "How do you cope with these stresses?" The responses by the informants to the questions of the researcher were recorded on paper by the researcher as the informant replied in order to insure verbatim recording. In addition, the researcher took notes of the key points and made specific notes of body language, of behavior, and of the employment of artifacts as the informant spoke.

Demographic information requested for the study included age, sex, educational preparation, nursing position, number of hours worked per week, and amount of time the person had lived and had worked as a registered nurse in the rural area. All questions were answered by all of the informants.

Interest in participation was the major criterion for selection of the informants. The criteria by Spradley (1979) for informant selection, namely, length of time spent in the culture and age range, were considered; however, the entire population of rural nurses available was very small. Consequently, a deviation from strict adherence to Spradley's optimum criteria was considered necessary. The rationale for inclusion of new members of the rural nursing culture in the sample was that they added knowledge of contrasts they experienced

between rural and urban nursing

Protection of Human Rights

The protection of human rights, assurance of anonymity, no identification of individuals and consent to participate was paramount. The study was submitted and was approved by the Human Subjects Review Committee of Montana State University, Bozeman, Montana (see Appendix A).

Prior to being interviewed, informants read, signed, and dated the consent forms. The consent form (see Appendix B) indicated appropriate information about the study upon which the potential participant could base a decision of whether or not to participate.

Sample and Setting

To identify potential informants for this study, the researcher sent a letter which described the researcher and the study. In addition, the researcher requested permission to hold a meeting of registered nurses in each institution to nursing service administrators in four rural hospitals in central Montana (see Appendix C). One week after the receipt of the letter, the researcher called the nursing service administrators to arrange a meeting with interested nurses. Meetings were held at four rural hospitals. Appointments for individual nurse interviews were scheduled during two of these meetings;

individual interviews were conducted following two of the general meetings.

Data Analysis

Analysis of the data began with a general reading of the answers during which the researcher watched for the spontaneous emergence of themes and phrases from the responses. No preconceived categories for stresses or coping methods were formulated prior to the analysis. Each informant's response then was listed by verbatim phrases under the general category of stresses or coping method. Many answers contained more than one theme. The number of times each theme or phrase was used was counted. When responses were difficult to categorize, the researcher utilized voice inflections and body language to assist in placing the response appropriately. The theme received single status when it did not fit with any other response. Some themes were mentioned by only one informant. The researcher chose to include these themes because her cultural experience indicated that the theme was a common concern of nurses.

Cultural, environmental, and situational considerations followed the responses of the informants. These situations have an important interface with the rural nursing culture and the behavior of the membership. Discussion of how these situations influence the culture was included in the body of the paper.

Lastly, inferences were made about the culture. Implications for future study and possible management techniques were listed. Finally, recommendations for the education of rural nurses were identified.

Chapter 4

RESULTS OF THE ETHNOGRAPHY OF RURAL NURSING

For this study the ethnographic data results were organized in the following sequence: demographic data; stresses; coping methods; cultural, environmental, and situational influences on the culture; and cultural inferences made by the researcher from the data. Many verbatim responses are included in the sections on stress and coping methods.

Demographic Data

Twenty-four rural central Montana registered nurses volunteered to participate in this study. All elected to reveal the demographic data requested by the study. (Appendix D is a summary of these data.) The overall age range of informants was 23 to 67 years of age. The age range for staff nurses was 23 to 61 years with the mean being 36.6 years. Age range for directors of nursing was 48 to 67 years; the mean was 56 years.

All twenty-four informants were women; therefore, the feminine pronoun she will be used in the report. Educational preparation and nursing positions are expressed as the nurses described them. Thirteen identified themselves as staff nurses: one had an associate degree in nursing; one had an associate degree plus a four-year degree in teaching; two had associate nursing degrees with additional credits

toward a baccalaureate; two had a diploma education; one had a diploma, one year of college, and a certificate in nurse anesthesia; three had diploma educations with courses toward a baccalaureate; and four had a Bachelor of Science (B.S.) degree in nursing. One identified that she was a charge nurse; she had a diploma education. One staff nurse worked in a doctor's office; she held a B.S. in nursing. Two held staff nurse/head nurse combination positions; both of them had B.S. in nursing degrees. One stated she was a staff nurse/janitor combination and held a diploma in nursing education. Another had a staff nurse/operating room nurse combination position; she had a B.S. in nursing. Two directors of nursing held diplomas in nursing education and one had a diploma plus two years of patient care administration education. One held a hospital administrator/director of nursing position; she had a diploma in nursing.

The amount of time the nurses had lived and worked in the area ranged from one month to thirty years. Staff nurses and the charge nurse had lived and worked in the area between one month and nineteen years; the average length of time for these nurses' stay was 7.26 years. The average length of time worked by the staff nurses was 3.68 years. The directors of nursing had lived and worked in the community for the same length of time which was between 13 to 30 years. The average was 21.25 years.

The demographic analysis revealed that seven of the 24 rural

nurses were under the age of 30 years. Directors of nursing--four in number--were over the age of 40 years. Males were strikingly absent from the scene. Staff nurses who held dual job responsibility held B.S. in nursing degrees. Only 23 percent of the 20 nurses who were staff nurses had B.S. degrees. Staff nurses had not lived in the community as long as the directors of nursing.

Frequently Cited Stressors

In answer to the question, "What stresses you in your job?" the following large body of verbatim responses was gathered. The responses evolved the categories of short staffed; physicians; physical exhaustion; competency; hospital administration; coronary care; taking care of friends; unknown; education; lack of experience; paperwork; equipment; and singly voiced stresses such as moral issues, anonymity, and cannot work in the area of choice. (Appendix E shows the listing of stressors.)

Being Short Staffed

Twenty-three nurses expressed stress centered around staffing, being short staffed, being the only registered nurse (RN) on duty, not having enough time to do everything, and feeling like a "Jack-of-All-Trades-and-a-Master-of-None." They expressed a concern about the quality of care while talking about the staffing ratio, indicating that

both issues were related. Responses in the nurses' own words follow.

"I'm from an urban, metropolitan hospital. To me a 200-bed hospital is rural. The fact you are the only nurse, the only RN is stressful. You are responsible for everything. You need to be knowledgeable in all areas from the Emergency Room (ER) to the operating room (OR). You feel like a 'Jack-of-All-Trades-and-a-Master-of-None.'" A second put the situation this way, "The fact you have to divide yourself three ways as the only RN in the whole hospital is stressful. You may have eight patients on the floor, four in the ER and cover the nursing home at the same time." A third said, "When you have someone in the Coronary Care Unit (CCU) and an obstetrics patient (OB) comes in, if you are expected to be in both areas, it is stressful."

This nurse said, "When you have 81 patients to watch and you are the only RN on, you are concerned about the care. That's a lot of people to watch and know about. You have to know them; they don't know themselves." Another said, "Staffing is spread so thin; you have to cover both the hospital and the nursing home. It isn't fair to the nursing home; they get second class care. The emergency room and hospital have to come first." "You worry about the quality of care they are getting," another said. "You can't supervise every patient's care every day. Sometimes you go in and wonder what has been done. You are working against the time element. An aide may have told you someone was not feeling well at the end of the hall, but you aren't

able to get there. Or the patient went to bed at noon and is still sleeping. You wonder if they're dead!"

As the nurses spoke, the researcher noted feelings of fear and tiredness. Sighs were uttered as they spoke; at times their heads would shake.

