Role resocialization and biculturalism in community health nurses
by Bernice Olga Bjertness

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

Abstract:
This study was designed to determine what nurses experienced in the process of role transformation and role resocialization when they initially moved from institutional to community health nursing practice. The presence and influence of supporting networks also were identified in the resocialization process and when bicultural adaptation occurred.

An exploratory, descriptive study design was used to gather data from eighteen community health nurses through ethnographic interviews. Fifteen predetermined questions were used in the ethnographic approach and allowed for flexibility and indepth probing of responses.

The data were summarized and analyzed for symptoms of role conflict in the resocialization process and for the presence of support networks in bicultural adaptation. Nurse informants initially moving from institutional to community health experienced professional-bureaucratic role conflicts and displayed symptoms of reality shock in varying degrees. Support for the illness and wellness continue of health was identified as informants described the need for additional preparation and skills for practice in community health nursing. Commonalities emerged from the responses and provided a basis for further studies.

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Date May 26, 1981

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by

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A thesis submitted in partial fulfillment
of the requirements for the degree

of

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BOB

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ABSTRACT

This study was designed to determine what nurses experienced in the process of role transformation and role resocialization when they initially moved from institutional to community health nursing practice. The presence and influence of supporting networks also were identified in the resocialization process and when bicultural adaptation occurred.

An exploratory, descriptive study design was used to gather data from eighteen community health nurses through ethnographic interviews. Fifteen predetermined questions were used in the ethnographic approach and allowed for flexibility and indepth probing of responses.

The data were summarized and analyzed for symptoms of role conflict in the resocialization process and for the presence of support networks in bicultural adaptation. Nurse informants initially moving from institutional to community health experienced professional-bureaucratic role conflicts and displayed symptoms of reality shock in varying degrees. Support for the illness and wellness continua of health was identified as informants described the need for additional preparation and skills for practice in community health nursing. Commonalities emerged from the responses and provided a basis for further studies.

CHAPTER 1

INTRODUCTION

Community health nursing takes place in a variety of settings with the majority of activities taking place outside the hospital in clinics, schools, or homes. This specialized area of nursing practice often requires the nurse to function in a generalist role by working in several of the agency programs. Agencies hiring community health nurses frequently require that nurses have previous employment in a hospital or in other institutions if they are to be considered for employment. This prerequisite to employment prevents most new graduates from entering community health nursing. Since the new graduate rarely experiences initial employment in community health, the utilization of research findings of new graduate role transformation may not be directly applicable to community health clinical nursing practice.

Purpose of the Study

The purpose of the study was to determine what nurses experienced in the process of role transformation and role resocialization when they initially moved from institutional to community health nursing practice. The presence and influence of supporting networks also were explored.

The role transformation which occurs as nurses move from student to staff nurse roles takes place in a fairly predictable

process identified by Schmalenberg and Kramer (1979) as the "reality shock process" (p. 2). The phases of this process are honeymoon, shock, recovery, and resolution. During six years of community health practice, the investigator has observed that newly employed community health nurses experience many of the same symptoms which Kramer (1974) initially identified from her research of reality shock and bicultural adaptation in the new graduate. Further studies by Kramer and others on reality shock and biculturalism have found that new graduate nurses find uncertainty and conflict in new roles, and satisfactory role socialization must occur if the highly desirable state of biculturalism is to emerge (Kramer, 1974; Kramer & Schmalenberg, 1977, 1978; Schmalenberg & Kramer, 1979; Lewandowski & Kramer, 1980).

No studies were found which suggested a need for the study on the reality shock experienced in role resocialization as nurses move from hospitals, or other institutions, to community health nursing. Schmalenberg and Kramer (1979, p. 1) suggested that nurses are not the only professionals experiencing reality shock and established nurses also can experience it. Thus, changing roles such as from staff nursing to supervision or changing areas of practice from hospital to community health could produce reality shock. Schein (1968, 1971) in his research with new college graduates in industry also noted that socialization/resocialization is a process that occurs and recurs throughout an entire career. Role expectations reflect the

individual's changes in career goals, career status, or work settings.

The investigator believed that reality shock might be experienced by established professionals as they moved to new roles in community health nursing and that they, in all probability, experienced the professional-bureaucratic role conflicts of role resocialization. The professional-school values must be translated into practice and action in another new subculture of work which demands further skills and interpersonal competencies. How and if the nurse resolves these conflicts is inherent in the bicultural adjustment process. Kramer (1974) stated: "It was anticipated that constructive conflict resolution and bicultural adjustment would increase the new graduate's job satisfaction, productivity and tenure on the first job" (p. 199).

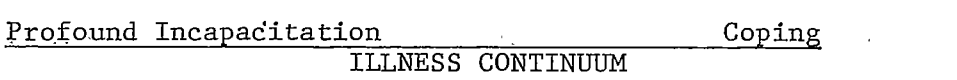
Building on Kramer's works and adapting her theoretical framework to the professional nurse's role resocialization in community health are feasible. Role resocialization into a different subculture of nursing produces practitioners who must resolve role conflicts if they were to become bicultural. If professionals in community health nursing were going to be assisted in achieving the highly desirable state of biculturalism, the presence and extent of role conflict produced in the new position and supporting networks must be identified.

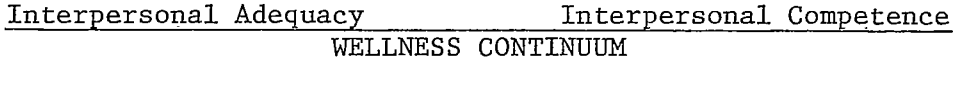
Osborne's theoretical framework (1970, pp. 699-711) which has two distinct continua of health (see Figure 1) maintains that prior nursing experience in an acute care setting is beneficial and often

required before entering community mental health nursing. Osborne's dichotomized illness and wellness health continua, and not the popular illness-wellness health continuum (see Figure 2), provide support for the assumption that the behaviors required of professionals on the different continua are varied and require different skills. Osborne further maintained that increased education and skills are demanded as the professional moves from the structured, mental institutional setting where direct care is given to the community and where service to populations becomes the focus.

Figure 1

Osborne's Continua of Health*

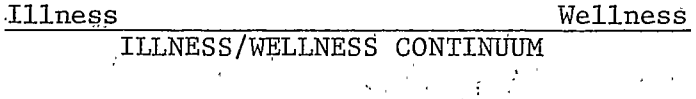




*Osborne (1970, p. 702)

Figure 2

Traditional Health Continuum



The belief of the investigator was that Osborne's concepts also hold true for nurses moving from hospital nursing, which is within the illness continuum, to community health nursing, which is within the

wellness continuum. The skills needed are best learned through further education and support must be provided in the new setting. Not only must role resocialization take place as the professional moves from the illness to the wellness continuum but also the professional must resolve new role conflicts. Reality shock is, therefore, a possibility for the nurse in the new role.

The concern from which this research project developed was not only about the resocialization of nurses into new roles in community health but also on the retention of nurses. The belief was that from this study suggestions could be made for inservice and continuing education which would facilitate moving into the new role. The inservice and continuing education offered would assist the newly employed community health nurse in the development of competence and congruent expectations.

Literature Review

The purpose of the literature review was to (1) examine/review (a) studies and theoretical or conceptual frameworks which focus on professional-bureaucratic role conflicts in neophyte and experienced nurses; (b) review articles and studies which apply to nurses' role resocialization and developing biculturalism; and (2) explore literature which supports Osborne's concept that advanced education and skills are needed in community practice because both the illness and wellness

continua are a focus of practice.

