Shame : the dark side of nursing
by Anne Demarest Engels

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Home Economics
Montana State University

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In this study, the roles of shame, shame prone identity and shame based family systems in which intimacy, accountability and dependency needs were unmet, were explored as possible explanations for registered nurses exposing themselves to abusive and adverse working conditions and enduring this environment.

A quota sample was drawn from a list of registered nurses employed in an acute care facility.

Data for the study was compiled from respondents' genograms and an ethnographic interview involving questions concerning the family of origin, the family of procreation, and relationships in the work place.

A DataIII Base computer program facilitated the organization of data collected about nurses' families of origin. Olson's Circumplex Model and Harper and Hoopes' Affirmation Triangle model were used to assess nurses' family systems to determine the presence of shame.

The study revealed that processes involved in management of relationships in families of origin are incorporated into the work environment. The findings suggest that processes learned in the family of origin enable nurses to endure adverse and abusive situations encountered in the work place.

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This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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Signature Anne D. Ingels

Date May 13, 1993

This body of work is dedicated to my brother,

Billy,

who gave the ultimate sacrifice for his family.

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ABSTRACT

Nursing literature offers little information concerning the influence of the family of origin upon registered nurses. This dearth of information leaves unanswered how families of origin impact nurses.

In this study, the roles of shame, shame prone identity and shame based family systems in which intimacy, accountability and dependency needs were unmet, were explored as possible explanations for registered nurses exposing themselves to abusive and adverse working conditions and enduring this environment.

A quota sample was drawn from a list of registered nurses employed in an acute care facility. Data for the study was compiled from respondents' genograms and an ethnographic interview involving questions concerning the family of origin, the family of procreation, and relationships in the work place.

A DataIII Base computer program facilitated the organization of data collected about nurses' families of origin. Olson's Circumplex Model and Harper and Hoopes' Affirmation Triangle model were used to assess nurses' family systems to determine the presence of shame.

The study revealed that processes involved in management of relationships in families of origin are incorporated into the work environment. The findings suggest that processes learned in the family of origin enable nurses to endure adverse and abusive situations encountered in the work place.

CHAPTER ONE

INTRODUCTION

Background of Problem

The author's 17 years of direct observation of nurses who have worked in an acute care hospital reveals nurses are exposed to abusive and adverse work situations involving relationships and working conditions. Nurses may have particular personality traits and family backgrounds that make them especially suited for working in such an environment.

The roles of shame, shame prone identity and shame based family systems in which intimacy, accountability and dependency needs were unmet, were explored as possible explanations for registered nurses exposing themselves to abusive and adverse working conditions and enduring this environment. Is caretaking in abusive situations and enduring adverse working conditions a way for nurses to have accountability, intimacy and dependability needs met?

To set the stage, the author will acquaint the reader to areas in which she has observed these phenomena. The author suggests the following as

illustrations of adverse or abusive experiences encountered by individuals working as registered nurses in an acute care facility. Nurses relate experiencing physical and emotional stress as a result of having to work at inconvenient times. Nurses with school age children, who work the evening shift, report limited opportunities to spend time in family activities. Endless fatigue serves as a hallmark for nurses working night shift. They constantly battle to find the "right" time to sleep uninterruptedly and biorhythms are in constant flux (Potter & Perry, 1989). Working night shift makes conducting "normal" family life or social life difficult.

Nurses subject themselves to emotional and physical stress (Mansfield, McCool, Vicary, & Packard, 1989) when physical boundaries of patients are broached. Intimate physical contact occurs in caring for patients, e.g., bathing patients, cleaning up excrement and blood (Heim, 1991), and performing procedures which necessitate handling of genitalia. Emotional stress for nurses may occur when patients' personal, physical, and emotional boundaries are crossed during the process of admitting a patient to the hospital. It is routine to ask the patient to undress and don a hospital gown. If the patient is unable to do this, the nurse proceeds

to complete the task for the patient. Further stress for nurses may occur during the process of performing the "personal assessment" in which several intimate questions are asked of the anxious, ill individual. A reciprocal situation exists regarding patients broaching nurses' personal boundaries.

Patients initiate crossing of nurses' personal boundaries by inappropriate touching and inappropriate story telling. Nurses report being punched, kicked, bitten, sworn at, urinated and defecated upon, and being sexually harassed. Examples of sexual harassment are: being propositioned, being fondled, and walking into a room to find a male patient masturbating.

Nurses also experience demeaning behaviors from physicians, e.g., throwing charts, being cursed at, sexual harassment, and expectations of being a servant ("Where's my coffee?").

There are pleasant aspects of working as a nurse. Nurses take pleasure in saving a life or helping in a patient's recovery. But, as this investigator observes nurses and listens to nurses discuss continual fatigue, unhappiness, anger, withdrawal, "burn out," and codependent behaviors, it appears stressors created by adverse work experiences and abusive situations weigh heavily.

