A nursing internship, does it bridge the gap?
by Mary Jo Mattocks

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

Abstract:
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The data analyzed suggest that there is no influence on role deprivation by marital status, age, and family member in a health profession. The data suggests the following relationships: with previous experience, role deprivation scores were lower ($p < .01$) and role deprivation varies according to the type and/or variation of clinical experience ($p < .01$) . Respondents satisfied with their job scored lower on the role deprivation scale ($p < .01$) and those respondents employed where they experienced the internship demonstrated lower role deprivation ($p = .0004$).

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

of

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ABSTRACT

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CHAPTER 1

INTRODUCTION

The Problem

The existence of a dichotomy between nursing education and nursing service has been identified, explored, researched, and analyzed. Role transition, however, from student to new graduate continues to lead to problems for the neophyte (Cass, 1968; Kramer, 1974; Logsdon, 1968; Niederbaumer, 1968; Sheahan, 1972). Kramer (1974) identifies this process the neophyte experiences when changing roles from student nurse to staff nurse as reality shock. Once out in the "real" world, the new graduate discovers "The way I was prepared in nursing is not the way nursing is practiced." That is, the school-bred values conflict with those in the practice setting. If these conflicts are not resolved, they can lead to role deprivation, job hopping, burnout, and even leaving the nursing profession (Kramer and Schmalenberg 1978).

The questions that logically come to mind once this problematic situation is recognized are: 1) What steps have been taken by nursing education and/or nursing service to ease this transition? 2) Are the steps taken successful?

The nursing literature suggests several areas in which the neophytes' role transition into the profession has been addressed. These will be discussed later; however, it is important to note that no formal studies have been conducted to determine the effectiveness of the programs.

Statement of Purpose

The purpose of this study was to determine if an internship program offered during the last six weeks of a baccalaureate nursing program influences the reality shock which occurs during the transition from nursing student to graduate nurse. The author was also interested in determining if marital status, age, job satisfaction, previous experience (aide, LPN), or family member in the health care field related to the amount of role deprivation experienced. The following questions served as the basis for data analysis.

1. Is there a significant difference in the amount of role deprivation experienced by nurses who participated in the internship and those who did not?

2. Is there a relationship between the amount of role deprivation experienced and age, marital status, job satisfaction, previous clinical experience or family member in the health care field?

3. Is there a relationship between the extent of the role deprivation and whether the nurse is working at the institution where she experienced the internship or clinical experience during the last quarter of the program?

Definition of Terms

Reality Shock: The discovery and the reaction to the discovery that school-bred values conflict with work world values.

Role Deprivation: The disparity between the nurses' role as she perceives it should be and the perceived situational limitations to enacting her role conception.

Nursing Internship: A learning experience designed to meet individual learning needs of each student, as defined by the student through self-written objectives, in an area

of nursing practice selected by the student. An intensive reality clinical experience planned to assist students in the integration of the competencies essential for their practice of professional nursing. This clinical experience occurs during the last six weeks of a baccalaureate nursing program. It is a joint endeavor by nursing education and nursing service to provide the student with a chance to "test her wings" in a facility and clinical area of the students' choice, independent of the college setting and direct supervision of the nursing instructors. Appendix A contains the course objectives, time sequence and requirements.

Bureaucratic Role: The office that the nurse holds as an employee of a particular hospital. Bureaucratic role conception is assumed to imply loyalty to the hospital administration (Corwin, 1960).

Professional Role: "The term used to refer to the institutional status of the nurse, her position within the nursing profession; it implies loyalty to the the abstract professional standards which are sanctioned by the profession" (Corwin, 1960, page 163).

Service Role: Is also associated with institutional status; however, it implies loyalty to the patient, particularly to the patient's psychological welfare.

CHAPTER 2

CONCEPTUAL FRAMEWORK

INTRODUCTION

The basis for the conceptual framework used in this study was derived from role theory and socialization. Three aspects of role theory are discussed: formation of role concepts, role transformation and three concepts of nursing. A general model of socialization, the initial professional experience and resocialization into a work setting are the components of socialization discussed.

ROLE THEORY

Role Concepts

Kramer defines role as a "set of expectations about how a person in a given position, in a particular social system should act" (1974, page 52). Roles do not exist in a vacuum, but they involve the expectations of significant others.

The formation of role concepts is significant because the process of conceptualizing role is a process of self

placement with respect to others. Nurses are judged and regarded by the others and therefore regard themselves on the basis of their ideals and actions (Corwin, 1960). As an illustration, consider the hospital nurse. If a nurse believes that she is essentially playing the role of hospital employee, she will act in a different way than if she pictures herself in the role of colleague to doctors and other nurses (who happen to work in hospitals). The concept of employee places her in a subordinate relationship to the hospital authorities that employ her, while the concept of colleague calls attention to her regard for relationship with her peers, rather than superiors. There is implicit in a role conception, not only an expected behavior but also a placement. Strauss states it "...the director of activity depends upon the particular way that objects are classified ...the naming of an object provides a directive for action" (1959, pages 21-22).

Benne and Bennis define four principle sets of expectations that determine the character of the nurse's role. First there are the expectations that stem from the work setting, from the institution (1959). Expectations of the nurse's colleagues and peers make up the second set. The third set of expectations which shape the role of the

professional nurse are those of reference groups. Typical reference groups would include family, church and political party. The last, but probably most important set of expectations comes from her own role image of what a nurse should be and do. If these expectations reinforce one another and if they are consistent, the role is stable. However, if there is conflict, the role definition is unstable.