Role Conflicts and Reality Shock

Kramer (1974) and researchers (Kramer & Schmalenberg 1977, 1978; and Schmalenberg & Kramer 1979) who participated in follow-up studies are the foremost authorities in studying the reality shock phenomenon in new graduates of nursing programs. Studies which support the phenomenon of reality shock and professional-bureaucratic role conflict in other professions are reported by Scott (1969), Corwin (1970), and Schein (1961, 1968). They reported that social workers, teachers, and business school graduates do experience reality shock and that the professional and bureaucratic systems of work are antithetical.

Corwin (1961) studied the professional-bureaucratic role conflicts in nurses and identified the disparity between the two roles. The professional ideals were the values and whole-task system taught and stressed in school. A work system organized around the whole-task principle required that the worker has the responsibility for the whole task and must possess the necessary knowledge and skills to do the job. A part-task system of work demands fewer skills and the work is segmented into component tasks and performed by different workers. As noted by Kramer and Baker (1971, p. 16), to have external controls and coordination usually in the form of rules and supervision when many people are performing tasks becomes mandatory. The need for a

hierarchical structure and an authority then becomes necessary. The professional system taught to baccalaureate nurses places prime importance on education, individual judgment, self-evaluation and improvement, and colleague relationships.

Corwin (1961), in work preceding that of Kramer, contends that a nurse must possess some loyalty or allegiance to patients, some to the employing agency, and some to the profession. Corwin labels the conflict between the idealized role conception and that found in the work situation as role deprivation. In the context of his research, role deprivation is one of the major sources of reality shock. The degree of conflict has a potential for causing problems. Corwin and Taves (1962) found that the type of role conception held, the firmness to which it is held, and the amount of role deprivation experienced will vary in nurses primarily because of their different educational backgrounds and stages of their career.

The comparative study of role transformation in special care unit nurses by Lewandowski and Kramer (1980) revealed that graduate nurses employed in highly specialized areas had high bicultural scores, self-esteem, and high loyalty to the bureaucratic system. In addition, Lewandowski and Kramer found that the degree of specialization was related inversely to empathy and effective change agent activity. All of these findings have potential implications for nurses who move from acute care settings to community health practice.

Much of the literature reviewed on role transformation and reality shock was based on Kramer's (1974) longitudinal study and research of new graduates of nursing programs. Kramer and Schmalenberg (1979) described reality shock as:

> The specific shock-like reactions of new workers when they find themselves in a work situation for which they have spent several years preparing and for which they thought they were going to be prepared, and then suddenly find that they are not (p. ix).

Implications of the reality shock process for new graduates were explored by Schorr (1979). She cautioned new graduates against accepting early promotions and encouraged practicing in primary care units in order to help to reduce and to resolve reality shock. Billings (1979) stated that the disparity between education and service is a two-way street and that both must work on the problem of reality shock in new nurses. In a study of new graduates nurses in San Diego and Imperial Counties in California, Benner and Benner (1975, pp. 139-144) found that little dialogue between educators, personnel directors, and supervisors existed and that each had discrepant views of new graduates' preparation and functioning.

Kramer and Schmalenberg (1977, pp. 4-24) and Schmalenberg and Kramer (1979, p. 2) described the reality shock process in new graduates as occurring in a fairly predictable pattern. The first phase was the honeymoon phase, characterized by concern for mastery of skills and routines with a goal toward becoming socially integrated into the

work group. The next stage was the shock phase in which the professional nurse experienced moral outrage that nursing was not practiced in the manner that the professional believed that it ought to be. In addition, at this phase, the professional nurse may experience fatigue, rejection, and perceptual distortion. The recovery phase is next in the process. It is characterized by a return of one's sense of humor and insight into discriminating between good and bad perspectives and situations. The final phase of constructive resolution is characterized by a bicultural adaptation. Bicultural adaptation is the process of re-evaluating school values, of retaining those which are worthwhile, of accepting some work values, and of infusing some of both values into a unique new nursing role.

Biculturalism

Bicultural adaptation is desired in experienced practitioners in community health nursing as well as in new graduates. Schmalenberg and Kramer (1979, p. 11) stated that "new graduate nurses do not have a monopoly on reality shock; it can and is experienced by people in many professions, and by the established professional as well as by the newcomer." Johnson (1971, p. 34) pointed out that nursing has given little attention to other "position holders" of role conflict. In her study which was focused primarily upon the nursing supervisor, the analysis of the questionnaire data revealed that supervisors did have

professional-bureaucratic conflicts. Noted was the fact that if role conflict were not resolved, a supervisor could remain in a state of role conflict and could fail to develop or to adapt to a bicultural role.

Socialization and resocialization are processes that occurred and recurred throughout an entire career (Schein, 1968). Such processes occurred when individuals changed career goals, changed positions within the work setting, or moved from an educational to a work setting, or vice versa. Resocialization also must occur when a professional nurse moves from a hospital or similar institutional setting to community health. The trajectory of the resocialization process is influenced by several major factors (Hinshaw, 1977). Two important factors are "professional orientation of the work setting [and] existence of role models" (p. 9). Community health agencies require professional activities which are nonroutine, unpredictable, and exceptional. These activities require professionals who have the knowledge and the background to handle them. If a strong professional attitude existed among employees, usually a strong colleague support group and role models who have achieved biculturalism were evident.

Illness-Wellness Continua

The concept of the two health continua of Osborne (1970, pp. 701-712) represent his basic ideas on the illness and wellness concepts. He believed competencies required in community mental health

are built upon education and competencies acquired in a hospital or in a similar institutional setting. Osborne stated that "it takes more time to develop competencies in community mental health nursing than in psychiatric nursing" (pp. 709-710). The same concept applies to community health nursing when the focus moves from individual patient care to providing service to populations. A change in work setting from institutional setting to community nursing also creates a need for further education and assistance in the resocialization process.

Kramer and Schmalenberg (1977) have identified the need for anticipatory socialization programs, seminars, and workshops to aid new graduates in the process of adapting and achieving biculturalism. Various internship and orientation programs have been developed to aid new graduates in this process. The new graduate hospital-based orientation programs varied but most contained planned didactic and clinical components (Fleming, Woodcock & Boyd, 1975; Ackerman & Baisel, 1975; Hammerstad, Johnson & Land, 1977; Carozza, Congdon & Watson, 1978; Alspach, 1978). Often group hiring, a buddy system or preceptors, and regularly planned classes or seminars were in existence. The length of time for the orientation/internship programs ranged from six weeks to twelve months. The conclusions offered included support for the programs because they increased the new graduate's adjustment and satisfaction in the job reduced role conflicts, gave assistance with role socialization, and increased job retention.

Review of literature revealed no studies of needs, programs, or planned support activities to assist the experienced professional nurse in role resocialization from the institutional setting to the community. This move from client-centered practice to practice with a focus on populations is likely to cause professional-bureaucratic role conflicts and produce symptoms of reality shock in the process of role resocialization with a goal of biculturalism.

Definitions of Terms

The definitions of terms which define reality shock in this study have been derived primarily from Kramer's (1974) and Kramer's and Schmalenberg's (1977) theoretical perspectives. Other terms have been defined by the American Nurses' Association (1974) and Hall (1977).

Biculturalism: The type of adaptation to role conflict resolution which permits the individual to develop a unique role of nursing by using worthwhile school-bred values and accepting some values from the work world.

