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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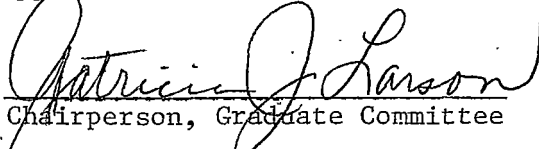RURAL NURSES' PERCEPTIONS OF JOB RELATED STRESSES
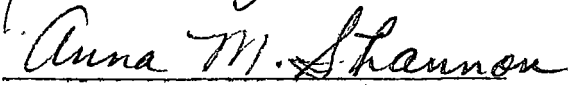AND COPING METHODS

by

MARIE LOUISE BUNDE

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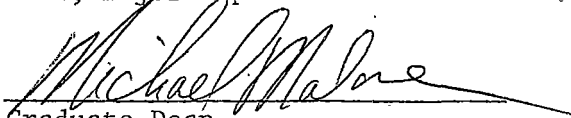of the requirements for the degree

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For the accomplishment of this thesis, I offer thanks

To my parents for birthing me

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To my chairman for her creativity

To my country for the freedom to learn, and

To God for His sustaining love.

MLB

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ABSTRACT

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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 power-
lessness, 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 ques-

tioned whether the coping methods of forgetting it and going on, of

working excessive hours, and of crying were truly effective in manag-

ing 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 per-

sons 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 infre-

quently. A professional isolation surrounds the rural nurses' prac-

tice. Nursing judgments within the rural setting must be frequently

based on one's own knowledge and experience. No immediate consulta-

tion 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 knowedge 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.

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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 influ-
ence on future stress is worth discussing. Meichenbaum (1975) sug-
gested that the individual experiences a moderate level of arousal when
covertly rehearsing the handling of a stressful situation. His conten-
tion was that this arousal prompts the emotional innoculation 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 informa-
tion can be found to be effective in reducing objective worry following
reality testing.

Differing types of past stress may have varied effects on indi-
viduals. Burgess (1978) pointed out that earlier victimization and
chronic life stressors such as economic hardship, lack of social sup-
port, and pre-existing biopsychological problems tend to delay a per-
sons' 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 con-
trols 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, psychologi-
cal resources, and specific coping responses of the individuals' per-
sonalities. 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 posi-
tive 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, pas-
sive 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, hyponosis, 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 proba-
bility, 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 rela-
tionship 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, con-
sistent nursing service support; having comparable pay to other pro-
fessions; 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 meaning-
ful 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 member-
ship; conflict in goals; lack of staff; physician interaction; admin-
istration; 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 inter-
pretation 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 forma-
tion 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 ethno-
graphic 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 cul-
ture 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 Shradley'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 fol-
lowed 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 iden-

tified.

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 knowl-
edgeable 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 your-
self 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 phyisicians 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 Mangensteen

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 pro-

fession. 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,

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"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 medi-
cal 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.

<center>Singularly Voiced Stressors</center>

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 responsi-
bility 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 frame-
work. 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. Ver-

batim 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