In order to understand concept formation one must look at the importance of role concept as it is related to the self concept. Conceptions provide perspective, an orientation to the world as well as one's self. Role conception therefore is intertwined with the problem of personal identity, i.e., the total self image produced by those conceptions a person regards important to himself.

Corwin believes that the most significant way concept formation is patterned is through training programs (1960). The concept adopted varies according to the school's relationship to the institutions that dominate the occupation. He dichotomizes programs into the following classes; "long and short duration, liberal and vocational, and autonomous and subordinate" (1960, page 8). Two types of programs become apparent, the professionally oriented and

the bureaucratic. The humanitarian-oriented concept of nursing is being confronted and replaced by emerging professional and bureaucratic concepts.

Students usually enter nursing school with some lay expectations of what nursing is. They typically enter their career with the desire to do something socially worthwhile. While in school they learn a nursing role as described by their instructors. Once out in the "real" world they often discover that what they were taught is not how nursing is practiced. The nursing school subculture places emphasis on total patient care, theory, and general behaviors that can be applied to many situations. In actual nursing often nurses are placed in a task-oriented "functional;" or "team" nursing role. The emphasis is on doing the "bestest for the mostest." Educators blame those in nursing service of being task-oriented and preoccupied with established routines and technical proficiency. Nursing service personnel are very critical of the "ivory tower" educators with their emphasis on creativity, individualized care and intelligence (Kramer, 1969). The neophyte is caught between the two antagonists. She is prepared in the idealistic professional environment, yet she is expected to function in the realistic bureaucratic setting. This places the new graduate in a role for

which she is unprepared and may feel frustrated, helpless, disillusioned, and dissatisfied. These feelings often lead to role deprivation.

Role Transformation

Role transformation is defined as the process of moving in and out of roles in the social system (Burr, 1972). When assuming a new status new concepts must be learned. Shifts in the conceptual framework create shifts in the perceiving, remembering, and valuing which is filtered through them. Graduation from an educational program and the beginning of the active career constitutes a turning point in the transformation process. This phase of the career, being the initial test of role concepts is likely to provide a "reality shock" which proves to be a disillusioning and depriving experience. This statement is made for two reasons. First, abstract role conceptions cannot comprehend the full complexities of experience (Corwin, 1960). "Role conceptions are images, in a sense fantasies, which set the ideals; they cannot provide a totally realistic picture of what to expect from the career" (Corwin, 1960, page 17). An almost inevitable discrepancy appears between concept and consequent experience.

The nature of schools which are at least partially removed from the mainstream of the occupation constitute the second reason why graduation is likely to provide reality shock. The schools are staffed by teachers who tend to fuse their conception of what exists as they transmit the occupational culture to students. Teachers tend to project their fantasies, ideals and aspirations onto their students by stressing ideals. A tendency may exist for people to attach their own futures on the careers of others.

The reality shock that nurses experience in their first job usually includes four phases: honeymoon, shock, recovery, and resolution (Kramer and Schmalenberg, 1978). Perceiving the world through rose-colored glasses, excitement and exhilaration typify the honeymoon phase. During this period the new graduate is concerned with "skill and routine" mastery. The shock phase is the exact opposite. The neophyte realizes that the school subculture and the work subculture are in conflict. Anger is expressed and is directed toward former teachers or present employers. The recovery phase is characterized by a return of a sense of balance. The world is neither all bad nor all good. Resolution of conflicting values between what is taught in nursing and those actually practiced occurs in the fourth

phase of reality shock. Resolutions may be accomplished by adopting completely those values practiced in the work setting, ("going native"), returning to the school environment ("lateral arabesque"), bottling it up inside ("the burn out"), changing from one job to another in search of a place where there will be no conflict ("the job hopper"), or "the quitter," one who leaves nursing altogether (Kramer and Schmalenberg, 1978). There is one other pattern that Kramer describes. It is referred to as biculturalism, or the ability to get along in both subcultures without being completely absorbed by either. Ideally, the conflict would be resolved if all new graduates could accept and work with the values of both subcultures.

Role Concepts of Nursing

Corwin has identified three conflicting orientations in the concept of nursing. One emphasizes "the office, another the profession, and the third the calling" (Corwin and Taves, 1962, page 223). These ideal conceptions are referred to as bureaucratic, professional and service role concepts. The nurse in the hospital has alternate identities. She is a hospital employee (a bureaucrat who

occupies an office) and a responsible independent professional and a public servant. Corwin (1960) states that each requires different loyalties and presents incompatible demands, particularly the professional and the bureaucratic conception of the organization. The bureaucrat is skilled in areas of administrative routine while the professional is concerned with expanding knowledge. The professional, therefore, focuses on problem solving and goal setting for his current clients while the bureaucrat stresses categorical and routine elements of his client's situation. The client may require highly individualized and unique attention yet the bureaucratic organization is interested in standardization, and routine operation based on policy and procedure. It therefore appears that the professional and bureaucratic principles provide competing sources of loyalty and the opportunity for potential role conflict. In a study conducted by Corwin (1956) in which he concentrated on the change from student status to professional office in the hospital bureaucracy, it was concluded that in the office which the nurse holds in the hospital bureaucracy, bureaucratic and professional principles converge and conflict seriously.