Community health nurse:

Operational: A community health nurse is a registered nurse employed in a community health agency in a distributive setting.

Theoretical:

> Community health nursing is a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations. The nature of this practice is general and

comprehensive. It is not limited to a particular age or diagnostic group. It is continuing, not episodic. The dominant responsibility is to the population as a whole.

Distributive setting: The field of health care in which the focus is on designated populations with an emphasis on health promotion, on the maintenance and the restoration of health, and on disease prevention.

Institution: A setting for nursing practice excluding the community. The service usually is rendered directly to individual patients in an acute care setting which may be either in a hospital or in a nursing home.

Professional-bureaucratic role conflict: Value conflicts in the method of work organization, involving whole-task (professional or school) or part-task (bureaucratic or work) systems.

Reality shock: A phenomenon which occurs when an individual discovers and reacts to the discovery that school-bred values and ideals conflict with work values and goals.

Resocialization: The process of learning a new role and thus resolving the conflicts that arise between the role and one's expectations of self.

Role transformation: The process of changing or mediating conflicting demands of previously held values with those of the present work group. This process leads eventually to a new behaviorally expressed role.

Conceptual Framework

The major tenets of Kramer's (1974) theoretical framework of reality shock and biculturalism in new graduate nurses provided a rationale for the study. Osborne's (1970) conceptual framework based upon a dichotomized health continuum consisting of an "illness continuum [and a] wellness continuum" (p. 701) also provided further rationale for the study. The two continua of health are in contrast with the popular ideology of one illness-wellness continuum.

Reality Shock and Biculturalism

Kramer's (1974) research findings identified professional-bureaucratic role and value conflicts in new graduates which lead to reality shock. New graduates must be educated for, and supported in, the conflict resolution process of role socialization. Bicultural adaptation is considered the best possible solution. Kramer also believed that nurses experience the symptoms of reality shock in the role resocialization which occurs when nurses move within the profession.

In all probability, nurses moving from institutional to community settings have increased potential for experiencing professional-bureaucratic role conflicts and the reality shock phenomenon in the role resocialization process. The community health practitioner thus

would benefit from assistance in becoming bicultural.

Kramer (1974) stated that the biculturally adapted graduate has learned the dominant work values while maintaining values learned in school. The fusing of the two values by compromise and synthesis produces a viable integration of both systems and allows the nurse to be the kind of practitioner that is desired.

Illness and Wellness Continua

The fields of mental health nursing and physical medicine were cited by Osborne (1970, p. 701) as examples of the two-continua model. The practice of mental health nursing within the illness continuum takes place within the community with a "focus upon populations at risk" (Osborne, 1970, p. 707).

Osborne stated that psychiatric nursing takes place in institutions, that community psychiatric nursing is carried out in hospital or community mental health institutions, and that community mental health is performed in the community setting. The focus of each area is different and requires increased and advanced preparation. Increased competencies also are required at each level beginning with the psychiatric nurse employed in institutions.

The foregoing concepts are believed by the investigator to be applicable to community health nursing practitioners. The belief exists that increased preparation and competencies are required of all

nurses, not only mental health nurses, when they move from modalities of practice in hospitals within the illness continuum to practice in community health within the wellness continuum. Nurses in the community health setting not only must be able to provide expert nursing care to individuals, as in the acute care setting, but also must be able to assess and meet the needs of populations and communities.

The conceptual frameworks of Kramer and Osborne provided insight and direction into the process of role resocialization which occurred in nurses who were newly employed in community health. The need for increased preparation and skills was believed by the investigator to increase the potential for newly employed community health nurses to experience reality shock in the role resocialization process.

CHAPTER 2

METHODOLOGY

The purpose of the study was to determine what nurses experience in the process of role transformation and role resocialization when they moved initially from institutional to community health nursing practice. The presence and influence of supporting networks also were examined as they relate to the resocialization process and bicultural adaptation.

Study Design

The design of the study was level one, exploratory descriptive (Brink & Wood, 1978, pp. 78-79). Personal interviews using 15 pre-determined, open-ended questions collected data from the informants' self-reports of experiences and perceptions (see Appendix A). Polit and Hungler (1978) stated, "personal interviews are regarded as the most useful method of collecting survey data because of the depth and quality of the information they yield" (p. 203).

Spradley's (1979) ethnographic approach was used to conduct interviews. Since what community health nurses experience in role transformation and resocialization was not known, the investigator believed that the ethnographic approach provided the best method for eliciting this information.

Ethnography allowed the investigator the opportunity to view the role transformation and resocialization process from the

perspective of the nurses who experienced it. The end result of ethnographic interviews is a verbal description which was achieved using the predetermined ethnographic questions as a guide in exploring informants' experiences and perceptions. Descriptive questions were asked, including grand tour questions (Spradley, 1979, pp. 86-91), such as "describe the orientation program in which you participated when you began your present position in community health nursing." The ethnographic approach, through exploration and probing, provided empirical data about the community health nurse informants.

Target Population

The target population consisted of community health nurse informants whose initial employment in community health had been a minimum of six months with prior nursing experience in an institutional setting. Informants fitting this criteria were solicited from several of the large community health departments in Montana as well as from some rural county health departments.

In an attempt to include rural nurses, the investigator contacted the Bureau of Nursing, Montana State Department of Health and Environmental Sciences but was unable to secure the names of potential informants among rural community health nurses because of confidentiality regulations. In October, 1980, a two-day orientation program was held for newly employed community health nurses from rural areas and

seven nurses attended. One nurse fitted the majority of the study's criteria and agreed to become an informant. The remainder of the informants were from two of the large health departments in Montana.

Interview Questions

The work of Kramer (1974), Kramer and Schmalenberg (1977), Schmalenberg and Kramer (1979), and Osborne (1970) provided the conceptual framework and gave direction for the ethnographic interview questions developed by the investigator.

Each of the questions was developed to elicit the presence and depth of symptoms of reality shock, role resocialization, bicultural role adaptation, and Osborne's two continua of health. The presence of supporting networks also was to be illuminated. Five questions explored the honeymoon phase of reality shock; four questions were intended to elicit symptoms of the shock phase; two questions addressed the recovery phase, and three questions provided an opportunity to explore the phase of resolution and the presence of bicultural adaptation (Schmalenberg & Kramer, 1979, pp. 2-9). Osborne's (1970) conceptual framework also was explored in four specific questions.

Revisions and clarification in the wording of the interview questions were completed following the second interview. Questions were added to elucidate information on feedback and to facilitate indepth discussion of bicultural role adaptation and its presence or absence.

After the first three interviews, a determination was made to include nurse informants through four years of employment in community health. Initially, the decision was made that data from informants would not be included beyond three years of current employment. However, the excellent recollection of experiences and perceptions of initial orientation and employment into the fourth year provided pertinent and rich data. The retrospective recollection of informants may not have been accurate or complete in detail or depth; however, the responses were congruent with the responses of the other informants. All of the data were collected by the investigator through personal interviews.

Protection of Human Rights

Before participating in the interview, the informants reviewed the study abstract and the demographic data sheet (see Appendix B). The demographic data sheet advised the informants that consent to participate in the study was given by agreeing to the interview. If no additional questions ensued, the demographic data sheet was filled out and the interview was conducted. The answers and the discussion of the ethnographic interview questions remained anonymous, and no attempt was made to identify the participants or the data. The Human Subjects Committee of Montana State University reviewed and approved the study (see Appendix C).