Physicians

The second most frequently cited stress was physicians. Thirteen informants shared this information. One said, "Physicians are a sore spot. Patients are left here who should be sent to [the urban center]. They are not being handled like I think they should be, from my past exposure. For instance, a patient comes in the ER. I examine the person; call the doctor, and give him the pertinent information. Eighty percent of the time from my experience he will order a medication or make a diagnosis from my verbal description, just from what I see; he will not even come in to see the patient. I have strong feelings; as a person comes to the ER, that may be the only opportunity that person has to see a physician. They pay the ER fee; they're entitled to at least a cursory visit by the doctor, not the nurse. The physician often knows the family name. He will say, 'Oh, those people! They are probably drunk or high on drugs.' He makes a judgment before he sees the person." Another said, "It is a fine line for the nurse to try to walk, that narrow line between diagnostics and

evaluation. Is it serious enough to call the doctor now or hold off?" Still another said, "It stresses me in this hospital when you have an OB. Some doctors say, 'When she is dilated to thus and so, call me.' Some doctors live 15 miles or more from here so if it's a 'multip,' you could deliver the baby; the doctor would not get here in time. I do not like the responsibility of a delivery of a baby."

The nurse seemed frustrated as she said, "Things here are done in an old-fashioned way. Before, a lot of the things I had done for the patient was nursing judgment. Here I have to call the doctor for everything. There isn't good use of the RN staff. I wonder why I learned all I did; I can't make any nursing judgments here anyway!"

Another nurse said, "Anybody who runs a little hospital has the stresses of the doctor; you know how doctors are!" A third said, "In the rural community the physicians begin to believe they are half hospital administrator and half education director. You know what I mean. They have their finger in every pie in the hospital. Then I have a hard time evolving any kind of changes. Nine times out of ten it comes to a physician who thinks he is an expert and demands it be done like it was done before or done elsewhere."

Nurses said they were caught in the middle between people, between doctors and other staff, between doctors and families, and between doctors and policies of the hospital. One informant said, "Times when it is hardest are when you are dealing with communication,

when the nurse is caught between the lab and the doctor or the doctor and aide. Everyone has worked his hardest and the doctor comes and says, 'Why isn't this done?' I feel like the middle man. I feel crunched!" Another said, "When the patient's condition has changed, you think the doctor should come to see them. Then if the family thinks the doctor should come and see the patient, that puts pressure on the nurse to get the doctor to come." A fourth informant said, "Then the doctor does not want to be on call. He walks in, is mad, and implies it is the nurse's fault. She is caught in the middle; she has to make excuses to the patient for the doctor." The last mentioned physician concern was expressed by this nurse, "The referral thing is a big problem. It puts the nurse in the middle, especially if you are knowledgeable enough to know that someone should be referred."

The researcher noted several types of body language while the informants talked about the physicians. The nurses would roll their eyes when they would say, "You know what I mean!" They would move about in their chairs as they told about the responsibility of relaying their observations to the doctor and their having to deliver a baby.

Physical Exhaustion

Inherently nursing is physically exhausting. When long hours, rotation of shifts, and no available sick time and vacation relief coverage were added to the inherent physical demands, the expectations were overwhelming according to the responses. Eleven informants

revealed these data. The first said, "I do not like to work nights; I just do not sleep well. But I have to take some turns at it." Another said, "Nights are not easy, but when I went into the profession, I knew it was a twenty-four-hour concern, not just eight." Still another said, "I get tired by the time the fifth day rolls around." Another commented, "There is no opportunity to leave the floor for breaks or lunch. If you happen to have the time, you can't leave because you are the only RN there." A new employee said, "Shift work is more physical stress than emotional. I am the newest employee, so I work all three shifts. I always work two shifts a week and sometimes three. It is really exhausting!" Another lamented, "Not being able to get sick time is real stressful. I am sick and tired of coming to work sick and tired." Lastly, an informant said, "We have one RN who stays through the entire labor unless it is over 20 hours long. I have helped in a labor 16 hours and had to stay for the delivery. I get stressful when I am tired and am belligerent then." The nurses heaved sighs while they spoke of the physical problems.

Competency

The informants felt frustrated by being short of staff; but nine also felt concerned about the competency of the staff. One said, "It is hard enough to have short staff and be the only RN on duty, but added stress comes from not being able to trust the competence of your co-workers. We have a number of aides; some of them are very

experienced and dependable. When they work, you have an extra right arm. But the other two-thirds, you can't count on them. They have no Cardiopulmonary Resuscitation training; they don't know where stuff is at. When you come to work and know you can't depend on the people you are working with . . . that is stressful!" Another informant said, "The aides are older . . . they have been here twenty years. They don't keep up with changes in nursing. They don't think there are advances in nursing. Nursing is nursing and it always will be. And a sixty-year-old aide doesn't take orders from a twenty-three-year-old RN very well. The younger aides are easier to work with." A third informant related, "One thing that stresses me is the lack of properly trained help. An aide should be able to get the Mangenstein or attach the patient to the monitor. An RN should not have to do that." This nurse said, "Another stress is that I see my peers as not working at growing professionally. They are at the same place they were . . . years ago. They are not willing to accept new or different ideas. There is seeming unawareness of what is going on in the profession. They seem to be up on the legislation but not new ideas of patient care. That is what is important to me." But another said, "Not all these new theories of nursing are for the betterment of nursing care. They are not necessarily better. Just because it is new does not make it better. After all, we are not a progressive hospital." There seemed to be some varying opinions regarding the knowledge

necessary for practice.

Hospital Administration

Hospital administration posed conflicts with definition of nursing practice for eight of the informants. This nurse told, "The RN has little say about where the money is spent. When there is equipment you feel the need for, like there are only two high low beds in the place and the autoclave is not dependable, you go to the administrator. He goes out and buys a time clock and an intercom, both of no help to the nurses, only to help the office personnel during the week You are not asked. You have no voice. When asked, it make no difference. You cannot get them to understand it; you can't give the care to the community, the patients will not come back. Then there will be no hospital and no job!" Another nurse said, "There is a lack of communication with the administrator. He never plans his time so it fits with mine, so I can't even see him." The third informant said, "I feel administration doesn't see the operation of the hospital as a business . . . there's a lot of equipment being sold by fast-talking salesmen. The administration has the inability to see what the most important pieces of equipment needed." Lastly, this nurse said, "I don't feel the new system or chain of command is in the best interest of nurses. Everything has to go through the administrator to the board of directors. In more situations that is not always necessary.

Another informant expressed these concerns about hospital administration. "I really did not want to go to work in the hospital. The hospital has the attitude that once you have agreed to work there you lay your life down on the steps of the hospital. There is a larger degree of commitment they expect. The nurses are very self-sacrificing there. They put the hospital before their personal life. Frequently, you work more than eight hours, almost every day. Almost always the nurses do not write down the overtime."

Tension between the ranks of administration fit under this category. One nurse said, "There is tension between the director of nursing and the administrator and it gets passed on to the rest of the staff. The administrator has his problems and gets the director frustrated. The frustration is passed on to us. You are in the middle and feel frustrated. One says one thing and the other says another. You do not know where you are going." Another confided, "In small communities there is a high incidence of short-term administrators. They are on their way up. When they are any good, they are gone in two years, so you start another generation again. You have to adjust to the new person and find out what is expected of you." These informants sighed while talking about the situations.

Coronary Care

Specialty units were kept available in the small community

hospital. Eight nurses related their feelings about the service. One said, "One stress for me is CCU, because I feel inadequate. I do not feel like I could not handle a cardiac arrest, but I just don't know what is going on on the monitor. Bad cardiacs are sent out, so you don't get a chance for follow through and to learn while working." Another said, "CCUs here are kind of stressors. The doctors have a kind of standing order. It would be nice to have a physician in the hospital to pop in and see the patient, especially one who is critically ill. But the RN is left to giving certain meds; well, that is fine, except not all cases are cut and dried. Just because you are to give this and give that, it isn't always all right." A third nurse said, "The monitors and coronary care stress me because I don't know about them. But I would just as soon not learn, because I am not really interested. I don't like to react fast because I am a slow-moving person and coronary care is not my area of interest." "Your skills become rusty; maybe you see an acute coronary once every three months," the fourth nurse related. These nurses voice concern about their keeping competent under adverse circumstances where their skills were not used frequently.