What does all of this mean for nursing? It probably

points to a conflict for nurses because they cannot practice nursing in the way they feel it should be practiced. In a system which does not reward initiative and creativity, which is routinized and task oriented, the nurse who views herself as an autonomous professional has three options; she may accommodate to the system, leave the system, or live in the system with a high degree of dissatisfaction.

SOCIALIZATION

Model of Socialization

Socialization is defined as the process of learning new roles and adapting to them. It is a continual process by which individuals become members of a social group. Kramer (1974) refers to socialization as a period of time individuals spend acquiring the necessary knowledge and skills and undergoing the self identity and internalization process to prepare themselves for a specific role. She also states that acquiring the necessary knowledge and skills for occupational roles is among the most important socialization/resocialization process adults experience.

From the professional nursing perspective, the adult

socialization/resocialization processes focus on providing the values and behaviors basic to delivering quality client care. Standards for this process are obtained from the norms of the nursing service profession and guide the specific role of the nurse. Socialization/resocialization provides both the values and behaviors required for nursing practice.

Simpson (1967) describes socialization as a sequential set of phases or "chain of events." Figure 1 illustrates Simpson's model.

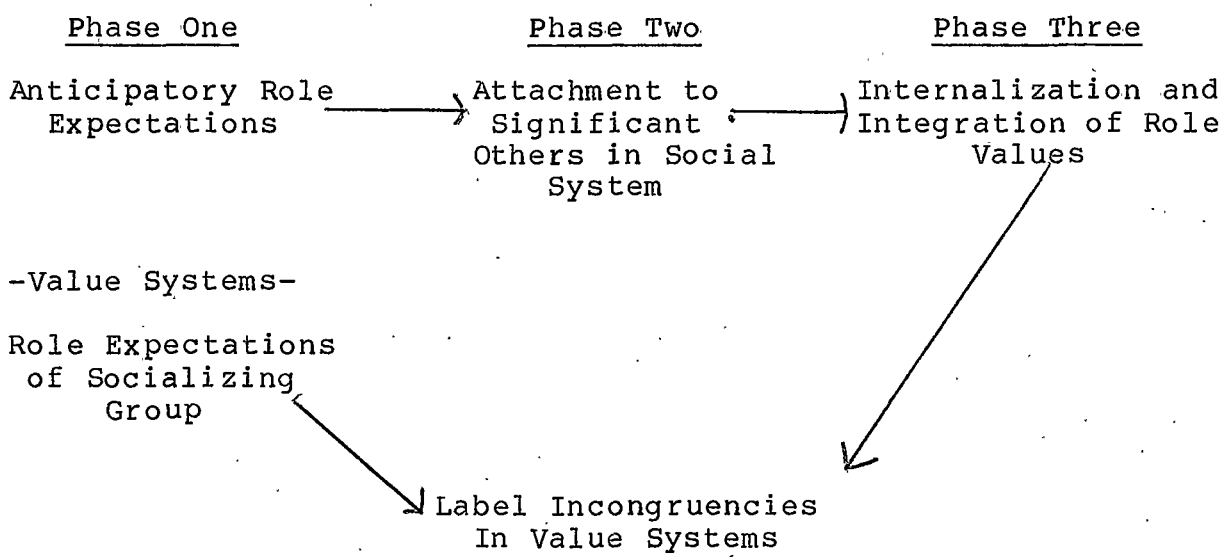

FIGURE 1

Phase one is the stage at which individuals shift their imagery of the role from the anticipated conception to the expectations defined by those already in the profession who are setting standards for them (Rosow, 1965). This phase assumes that the individuals entering the social system have learned a number of roles and values which give them experience for evaluating new roles. Also, the individuals are assumed to have an active part in the socialization to the new role. In other words, they have chosen to learn the new role expectations.

Phase two contains two components: 1) individuals will attach themselves to significant others in the social system and, 2) at the same time will label encounters with incongruencies between what they anticipated their new role would be and what is demonstrated by others. The significant others generally come from the social system in which the individuals are accountable. For example, the faculty tends to be this group in the initial professional socialization experience. The faculty are seen as role models for the values and behaviors of the new role. In the work setting, colleagues or immediate supervisors make up the significant others, who serve as role models. Successful outcomes for this stage of socialization/resocialization

depend on the existence of appropriate role models. This being the case, educational programs and work settings must deal with the problem of selecting and providing such models.

As the neophyte learns the expectations and develops relationships with role models, a point is reached where they are able to label or articulate that these role expectations are not what they had anticipated. Often this stage is accompanied by strong emotional reactions to the conflict generated as they are faced with different sets of expectations. The ability to successfully resolve the conflict is dependent on the existence of role models who exhibit behaviors that illustrate how to integrate the standards and values of the conflicting systems (Simpson, 1967). Thus, one can see that the two aspects of this phase, identification with significant others and the use of role models, are strongly interactive.

The third phase of this process involves the individual's internalization of the standards and values of the new role. Two aspects of this phase need consideration: (1) to what degree are values and standards internalized, and (2) by what processes did the resolution of the incongruencies of role expectations occur?