Data Analysis

Data for the exploratory descriptive study were collected from 18 informants using the ethnographic approach with 15 predetermined interview questions. After the completion of the interviews, the data were analyzed. The presence or absence of the symptoms of reality shock and supporting networks was analyzed in the role resocialization process of the community health informants. Responses to the questions were categorized, the commonalities or frequencies determined, and typical or unusual responses noted.

The 15 interview questions were analyzed individually and grouped together according to the phases of reality shock and bicultural adaptation identified in Kramer's (1974) and Schmalenberg's and Kramer's (1979) theoretical frameworks. The data also were examined for Osborne's (1970) two continua, illness and wellness models of health as shown in Figure 1, page 4, instead of the popular illness-wellness continuum shown in Figure 2, page 4.

CHAPTER 3

RESULTS AND DISCUSSION

The purpose of the study was to determine what nurses experience in the process of role transformation and role resocialization when they initially move from institutional to community health nursing practice. The presence and influence of supporting networks also were identified in the resocialization process and when bicultural adaptation occurred.

Sample

The sample consisted of 18 community health nurse informants who had experienced initial employment in community health for a minimum of six months with prior nursing practice in an institutional setting within the illness continuum. A total of 22 ethnographic interviews were conducted among the target population. The responses from four of the informants did not meet the criteria of the study; three of the informants were employed in their second position in community health while one informant was not employed for a minimum of six months.

The sample size is indicative of the difficulty the investigator had in reaching informants who met the criteria of the study. In 1980, approximately 124 nurses were identified as community health nurses in Montana by the Montana State Department of Health and Environmental Sciences, Nursing Bureau (Ferguson, 1981). This number excluded nurses employed as school and home health nurses. Over one-half of the

community health nurses were employed in health departments in the counties of Cascade, Gallatin, Lewis and Clark, Missoula, and Yellowstone. The remainder were employed in health departments listing from one to six nurse employees in small, rural county health departments.

Demographic Data of Informants

The demographic data shared by the informants (see Appendix D) provided a profile of community health nurses in the study. Employment in community health frequently requires a bachelor of science degree, prior hospital experience, and involvement in current nursing practice. However, a variation exists in adherence to criteria in different areas, often with the availability of nurses.

The community health nurse informant in this study was most often a female, 28 years of age, and currently employed for at least one and one-half years in a generalist role within a health department which employed more than 16 nurses. The informant was baccalaureate-prepared within Montana, with one-half quarter of student experiences in the community setting. Nursing experience prior to initial employment in community health averaged three and one-half years in an acute care setting often in a hospital with an occupancy over 120 beds.

Twelve of the informants were employed in a generalist role within the community setting. The generalist role required nurses to function in all of the major community health programs in direct client

services. The major programs often included school health, home health, maternal-child health, and communicable diseases. Six of the informants were employed in specialist roles, for example, as a clinic nurse, or within one program as a pediatric nurse specialist. All but one of the informants had prior nursing experience which included some time in an acute care institutional setting. One informant, on the other hand, had been employed in the office of a physician with a generalized medical practice. Length of employment for all of the subjects ranged from nine months to ten years before they moved into the community or wellness continuum.

All but one of the informants were employed in a community health agency that employed more than one nurse. Seventeen informants worked in an agency employing from ten to thirty nurses. However, not all of the 17 had close contact with peers. They often worked within a smaller division or team. Sometimes, such divisions or teams were comprised of one or two other immediate peers.

The institutional nursing experience of two of the subjects occurred in a small, rural hospital and the others' experiences took place in institutions which ranged in size from 120 to 1000 beds. Opportunities to develop and to practice many nursing skills and interventions were the benefits identified in having prior nursing experience in institutional settings.

Finding: Commonalities/Differences

The following discussion will describe responses question by question and categorized by the phases of reality shock. A summary of each phase is included following discussion of the questions which address the phase.

Honeymoon Phase

The honeymoon phase of the reality shock process (Kramer, 1974; Kramer & Schmalenberg, 1977; Schmalenberg & Kramer, 1979) includes the mastery of skills and routines and social integration including a period of testing. Characteristics, or symptoms, of this phase include moral outrage, rejection, fatigue, and perceptual distortion.

Question 1. Describe if and how you felt prepared for your first position in community health nursing. The responses were evenly divided with six each between perceptions of feeling prepared, partially or semi-prepared, and not prepared. Typical responses of the subjects who felt prepared were: "I felt comfortable with my skills; the length of time [four years] in hospital experience helped," and "I felt I had expertise because of my 14 months' experience in critical care and with my assessment skills." The informants who did not feel prepared responded with statements such as, "I felt overwhelmed with the variety and number of roles of the community health nurse and with the amount of general information the community health nurse must have

to practice and make referrals."

Question 2. How did the curriculum in your nursing education prepare you for community health nursing? Tables 1 and 2 illustrate the commonalities which emerged from this question. Less than one-half of the informants believed that they were well prepared by their educational programs. No correlation emerged between the length of community health preparation and the perception of being well or poorly prepared for beginning practice in community health nursing.

Table 1

Length of Community Health Curriculum

Length	Number (N=18)
No formal preparation	1
1/2 quarter	10
1 quarter	3
1 semester	4

Table 2

Personal Perceptions of Educational Preparation

Perception	Number (N=18)
Well prepared	8
Semiprepared	4
Not well prepared	5
Unrealistic view	1

Question 3. Did your nursing curriculum or any individual stress that additional education and skills were needed in community health nursing? Elaborate on who, what, and how. Three informants identified that their nursing curriculum or instructors emphasized that additional education or skills were needed before moving into community health nursing. One response was: "My community health instructor discussed how community health nursing is different from hospital nursing and more than just hospital skills are needed to work in the community with people." Four informants identified someone else, such as a community health nurse or the management personnel in a visiting nurse service as the actuator of the idea for them. Six informants responded that their curriculum had not stressed the difference between hospital and community health nursing. Five informants were unable to recall if the difference had been stressed. In summary, the view held by the majority was that the difference had not been stressed by their nursing curriculum or any individual or that additional education and skills were needed to practice in community health.

Question 4. How did your previous work experiences prepare you for community health nursing? One common response emerged from this question. Ten, or over one-half of the 18 informants, identified the hospital environment as providing opportunities to practice and to perfect their technical and nursing assessment skills. They gained expertise and increased skills in communication and in establishing

priorities. The background of 17 of the 18 informants included hospital nursing experience which ranged from as little as nine months to as much as five years. The remaining informant had been employed in a physician's office. According to some of the informants, these experiences "established credibility." The range of total previous nursing experience was from nine months to 10 years. Such experience included work in hospital nursing (17), office nursing (3), a health maintenance organization (1), and a nursing home (1). Work experiences, prior to employment in community health, were described as varying in length and in area of nursing practice.

Question 5. Describe the orientation program in which you participated for your position in community health nursing. The orientation programs of the 18 informants are summarized in Table 3. One subject had no orientation program; no one was immediately available to her as a role model and for feedback. This lack of orientation and feedback occurred because the nurse was in a rural county which had only one position in community health nursing. Nurses who had on-the-job orientation, with no specific structure, described it as occurring either because of arriving at mid-year to fill a vacancy, because of agency preference, or because of a lack of a specific orientation program. Eleven informants described a general agency orientation which was two weeks in length; 10 of the 11 also had participated in a residency program in one health department. The general agency

orientation most often included acquainting informants with policies, procedures, billings systems, physician orders, observations of home visits, recording, and practical job experiences. The residency program consisted of weekly seminars for eight to nine months for newly employed community health nurses. The seminars were designed to aid in orientation activities, to provide a peer support group, and to assist informants in applying the principles of community health nursing through role models, community and staff resources, and case discussions.