The nursing literature presents little information

The nursing literature presents little information regarding the adaptation of nurses in the hospital environment. The literature that exists tends to focus on codependency, addictions, and burn out. Are these examples of behaviors of nurses' adapting to the adverse conditions to which they are subjected (Carpenter, 1991; Cipikala, Kane, & Cleveland, 1991; Hall & Wray, 1989; Hare, Pratt & Andrews, 1988; Moss, 1989; Prout, 1991; Williams, 1989)? Studies in the area of shame, addictions and burn out are few. Snow and Willard (1989) conducted a computer search of medical and nursing literature using descriptors of addiction and chemical dependency. Only 1,400 of 813,000 citations or 0.02 percent were found relating to those descriptors. In the present study, a search of Montana State University's computer data base using the descriptors of shame, shame prone identity, shame bound family system, guilt, self concept, intimacy, shame and relationships, embarrassment, self perception, and codependency yielded 123 citations. The majority of citations were found in journals related to alcoholism and addiction. A search of the Psychology Literature and Medical Data Bases using shame as a descriptor revealed no citations. Although areas such as codependency, addiction, and burn out

have been examined, they may be representative of a more encompassing problem.

Purpose Statement

The purpose of this study was to explore nurses' perceptions of their families of origin and how these perceptions may have contributed to their abilities to remain in and tolerate abusive or adverse working conditions or both. It is possible that individuals with shame prone identities fulfill their unmet needs by working in caretaking environments found in acute care facilities. Such an environment may foster and exacerbate unhealthy interactions similar to those experienced in families of origin. Specifically, is there a connection between how individuals experience their family of origin and their ability to tolerate and endure abusive relationships or adverse work conditions or both?

This investigator contends that nurses develop a shame prone identity when raised in a family system in which intimacy, dependency and accountability needs are unmet (Harper & Hoopes, 1990). Perhaps caretaking is a way for nurses to have accountability, intimacy and dependability needs met, needs which were unmet in respondents' families of origin.

Significance of Study

A review of nursing literature revealed unhappiness, anger, fatigue, withdrawal (Baldwin, Welches, Walker & Eliastam, 1987), co-dependency (Cipkala, et al., 1991; Hall & Wray, 1989; Hogg & Frank, 1992), intershift rivalries, one-upmanship (Covell, 1991), burn out (Hare, Pratt, & Andrews, 1988; Mansfield, et al., 1989; Moss, 1989; Prout, 1991; Williams 1989), depression and substance abuse (Heim, 1991; Sherman, Cardea, & Gaskill, 1989; Williams, 1991) to be, according to these authors, representative of dissatisfaction in nursing. Although these authors offer solutions on how to handle these various problems, none delves into an understanding of what lies beneath these signs of dissatisfaction. Absent were discussions of the impact of interactions within families of origin on nurses. The intent of this study was to determine if the impact of nurses' families of origin could have contributed to these dissatisfactions.

Limitations of Study

A small segment of the sample were individuals with whom the researcher has a close friendship. The reader might assume the presence of bias during these

interviews. Training in a Master's level program of Marriage and Family Therapy provided the researcher with skill to recognize transference and countertransference. Such events were included in the field notes for the study.

Trust is an issue for shame prone individuals (Bradshaw, 1989; Harper & Hoopes, 1990). Harper and Hoopes (personal conversations, November 3, 1991) commented that individuals with shame prone identities tend to "cover up" their shame. The effect of trust upon the "covering up" process will be addressed in Chapter Five.

Bias may occur in respondents' perceptions of their families of origin. Memories of interactive patterns may be colored by events respondents experienced in their families of origin.

There is a set of sisters included in the sample. Assessment of their responses to the interview questions may yield information that would suggest presence or absence of memory bias.

The data from this study will not be generalizable to nurses in other institutions. The methodology used does not lend itself to accumulation of statistical data. However, naturalistic inquiry serves well to explore the multiple realities (Lincoln & Guba, 1985)

that respondents experienced growing up in their families.

Definitions

1. Boundary: " A concept used in structural therapy to describe emotional barriers that protect and enhance the integrity of individuals, subsystems, and families" (Nichols, 1984, p. 583).

2. Family System: " A group of related individuals that interact as a whole entity (Nichols, 1984). Change in one individual in the system affects the entire system much like moving one piece of a mobile sets the entire mobile in motion (Bradshaw, 1988).

3. Genogram: A pictorial representation of a family system covering three generations using standard symbols to represent family members (Horne & Passmore, 1991; McGoldrick & Gerson, 1985; Nichols, 1984).

4. Guilt: Feelings or emotions resulting from a deed performed that goes against an individual's moral standards or moral standards of that person's family, group, or society (Bradshaw, 1989, Harper & Hoopes, 1990; Lynd, 1958; Piers & Singer, 1986).

5. Perception: "A process of organizing, interpreting and transforming information from sense data and memory. It is a process of human transactions with the environment. It gives meaning to one's experience,

represents one's image of reality and influences one's behavior" (King, 1981,).