Three levels of opinion change have been defined by Kelman (1961). Compliance is one level of value orientation. At this level, the individual has not accepted the values as his own but enacts the expected behavior in order to obtain positive responses. The second level of opinion change is identification. Adopting certain roles that are acceptable to the individual typifies this level. It must be noted that in this phase there is an acceptance of the behavior, not necessarily the values. At the point the individual accepts the new roles, including norms and standards, internalization occurs. This is the third level of opinion change. The values and behaviors of the role have become a part of their own value system.

In nursing, two major socialization/resocialization processes have been described: (1) the initial adult socialization era and (2) the resocialization process that occurs as graduates enter the work setting. What occurs during those two processes is crucial to the development and maintenance of professional values in nursing practice.

Initial Professional Experience

Through the initial professionalization experience,

individuals not only learn the skills, knowledge, and values of the new role, but they acquire a degree of identification with the role (Simpson, 1967). Davis (1966) has described the process of the initial experience as the doctrinal conversion process. This is a six-stage process that focuses on the transition of changing values and imagery of a role from that of a lay person, to that of a professional nurse. This first job is crucial in the development of the nurse's identity as a professional. It is a time of vulnerability and role transformation. How the neophyte copes with those initial changes may set the pattern for the remainder of the career (Schein, 1966).

Stage one is referred to as "initial innocence" (Davis, 1966). Individuals enter a professional program with expectations of what they will become and how they "should" behave. Davis (1966) suggests that individuals enter nursing with a service orientation. This means helping people with the use of tools and procedures in order to ensure successful outcomes for sick people. In contrast, the professional educational imagery of the nurse is of one who defines clients in terms of maintaining health, uses critical inquiry to creatively manipulate knowledge the client requires, approaches skills from the viewpoint of

knowledge principles that guide their use and the use of problem-solving nursing process and decision making.

The conflict that occurs is based on the lay imagery of someone who is being socialized and not positively reinforced. Pressures are present for that person to behave in ways that he or she does not comprehend. That is, instead of being praised for bed bath technique he is asked to analyze the interaction with the patient. This confrontation results in disappointment and frustration for the individual. Often these emotional feelings are denied, but begin to be expressed soon after the first faculty-student evaluation conferences occur (Davis, 1966).

The formal evaluation process provides the student with the opportunity to express his concerns. It becomes evident to them that through that process they are not alone but share a set of value incongruencies with their peers. Labeled recognition of incongruity in what Davis identifies as stage two. Verbal sharing leads to collectively labeling what the incongruencies are. Davis notes that this is a problematic stage because those being socialized have only a vague insight into the rationale of the professional/educational value system. Yet these individuals are pressured to produce behaviors based on that system.

Stages three and four are referred to as "psyching out" and role simulation. The individuals who wish to continue in nursing begin to identify the behaviors they are expected to exhibit and to role model such behaviors. It is what Davis refers to as "psyching out" the faculty. At this point the internalization of professional values begin to take shape. The more the role simulation is done, the more the behaviors will become an authentic part of the individual. Often a feeling of moral discomfort occurs, of not being "true to oneself" and "playing a game," which results in guilt.

In stage five, provisional internalization, the individuals vacillate between commitment and performance of new behaviors of the profession and behaviors reflecting their lay imagery. An increasing ability to use the language of the professional role models, faculty, reinforce the use of the new professional imagery model.

Stable internalization, the sixth stage, allows the imagery and behavior of the individual to reflect the professionally/educationally approved model. Socialization is not complete with acceptance of this stage but is specific to the educational institution. What happens to the new graduate as she enters the work setting?

Resocialization Into a Work Setting:

This phase of the socialization process deals with what occurs when nurses enact their professional roles as employees in organized work settings. This issue has been labeled "the professional/bureaucratic conflict" and was discussed earlier. It is now appropriate to expand the concept.

To review, "the professional work system focuses on the entirety of a service activity which is based on a systematic body of knowledge acquired through extensive study" (Hinshaw, 1977). Accountability and loyalty are to the professional colleague group. On the other hand the bureaucratic work focuses on rules and regulations and on-the-job technical training. The conflict anticipated, that of resocialization of the neophyte into an organized work setting has different expectations for resolution than does the lay/professional conflict. In resocialization the desired outcome is an integration of the two value systems.

Kramer (1974) identified four stages of the resocialization process which were based on her research.

Stage one is that of skill and routine mastery. The new graduate must apply universal principles of how to

function and behave in a specific manner, unique to the work setting. Feelings of incompetence and frustration lead to the solution of learning or mastering specific skills and techniques.

The major concern with stage two, social integration, is becoming one of the group, developing rapport with coworkers. Usually this requires having mastered the skills. Not only does the stage deal with interpersonal relationships, but also gaining entrance to the "backstage" reality of the work setting (Kramer, 1974). That is how to act and behave as others do and being "let in on" doctors' particular likes and dislikes. The neophyte has to choose which behavior she wishes to enact. She can choose to enact backstage behavior, remain with skills mastery or begin to apply more of the knowledge that was learned through the initial socialization process.

Stage three, moral outrage, is the period in which incongruencies between the professional/educational values and the work setting behavior surface. Nurses were prepared one way but nursing is practiced another way. This is a crucial period for neophytes. They are experiencing a developmental and situational crisis. Questions that must be asked are: How were they prepared? How could this

crisis be prevented? Who in the work setting can intervene? If this conflict is not resolved, professional nursing pays a high price from the standpoint of both educational and work-setting programs (Kramer and Baker, 1971).