Taking Care of Friends

Taking care of friends was a stressful situation discussed by seven nurses. One said, "One thing that is a lot of stress is going

through labor with friends. I don't think I will ever do it again if I can get out of it!" A second informant said, "In a small town like this, the patient who comes in the door or by ambulance 90 percent of the time it is someone you know. If something goes wrong, such as loss of a baby, you have to go out and face the family, friends, and neighbors, people you see every day." Another said, "There is a lot of stress in the care of patients who are your next door neighbors; you have to fight to be objective. It is hard to care effectively." Last, this nurse said, "It is hard to make out the schedules and try to control all the employees. They are your neighbors and social contacts. It is hard to play cards with a person one day and have to call them into your office the next day to tell them they are not doing their job. It is hard to be effective in the role."

This nurse expressed another problem with the public. "It is difficult with the public, sometimes they do not understand. The situation may not be a real emergency, such as the child has been sick; now it is 10 p.m. and they bring the child to the ER. Then they do not understand why the doctor does not come, especially if they have not lived here a long time." The informants recognized the difficulty they have in caring for people who are well known to them.

Unknown

The fear of the unknown bothered six of the informants. One

said, "The biggest stressor is when you walk through that door. I find myself hoping I will not have to choose where I am needed worse, for an OB or a cardiac!" The second nurse said, "The unpredictability of your day is stressful. You can come in and have two hospital patients and 60 nursing home patients. You can have no ER patients or eight or ten." A third nurse said, "Outpatients are stressful. You spend more time worrying about what might come through the door."

Education

Six of the nursing informants discussed their frustrations about having been taught to make nursing judgments and then not being allowed to practice the skill. The first nurse said, "You find out your education was not what you thought it was. You have to go back and learn again. The heart patients are not the same; it is all different. Practice here is not like it is in a big hospital. There are not many people to call." A second comment was, "They do not make good use of the RN staff. I wonder why I learned all that I did. I cannot make any nursing judgments any way." Another informant said, "When the census is only one or two, you do not have a lot of work to do. Because of that you tend to feel that you are not working to your capacity or using your education to your utmost." Then, too, the nurses were concerned about their usefulness at these particular hospitals.

Lack of Experience

Though five of the informants expressed stress from a lack of experience, they did not go into any detail about the subject. The phrase was used with no further discussion.

Paperwork

The paperwork requirements at hospitals were mentioned by five nurses as stress producing. One said, "The classic stressor is paperwork. You have no ward clerk, so the RN has to do everything. You take off all the orders, make up the Kardex, plus chart everything. The aides don't chart." Another said, "You get bogged down in paperwork which takes your time and attention away from patient needs and attention he deserves." According to this nurse, "There is no ward secretary, no central supply room (CSR), you have to make records of all supplies in notes. You answer the phone; I think they are using people, making money off of RNs. There are tons of paperwork. Then you are told, 'You are now the new . . . nurse. You can do that work too!'" The nurses shook their heads as they talked.

Equipment

These comments about equipment showed the cross-section of concern by relatively new employees who were uncertain about the function of the machinery and those who had worked elsewhere with better equipment or readily available service. One concern was,

"The maintenance of supplies is a stressor. You just cannot call the service department and have someone stop by. You may have to wait weeks or months to get someone to work on the broken or nonfunctioning equipment." A second said, "Knowing you have to handle whatever medical problem that comes up with limited equipment is stressful. Obviously, there is not enough money to buy fancy equipment." And, last, "Working with this new equipment is stressful to me." Each nurse had a different view of the equipment problem.

Singularly Voiced Stressors

Moral Issues

Only one nurse expressed this stress about the decision to support life or let death occur with dignity. "There is a moral issue to deal with. You get attached to the babies. You know that they are vegetables; you do not want them to die. It would be the kindest thing that could happen. It is hard to let them go when they should. It is like we are keeping the child alive for us. Yet you can't stand by and not do something."

Anonymity

Being known by everyone seemed to be a burden faced by two nurses. The first said, "I think it is really time someone understood what we are doing. I had never worked in a small hospital. How much

the people in the community depend on you! That is lots of responsibility and it equals lots of stress. It is peculiar only to rural; on your off hours people see you on the street; you can't go out in your old sloppy shoes. I am aware I represent the hospital 24 hours a day. In the big city, you have a lost identity; you get lost into the framework. Here you are on display." The other nurse expressed a different angle by saying, "In a hospital this size, the lack of anonymity is a real stress. The director of nursing and administrator each says it is not their responsibility when problems are brought to them. If a nurse gets no satisfaction from the director of nursing, the next recourse is the administrator. I know the director of nursing so well and the situations we are in that I do not think I could go to him (the administrator) with problems, because the director of nursing will take it too personally." Two problems were presented by the informants about the lack of anonymity in the small community.

Cannot Work in the Area of Interest

One nurse voiced her frustration at not being able to work where she preferred to work. This comment is frequently listed as a stressor by nurses outside this study. The nurse said, "One of the biggest things that bothers me now is that I cannot work in my chosen area. I see it as available; there does not seem to be enough coverage. I get down to that end only every three months. It is

geriatrics I like. You just pass a few pills down there and that is the extent of it. Things I perceive down there as needs, I cannot do anything about. That is real frustrating to me."

These categories of answers concluded the responses that the nurses gave to the first question of the study. Next, the coping methods will be considered.

Frequently Cited Coping Methods:
Subjective Presentation

The informants' answers to the question, "How do you cope with these stressors?" fell into natural categories (see Appendix F). The coping methods are arranged in the following manner: talking; leaving work at work and forgetting it and going on; helping one another; using expressions of despair; setting priorities; using assertive skills; doing the best you can; attending educational offerings; solving problems; engaging in outside activities; experience; smoking or drinking alcohol; crying; praying; joking; and using patience. Verbatim responses revealed the richness of the culture.

Talking

Talking was the most popular method of coping used by twenty informants in this study. Talking occurred in groups at work, with the family, with other RNs, with the director of nursing, in professional meetings, with oneself, and directly with persons involved in the

creation of the stress. Several people mentioned the use of more than one talking technique.

The first informant said, "Talking to my husband is my major outlet. I can count on anything I tell him will be kept in confidence and the same applies to me for his concerns. I know nothing will go past him. Being able to ventilate at home is one of my best outlets." Another said, "I do talk to my husband about my peers and how I feel about things. He knows these girls, so that helps; he listens well. I do not know if he understands, but he listens." The third nurse said, "I talk it over with my husband. He gets a lot of the brunt of things before it is resolved." Another informant said, "Talking with my husband and other friends helps." Still another said, "I am fortunate to have somebody to confide in and get rid of it [stress] that way." This nurse confided, "I take it [stress] out on the people I care about at home. My family has adjusted, or not adjusted; they may have been damaged. Men resent the demands of nursing. 'Why can't you get off at three o'clock?' They are a very understanding family. They are not sitting there steaming when I come home late; they know when I want to talk and when I don't want to talk."

Talking with other professionals was the second most popular talking outlet. This type of talking occurred at work, at the change of shift, over the telephone after work, at professional meetings, and with the director of nursing. One said, "Good peer and interpersonal

relationships gets us through. We enjoy one another a lot. In a bigger place, you have more people on a rotating basis and it is not so necessary to have good personal relationships. But in a small place, the relationships are intense and you spread your feelings to them."

Another informant said, "There is good communication between the professional staff and that helps. There is pretty good rapport with everyone we deal with. We feel free to call each other and discuss our problems. We do not have too many staff meetings, so we call each other. We feel free to do this." Another related, "I talk to the director of nursing about problems, not friends; they would get the wrong impression." This nurse said, "When we get mad, we talk it over and over and over among ourselves. But the feeling does not get less, so we have to go further." Another said, "I ventilate at the staff meetings, when we get together. I might ventilate at report about my busy day, but I am usually busy with so many things to get caught up and the nurse coming on does not have time, so it passes." Another lamented, "I certainly have voiced concerns to the director of nursing and the hospital administrator regarding concerns I have regarding the lack of staff to provide quality care. There is no change. So I have sought ways to cope for myself by limiting the number of hours I work." Another related, "I mostly mutter and grumble, bitch and moan about the administration; that is one way to relieve the stress." Another coped by saying, "I talk to nurses; some of them I am close

with. I air out my feelings. Then I listen to sympathy and again face my own feelings. You get it out of your system that way." Another said, "We try to have meetings when things get difficult and discuss what is happening. We air our feelings; then everyone settles down. That is how we cope." This nurse related, "I went to the director of nursing, explained what was going on, and explained that it was her responsibility to do something about it. I charted in the nurse's notes that I have discussed it with the director of nursing. Then I took out a large liability insurance policy."