Table 3

Orientation Programs for Community Health Nurses

Program	Number (N=18)
Planned	11
Two weeks in length	11
Residency program	10
Unplanned	7
Unstructured (on-the-job)	4
Structured with supervision	2
None	1

In summary, mastery of skills and routines and social integration with a period of testing are the characteristics of the honeymoon phase of reality shock identified by Kramer (1974), Kramer and Schmalenberg (1977), and Schmalenberg and Kramer (1979). Exploring the

honeymoon phase in role resocialization of the informants revealed some symptoms of reality shock but did not reveal all of the symptoms which might have occurred. Possibly some difficulty was encountered by the informants in an effort to recall these experiences and perceptions. A nurse interviewed, although not included in the study since she had not been employed as a community health nurse for six months, impressed the investigator as displaying symptoms of this phase. She stated that the work situation was exciting, that the area was a pleasant place in which to be involved in nursing practice, that the pace was busy but not pressured, that no surprises occurred on the job, and that no problems were present.

Questions 2 and 3 were intended to elicit support for Osborne's (1970) conceptual framework. In Question 2 the informants did not describe experiences or beliefs indicating that a difference existed working in the illness and the wellness continua or that additional preparation and skills were needed to work within the wellness continuum. Question 3 did indicate support for Osborne's illness and wellness continua of health. Seven of the 18 informants described their nursing curriculum or instructors, or someone else, as emphasizing that hospital nursing was different from community health nursing and that additional skills were needed in order to work in this area.

Shock Phase

The shock phase of the reality shock process was next to be

explored in role transformation and resocialization through Questions 6 through 10. Symptoms identified by Kramer (1974), Kramer and Schamlenberg (1977), and Schmalenberg and Kramer (1979) included moral outrage, rejection, fatigue, and perceptual distortion.

Question 6. Describe any surprises you encountered in community health nursing. "The amount of paperwork" was the most frequent answer with five subjects readily offering the response. The other responses varied but included surprise in the number of roles required of the community health nurse, the amount of flexibility needed, the number of people the community health nurse must work with in addition to clients, and the number of high-risk families in the caseload. Typical responses included: "My main surprise was feeling so insecure in the new role"; "I was no longer the expert as in the intensive care unit," and "the generalist role is impossible at first--it makes you feel insecure about everything. It is good in theory but hard in reality."

Question 7. Did you receive respectful, accepting, and concerned treatment from others? Describe and identify people with whom you came in contact and what their roles were. All of the 18 informants replied that they received respectful and accepting treatment from others, but variations existed in treatment by people in different roles. Nine informants identified their immediate peers and supervisors as providing acceptance and the most support. Six informants identified their immediate peers, including senior nurses and residency seminar members

as the ones who provided acceptance and support. Two informants identified their supervisor as the primary person providing acceptance and support while one informant identified clients as the primary source of acceptance and support.

Typical comments included: "I had the most supportive group of peers I'd ever worked with," and "I was able to sound out ideas with my team and co-workers and get support." Another response was "The residency class members, especially, accepted the person and ideas and were interested in each other. There isn't enough time to sit down together in team meetings for this to occur." A pertinent response was: "I had a feeling of acceptance but little change occurs as a result of suggestions."

Question 8. Did you experience illness or unusual fatigue during the first nine months of employment? Two informants reported no episodes of illness, but further inquiry revealed that one did return to smoking at the end of the first month of employment and gained 10 pounds during the first year of employment. Symptoms of respiratory infections or fatigue began at the end of the first month for seven of the 18 informants. By the end of six months, 16 of the informants had experienced either one episode, or a combination, of influenza, upper respiratory infection, fatigue, self-reported depression, and ulcerative colitis.

Informants reported that as newly employed staff nurses they

frequently worked while experiencing upper respiratory infections. One informant said, "I waited for someone to send me home--and no one did. I frequently had colds on Monday but was afraid to go home." Other informants stated that fatigue and depression occurred at night. One confided that symptoms occurred as she "was learning her new role and wondered if she made any difference." This informant also identified that her supervisor provided support at this time and the symptoms were resolved. One informant who had been employed in community health for four years shared that she used approximately one day of sick leave every two months to prevent illness and "burnout." Usually following, or during a long, busy schedule she stayed home "for a day to herself" which might include cleaning house, sleeping, going out window shopping, or going to the library. "My immediate supervisor and older nurses understand this, but new nurses do not feel comfortable doing this." She also reported being much healthier than she was in the time of initial employment in community health nursing.

Question 9. Did you have available and use role models? Identify who they were. Tables 4 and 5 summarize the responses to this question. Three community health nurse informants did not have a role model available. The remaining 15 informants identified a supervisor, senior staff nurses, peers, or a nursing specialist as their role models. All 15 informants had an immediate supervisor but her availability varied. Some supervisors were readily available, while others

were identified as being "too busy" and often not accessible when they were needed.

Table 4

Availability of Role Models for Community Health Nurses

Role Model	Number (N=18)
Available	15
Not available	3
Used	13
Not used but available	5

Table 5

Role Models Used by Community Health Nurses

Role Model Used	Number (N=13)
Supervisor	5
Senior staff nurse	5
Peer	2
Nurse specialist	1

Question 10. Were you able to share your ideas or problems with others? How and with whom were you able to do this, and were your ideas accepted? Nearly all, or 17, of the informants stated that they were able to share their ideas and problems with others and their ideas

and suggestions were accepted. Eight of the informants' first choice for sharing was with their supervisor; three identified this sharing as occurring with their peers; three identified their choice to be with members in the residency seminars; and four identified others. The others included school personnel, a clinic nurse, a director of nursing, a community health nursing consultant, and a team peer. A typical response was: "The team gives support to each other as people with needs, and the support occurs more often than it does in the hospital."

A summary of the shock phase of reality shock identified by Kramer (1974), Kramer and Schmalenberg (1977), and Schmalenberg and Kramer (1979) revealed that the characteristics and symptoms of moral outrage and fatigue were identified most easily. Some of the contributing factors to shock and moral outrage were identified as working with high-risk families in their homes, the vast amount of paperwork required, the amount of role flexibility needed, and the variety and the ambiguity of roles. Changes in the subjects' roles from "expert practitioner" to the generalist, which required a great deal of flexibility, produced role conflicts and symptoms in this phase.

Osborne's (1970) conceptual framework also was supported by responses such as, "I was no longer the expert," and "the community health role was varied and I needed to have people to call [when I didn't have the necessary skills or knowledge]." The responses

supported Osborne's belief that increased skills are needed to function within the wellness continuum.

Recovery Phase

The recovery phase of reality shock was explored in the ethnographic interview Questions 11 and 12. This phase is characterized by the return of a sense of balance, by being able to see things from more than one perspective, and by the ability to see humor in situations (Kramer, 1974; Kramer & Schmalenberg, 1977; Schmalenberg & Kramer, 1979). This phase is a time for growth and for creative conflict resolution.