Conflict resolution is the fourth stage of resocialization. This can occur in several ways; behavioral capitulation, going native, conformity or biculturalism. Those who choose behavioral capitulation change their behavior but keep their values. Usually these neophytes choose to return to educational settings or leave the profession. One can also choose to adopt the values of the bureaucratic setting and discard those of the professional/educational setting, or "going native." Conforming to the values and behaviors of the bureaucracy is also an alternative. Kramer (1974) suggests that biculturalism is the healthiest resolution to the conflict. These graduates are able to utilize the values and behaviors of both systems as they see appropriate. However, in a nationwide sample of 220 new graduates Kramer and Schmalenberg (1978) found less than 9% to be bicultural. Twenty-one percent of the sample had left nursing, 17% were either teaching or in school and 45% were "rutters, burn-outs, or job-hoppers."

SUMMARY

Role theory and socialization provide the basis for the conceptual framework of this study. The identification of the professional - bureaucratic conflict and its effect on role deprivation is significant to this study. Resocialization from new graduate to staff nurse also plays a role in the development of this study. Several questions come to mind in view of role theory and socialization. What steps are being taken by nursing educators or employees to alleviate the conflict? If programs exist, are they effective? What studies have been done that document this conflict? These questions served as the framework for the review of the literature.

CHAPTER 3

LITERATURE REVIEW

Corwin was one of the first to study the differential pressures of professional-bureaucratic role conflict (1960). In his comparative study of 296 graduates and students from seven hospitals and four schools of nursing in a midwestern metropolis, Corwin asserted that professional conceptions interfere with bureaucratic values and that both the bureaucratic and profession conceptions interfere with traditional nursing. The professional has shifted attention from the patient to technical activities and the bureaucrat is rewarded for skill in administration. Corwin anticipated that graduation from a nursing school and beginning employment in a hospital would be a period of great conflict. Professional ideals stressed in school confront the bureaucratic principles operating in the hospital. Corwin assumes that a difference between hospital and college nursing programs is in the direction of greater professionalism in the latter (Corwin, 1961).

Corwin developed and administered three Likert-type scales specifically designed to measure relative degrees of loyalty to bureaucratic, professional and service role conceptions to staff nurses, head nurses, and junior and

senior student nurses. Corwin found a systematic difference in the role organization of diploma and degree nurses. Degree nurses maintained high professional concepts more frequently than diploma nurses, combining them with either high or low bureaucratic conceptions. Those nurses who expressed strong ties to bureaucratic and professional roles simultaneously reported the greatest discrepancy between ideal concepts and perceived opportunity to fulfill them, that is, role deprivation. The professional role conception of diploma nurses was found to decrease after graduation, their loyalty to the hospital is maintained, but for degree graduates the reverse is true.

Corwin and Taves (1962) used the same frame of reference described above to expand Corwin's study. The findings in their study indicated that the type of role conception held, the certainty with which it is held, and the amount of role deprivation will be experienced differently by nurses with different types of training and in different stages of their careers. Baccalaureate students were found to develop relatively low identification with the hospital and to feel deprived in their bureaucratic role after graduation in spite of a rather high professional self-concept. Diploma nurses who demonstrated strong

bureaucratic orientations are less interested in teaching but more interested in promotion within the hosptial.

These two studies indicate that collegiate nurses are more likely to experience greater role deprivation because they hold higher professional role conceptions. It was at this point that Marlene Kramer became interested in Corwin's work and began studies which span a decade. Her studies have been investigating the process of the new graduate nurses' socialization to their first work experiences. It was from this research that the concept of reality shock was born (1974).

In a longitudinal study of 79 graduates from three California State College baccalaureate nursing programs, Kramer administered the Corwin role value scales at graduation, three months after beginning employment and then three months later (1966). She concluded from this study that new graduates (1) are oriented and loyal to the profession, not the place of employment, (2) wish they had had experience on the evening and night shifts as graduate students, and (3) expressed a desire for self identity and the opportunity to use their knowledge and skills. Standardized tape recorded interviews were also conducted during the last two time periods. Further results indicated that:

(1) "neophyte nurses will express more bureaucratic values after exposure to bureaucratic principles of work organization than they did at graduation" (Kramer, 1966, Pg. 89); (2) role deprivation scores are significantly higher three months after employment and (3) participants who left nursing, changed jobs because of dissatisfaction, or returned to school, demonstrated greater role deprivation scores than those who remained in the same job.

Two years later, Kramer did a follow-up study using the same sample. This study showed that the professional role conception decreased even further in comparison to the six-month post graduation testing (Kramer, 1969). This study also indicated that unless the bureaucratic orientation score increased, the role deprivation scores continue to remain higher than the median of the group.

Kramer's study entitled "Professional-Bureaucratic Conflict and Integrative Role Behavior" asks the question; "Why is it that some nurses seem able to adapt to role conflict and others do not? Can nurses be taught the mechanisms of integration in their educational program?" (1971). The conceptual framework for the study utilized Merton's idea of "anticipatory socialization" and McGuire's notion of "prevention by inoculation." A program was

developed to introduce students to potential professional-bureaucratic conflicts early in their professional socialization and in a sense to immunize them against such conflicts. The idea was to teach the student role values, behaviors and strategies characteristic of a group of nurses who had developed conflicting-relieving behaviors. It was found that those students who participated in the program (bicultural training program) had experienced effective role transformation as measured by role conception, role deprivation, role behavior, self-actualization, self-esteem and valuation of conflict.