Others talked directly to the ones concerned in the stress production. One said, "When I feel crunched, I usually let people know how I feel. At first I could not do that. It took a while to get to know people to know what I could and could not say." She went on, "The doctors understand that when the stress level in the ER is up and they need to tell me what to do. I have talked with both of them. I told them my brains go out the door when I am under a lot of stress; at that time they need to tell me what to do and I'll do it."

Another informant handled things this way, by saying, "With the aides, I let it build up until I am completely justified with my criticisms. If they do not come through after subtle hints, we then have a talk, with good results." This nurse related, "I am not an avoider of conflict, so in relationships with aides, I do deal with them. The outcome is not always good, but I do try to talk it over."

Others talked to themselves during stressful circumstances..

The first nurse related, "I had a myocardial infarction (MI); through rehabilitation I learned not to let things bother me. I think things through. I used to be a perfectionist; now I am not so picky anymore. I have learned to be more relaxed." Another said, "I do a lot of introspection. I feel free in being myself and can say 'I do not know how to do this,' so I ask the doctors. They give a lot of answers; they enjoy the teaching role." Another said, "I try to feel good about what I am able to do rather than badly for what I am not able to do." The last nurse said, "I had hoped not to be quite so slow, but I will get it eventually."

Leaving Work at Work; For-
getting It and Going on

Leaving work at work and forgetting it and going on were phrases sixteen nurses mentioned as coping methods. The first said, "Just forget what is said and go on. Keep the situation in its proper perspective. You do the best you can under the circumstances and try not to let it eat at you." Another disclosed, "I hate to tell you; I ignore him sometimes." This nurse said, "I have learned not to let most things bother me. A lot of it [coping style] is my personality. I have always not done any shop talking on the outside. I try to forget it and leave it behind." The researcher sensed some feelings of ambivalence from the informants toward the coping methods. Some felt

positive relief from the method; others used it because they could not identify any other method to use.

Helping One Another

Helping one another was the third most commonly used coping method, being used by fourteen informants. One said, "We do not put in a lot of overtime. The professional staff works well together. If someone is running late, someone else steps in to help." Another said, "I get help from the director of nursing and the rest of the staff helps a lot." This nurse was comforted by the fact that "All the RNs come through in a pinch. If you call for help, they will be there. They stay later for no pay to help the next shift with a car accident. They all know that the next time it might be me." Another confided, "We are all close to one another. We do not leave one another alone; it is like a big family." Another's comfort was, "I have had to call someone (RN) and wake them up to help. They have never refused. I would do the same myself for someone else." Lastly, "The best thing [for coping] is that there is always back-up nursing support. In a tight spot you can call them and they are always willing to come or to talk to you by phone."

When describing communication with the administration, these nurses shared these relevant situations. First, "There is much more cohesiveness between hospital staff, hospital administration, and the

Board of Directors regarding the doctors and how much trouble we are having. . . . There has been a political turn around." A second nurse commented, "As a group [of RNs] we tried to go to the Board of Directors last month. It didn't make any difference. Now we plan to write to the company that runs the hospital." Another said, "I am helping cope with administration by being supportive of the group staff effort to make the board aware that things are not changing. We are trying to educate the board; they are not aware of the specific problems." This nurse concluded, "We need to stick to what we believe in. We still have a right to voice our opinion together. What we need is more power and to let them know certain things are a necessity." The coping methods were in combination in the answers much like the stresses; coping methods interrelated with one another.

Using Expressions of Despair

Some of the coping methods conveyed despair. Fourteen informants mentioned methods of this nature. One said, "I get angry at the staff sometimes for not showing up. I try not to portray it to them; I just keep it inside." Another said, "I do not talk about my frustrations. No! I really do not have trouble with people. I just hold it in." Another related, "I do not like to do things with less quality and what that encompasses. I have adjusted to the fact I cannot do everything and so I make do with what I have. I have said it over and

over; my options are if I cannot live with it I have to quit or realize this is the reality, the shortage of staff in a small area and make suggestions of how to improve the care under the circumstances." One nurse said, "I am almost at the point of quitting." Another said, "I don't know how we cope. I don't understand why we don't walk out! I have left the hospital to go to do work in a nice quiet doctor's office before." This nurse lamented, "Because of the incompetent staff, I do a lot of things myself that I should not have to do. I check behind them. I try to give the patients care, but I feel the need to check up on the staff. That puts me behind and I stay longer than I am supposed to." This informant coped by saying, "Lots of times I have to pull a shift. I put in a lot of extra time." Yet another got help from others; she said, "Sometimes I get the doctors to help me with problems with administration." This nurse said, "When I have had problems, I ask the supervisor to talk to the doctors." The informants clearly conveyed sadness regarding these issues.

Setting Priorities

Setting priorities, organizing, assigning staff, and working with the staff were coping methods used by eleven informants. An initial comment was, "You set your priorities or determine which person needs your help the most. Then you work with the staff and put the one most capable in the area needed with that patient. The aides are

exceptional here and also the Licensed Practical Nurses (LPNs). They can work in all areas." This informant described her coping by saying, "Assign your help, let them do as much as they are capable of. If the patient on the monitor is not too bad, you can put the aide with them. In the ER if there is nothing serious, you can let the office girl fill out the forms, let the aide get the vitals, and the doctor can see the patient." Another nurse said, "Through the course of the shift when you have a spare moment, you prepare for the next moment. You never know what will come and if you wait to be organized you will not have the time." This nurse related, "I come in early to get on top of things." Still another said, "I always check the ER that I have the blood pressure (BP) cuff, stethoscope, and basic equipment there." Another lamented, "Initially, I feel, 'Oh, no! Here goes another anxiety-ridden day.' My stomach knots up and I feel myself becoming irritable. I take a few deep breaths, tell myself 'You have made it through this before'; and I guess I spend the first 10 to 15 minutes getting organized, setting priorities, talking with the aides in their priorities for the team for the day. If not everyone gets a bath that day, they will be first to get one tomorrow." A further comment by this nurse was, "You have to set priorities, but that means that someone is at the bottom of the list and someone is at the top. Those at the bottom of the list are not getting the care they should get."

Using Assertive Skills

Assertive coping skills were used by eleven informants. The first comment was, "I just plain refuse to do some things I do not think are nursing care, like cleaning equipment, wrapping packs, running the autoclave, and doing CSR work, in order to get my work done. I refuse to clean the delivery room after a delivery; they can call the cleaning people after hours to do that. My salary offer was not acceptable. We had a three-way conference. I am trying to get the salary increased for rural nurses. . . . I am trying to keep the lines of communication open even though we do not agree. I always write down my overtime. . . . I trade work days or find people to cover for needed time off. I plan to become more assertive in terms of patient advocacy. I made a decision to be an advocate and tested it out. I think the results were rewarding. I thought I would get fired but no one did." Another said, "I am on the verge of refusing to cover the nursing home, but I have not quite gone that far yet." To cope, this nurse relayed, "I try to offer a viewpoint the gossipers may not be seeing. When comments are made about someone, I try to diffuse it by saying, 'You may not have all of the story' or 'This is not the appropriate place to talk.' I try not to participate, but being human that is not always easy to do. I try to be cheerful at work and not bring my own problems here." This nurse shared, "With doctors, when I see something I think they should be doing or check, I check my fact well

in the Physicians Drug Reference (PDR) and nursing books; I make sure I know what I am talking about. Then I call them and ask them if they want to do something about the facts I give. . . . When they do not follow my suggestions, I watch the patient a lot closer. And then I pray, 'Should I have done more or tried harder?'"