6. Shame: An emotion an individual has when he/she gives himself/herself a negative evaluation (Harper & Hoopes, 1990); "an emotional experience or feeling of painful embarrassment or humiliation that includes a sense of being insufficient as a person" (Fossum & Mason, 1986, p. 5).

7. Shame Prone Identity: When an individual believes him/herself to be flawed, unworthy, defective, unlovable (Harper & Hoopes, 1990 (Fossum & Mason, 1986; Harper & Hoopes, 1990, Lynd, 1958; Piers & Singer, 1953); when "humiliation is so painful or an indignity so profound that one feels one has been robbed of his/her dignity or exposed as basically inadequate, bad, or worthy of rejection" (Fossum & Mason, 1986, p. 5).

8. Shame Prone Family System: A family system in which "patterns of structural, attitudinal, and behavior within the marital and family systems fail to meet the needs and goals of both the system and the individuals" living in that system. "The patterns do not allow for continued growth of individuals, of the marriage, or of other family relationships" (Harper & Hoopes, 1990, p. 72).

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

The Affirmation Triangle Model, formulated by Harper and Hoopes (1990), and the Circumplex Model, developed by Olson (1983), serve as the bases for investigating how the family of origin impacts registered nurses. Olson's Model provides the means to assess family systems which assists the researcher in evaluating how the processes of affirmations are managed. The processes of affirmations determine the potential for development of individuals with shame prone identities or shame based family systems.

The researcher has provided a review of these theories. In the latter part of Chapter Two the author has provided a brief review of six family systems Harper and Hoopes have determined to be most conducive to developing shame based family systems. Harper and Hoopes (1990), through their description of the Affirmation Triangle Model, describe the development of healthy families as involving the processes of positive affirmations. Heavily influencing these processes are

the relationships within subsystems of the family of origin. The development of healthy identities of members within a family system is dependent upon how the marital dyad in its spousal and parental roles, the sibling subsystem, extended family members, and the relationships outside the family system manage positive affirmations involving intimacy, dependency, and accountability (Harper & Hoopes, 1990). To evaluate how families manage these processes, Harper and Hoopes (1990) draw from Olson's Circumplex Model.

Olson's Circumplex Model

Adaptability

Olson's Circumplex Model uses the dimensions (axes) of adaptability and cohesion (Barnes & Olson, 1985; Olson, 1983,1986) and an additional dimension, communication, to assess families. Adaptability is "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress" (Olson, et al., 1983, p. 70). In identifying characteristics of adaptability, Olson uses these descriptors: rigid, structured, flexible, and chaotic (Carnes, 1987; Olson, et al., 1983; Olson, 1986). How family systems maintain behavioral patterns in areas of power, control, discipline, negotiation,

roles, rules, and type of system feedback can be construed to reflect levels of adaptability (Harper & Hoopes, 1990).

Chaotic is the descriptor used for one end of the continuum of the adaptability axis. Adaptability is described as chaotic when parents are under-responsible (Black, 1988; Bradshaw, 1988; Carnes, 1987; Kerr & Bowen, 1988; Nichols, 1984). Parents in chaotic family systems rely on outside controls. These parents expect schools or their church to provide guidelines for responsibility and limit setting (Carnes, 1987). Promises are not kept. Members within the chaotic family system cannot depend upon each other. A family system with a chaotic structure will move from crisis to crisis (Olson, 1986) with little if any homeostatic maintenance between crises (Horn & Passmore, 1991; Nichols, 1984). As a result of lack of structure within this type of system, individuals in this family system feel they lack a sense of identity (Carnes, 1987). Distrust of self resulting from lack of consistency is generated for individuals within this system (Harper & Hoopes, 1990).

At the other end of the continuum lies the rigid family system. Over-responsible parenting is a major presence in the structure of the rigid family system.

Parents strive to control all outcomes. Children learn, as they experience the many rules and regulations for everything, that they are incapable of assuming personal responsibility for their behavior (Carnes, 1987). As children become older, they begin to resist parental rigidity (Beavers, 1990; Friel & Friel, 1989; Olson, et al., 1983). These individuals possess few or no internal controls to replace the controls established by parents. Their parents complain about disrespectful children. Children do not share the same values as the parents. Outsiders are not to be trusted. This concept may be perceived as a way parents shelter their children from a threatening world.

Crises create stress for this type of family system. Members within the rigid family system feel very uncomfortable when confronted with the prospect of change (Carnes, 1987). Adolescence is such a time. As an adolescent strives to develop an identity (Erikson, 1950; Hoffman, 1984; Ryan & Lynch, 1989; Steirlin, 1981), he/she buffets the systemic rigidity. Adolescents searching for identity are viewed by their parents as immature; not measuring up to the family's standards (Beavers, 1990; Carnes, 1987). Not measuring up to the family's standards creates feelings of worthlessness for the adolescent. Repeated episodes of

feeling worthless may produce shame within the adolescent (Bradshaw, 1989; Harper & Hoopes, 1990).