In a study by Paynich (1971), nursing students were asked why they worked on a salaried basis in nursing while enrolled in a baccalaureate program. The sample population identified four reasons: to gain more experience in nursing, to gain self-confidence, to gain independence and to learn to assume more responsibility. The students identified needs which were not being met during their basic education program. They viewed their summer jobs as "independent endeavors done without the instructors looking over their shoulders."

Olmsted and Paget have reported that for medical students professional socialization occurs after completion of

medical school during internship and residency programs (1969). It is during this period that the neophyte learns specific role behaviors. If this is true for the medical profession could it be true for the nursing profession? Should nursing education provide a nursing internship? If nursing education is not meeting the needs of the students, is this responsibility being assumed by the hospitals in which the students experience their first employment?

The recent nursing literature suggests several areas in which the neophytes' socialization into the nursing profession has been addressed. Interventions have been developed for student nurses as well as for the neophyte nurses.

Programs developed for the student nurse include anticipatory socialization programs spanning the entire nursing curriculum (Appleby, 1972; Adams, 1980; Bell, 1980; Kramer, 1974), work-study type externship programs sponsored by schools of nursing, hospitals or joint endeavors (Bushong, 1979; Huckstadt, 1981), and independent clinical experience in the final semester of the nursing education program utilizing preceptors or faculty advisors (Crancer, 1975; Chickerella, 1981; Brodt, 1974; Lunberger, 1975; Sciprin, 1977, Maraldo, 1977).

Transition programs for graduates are becoming popular

throughout the country. These programs include preceptor orientation programs (Ackerman, 1975; Gibbons and Lewison, 1980; Atwood, 1979; Dell, 1977; Friesen, 1980; McGrath, 1978; Martin, 1975; May, 1980; Myers, 1968; Strauser, 1979; Maraldo, 1977), specialized orientation programs and internships (Archbold, 1977; Armstrong, 1974; Burrell, et al., 1977; Dennen, 1972; Fleming, 1975; Hammerstad, et al., 1977; Hekelman, 1974; Kjolberg, 1975; Martel and Emunds, 1972; Nixon and Russel, 1975; Weiss and Ramsey, 1977; del Bueno, et al., 1980) and bicultural training programs for the new graduate (Hollefreund, et al., 1981; Holloran, et al., 1980; Kramer and Schmalenberg, 1978).

All of the programs vary in time spent in the program, whether it is a requirement or an elective, and the type of evaluation. However, all had three desired outcomes: (1) to assist new graduates in the transition from student to staff, (2) to increase basic technical skills, and (3) to improve recruitment (Gibbons and Lewison, 1980).

The major problem with these programs is that effective evaluation has not occured. With the exception of Kramer and Schmalenberg and Gibbons and Lewison, the evaluations have been limited to subjective assessments of the program success by directors and enrollers. It would seem necessary

to provide more systematic evaluations to judge the effectiveness of these programs.

Kramer and Schmalenberg (1978) conducted a study to determine whether a specially designed training program would help in fostering bicultural role transformation in a group of students working in their first job. Three hundred and seven new graduate nurses from eight large medical centers in the United States participated. A pretest-posttest control group design with random assignments of subjects to groups was utilized in this study. All of the new graduates in both the control and experimental groups retriceived the standard hospital orientation program. All participants were pretested on role conception, role deprivation, role behavior, self-actualization, self-esteem and valuation of conflict. Then the bicultural training began for those in the noncontrol group. At nine months post employment, all subjects were posttested on the same measures. For the purpose of this study the results regarding role conception and role deprivation will be discussed. Role conception and role deprivation were measured using the scale developed by Corwin (1960). The results of the study showed that the new graduates who had participated in the bicultural training program had

significantly higher (7.001) Professional Role Conception scores nine months after employment than did those in the control group. Another hypothesis that Kramer and Schmalenberg (1978) tested in this study dealt with Total Role Deprivation. They hypothesized that the nurses in the program would experience less role deprivation than the control group because those in the program would have learned how to deal constructively with professional-bureaucratic role conflict, the major determining factor in role deprivation. The data collected demonstrated an overall drop in role deprivation scores for the total group from pretest to posttest. The difference in scores between the two training groups was not significant. If one looks at what occurred it does make sense. The tension produced by school-work conflict would decrease over time, however, the form of conflict resolution used by the new graduates probably differs. The Corwin role deprivation does not measure type of resolution, whether it was bicultural, destructive, constructive or a "burned out" type.

Gibbons and Lewison (1980) reported on a study conducted at a 1058-bed university medical center which initiated a 26-week internship program. This program enrolls selected new graduates who have had no prior nursing employment. It

is a six month nonrequired internship and the nurse interns are assigned to one nursing unit. The sample for this study was six groups of nurse-interns and six groups of nonintern controls. The evaluation model considered effects of the internship on clinical competence, role transition, job satisfaction, perceived autonomy, role conflict, job turnover and career patterns. Various instruments were utilized to measure the variables. Of importance to this study are the results regarding the role conflict/ambiguity scale and the role transition questionnaire. The data collected in the first year of the three year proposed study was analyzed using the Student's t-test. The role conflict/ambiguity scores of the two groups showed no significance, however, the scores on the role transition questionnaire were significant at $p<.01$. This indicates that the control group made a significantly better adjustment to the staff nurse role than the interns. One must use caution in analyzing this outcome because the reliability and validity of the instrument used, a ten-item role transition questionnaire devised by the project staff, has not been demonstrated.