Doing the Best You Can

Another category of coping discovered was doing the best you can. The informants did not elaborate beyond the phrase, "Just do the best you can." The feeling conveyed by some of the informants was that they have a positive attitude and hope to do the right thing at the right time. Some of the informants seemed to feel good about the coping method. In addition to those who felt the coping method was positive, some did not feel it was effective viewing it as the only thing they could do.

Attending Educational Offerings

The rural nurses coped with their professional isolation by attending inservice classes when available, by subscribing to journals, and by going to the urban centers to observe and work in areas of need. One nurse said, "I study a lot to cope with the stress of not knowing." A second nurse said, "I look things up and try to deal with each person as they are admitted. I do not try to know it all." A

third nurse related, "I have just tried to expand my reading and get more knowledge. I do not feel I know enough." This informant suggested, "I subscribe to three or four nursing journals and skill books to cope with the lack of continuing education (CE). I have also asked to have CE brought here." The fourth nurse said, "I'm going to [the urban center] to work in an intensive care unit there so I can learn about the monitors."

Working with the co-workers to increase their knowledge and skills assisted the nurses to deal with their own stress. One said, "When the aides need some help in learning, I take them with me and try and show them the right way or just how to do it, if they have never done it before. Then I test them: 'Do you know what to do if _____? Name the item. Do you know where to get it?' I get them to think about 'if you were called upon, what would you do?'" Another said, "I am giving an inservice to the staff about my own particular areas of expertise."

Solving Problems

Problem-solving offered practical solutions to stressors. One said, "Before I call either doctor, I do a complete physical to get as much pertinent information about what is going on. When he says, 'Oh, that's _____', I ignore the comment and go on with the facts. I have not been here too long, so I treat each person as having a legitimate

complaint until proven otherwise. I think if you do set that type of example, maybe it will rub off. One time I did tell the doctor that even though a person was drunk, they could have sustained an injury." A second nurse said, "I try to delegate some of my work; that helps." Another suggested, "When things do not work, I change the procedure or modify it. That seems to work out." Still another suggested, "Making suggestions for change of how to improve the care under the circumstances. Some things have happened like getting an intravenous pump (IV) to let you know if an IV has infiltrated." This nurse said, "I made the suggestion of having business office people help us . . . to take orders off when they are not busy."

Engaging in Outside Activities

Nine nurses engaged in outside activities and had several that they used in their daily repertoire. One said, "I go on motorcycle rides. In the spring and summer I run when I am not pregnant. We go out to a movie once a week if we have the money or out for dinner." A second nurse said, "Going home and getting lost in my son helps. We go skiing." A third said, "I go home and be home. I enjoy that. I get a good book, watch television, or just plain do nothing. In the summer I raise a little garden." This nurse said, "I enjoy organizations to get away from the hospital completely. There is no way you really can get away completely. These organizations are totally different

from the health care field. I like to play bridge, golf, and not think about anything." Another said, "Physical activities are what I do [to cope]; I can really hoe up a row when I have had a hard day. I spend time with my animals--horses, dogs, and cats. I do physical work around the ranch. In the winter I snowmobile. In the summer I jog and motorcycle ride. That gets rid of the physical and muscle tension. I do not have problems with somatic problems from stress, just muscle tension." Another said, "I like to sew and read to relax." This informant related, "I do needlepoint and relax at home." Another said, "When things are really bad I think about our cabin. It is on the river without a telephone." The last informant said, "I crochet and knit; I can be so tense and doing these things help me to think of nothing."

Experience

Experience was mentioned by eight of the nurses as a method to cope with their stress. One nurse said, "When I first started working, I felt a lot of pressure. Now after I have worked a while, it just seems to come easier." Another nurse said, "I have learned a lot from bad experiences." This informant shared the following: "I have learned some good things from the new staff. I also feel I have had enough experience to teach them something. I feel that experience is a good teacher."

Smoking or Drinking
Alcohol

Four of the informants talked about smoking or drinking in order to relax. Seven of the informants smoked while they were answering the questions from the researcher. One of the nurses said, "We have a meeting once a month among the nurses. We have wine, cheese, and crackers. We get to know one another. We send patients back and forth, so we know who is on the other end receiving the patient. I look forward to that." Another informant said, "Taking a break from the floor to have a cigarette helps to unwind." The informant disclosed, "Smoking is a way to relax, no alcohol, tea, or coffee, just smoking." Yet another informant said, "Smoking may release some of the tension, I do not know."

Crying

Three of the informants stated that they used crying as a technique for the release of tension. The first remark was, "I got three critical patients. Two of them were screw-ups. I called the doctor at 4:45 in the morning. I cried once I got off the phone. Later in the day the patient was transferred. He had what I thought he had!" A second informant from the group confessed, "I cry." The third nurse stated, "My bad OB, a friend involved, I was tense and the doctor was tense, so we got into it. I bawled a half an hour and then things were fine."

Praying

Three nurses used praying as a method to cope with stress. The first related, "I pray a lot before I come on duty. I pray to be in the right place at the right time." A second nurse said, "At times there is no way to deal with the stress. The doctor is 45 minutes away or cannot come. You do what you can do and you pray a lot." The third nurse's comments appeared under another heading.

Joking

Others used joking to cope with stress; three used the technique. One said, "We get crazy and joke a lot and make light of things. I guess we get so down and then we rebound in the opposite direction. We play jokes." Another related, "Sometimes you just laugh it all through because if you didn't, you would cry."

Using Patience

Two nurses stated that they tried to cultivate patience to help cope with stress. The first said, "I try to be patient and not try to change everything. I pick out one thing that is more important than the others. I try not to present it as, 'This should be.' Rather, I make more of a suggestion and say why I think it should change and give the theory. Then change comes about because others think it is good, not because I am saying it should be. I try to remember I do not like change that well. I need to be patient. There have been changes

for the better, but nothing happens overnight."

General Comments

Since many positive coping responses were given, apparently some nurses felt all right about their jobs. They seemed relaxed while answering the study questions. Everyone described at least one positive coping method that she used while many had several coping methods. Some possessed both effective and ineffective coping techniques; as a result, a conflict was created in their choice of methods. Both verbal and nonverbal expressions of affect indicated some nurses were tired, frustrated, and overwhelmed with responsibility. No one seemed totally near exhaustion, though a few nurses utilized several ineffective coping methods.

Cultural, Environmental, and Situational Influences

Based on observation of the environment, from informal discussion, data analysis, and news reports, cultural, environmental, and situational influences on the rural nursing culture were identified. Cultural influences include individual visibility, lack of anonymity, stability and cohesiveness of working relationships, agreement on the definitions of problems is necessary for progress to occur, traditional expectations of women, and suspiciousness about newcomers to the culture. Environmental influences include recreational opportunities

and esthetics of the surroundings. Situational influences include limited resources, competition for the scarce resources of nurses and money, and the community focus of concern on the hospital.

Since rural people knew most of the other community members, they had many other people to call upon in time of need. They had difficulty maintaining seclusion or privacy because of their lack of anonymity. Some nurses felt like a representative of the hospital 24 hours a day; they felt visible at all times; such visibility prevented their relaxation. Others had difficulty maintaining objectivity when caring for close friends and neighbors.

Working relationships had the characteristics of cohesiveness, defined role expectations, concern for one another, and mistrust of new members. Entrance into a group of rural nurses or health care workers generated anxiety because the individuals' credibility depended on the groups' accepting them. New ideas were scrutinized closely by the group. Change was a slow process since group members had to be convinced the change was needed; they had to arrive at a group consensus or continue with the change. To maintain enthusiasm for change, new members needed external support from outside the small community. The group focus of concern varied from one community to another. Areas which had new group members tended to have diversity of concerns along with the central focus of concern.