Cohesion

The second axis of Olson's Circumplex Model is family cohesion. Cohesion is defined as "the emotional closeness family members have with one another" (Olson, et al., 1983, p. 72.). The descriptors used by Olson's Model to describe a family system's cohesiveness are: separated, connected, enmeshed, and disengaged. The feelings of "warmth and care between family members" (Carnes, 1987, p. 65), family members being supportive of each other, collaborative decision making, common interests and feelings of pride in family membership (Beavers, 1990) describe a sense of cohesiveness within a family system (Carnes, 1987; Olson, 1987).

Moving outwardly in both directions on the cohesion axis, the reader finds the family cohesion descriptors of disengaged and enmeshed. If the reader examines a disengaged family system, low levels of intimacy are found leading to unmet intimacy needs. Potentially, this might enhance development of shame prone identities for individuals in the family or create a shame based family system as it relates to the intimacy aspect of the Affirmation Triangle (Harper & Hoopes, 1990). A great sense of loneliness pervades the

disengaged family system (Bradshaw, 1988; Carnes, 1987; Friel & Friel, 1988; Wegcsheider-Cruse, 1988).

At the opposite end of the cohesion continuum is the enmeshed family system. Over involvement with one another and high dependency levels flourish within this family system (Carnes, 1987; Olson, 1983; Olson, et al., 1983). Everything is shared within this family including intimate details of each other's lives (Carnes, 1987). Decisions are assumed to be made unanimously, when actually one person may decide for the whole group. Individuality is lost as members of the enmeshed family system take on a collective identity (Olson, 1983, 1986). "Neither parents or children take responsibility for their own behavior because of the involvement with others. The intensity of the relationships obscures personal boundaries" (Carnes, 1987, p. 77).

Olson has identified 16 family systems according to how these families manage the processes of adaptability and cohesion (Olson, et al., 1983). These family systems are categorized into three groups: balanced family systems, mid-range family systems, and extreme family systems.

Balanced family systems are identified as: flexibly separated, flexibly connected, structurally

disengaged family system (Bradshaw, 1988; Carnes, 1987; Friel & Friel, 1988; Wegcsheider-Cruse, 1988).

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Balanced family systems are identified as: flexibly separated, flexibly connected, structurally separated and structurally connected. Mid-range family

Communication

Olson considers communication to be a facilitating dimension. Empathy, reflective listening, and supportive comments allow "couples and families to share with each other their needs and preferences as they relate to cohesion and adaptability" (Olson, et al., 1983, p. 61.) Movement on these axes is restricted when familiy members use negative communication skills such as criticism and double messages.

Affirmation Triangle Model

Harper and Hoopes (1990) believe the development of healthy families involves the process of positive affirmations involving accountability, dependency and intimacy within the family system. These three concepts, described below, form the "sides" of the "Affirmation Triangle". Harper and Hoopes define affirmation as the "interactive process that one's self or presence is confirmed and recognized both by others and by the environment" (1990, p. 23).

Accountability

One aspect of the Affirmation Triangle is accountability. To be accountable means feeling

responsible for one's own behavior towards another (Harper & Hoopes, 1990). Parents have particular expectations for their children. Young children are counted upon to live up to these expectations. This develops the process of conforming to rules. As children mature, a healthy regard or sense of loyalty develops towards their parents (Boszormenyi-Nagy & Spark, 1973; Nichols, 1984). It is from a well developed sense of accountability within a healthy family system that children are able to develop a sense of the world's being a safe place (Harper & Hoopes, 1990).

Harshly imposed rules make accountability difficult for children to achieve. Excessive guilt may develop and become shaming for the individual (Bradshaw, 1989; Fossum & Mason, 1988; Harper &1990).

Dependency

Dependency forms another side of the Affirmation Triangle. Dependency is the condition of "being dependent, or needing assistance to survive" (Harper & Hoopes, 1990, p. 25). Children who depend upon their parents learn they are unique, persons of worth. This sense of being an unique individual is fostered for children when parents respect and accept the child's emotional experience (Harper & Hoopes, 1990). Children

experience feelings of low self worth and have doubts about their identity when they perceive they are an inconvenience to their parents (Harper & Hoopes, 1990; Boszormenyi-Nagy & Spark, 1973).

As children gradually begin to accept responsibility for their decisions and behavior, they learn to be interdependent (Harper & Hoopes, 1990). The maturing child's capacity to have interdependent relationships within his/her family of origin will foster the process of individuation and separation occurring during the child's adolescent years (Bowen, 1978; Harper & Hoopes, 1990; Kerr & Bowen, 1989; Steirlin, 1974). Interdependency fostered within the healthy family system will allow the young adult to separate from his/her family of origin but continue to be connected to the family (Bowen, 1978; Kerr & Bowen, 1989; Nichols, 1984).