Question 11. How long did it take you to master the new skills and routines and feel comfortable in your new role in community health nursing? The process also was to be described. Informants described mastery of new skills and routines as beginning to occur by the end of the first month, and all had mastered the new skills and routines by the end of the first year as illustrated in Table 6. Feelings of being comfortable in the new role were described by informants as beginning following six months of employment and developing through three years of employment as illustrated in Table 7.

For the 12 informants to be employed as generalists took an average of 8.2 months to master the skills and routines initially and to feel comfortable in the new role. The six informants employed in

Table 6

Mastery of New Skills and Routines

Length of Time	Number (N=18)
At initial employment	1
1 month	1
2 months	1
3 months	1
4 months	2
5 months	2
6 months	2
8 months	2
9 months	2
1 year	4

Table 7

Comfortable in New Role

Length of Time	Number (N=18)
6 months	1
8 months	2
9 months	2
1 year	8
16 months	1
18 months	1
2 years	2
3 years	1

a specialized role accomplished this adjustment more quickly than for those informants who were employed as generalists. Those nurses in a specialized role took an average of 6.8 months.

Several commonalities emerged in the responses to Question 11. Confidence in the role increased as skills were mastered. At the same time, satisfaction in the role also rose. Mastery of skills and feeling comfortable in the role was, however, a gradual process. Moreover, summer employment was identified as assisting in this process; "the pace was slower and one could be more relaxed and creative." One informant indicated that the termination of the residency seminars after nine months of employment became a time for feeling "real preparation" for community health nursing.

Question 12. Describe what and who helped you most in your job transition from hospital to community health nursing. Who provided feedback? The majority of the informants did not identify any particular person or group as the primary facilitators in the transitional process. However, experienced staff members and the residency program were identified most frequently and individual responses are tabulated in Table 8. Typical responses included, "No question was too dumb to ask--it was a good natured staff"; "My supervisor helped most with many positive strokes and suggestions for interventions"; and "Residency class provided practical skills and a lot of support from others in the group."

Table 8

Assistance Provided in Job Transition

Who or What	Number (N=18)
Experienced staff nurse	5
Residency program	5
Supervisor	3
Staff	1
Internal motivation	1
Previous employment	1
Nursing consultant	1
School personnel	1

In summary, the recovery phase identified by Kramer (1974), Kramer and Schmalenberg (1977), and Schmalenberg and Kramer (1979) occurred in informants experiencing initial employment in community health nursing. Informants had opportunities to solve role conflicts. New strategies were tried out with the support of experienced staff, residency seminar members, supervisors, and others.

Resolution Phase

The final phase in reality shock is resolution and Questions 13, 14, and 15 explored this phase. The conflict between school- and work-held values must be resolved or the tension of the conflict reduced. Kramer and Schmalenberg (1977, pp. 17-24) and Schmalenberg and Kramer (1979, pp. 5-9) identified the constructive and destructive adaptations to role conflicts. The most useful and satisfying

resolution is bicultural adaptation which is achieved by only a few nurses. This type of adaptation uses both school- and work-held values and is the most constructive for the individual and for the improvement of the health care system. Types of destructive school-work conflict resolutions include changing jobs, returning to the school setting as either a student or a teacher, becoming complacent or bored in the job, or exiting from the nursing profession. Destructive role conflict resolution hinders, or decreases, an individual's growth and changes agent activities. Such a change results in no improvement in patient care.

Question 13. Can you practice nursing as you would like in your present job? What, if anything, keeps you from doing what you want to do and being the kind of nurse you want to be? Eight of the 18 informants said they could practice nursing in their present jobs as they deemed appropriate. Appropriateness was based on their nursing judgment. Two other informants indicated that they could do so but qualified the statement by stating that additional depth and involvement, especially in the schools, could be accomplished with an assignment which was smaller than the present one. They also stated that satisfaction would be increased with additional "hands-on" type of activities.

Four informants indicated that they had mixed feelings or were uncertain about being able to practice currently as they desired.

Comments included such statements as, "I don't have time to read on pertinent topics to increase my background and it's hard to keep current," and "the amount of paperwork required for each client reduces the time I have to work with people."

Not being able to practice as they desired was a response of four of the 18 informants. Two informants identified the generalist nursing role as causing conflict for them in the area of practice. The other reasons cited for not being able to practice as they desired included the amount of paperwork required, the inability to use highly technical kinds of nursing procedures regularly, such as intravenous therapy and trauma care procedures, and the goals of the administration which came before those of the individual nurse.

Question 14. Do you have anything in your job that you wish you would not have to do very often? Two of the informants responded that there was nothing they wished they did not have to do very often. One-half, or nine, of the informants quickly identified "paperwork" as the task they disliked the most in their practice of community health nursing. Two other informants described paperwork as the second most disliked task in their job. The commonalities identified were that informants believed that the amount of paperwork is overwhelming, especially at first, the number of reports and recording needed is far more than that required in previous hospital practice, and paperwork takes too much time away from client services in a busy schedule. One

nurse commented, "Recording takes more time than I am comfortable allowing."

Working within special programs such as with maternal and infant high-risk cases, child abuse cases, and school nursing was identified by six informants as the most undesirable involvement they had in community health nursing. Setting fees for home health services was another function that one informant wished she did not have to do in her job.

Question 15. Describe the degree of comfort you experienced in working with the acutely ill and in preventive health. Two informants expressed equal comfort in working in insitutions and in community health. Eleven informants indicated that they were more comfortable in their present job in community health than they were in the acute care setting. One informant described being more comfortable in community health because "there is a higher degree of satisfaction, and opportunities for change, creativity, and prevention." Another stated preference for "dealing with the holistic approach." One informant said, "I'm more interested in ambulatory care so would chose community health. We produce a more long term effect with education and long term care--we can have more impact." Yet another informant stated, "I've reached a comfortable feeling now in community health beginning my third year with more responsibilities and independence [in the job]. I have more satisfaction from being skilled in more areas."

Comments from the five informants who preferred the acute care setting, or illness continuum, focused on the need to see results of the care given, on the unstructured and ambiguous role of the community health nurse which caused discomfort and frustration, and on the lack or lessening of control of situations and environment in community health. One informant said, "I feel comfortable but would feel even more so if I had more time, especially in the schools. Politics in the office and lack of support from my supervisor cause frustration." Yet another informant responded, "In community health it takes a long time to accomplish one minor goal. Rewards in working with the acutely ill are seen quickly, and the time lapse for feedback is much less." One informant stated, "It is much easier working with the acutely ill--one goes home after eight hours and not with the total responsibility for the patient."

The last three interview questions which explored the resolution phase of role conflicts in reality shock also allowed the investigator to explore bicultural role adaptation in the community health nurse informants. Since completion of the interviews, the investigator noted that at least three of the informants identified as preferring nursing practice within the illness continuum have terminated their positions in community health nursing. This reaction raises a question if the terminations were due to lack of resolution in role conflicts and lack of bicultural adaptation or because of personal or

other reasons.

Summary of Findings

Symptoms of the honeymoon, shock, recovery, and resolution phases of reality shock (Kramer, 1974; Kramer & Schmalenberg, 1977; Schmalenberg & Kramer, 1979) were identified in nurses who experienced initial employment in community health. However, the presence of all of the symptoms possible in each phase and the degree of the symptoms present were not ascertained.

No contradictory findings occurred in the responses by the informants; however, the majority of the interview questions did not illuminate support for the two continua models of health. The questions clearly elicited information about the symptoms and phases of reality shock.