Interpersonal relationships in the rural community were

intense. Friends were held in nearly as high esteem as family members. Intense concern occurred when community members were ill and had to be cared for by the nurses. Managing friends as employees quite often created strained feelings of frustration; to remain objective in these situations was difficult.

The rural community held traditional expectations of women. The women were identified as mothers or someone's spouse rather than as an individual with her own identity. The traditional role of nursing was conveyed, namely, as that of the physician's helpmate. Persons who held these values fit well into the community; those who disagreed with the value did not blend well into the rural group or nursing culture.

The esthetic countryside and recreational capabilities of the land prompted outdoor lovers to live in the areas. Physicians could afford to live far from town; as a result, they distanced themselves from emergency medical care and placed an added legal burden on the hospital nursing staff.

Rural communities did not have resources to compete with the urban centers for professional people. Therefore, professionals, not attracted by outdoor activities and small communities, were not available. Salaries, job opportunities, and peer support were not available for people with advanced degrees. Urban centers advertised for rural nurses; they offered attractive benefit packages; such an approach

created an added anxiety and feeling of anger for the rural hospitals.

Rural hospitals tended to be the community group focus of concern as indicated by the informants. Community pride was vested in the structure and modern equipment available in the facility. Energy and resources were directed toward keeping the facility open, neglecting to take into account the need for trained people to be accessible to perform the tasks mandated by the technology. Issues of safe practice and competence emerged from situations such as these.

General cultural inferences were developed from the subjective and objective data received from the study. The next section of the paper contains these inferences.

Chapter 5

CULTURAL INFERENCES OF RURAL NURSING

By using the language of the informants, their voice inflections while they spoke, the body language, and the use of artifacts, the researcher arrived at inferences about the culture of rural nursing. These inferences are discussed in the same order as the stressors and coping methods were discussed in the ethnography.

Inferences About Stressors

The informants felt overwhelmed by the responsibility of being the only RN on duty. They had to make critical decisions about patients' care with the only comfort that they had another nurse to call upon, a doctor to call upon, or the auxiliary helper to rely upon.

The informants felt overextended when they could not address every patient's need at the time that it occurred. Frustration accompanied the feeling along with a lowered self-worth when they could not perform to their expected performance levels. They believed everyone deserved equal care, whether they were acute care or extended care patients. When inequities were viewed in care, the nurses felt guilty and responsible for the problem.

The informants were confused by the rural physician's definition of medical practice. First, some of the observed medical care

was of a different standard than that found in a medical center. Emergency care varied for people; such care was dependent upon the time of day that they came to the ER. Informants asked, "Who has the legal sanction and clinical expertise to say this person needs direct medical care?" The answers were ambivalent; namely, sometimes the doctors had the sanction, and sometimes the nurses had it. Nurses were to call the doctor for any consultation during the hours of 7:00 a.m. to 5:00 p.m. After those hours, nurses had to make judgments about whether or not to call. The nurse walked a fine line between nursing practice and quasi-medical/nursing practice delineated by time. Massive legal implications pervaded these practices; these nurses appeared to be at legal risk.

Physician control over nursing practice caused angry feelings. Because of having been in a position of oppression, nurses had requested assistance from physicians to support their cause. One unfortunate outcome from this situation was the reinforcement of the physician's belief that they retained the right of control of nursing practice. The interactions between the doctors and the nurses became circular; as a result, the anger of nurses and the physician control of the practice were maintained. The anger of nurses was generated in part from their insight that they themselves had enabled the control behavior of the physicians.

The informants interpreted their helping status as putting

them in "middlemen" positions as mediators. Guilt was transferred to the nurses in most situations for their having been unsuccessful in resolving problems of which they had no part; the nurses felt inadequate as a result. The researcher's inference was that the nurses had allowed themselves to be placed in these middle positions and had compromised themselves in the process.

Some informants had identified patient advocacy as an appropriate nursing function, but they were blocked by the physician. More guilt and feelings of inadequacy were generated in these nurses. Frustration followed because the nurses had no avenue through which they could relay concerns and complaints about medical practices.

The nurses experienced physical exhaustion because of the hours they worked, because of the rotation of shifts, and because of the on-call requirement. Fatigue eroded coping skills; therefore, their coping became less flexible, and their working conditions became less tolerable.

Direct communication was difficult for some informants. They waited until several disturbing situations happened before they could discuss an issue with their co-workers. The behavior implied a diminished self-esteem. Direct communication occurred successfully when informants had good knowledge of their own capabilities, beliefs, and weaknesses. When trust was absent or lacking, then communication did not occur.

Informants complained about the performance and the obsolescent knowledge of both peers and co-workers. Some of the criticisms were accurate; others, however, projected concerns about their own knowledge expansion onto others. Resentments and lack of trust created a barrier to sharing knowledge with others. When sharing occurred, the situation provided desirable outcomes.

The nurses felt unimportant in relation to the hospital administration. Viewing their knowledge as valuable, the nurses felt insignificant because they were not consulted about new equipment needs and they did not get new equipment to assist them in their practice. The nurses' self-esteem was lowered by the failure of the administration to ask for their suggestions.

New culture members refused to dedicate their lives to an institution they believed had no concern for them as people. These nurses felt discredited by members of their own profession who had enabled the institutions' oppressive stance toward nurses. They felt the institution was making a profit at the expense of nurses' human dignity. Neither patients nor the institution suffered under these circumstances; nurses were the ones compromised.

The nursing profession was expected to be the flexible department in the adjustment to management trainees in rural hospitals, as was discussed by one informant earlier. The nurses emerged from these conditions in a state of confusion, wondering who they were and to

what profession they really belonged.

Mistrust of themselves was generated by the inexperience of some nurses. Infrequent exposure to critical patients, specialized procedures, and questions about physician competency are causes of the increased stress in emergency situations. Though professional value is put on specialization, the nurses seemed to question the validity of keeping critical care and emergency units open in the rural hospital.

The informants' feelings toward community members were intense and similar to those which the nurses had toward family members. They identified with the illness, the grief, or the pain of friends. The informants found difficulty in keeping wellness and illness behaviors separated and to remain objective in their assessments.

Informants had role expectations about community members in reference to emergency room utilization. The nurses may have felt some frustration because health maintenance had not been taught to community members. A feeling of inadequacy may have occurred because nursing had not been able to address this educational need of the community effectively.

Nurses expressed fear of the unknown; some spent time in a nonproductive activity, namely, worrying. Though seen as problem-solving, worry used energy inefficiently. Worry may have been excessive in some nurses and conveyed a feeling of insecurity.

The informants felt over-informed and under-utilized in their

jobs. The job expectations were not met; consequently, disillusionment with the job occurred earlier in their careers. Having been taught assessments, decision-making, and technical skills, the nurses wished to practice and to be recognized and valued for their knowledge and skill. A tendency seemed to exist to blame the educational programs for the feelings; the real issue seemed to be the paradoxes of practice such as dependent on the doctors during the day and independent from them at night.

The paperwork required was seen as a non-nursing function, particularly having to order supplies, etc. The nurses perceived their practice of being controlled by the institution rather than by themselves. They felt as though their creativity was being thwarted.

Equipment was a maintenance, operation, and acquisition problem. For informants, the importance of their practice was minimized when obsolete equipment was kept in the hospital in preference to obtaining new pieces of equipment for administration.

Conflict was present in the mind of the nurses faced with the moral issue of sustaining life or allowing death to occur. The nurse felt guilty for wanting a retarded child to remain living and yet felt compelled to act when a crisis arose in the child's status. Conflict of values was a part of the nurse's thinking.

The informants felt responsible to be a role model and hospital representative to the community. The nurses were readily

available and easily identifiable; such a situation served to place a burden on the nurses and to prevent their relaxation and rest.