Rules of how one relates to another are developed when dependency needs are met. Young children have not developed standards by which they can maintain their relationships (Harper & Hoopes, 1990). Parents serve as models for such standards. Through clear parental values created as part of the dependency relationship, children learn common sense and a sense of order (Green, 1989). If parental guidance is lacking, a

child learns to be mistrustful or disdain authority (Harper & Hoopes, 1990).

Intimacy

The remaining aspect of the Affirmation Triangle is intimacy. Harper and Hoopes (1990) define intimacy as the feelings of emotional closeness between persons. As a process, intimacy teaches family members they are valued and belong in the family. Healthy intimacy within the family system teaches children rules for touch and physical expression, expression of feelings and the ability to share them with others. When children experience negative affirmation ("big boys don't cry: or "you really don't feel that way"), they learn their feelings are not to be trusted and to be afraid when others express their feelings (Bradshaw, 1989; Harper & Hoopes, 1990; Weigscheider-Cruse, 1988). It is through the process of healthy intimacy that one learns to handle conflict in relationships (Bradshaw, 1989; Harper & Hoopes, 1990; Fossum & Mason, 1988).

The concepts of Harper and Hoopes Affirmation Triangle Model and the concepts of Olson's Circumplex Model provide a framework for the process of the development of shame prone individuals or families with a shame prone identity. The six family styles which are most prone to producing individuals with a shame

prone identity or creating family systems with a shame prone identity will be identified and examined.

Shame Prone Family Identities

Harper and Hoopes identify six family systems that provide few opportunities for intimacy, dependency and accountability needs to be met. These family styles are most likely to induce shame in individuals or establish a family system with a shame prone identity. These specific family styles are described below.

Rigidly Disengaged Family System

Respondents describing a rigidly disengaged family system relate high levels of accountability (Harper & Hoopes, 1990). Respondents' perceptions of discipline would be described as harsh. Rules that determine who talks with whom about what regulate interpersonal and family system boundaries (Calapinto, 1991). Boundaries serve to regulate contact with others (Nichols, 1984). Rigid boundaries are restrictive and permit little contact with outsiders (Nichols, 1984). This may produce isolation (Minuchin, 1984). There would be low levels of intimacy; little affectionate touch (Harper & Hoopes, 1990). Affirmations are negative. Levels of criticism are high (Harper & Hoopes, 1990). Respondents from rigidly disengaged family systems

would describe parents as being undependable (Harper & Hoopes, 1990). Respondents would report that they had to fend for themselves from an early age until they left the family home.

Rigidly Separated Family System

Respondents describing a rigidly separated family system would describe perceptions similar to those people who were raised in a rigidly disengaged family system. Discipline, although perceived as harsh by the respondent, would not be as severe as found in a rigidly disengaged home. Affirmations would be negative most of the time (Harper & Hoopes, 1990). Intimacy would be described as somewhat closer than in the rigidly disengaged family, but most likely, not provided at levels that would avoid shaming (Harper & Hoopes, 1990).

Chaotically Separated Family System

The perceptions of respondents describing a chaotically separated family would reveal low levels of accountability. Discipline would be nonexistent or sporadically enforced (Harper & Hoopes, 1990). Levels of intimacy and the meeting of dependency needs would be low. Communication in a chaotically separated family system would reflect lack of connection amongst family members in this family's style (Olson, 1983).

Affirmations would be essentially negative. Criticism would be commonplace in this family system.

Chaotically Disengaged Family System

A chaotically disengaged family system would have characteristics similar to the chaotically separated family system, but at a greater degree of lacking (Harper & Hoopes, 1990). Levels of accountability would be less. What little enforcement of accountability that exists would be done to a lesser degree. There would be a sense of not being able to depend upon one another (Harper & Hoopes, 1990).

Chaotically Enmeshed Family System

Accountability levels and enforcement of accountability would be related as low. Similar to other family systems described, respondents might comment on low levels of dependability amongst family members. There would be few rules around family boundaries. Personal boundaries in a chaotically enmeshed family would be very permeable (Nichols, 1984). Respondents would describe negative affirmations (Harper & Hoopes, 1990).

Structurally Separated Family System

In the structurally separated family system, there are moderately high levels of accountability and the enforcement of accountability will be firm, and, at times, harsh (Harper & Hoopes, 1990). As with previously described family systems, respondents might relate low levels of dependency amongst family members. Levels of intimacy would be moderately low. The boundaries of this family system would be firmly established (Harper & Hoopes, 1990). There would be little question of who was "in" or who was "out" (Nichols, 1984). Affirmations may be negative at times. This family system would be shaming due to unmet dependency needs and poorly met intimacy needs.

CHAPTER THREE

METHODOLOGY

The purpose of this study was to explore nurses' perceptions of their families of origin and how their perceptions contributed to their ability to remain in and tolerate abusive or adverse work conditions. A case study format was used to examine nurses' perceptions. The following describes the study design, questions used in the ethnographic interviews, the rationale for the questions, the participant sample, and the procedures.