Support for Osborne's (1970) two continua--illness and wellness models of health--was identified in at least three questions. Seemingly, increased difficulty occurs with work in the wellness continuum. The reasons that the nurses described included ambiguity of role, the need for increased flexibility, the different view of health--holistic and preventive--and the use of psychosocial skills in addition to hospital-acquired skills. Nurses' complaints were that they had been experts in the hospital role and felt uncomfortable in the generalist role in community health. Too much time was needed in order to feel

comfortable in the new role.

The role ambiguity present in community health influences the presence of symptoms of reality shock and supports the use of separate and different illness and wellness continua of health. Time was needed to become a generalist in community health since competencies and skills are needed in widely diversified areas. A difference exists, also, in the feedback system. In community health feedback is absent if the nurse is working alone, or it may not be as immediate as in institutional nursing. In practice, support systems also vary in the two continua. Supporting networks for community health nursing include peers, experienced nurses, supervisors, and residency seminar members who assist in varying degrees in the role transformation and resocialization process.

The data are strongly supportive of the notion that reality shock is present in the resocialization process of community health nurses and that a difference is present in nursing practice in the wellness continuum. Further studies are needed to determine all of the symptoms and degree of reality shock that newly employed community health nurses experience and to determine what differences exist in nursing practice in the wellness continuum.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The study was designed to determine what community health nurses experience in the process of role transformation and resocialization in moving from the illness to the wellness continuum of practice. The presence of supporting networks in the bicultural adaptation to work role conflicts was identified in orientation programs and daily practice. The ethnographic research approach to interviewing provided the method for gathering rich and pertinent data. The rich data gained through open-ended questions could not have been obtained by survey. The only approach to formulating questions in informants' terms and learning what was important to them was ethnography.

Symptoms of reality shock identified in new graduates by Kramer (1974), Kramer and Schmalenberg (1977), and Schmalenberg and Kramer (1979) were identified in the role transformation and resocialization process of community health nurses. Symptoms were identified in the honeymoon, shock, recovery, and resolution phases. However, the degree and the number were not ascertained through the interviews conducted.

Presence of supporting networks was elucidated by informants in the process of role resocialization and in bicultural adaptations.

Experienced staff nurses provided the most frequently identified support, followed by residency program members, supervisors, and staff peers. The foregoing support networks assisted in varying degrees in the resocialization and bicultural adaptations.

The illness and wellness continua of health theorized by Osborne (1970) provided insight into the role transformation and resocialization processes. Responses to at least three of the 15 questions indicated support for the two continua of health. Informants identified that advanced preparation and skills were needed as they moved from the illness to the wellness continuum of health and nursing practice. A difference in nursing practice between the illness and the wellness continua also was described by some informants.

Limitations of the Study

The purpose of this study was hypothesis generating rather than hypothesis testing. Qualitative data were sought rather than measurement of variables. The small number of informants (N=18), from primarily two health departments, limits the generalizability of the information elicited.

Some researchers place little value on instruments in which reliability and validity have not been established. The ethnographic interview method of exploratory descriptive research does not lend itself to establishing reliability and validity for the interview

questions. Scores were not computed or relationships established from the informants' responses. Again, caution must be exerted relative to generalizability because relationships identified may have been due to chance.

The ethnographic research approach seeks to learn from and understand informants through flexible and probing inquiries about their experiences and perceptions. The optimum time for conducting interviews may not have been attained for all of the informants. This factor could have influenced the depth and accuracy of descriptions provided.

The retrospective recollection of informants about initial employment experiences and perceptions may not have been complete or accurate following three years of employment. However, the responses of those employed for longer periods of time were congruent with the responses of other informants.

The skill and proficiency of the investigator in conducting the interviews also can be a limiting factor. However, the interviews for the study were not the investigator's first attempt at conducting ethnographic interviews. The investigator had one year of experience under the supervision of an experienced ethnographer.

Implications for Nursing

Implications for nursing emerged from this study of role

transformation and resocialization of nurses when initially moving from institutional to community health nursing. The implications have relevance for the orientation programs for community health nurses, the role of immediate supervisors, experienced senior nurses, and peers in the resocialization process, and the management staff of community health programs and services.

Orientation Programs

Agencies employing community health nurses either as generalists or specialists need to be aware of adaptations that may need to be made in hiring schedules and in orientation programs. Since the generalist needed an average of two months longer than the specialist to master skills in the job, adaptations must be made in orientation programs to provide guidance and support for the generalist over a long period of time. The sequence of orientation programs should be planned carefully to avoid overloading the generalist with vast amounts of new information, especially during the first two weeks.

Regularly scheduled seminars for newly employed community health nurses also were cited by informants as assisting in the role resocialization process. Based on this study suggestions can be made for continuing education programs and seminars which would reduce reality shock. Seminars under expert leadership can provide support for newly employed nurses, offer opportunities to practice skills and

apply principles, and assist in the resolution of role conflicts and bicultural adaptation.

Summer employment and/or 12-month contracts also were cited as promoting mastery of skills and role transformation. For new staff to be hired and begin employment during the summer months or to be employed on 12-month instead of 10-month contracts would be beneficial.

The generalist community health nursing role was identified by several informants as creating role conflicts. Reasons cited which contributed to generalist role conflicts included lack of depth in practice, lack of time and demand to develop expertise in one area, as well as the length of time required to feel comfortable in the job. Careful selection of nurses with wide backgrounds of experience and expertise in at least one area would help to resolve or lessen the generalist nursing role conflicts. Also, orientation programs which occur over long periods of time would enable the new employees to gain comfort or minimal expertise in one area, or program, prior to being introduced to a new program.

Supervisors

Less than one-half of the informants identified their supervisor as their role model. Traditionally, this function is an important one for supervisors. Efforts should be made to increase their availability and to provide opportunities to role model for new staff.

Some informants informally selected senior staff nurses for support and as role models. Supervisors informally could choose qualified senior staff and assist them in this role.

Informants identified being more comfortable in their role as they had developed added expertise in one area. Supervisors can help facilitate this process by recognizing contributions of new staff and encouraging staff development in areas of interest.

Problem identification and the need for support were acknowledged by the informants initially only to supervisors followed by other new staff. Lack of comfort with team peers may have been caused by informants' feelings of inadequacy or to competitiveness among the experienced staff. Initial lack of comfort in groups, moreover, has relevance for group or team activities and expectations for newly employed community health nurses. Participation in team meetings and activities such as presenting cases for discussion may produce anxiety in newly employed nurses.

All but one of the 18 informants identified some illnesses, or increased stressors, beginning shortly after employment. Almost all of the employing agencies offer sick leave for staff; however, new employees often are not eligible to use such leave until after 60 days of employment. The supervisor needed to look at the stress level of the nurses and facilitate earlier use of sick leave if necessary. Diversional or different assignments following particularly strenuous

schedules also may be necessary in order to reduce illness.

Management Personnel/Administration

The amount of paperwork produced shock and frequently was identified by informants as keeping them from practicing nursing as they wished; thus, role conflict resulted. Paperwork was described as overwhelming and taking more time than informants were comfortable allowing. This source of role conflict needs to be analyzed carefully because of the large amount of required forms that are used in community health. The use of dictaphones with recorders that can be used in the office or in the car may be one solution. The use of new electronic office systems, such as word processing, may be yet another satisfactory solution for this dilemma. The cost of such systems has to be evaluated against the factors of time spent in recording and in orientation to presently used records, employee dissatisfaction, and ultimately the cost of employee turnover.