The inability to work in an interest area caused further disillusionment and anger. The needs were identified in the area; yet, the nurse's expertise was overlooked and she was placed elsewhere or asked to cover the whole hospital. The nurse's needs were not met; this failure caused feelings of disillusionment and anger.

Inferences from job-related stresses are concluded here. Inferences about coping methods conclude this chapter; they are discussed in the same order as the subjective responses which dealt with coping methods.

Inferences About Coping Methods

Talking seemed to allow the nurses to get the concern out in the open. Talking was most helpful for them since they would have a trusted other person who would listen and support them. The nurses seemed to gain a feeling of acceptance about themselves and their thoughts, and talking allowed them a catharsis of the feelings. Some were able to determine methods of coping beyond talking from the activity.

Talking to other professionals relieved tension when the recipient was supportive and empathetic. Talking became a stressor when no resolution occurred or when blocks were erected. A lack of

trust between the professionals seemed to develop as a result of the blocks. Such development caused a desire to retaliate on the part of the staff nurses against the nursing administration.

Those who used direct communication experienced rewarding outcomes and lowered stress. The direct communication eliminated the guess work about what was meant. Therefore, energy was allowed to be channeled to mutual respect and problem-solving. The technique was used most often by new group members.

An overtone of lowered self-worth permeated the responses by the nurses about building a list of problems before confrontation with a co-worker could occur. Direct confrontation necessitated a feeling of self-worth; such feeling would allow one to take risks.

Those informants who used the technique of positive thinking, self-talk, and introspection techniques felt comfortable and in control. They were able to choose whether or not to expend energy by being concerned. Consequently, they were able to eliminate many uncomfortable concerns from their lives.

Those informants successfully leaving work at work were able to choose whether or not to accept a concern and deal with it. Others who used the method seemed to state the words about leaving work at work but did not believe in the technique because the underlying stress was not relieved or resolved.

Self-sacrificing themes predominated the discussion about

overtime without pay and double shift work. The informants meant well in doing all of this additional work; they wished to help their fellow workers to care for the patient. However, both self-respect and self-protection were missing since they did not document their time. The administration may have appealed to the nurses' guilt when asking the nurses to work additional hours; or the implication may have been made that overtime was unnecessary and, therefore, not reimbursable.

The informants had a positive coping method with their establishment of common goals and their group cohesion. This technique was a vital beginning to the solution of disorganization and fragmentation which face nursing today.

As the researcher listened to the replies, the impression conveyed was one of being overwhelmed with work and with responsibility. Seemingly, the nurses found some difficulty in identifying their inner strengths. When inappropriate persons, such as physicians, were called upon to solve nursing problems, the nurses gave away their personal and professional power and helped to propagate the oppressed position of the profession. They did not recognize that they needed to learn how to solve their own problems.

The nurses controlled crises more effectively when they assessed their working environment, made assignments, and set priorities. Feelings of compromise surrounded priority setting, since some tasks had to receive less attention and importance than others.

In the desperate attempt by the nurses to maintain importance in a system which showed them little recognition, their interventions may be misdirected. They may be making clients more dependent on than independent from the health care system.

New cultural informants used assertive techniques when they were making change occur. The researcher sensed ambivalence in that the nurses felt good about themselves for having expressed their thoughts, values, and ideas but felt alone within their own profession when they presented ideas to the members.

Nurses indicated their high self-expectations when they said they just did the best they could. They felt they should be all things to all people. The attitude of perfection could have lead to simple exhaustion. For others using the phrase, the researcher sensed frustration from them, because they seemed to be saying that staff and time were minimal and no other alternatives in the situation existed. Guilt could be intermingled with the burden, particularly when the nurses did not feel or could not do their best.

Group trust developed in areas where the nurse assisted in helping the co-workers to acquire knowledge and skills. Mutual satisfaction prevailed in these instances. Where trust was lacking, the nurse over-extended herself, tried to oversee everyone's work, and made her job a sentence rather than a privilege. She could not see that helping the others grow would extend her locus of control over the

work situation.

The informants maintained hope through group effort. Outside activities complemented many lives and provided an important outlet for tension. Great pride and pleasure surrounded the discussion of hobbies and free-time activities. The coping method was effective in relief of stress.

Experience created inner peace and self-confidence. Pride accompanied the discussion because the nurses gained a sense of self-worth as they shared their knowledge with others. The coping method assisted them in getting to know their co-workers on a more personal level.

Smoking was such an integral part of the lives of the nurses who used that coping method that they no longer specifically identified the activity with coping. The activity was a vehicle to assist them in getting a moment to sit down and relax or talk. Most appeared casual about the activity rather than compelled to smoke. The activity of consuming alcohol centered around social activities when it was mentioned. Only a few verbalized they used the method.

Crying provided an appropriate release of excessive tension for some. It occurred when the nurses were near exhaustion either physically or emotionally. Situations in which physicians did not allow the nurse to discuss problems with them seemed to evoke the use of this coping method most frequently.

Praying answered the need for additional strength. Fear of the unknown and the weight of responsibility to perform perfectly prompted many prayers.

Joking released immediate tensions. It helped to encourage group cohesiveness. It was used at times when the tensions of the situation were very high, where crying might have occurred, to ease the feelings of the persons involved in the activity.

Cultural inferences for job-related stress and coping methods were discussed in this section. The conclusions from the study are presented in the following chapter.

Chapter 6

CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

Conclusions

The first conclusion from the study was that rural nursing is a definable culture of nursing. The majority of the informants met the interpretation of Spradley's (1979) for a fully enculturated member, namely, having lived in the area full time for over a year and having a narrow age range. All informants brought a broad perspective to the knowledge about rural nursing; as a result, the common language of the culture was allowed to emerge.

Nurses in the study expressed the opinion that they believed physicians expected them to be dependent upon the doctor during the day and to be independent during the evening and night hours. They believed that hospitals expected great loyalty and that the public expected friendship and professional consultation. These expressions were in keeping with the research findings of Kramer (1974), Brief (1979), and Claus (1980).

The nurses in this study seemed to have high expectations of themselves regarding amounts of work, scope of knowledge, and quality of delivered care; such expectations could have contributed to distress. Scully (1980) talked about the perfectionistic expectations nurses have of themselves which cause stress.

The nurses in the study felt caught in the middle in many of the situations; such a reaction apparently seemed to cause distress. The feeling correlates with the discussion by Stein (1968) of the doctor-nurse game.

Another way of looking at the problem was to conclude that stress production was inherent in the system, not in the individual. The system in which the nurses were enmeshed exerted external control on nursing practice. The theory expressed by Pearlin (1979) concurred with these feelings of the rural nurses.

The conclusion was made that the nurses in this study exhibited personal coping styles that were predominantly healthy in nature as described by Pearlin (1979), by Folkman (1980), and by Scully (1980). Talking situations over with others, organizing group efforts, supporting one another, and engaging in outside activities were examples of effective coping techniques used by these nurses. "Leaving work at work" and "forgetting and going on" are, in all probability, ineffective coping methods.

Some of the distress that the nurses seemed to experience came from their perceptions of not being treated with respect both by the hospital administration and by the physicians. Possibly, the system, including the hospital/nurse and doctor/nurse relationships served to hamper the ability of the nurses to cope as was described by Pearlin (1979).

Limitations

Limitations of the study include the following:

1. The possible desire of the informants to provide the researcher with information that they felt she wanted to hear, rather than sharing their own perceptions. The researcher had previous interactions with several of the nurses through continuing education programs. They may have still perceived her in the teaching role. However, these nurses' responses were generally in accord with the responses from the nurses who did not know the researcher.
2. Interview time and setting were possible limitations since interviews were conducted during working hours or in the evening. Conceivably some nurses felt rushed in their giving of the answers. The large amount of data provided by the informants, however, would not indicate that these factors were a major concern.
3. Only negative responses were given in response to the question about stressors and stress. Selye (1954) states that stress is essential for maintenance of life. Perhaps these informants were indoctrinated to believe that stress is only negative, as is commonly conveyed by the media. By first sharing Selye's definition of stress prior to the

interview, the researcher possibly could have avoided this bias.