Design of the Study

The author selected naturalistic inquiry (qualitative case study) to investigate nurses' perceptions of their families of origin. The paradigm of naturalistic inquiry provided the investigator opportunities to study the multiple realities of respondents' experiences in their families of origin and the work place (Guba, 1978; Lincoln & Guba, 1985; Polit & Hunger, 1989; Spradley, 1979). With this methodology, the investigator endeavored to gain knowledge and understanding of the true nature of

respondents' experiences (Leininger, 1985). Naturalistic inquiry allowed a view of the complexities of the respondents' involvement in their families of origin; a window to their human experience "as it is lived and as it is defined by the actors themselves" (Polit & Hunger, 1989, p. 312). Through analysis of the data, the researcher sought to establish "the existence and nature, essence, and underlying attributes of the phenomenon" (Leininger, 1985, p. 69).

Genogram and Ethnographic Interview

Genogram

The first step of the interview process involved the construction of the respondent's genogram for the purposes of: developing rapport (Gay, 1991), presenting a clear picture of family members to the investigator (McGoldrick & Gerson, 1985), providing a graphic view of family patterns, (McGoldrick & Gerson, 1985), and providing a pictorial representation of the emotional forces across generations (Kerr & Bowen, 1988; Marlin, 1989). Additionally, the genogram served as a subjective tool to aid in evaluating the impact of the respondents' families of origin and aid in assessing individuals' family systems, using the

theoretical bases discussed in Chapter Two. Upon completion of the genogram, the investigator conducted the ethnographic interview.

Ethnographic Interview

The researcher designed a series of open ended questions to ascertain how nurses perceived their upbringing in their families' of origin, experiences in their families' of procreation and perceptions of their work experiences. Individuals (a registered nurse, a marriage and family therapist, and a clinical psychologist) familiar with the paradigm of family systems were asked by the researcher to review the questions for the purpose of determining whether these questions would delve into respondents' perceptions of the precedingly mentioned areas.

The investigator used these questions to conduct the semi-structured ethnographic interview. Questions were grouped according to perceptions involving family of origin, family of procreation, and work experiences. The questions and rationales follow.

What was it like growing up in your family?

What events happened in your family which made you feel as though you belonged?

What events happened in your family which made you feel as though you didn't belong?

These questions were designed to gather general information about the respondents' experiences with their families of origin. Using concepts from the Affirmation Triangle Model and Olson's Circumplex Model, characteristics of families with shame prone identities may emerge.

Were there any traumatic events in your family of origin such as the death of a parent or child, divorce, or perhaps an event like a business failure or someone with a chronic illness such as diabetes, heart disease or depression?

How did this affect you? Your family?

The developmental level of children influences how they perceive their environment (Green, 1989). The egocentricity of children may lead them to believe they are responsible for their parents' actions or an event in the world of their adults (Bradshaw, 1988; Green, 1989). As an example, children may believe they are responsible for the death of a parent or their parents' divorce (Bradshaw, 1988). This perceived responsibility may be understood as "I am bad. If I had been good, this would not have happened". Believing the self ("I") is bad is shaming (Fossum & Mason, 1986; Harper & Hoopes, 1990; Steirlin, 1981).

A traumatic event may cause depression (Black, 1985; Weigscheider-Cruse, 1988). Chronic illness may

be accompanied by chronic depression (Potter & Perry, 1989). Parents in the throes of depression have difficulty managing accountability, dependency or intimacy needs of their children. These parents induce shame in their children through absent or negative affirmations (Harper & Hoopes, 1990; Fossum & Mason, 1986).

Are there any family secrets? How did this affect your family?

This question assesses whether the respondent's family system operated to cover up or deny the reality of compulsive or harmful behaviors that were present in the respondent's family of origin. "When family secrets exist, they form central pillars in the structure of a shame-bound system" (Fossum & Mason, 1986, p. 102). Another technique family systems may use to hide family secrets is the "no talk" rule.

The "no talk" rule flourishes in alcoholic family systems (Black, 1981; Bradshaw, 1989; Friel & Friel, 1988; Wegscheider-Cruse, 1988) and may be present in dysfunctional family systems other than alcoholic family systems (Nichols, 1984). A "no talk" pattern of family interactions may promote shame for certain

family members by denying the reality of their perceptions.

If you have any, what kind of rules have you made for yourself regarding your family of origin?

There are rules characteristic of shame-bound family systems (Bradshaw, 1988; Harper & Hoopes, 1990). A respondent from a shame-bound family might describe rules revolving around control, blame, denial, reliability, and intimacy. As transcripts are analyzed, experiences reflecting these rules will emerge. The ensuing provides illustrations of these concepts.

If nurses reflect rules about control, the researcher expects to hear themes of dominance or submission or both (Bradshaw, 1988; Weigscheider-Cruse, 1988) or overfunctioning or underfunctioning or both (Kerr & Bowen, 1989). Nurses may express desires to be in charge of their own lives; to be free of parental constraints and admonitions.