SUMMARY

This chapter has dealt with reviewing the literature regarding the transition of the new graduate nurse into the professional nurse role. Intervention programs to deal with this transition have taken the form of classes within the nursing curriculum, special extern programs and special orientation programs provided by employers. The major factor that most of these programs lack is an effective evaluation tool.

CHAPTER 4

METHODOLOGY

INTRODUCTION

The design chosen for this study was preexperimental. The independent variable, the internship program was not manipulated by the researcher, nor did she have a role in deciding who would be in the program (randomization). In order to determine if a relationship exists between variables, a control group was used. This type of study has also been referred to as a nonequivalent control group design because the two groups are not homogeneous (Polit and Hungler, 1978). In this study, a pretest was not administered to either group, therefore cause-and-effect influences cannot be made, however trends and relationships can be observed.

POPULATION

Sample

The target population for this investigation consisted of two groups:

1. All 1981 Carroll College School of Nursing graduates who participated in the nursing internship during their last quarter; and

2. All 1981 Montana State University School of Nursing graduates who participated in clinical experience weekly but not a specific internship.

Sample Size

The intended sample included 32 Carroll College graduates and 146 Montana State University graduates. The author was prepared to use the table of random numbers to obtain the same number of participants from each group.

DATA COLLECTION

A preliminary letter which described the study and asked for participation was mailed to all potential participants during the last quarter of their senior year. The names were obtained from each School of Nursing and the letters were mailed to the schools. A self-addressed stamped postcard for the students to return to the author

with their name and address, was enclosed. The return of the postcard was considered consent to participate in the study. Appendix B contains a sample letter.

Since the study was designed to reflect role conception after the transition from nursing student to new graduate, the questionnaires were mailed three months after graduation. According to Kramer (1974) role deprivation among neophytes is at its peak three months into the first job.

The use of a mailed questionnaire is the most common form of self-administered instruments, however, it does have disadvantages. The disadvantages include lower completion and response rates, inability to clarify questions and the author has no assurance the participant acted independently in responding (Polit and Hungler, 1978). The author chose the mailed questionnaire because of cost, time, no interviewer bias and the fact that this type of instrument offers complete anonymity.

A cover letter accompanied the questionnaire. This letter contained the purpose of the study, what to do with the questionnaire when completed and explained that participating in the study was strictly voluntary. The participants were also thanked for their time and participation. Appendix C contains a sample of the letter.

The questionnaires had no identifying marks, other than whether the participant was a Carroll College graduate or a Montana State University graduate. The author anticipated no physical or psychological harm that could come from participating in the study.

INSTRUMENT

Tool Description

The data collected for this study were derived from: 1) a personal data form, and 2) three role conception and role deprivation scales.

1. The personal data form was used to elicit background information and characteristics of the respondents. The questions asked were used to gain information regarding variables thought by the author to influence the transition from student to staff. Those variables included age, marital status, job satisfaction, previous nursing experience and whether or not the participant was employed by the institution in which they; experienced the internship (Carroll College

graduates) or participated in clinical experience during the last quarter of the program (Montana State University graduates). Appendix D contains a sample.

2. Corwin's Role Conception and Role Deprivation scale was used to measure the respondent's loyalty to bureaucratic, professional and service role conceptions, as well as role deprivation. Permission to use the scale was obtained from R. Corwin (Appendix E and F).

The Corwin Likert-type scale consists of 22 items: 6 to measure bureaucratic role and 8 on both the professional and service scales. Bureaucratic role conception scales assess loyalty to the work setting, including upholding rules and regulations. Items pertaining to the professional role include commitment to the nursing profession, ability to use judgment and continual self-education. The service scale measures the desire to do "bedside" nursing and the adherence to the concept of nursing as dedicated and devoted "angels of mercy" (Corwin 1960, pg. 72).

The items on each scale are stated in the form of hypothetical situations. For each item the respondent is asked to indicate the extent to which she thinks each situ-

ation should be the ideal and also to judge the extent to which the situation actually exists in nursing. A five point scale is used from strongly agree through strongly disagree. A semantic equal interval between adjacent scale points was assumed. The sum of the answers to the "should be" questions constitutes a total normative score. The sum of the answers to the "ideal" questions constitutes a categorical score. By subtracting the normative score from the categorical score on each item, a difference score of each of the three scales is obtained. This is then the role deprivation score for each scale. Total role deprivation is derived by summing the role deprivation score for each of the three categories (Appendix G).

The Corwin Role Conception and Role Deprivation Scales measure role conceptions. It must be remembered that role conceptions are attitudes, the scales do not measure behaviors (Kramer, 1971).

The validity testing Corwin used when developing these scales focused on face and content validity. A series of tests was conducted to validate these scales against "known groups." Known groups are those nurses known to have a high professional orientation (baccalaureate nursing faculty) and high bureaucratic orientations (nursing service super-

visors). Analyzing the critical ratio between the mean scale scores of these "known groups" (significant at $p<.05$) leads to the conclusion of validity (Kramer, 1970, pg. 42). Kramer conducted a series of test-retest studies on a sample of 52 senior baccalaureate nursing students. The testing was done immediately before and directly after a three-and-a-half week break. The reliability coefficients yielded by this testing were: .89 on the bureaucratic scale, .88 on the professional and .86 on the role deprivation scale (Kramer, 1970).