4. A mixture of stressors and coping methods were often a part of the responses to each of the questions. Perhaps the researcher should have spent additional time in the exploration of the exact meanings that informants were attaching to various words and phrases. However, the type of study to determine specific coping methods to stressors was beyond the scope of an interview approach. Such a study would require observation and objective evaluation.
5. Certain political environments such as the fear of rural hospital closure and fear of losing professional staff to the urban center may have limited some informants' "telling it like it is." During the study urban centers were actively advertising for nurses from these rural communities and were offering higher salaries and complete travel expenses. This approach by urban centers created anger and apprehension among many of the rural nurse informants.
6. The demographic variables of age (23 to 67 years) and length of time employed in the rural hospital setting (one month to 30 years) may have affected the validity of the data. Nine informants did not meet Spradley's (1979) criteria of being a member of a culture for one year to be

a thoroughly enculturated member. The majority of the informants (13), however, did conform to these criteria.

7. Place of work was not included as a question in the demographic data; this information was sporadically available through the informal conversation of the informant. The absence of these data hindered any comparison of the variable with other studies done on rural burnout by Wickham (1980).
8. The smallness of the sample (N=24) and the ethnographic methodology preclude generalization of the study results to other rural nurses.

Recommendations

Strengths of the rural nurses of the study which could be capitalized on are their group behavior, namely, cohesiveness, caring, and consensus of patient care concerns. To support these strengths, assertiveness training, change and management skills, patient assessment skills, increased communication skills; problem-solving techniques; and relaxation and coping techniques would be of benefit in helping them to cope better with their ongoing stressors. The rural nurse could receive these types of education from health care learning centers, professional organizations, academic institutions, or consulting services of nurse experts within or without the state. They

no doubt would benefit from the interactions with other nurses during these encounters.

A major weakness which has to be overcome is the establishment of a professional identity as a rural nurse. Changes in relationships between nurses, hospitals, and physicians also must occur. Rural nurses must be included in patient decision-making with both the institutions and the physicians. The rural nurses of the study were often the most consistent professionals for the patients in the rural hospital settings.

Nursing education must be examined. For one thing, the rural practitioner is a generalist. Does the present nursing educational program prepare the professional for this practice? A strong background in patient assessment, interpersonal skills, teaching skills, coping skills, change initiation and management, and assertiveness skills are needed within the rural setting. In addition, student nurse experience in predominantly rural states should include experience in rural settings in order to interest students in the area and to prepare them for the practice. Furthermore, the development of graduate level programs with a focus on rural nursing would be the beginning step in meeting this need.

Questions for further research prompted by this study include the following: Do job satisfactions differ between nurses working in an institution--both urban and rural--and nurses working independently

in these settings? How do stress and coping methods differ or demonstrate similarity between rural and urban nurses? What coping methods are most effective for nurses? Do coping methods vary from urban to rural settings?

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APPENDICES

APPENDIX A

LETTER OF APPROVAL FROM THE HUMAN SUBJECTS REVIEW
COMMITTEE, MONTANA STATE UNIVERSITY



SCHOOL OF NURSING

BILLINGS EXTENDED CAMPUS EMC CAMPUS BOX 574 BILLINGS, MONTANA 59101

Marie Bunde, R.N., Graduate Student
School of Nursing
Montana State University

Dear Ms. Bunde:

Your research proposal, "Rural Nurses Perceptions of Stress and Coping Mechanisms", was reviewed and approved for protection of human subjects. All consent forms will be secured in a locked file in this office for five years.

Sincerely,

A handwritten signature in cursive script, reading "Ruth Vanderhorst".

Ruth Vanderhorst, R.N., M.S.
Education Director

RV/dk

APPENDIX B

CONSENT FORM

Information for participants:

You are being asked to voluntarily participate in a research study which will identify what stresses you in your job and how you cope with these stresses. Personal growth and increased job satisfaction are possible benefits to you from participation in the study. Personal insight into your stresses and coping methods and your time involvement could be viewed as risks of participation. Data collected from the study will be used to contribute to the development of a theory of rural nursing practice, being studied by the Graduate Program of Montana State School of Nursing, Bozeman, Montana. It is hoped that patient care would improve with the use of this theory, thus benefiting society.

Letters of introduction, accompanied by the study abstract, were sent to nursing service administrators in your area, asking for consent for the researcher to attend an area registered nurses' meeting to locate possible participants. Interview appointments will be made with consenting participants. Persons will be interviewed one time only. Participants may withdraw from the study at any time. Answers in your own words to the open-ended questions will be recorded on paper by the researcher as the interview proceeds.

APPENDIX B (continued)

Anonymity as to person, place, and geographic area will be insured, since no identification will be placed on the answer sheets. Consent forms will remain locked up at the MSU Extended Nursing Office at EMC (Eastern Montana College) apart from the answer sheets. The collected data will be destroyed at the completion of the study.

Researcher:

Marie L. Bunde, RN, BSN

Graduate Nursing Student: Midlevel Clinical Specialist

Extended Campus of Montana State University School of Nursing,
Billings, Montana

The research study:

"Rural Nurses' Perceptions of Their Own Job Related Stresses and Identified Coping Methods to Stressors"

The proposed research study seeks to identify the job related stresses and coping methods of nurses living and working in outlying areas of Montana. The following information will be gathered in the interview:

1. Optional demographic data: age, sex, educational preparation, number of hours worked per week, nursing position, and time spent in the rural area.
2. What stresses you in your job?

APPENDIX B (continued)

3. How do you cope with these stressors?

Identification of participants, method of data collection, and anonymity have already been discussed. Anonymity in the thesis will be insured by using the phrase "nurses living and working in an agricultural area in Montana."

Having read the above information and understood its implications, I affix my signature and today's date on this form.

Name _____

Date _____

APPENDIX C

LETTER OF INTRODUCTION

507 Bench Blvd.
Billings, Montana 59101
January 16, 1981

Director of Nursing Service
Harlowtown, Montana
Big Timber, Montana
Columbus, Montana
Roundup, Montana

Dear Madam:

This is a letter of introduction and information. I am a graduate nursing student in the midlevel clinical specialist program at Montana State University School of Nursing, Extended Campus, Billings, Montana. I would like your permission and assistance to meet with registered nurses from your area to discuss my proposed research study and to locate possible participants. Further, I would need your assistance to set up such a meeting or to be put on the agenda of an already scheduled meeting.

Enclosed please find an abstract of my proposed study for your review. I will be calling you during the week of January 19th to establish my status with you and make necessary arrangements.

Thank you for your consideration.

Sincerely,

Marie L. Bunde, RN, BSN

APPENDIX D

DEMOGRAPHIC SURVEY

	2 yr	2 yr+	3 yr	3 yr+	4 yr	4 yr+	Other
Staff nurse	1	2	2	3	3		2
Charge nurse			1				
Staff/office nurse					1		
Staff/head nurse					2		
Staff rural/urban						1	
Staff (includes janitor)			1				
Staff/surgery					1		
Director of nursing			2				1
Hospital administrator/Director of nursing			1				

APPENDIX E

STRESSORS

Being short staffed	23
Physicians	13
Physical exhaustion	11
Competency	9
Administratioon of the institution	8
Coronary care	8
Taking care of friends	7
Unknown	6
Education	6
Lack of experience	5
Paperwork	5
Equipment	4
Moral issues	1
Anonymity	1
Cannot work in favorite area	1

APPENDIX F

COPING METHODS

Talking	20
Leaving work at work; forgetting it and going on	16
Helping one another	14
Using expressions of despair	14
Setting priorities	11
Using assertive skills	11
Doing the best you can	10
Attending educational offerings	10
Solving problems	10
Engaging in outside activities	9
Smoking or drinking alcohol	4
Crying	3
Praying	3
Joking	3
Patience	2

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