Rules reflecting the affirmation process of accountability may center around blame in family interactive patterns (Bradshaw, 1988; Harper & Hoopes, 1990; Wegscheider-Cruse, 1988). The process of blaming may serve to: reduce anxiety, transfer shame to another (Bradshaw, 1988; Fossum & Mason, 1986), and cover up a sense of not having control (Harper &

Hoopes, 1990). Another process invoked in families with a shame prone identity involves denial.

The process of denial serves to protect the respondent from strong feelings, especially negative feelings such as anxiety, fear, rejection, and loneliness (Fossum & Mason, 1986). An example of denial would be a respondent's depreciating the effects of being raised in an alcoholic family system (Black, 1981).

Rules about reliability and intimacy reflect the quality of affirmations regarding accountability and intimacy (Harper & Hoopes, 1990). A respondent replying, "I can't count on my family for anything" may be reflecting unmet dependency needs. It is difficult to meet intimacy needs in the absence of unmet dependency needs (Harper & Hoopes, 1990). Unmet dependency needs and intimacy needs are markers for inducing shame prone identities (Fossum & Mason, 1986; Harper & Hoopes, 1990).

Questions for married respondents and respondents with children:

How are things going for you in your own family?

How are you finding raising your own children?

A characteristic of qualitative research is that the researcher is interested in meaning (Merriam, 1988). The qualitative researcher is attempting to find out how respondents interpret their experiences and how they structure their social world. These questions seek to make clear how respondents perceive their lives within the family of procreation.

Could you tell me about some things that were done in your family of origin that you have sworn not to do in your own family?

Bowen's Extended Family Systems Theory (Kerr & Bowen, 1989; Nichols, 1984) posits emotional processes of emotions, values, feelings, and beliefs of a family can be passed from one generation to the next via the interplay of genetic and environmental influences. Shame, induced in childhood as a result of unhealthy or dysfunctional relationships or both between parents, becomes part of that child's being (Nichols, 1984). Bowen proposes these emotional processes are passed on from one's family of origin to one's family of procreation (Kerr & Bowen, 1989).

Changes made in respondents' families of procreation from behaviors in respondents' families of origin may reflect an attempt to become more differentiated and break the transgenerational effects

of being raised in a shame bound family system (Harper & Hoopes, 1990).

How are you managing to get your own needs met in your own family (of procreation)?

Nurses fulfill their needs by meeting needs of others (Cipkala, Kane, & Cleveland, 1991; Hall & Wray, 1989; Willard & Snow, 1989). An assessment of whether one's needs are met from within one's self or as a result of external sources (e.g., taking care of patients) might be a factor in determining whether an individual has a shame prone identity (Harper & Hoopes, 1990). Good feelings and self-validation derived from external sources are shaming (Bradshaw, 1988; Wegscheider-Cruse, 1989).

If a difficult situation arises in your family, how is it handled? Some examples of "difficult situation" might be: your teenage daughter comes home at three in the morning, your sixteen year old son is escorted home by the police from a kegger, or your spouse is fired from his/her job.

How anxiety within the family system is managed may be discerned by respondents' perceptions of "difficult" situations. Family rules reflecting issues of control, parental roles, and protective mechanisms such as

denial or blaming may be present which may identify a family system with a shame prone identity (Fossum & Mason, 1986; Harper & Hoopes, 1990).

Questions relating to respondents' work situations:

How are things going for you at work?

The purpose of this question is to expose the respondents' multiple realities of the work place. Issues concerning management of relationships, anxiety, emotions, and control can be exacerbated by the work situation (Baldwin, Welches, & Walker, 1987; Covello, 1991; Hall & Wray, 1989; Willard & Snow, 1989). Protective mechanisms may be uncovered which indicate individuals with shame prone identities (Friel & Friel, 1988; Harper & Hoopes, 1990).

If a difficult situation arises at work, how do you handle it? For instance, your co-worker rarely or never gives you a hand in turning a patient or cleaning someone up or leaves a little before the end of the shift. Or a physician "chews you out" for something that you didn't do or knew nothing about or was not your responsibility. Or a patient is telling you off-color jokes you don't care to listen to or is on the call light incessantly or continually fails to call you in time to avoid soiling his/her bed.

Rationale for this question is drawn from Bowen's concept of the emotional system and intellectual system (Bowen, 1978; Kerr & Bowen, 1989; Nichols, 1984). Bowen states, "The degree to which people are able to distinguish between the feeling process and the intellectual process" will determine the success of the relationship (Freidman, 1991, p. 64). Nurses may manage relationships at work similarly to the way relationships were managed in the family of origin or family of procreation or both.

At the core of an individual's ability to determine whether the emotional processes or the intellectual processes are in force is the individual's level of differentiation. Individuals with low levels of differentiation will have greater problems escaping anxiety generated by emotional fusion created by the intermeshing of the feeling process and intellectual process (Kerr & Bowen, 1989).