Recommendations

The base line of information gathered through ethnographic interviews suggests the need for further studies. The data support the premise that different roles and skills are needed for nurses working in the wellness continuum. A study determining the correlation between Osborne's two continua theory of illness and wellness and

role resocialization would help to establish if a difference existed between working in the two continua of health. A comparative study between professional nurses' orientation toward the illness or wellness continua would provide insight and direction into recruitment and job retention efforts.

Determining the relationship between staff illness, job changes, and personal problems would help differentiate between the illness caused by role conflicts and that caused by personal problems outside the job. Knowing to what extent stresses and illnesses were influenced and related to reality shock and role resocialization or from personal outside-the-job causes would be useful in assisting and supporting community health nurses.

The data from this study were strongly supportive of the premise that reality shock is present in the resocialization process of community health nurses. A follow-up study addressing the degree to which newly employed community health nurses experience this phenomenon is essential. The results of such a study would delineate specific programs which could be instituted to support nurses through this process.

Little is known about the personal background and experiences of rural community health nurses or the variety of expectations in their roles. A study to determine a profile and the needs of the rural community health nurse as compared to community health nurses in large health departments would be of value to educational institutions

preparing nurses, in job recruitment, for staff development and contuing education, and for determining needed support systems and resources.

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APPENDIXES

APPENDIX A

INTERVIEW QUESTIONS

1. Describe if and how you felt prepared for your first position in community health nursing.

2. How did the curriculum in your nursing education prepare you for community health nursing?

3. Did your nursing curriculum or anyone else stress that additional education and skills were needed in community health nursing? Elaborate on what or who and how.

4. How did your previous work experiences prepare you for community health nursing?

5. Describe the orientation program in which you participated for your position in community health nursing.

6. Describe any surprises you encountered in community health nursing.

7. Did you receive respectful, accepting and concerned treatment from others? Describe. Identify who and their roles.

8. Did you experience illness or unusual fatigue during the first nine months of employment? If so, describe.

9. Did you have available and use role models? Who were they?

10. Were you able to share your ideas or problems with others? How and with whom were you able to do this? Were they accepted?

11. How long did it take you to master the new skills and routines and feel comfortable in your new role in community health nursing? Describe the process.

12. Describe what and who helped you most in your job transition from hospital nursing to community health nursing.

APPENDIX A (continued)

13. Can you practice nursing as you would like in your present job? What, if anything, keeps you from doing what you want to do or being the kind of nurse you want to be?

14. Do you have anything in your job that you wish you would not have to do very often? Describe.

15. Describe the degree of comfort you experienced in working with the acutely ill and now in preventive health nursing.

APPENDIX B

DEMOGRAPHIC DATA SHEET: STUDY OF ROLE RESOCIALIZATION AND BICULTURALISM IN COMMUNITY HEALTH NURSES

You are being asked to participate in a study of role resocialization and biculturalism in community health nurses. This study is attempting to identify to what extent nurses experience reality shock when moving from institutional nursing practice to community health.

By participating in the interview you are giving your consent. All answers will remain anonymous and the results will be compiled. The answers to the questions will have no names or identifying numbers attached.

Please complete the following information before the interview. Check the appropriate answer or fill in the blanks.

_____

1. Is this your first job in community health nursing?

   Yes____ No____

2. Your present Age_____ Sex_____

3. Your basic education preparation

   AD_____ Diploma_____ BS_____ MS_____

4. Year of graduation_____ Highest degree held_____

5. How much hospital experience did you have as a registered nurse prior to initial employment in community health nursing?

   Years_____ (or) Months_____

   Where_____

   Size of hospital_____

APPENDIX B (continued)

6. How long have you been employed in community health nursing?

   Years_____ (or) Months_____

7. How many staff nurses are employed in the agency of your present employment?

   Nurses_____

APPENDIX C

HUMAN SUBJECTS COMMITTEE LETTER

msu DEPARTMENT OF HEALTH, PHYSICAL EDUCATION & RECREATION

COLLEGE OF EDUCATION MONTANA STATE UNIVERSITY, BOZEMAN 59717

June 3, 1980

RECEIVED

JUN 1980

Bernice O. Bjertness
c/o Anna M. Shannon
School of Nursing

Dear Ms. Bjertness:

You have the approval of the Human Subjects Committee to do your research entitled "Study on Role Resocialization and Biculturalism in Community Health Nurses."

Please have the release forms filled out and send them to me.

Good luck with your research project.

Sincerely,

George Shroyer

George Shroyer, Chairman
Human Subjects Committee

GS:bam
cc: Dr. John Jutila, VP for Research

TELEPHONE (406) 994-1001

APPENDIX D

DEMOGRAPHIC TABLES

Demographic Data of Community Health Nurse (CHN) Informants
(N=18)

Table A

Length of Nursing Experience Prior to Employment in CH*

Length		Number (N=18)
9	months	1
10	months	1
14	months	1
15	months	1
1.5	years	2
2.5	years	1
3	years	3
4	years	2
4.5	years	1
5	years	2
5.5	years	1
6.5	years	1
10	years	1

*Range--9 months to 10 years; Mode--3 years; Mean--3.5 years.

APPENDIX D (continued)

Table B

Length of Employment in CH*

Length	Number (N=18)
8 months	1
1 year	8
15 months	1
2 years	5
3 years	2
4 years	1

*Range--8 months to 4 years; Mode--1 year; Mean--19.5 months.

Table C

Age of CHNs
(17 female, 1 male)

Age	Number (N=18)
25	2
26	3
27	3
28	3
29	2
31	1
32	2
41	1

*Range--25 to 41 years of age; Mode--26 years of age; Mean--28.4 years.

APPENDIX D (continued)

Educational Preparation

Degree	Number (N=18)
A.D.	1
B.S.	16
M.S.	1

Location of Educational Preparation

Location	Number (N=18)
Within Montana	12
Outside Montana	6

Staff Nurses in Employing Agency

Number of Staff Nurses	Number of Respondents (N=18)
1	1
10	1
16	3
30	13

APPENDIX E

LETTER TO HEALTH DEPARTMENT

September 4, 1980

Dear Ms. :

I am a Montana State University graduate nursing student on the Billings Extended Campus and am doing a research study in the area of role resocialization and biculturalism in community health nurses. My data will be gathered through interviews conducted with nurses who are employed in community health nursing, and I would like to interview nurses in your agency.

The role resocialization experiences of nurses who move from hospital nursing to community health nursing will be explored. My assumption is that nurses experience role conflicts and reality shock in becoming bicultural in their new role and area of practice. If my data reveal that nurses experience reality shock symptoms, then the results would be of value in planning orientation programs for nurses newly employed in community health.

Enclosed you will find a copy of the abstract for the study, a sheet asking for demographic data and providing an explanation of the study, and a copy of the interview questions. I would like for you to allow me to interview any consenting staff nurses who have been employed in community health nursing for a minimum of six months up to three or four years. If it is convenient, I would like to conduct interviews on September 18, 1980. If you have further questions, please feel free to write or call me. I can be reached during the day at work at Yellowstone City-County Health Department, 252-5181, Extension 320; or at home, 656-7463. I shall be awaiting your reply.

Sincerely,

Bernice Bjertness

(Mrs.) Bernice Bjertness, R.N., B.S.
1912 Howard Avenue
Billings, Montana 59102

Bjertness, Bernice O
Role resocialization and biculturalism in community health nurses