The technique of internal consistency provides a way of constructing a scale which will discriminate between relatively high and low categories for comparison within the sample (Corwin, 1960). Corwin distributed his original questionnaire to 150 nurses, head nurses, student nurses and licensed practical nurses. Each scale was analyzed for internal consistency. The mean item difference of upper and lower 25% of the total scale distribution was tested for significance of difference with the Critical Ratio. Those items which were not statistically different from 0 at the 5% level of significance were omitted from the final scale (Corwin, 1960). Corwin also computed the F ratio of variances between the upper and lower 25% of each scale

distribution. "It is important to note that some items with significantly different variances between high and low categories were included on the scale on the assumption that a scale should discriminate between the consistency with which categories of persons hold attitudes as well as their mean differences" (Corwin, 1960, page 212).

Corwin also analyzed his scales on the basis of respondent's comments (1960). All of the respondents answering the pretest questionnaire were asked if they had difficulty answering any of the questions and for their suggestions for revising the questionnaire. These comments were analyzed and the items which caused difficulty were omitted or revised.

After the revisions, the final questionnaire was constructed. When the results obtained from the final questionnaire were statistically compared with the results of the original version, no significant differences in total scale scores were found (Corwin, 1960).

DATA ANALYSIS

Introduction

The data collected in this study were analyzed using the two types of statistics:

(1) Descriptive statistics can be used regardless of the type of measurement scale used. All data can be described in terms of the frequency with which a given class or category of observation occurs (Phillips and Thompson, 1967). Percentage, mean, median and standard deviation are the descriptive statistics used in this study.

(2) Inferential statistics use quantitative information about a particular group of observations for drawing more general conclusions, that is, for generalizing beyond descriptive data (Kviz and Knafl, 1980). The inferential statistics employed were chi-square, Fisher's exact probability test and the t-test.

Descriptive Statistics

Percentages are used to make comparisons more apparent.

In this study, percentage was used to determine response rate to the questionnaire; the number of nurses employed at the institution in which they experienced the internship and the number of respondents; satisfied with their current job, having had previous experience and having a family member in the health care profession.

The median is the point that divides a distribution into two equal parts (Kviz and Knafl, 1980). This measurement is an extremely stable measurement since it is not influenced by changes in the way data are grouped into categories. The median in this study was used in conjunction with an inferential statistic. The median for each of the role conceptions and role deprivation scales was calculated.

The mean is also referred to as the average. It is defined as, "the sum of the values of a set of observations divided by the number of observations" (Kviz and Kraft, 1980, pg. 80). The mean reflects the magnitude or value of every observation in the data. This statistic is also utilized, in this study, to not only describe variables, in the computation of an inferential statistic.

Standard deviation is important because it too is used in advanced statistical computations (as utilized in this

study). This descriptive statistic is a unit of measure of the variation among a set of observations.

Inferential Statistics

Chi-Square (x^2) is an inferential statistical test used to determine if two or more groups differ in some respect. This test determines the probability that differences between samples reflect corresponding differences in the total population.

Chi-square is applied to contingency tables to test the significance of different proportion (Polit and Hungler, 1978). The chi-square is computed by comparing the observed frequency actually collected and the expected frequency if there were no relationship between the variables. The formula for computation is:

$$x^2 = E \frac{(O-E)^2}{E}$$

Where O = observed frequency in each cell of table

E = expected frequency in each cell.

Before calculating chi-square, a significance level and

degrees of freedom must be determined. Level of significance is the cutoff point at which probability is small enough that one is able to say a relationship exists between variables. In this study, a level of significance of .05 was used ($p < .05$). Degrees of freedom for chi-square are determined by the size of the contingency table:

$$df = (R-1)(C-1)$$

Where R = number of rows in the table

C = number of columns in the table

Once the degrees of freedom, significance level and chi-square are determined, the probability is determined by using a statistical table which summarizes the chi-square sampling distribution.

There are several restrictions on the use of chi-square. Chi-square cannot be calculated if any expected frequency is zero and if more than 20% of the expected frequencies are less than 5. Another restriction exists with 2 x 2 tables. If any expected frequency is between 5 and 10, one must apply a Yates Correction (if expected frequency is larger than observed, add .5 to all observed

frequencies, if expected frequency is smaller than observed, subtract .5 from observed frequencies).

These restrictions are necessary because chi-square is sensitive to sample size. As the sample size increases, it becomes easier to establish relationships (Kviz and Knafl, 1980). There is an alternative when using a 2 x 2 table in which any expected frequency is below 5, Fisher's exact probability.

Fisher's Exact Probability Test is useful when two independent samples are small in size. When scores from two independent samples all fall into one or the other of two mutually exclusive classes, this test is useful (Siegel, 1956). "The test determines whether the two groups differ on the proportion with which they fall into the two classifications" (Siegel, 1956, pg. 97). The formula for this statistic is:

$$p = \frac{(A + B)!(C + D)!(A + C)!(B + D)!}{N!\ A!\ B!\ C!\ D!}$$

Where, A, B, C, D = the observed frequencies in each cell table

N = the total number of observations.