Nurses describing reactions to difficult situations may be reflecting their anxiety. Respondents with moderate levels of differentiation may exhibit intense versions of feelings (Friedman, 1991). Strong emotional reactions to a difficult situation may enable the respondent to repress feelings which trigger shame (Bradshaw, 1988). Individuals may describe

stuffing feelings or presenting retaliatory behavior such as ignoring a patient's call light or responding slowly to the call light.

Issues involving establishment of appropriate interpersonal boundaries may become apparent. Respondents might discuss ways of handling difficult situations which would illustrate a need for control. Limitation of joke telling would establish appropriate personal boundaries; continuing to listen may indicate blurred boundaries, a shame inducing situation (Harper & Hoopes, 1990). The nurse-physician relationship can be used to assess boundaries. The involved nurse's level of differentiation will be well challenged by the physician who is angry, upset, or irritated.

When you make a mistake, what are you likely to say to yourself or what do you feel like doing?

An individual with a shame prone identity may comment about "wanting to hide" or "fall through a hole in the floor" (Bradshaw, 1988; Fossum & Mason, 1986; Harper & Hoopes, 1990). There may be an admission of an attempt to cover up the mistake. Respondents with shame prone identities will indulge in negative self talk: "I am so dumb", "What a jerk I am", or "A good nurse wouldn't do such a stupid thing". Negative self talk may reflect rules about perfectionism (Bradshaw, 1988; Harper & Hoopes, 1990).

Mistakes may serve to increase addictive behaviors (Black, 1990; Harper & Hoopes, 1990). Respondents may talk about going on eating binges or shopping sprees. Respondents may describe drug usage, e.g.,"I had a good stiff drink when I got home" or "I took a break and had a smoke".

Is there any particular event in your life which has influenced you to have a nursing career?

Transgenerational influences may be involved in this process. Caretaking is a common family system role (Bradshaw, 1988). An individual with a shame prone identity may be using the caretaking role to assuage feelings of being defective, powerless or helpless or both. When that individual is taking care of others, he/she is feeling good about him/herself. The shame prone individual is altering his/her feelings of inadequacy (Bradshaw, 1988; Harper & Hoopes, 1990; Wegscheider-Cruse, 1988).

If there were something in your relationship between your family of origin, within your own family, or at work you would like to change, how would you go about it?

This broad question may reveal the respondent's sense of personal worth. An individual with a shame prone identity may relate a sense of hopelessness,

powerlessness or helplessness or both (Bradshaw, 1988; Harper & Hoopes, 1990). Respondents may perceive themselves as victims of circumstance. Individuals describing a greater sense of self may describe feeling sufficiently empowered to make whatever changes are needed to meet their needs (Harper & Hoopes, 1990).

Sample

Selection

The researcher contacted the Vice President in charge of Nursing Services at a mid-sized Montana hospital and, after explaining the research project, was granted permission to conduct the survey at this institution. Sample members were limited by the prerequisite that they be licensed registered nurses. The investigator was not given direct access to names of registered nurses employed at this institution. Therefore, the payroll clerk was asked to provide a list of 50 names picked through a method of quota sampling (Gay, 1991).

An introductory letter explaining the project was inserted in pay envelopes of nurses selected by quota sampling. A self addressed postage paid postcard indicating whether or not the individual wished to participate in the study was included. Of the fifty names selected, thirty individuals agreed to

participate in the study. One participant was a male nurse, which approximates the percentage of male registered nurses employed at this institution. One interview was not conducted due to the participant's delivering a child the week before her appointment for the interview. Due to saturation of categories, the researcher limited interviews to 28 respondents. Nurses providing patient care in several areas of the hospital and nurses involved in mid-level and upper management administrative duties were part of the sample.

Table 1. Distribution of Participants by Work Area

Administration	4
Case Management	2
Dialysis	2
Infection Control	1
Intensive/Cardiac Care	4
Medical	6
Obstetric	3
Outpatient Neurology	1
Pediatrics	2
Psychiatry	1
Surgical	2

Respondents were individuals with varying amounts of education. Registered nurses with associate degrees (two years of training), diplomas (three years of training), Bachelor Degree (four years of training) and Master's level prepared individuals were interviewed. Work experience ranged from individuals with less than one year of experience to one individual who has worked

as a registered nurse for over 32 years. One individual was a new graduate. Four individuals started as "candy stripers", progressed to nurse's aid (nursing assistant) to licensed practical nurse to registered nurse. Two individuals in the sample are or have been members of a Catholic Order. The youngest participant was 32 and the oldest participant was 62. Average age was 41.

Four individuals have never been married. The time span for marriages ranged from three months to 33 years. Average length of marriage was 14.6 years. Seven respondents have been married more than once. Average number of children per family of those respondents with children was 2.3. Four of these children were adopted. Age range of children is two months to 33 years old. Five respondents are without families of procreation. Nine respondents have been or are divorced.

Collection of the Data

Pilot Study

Harper and Hoopes (personal conversations, November 2, 1991) state that conducting research about shame is difficult when working with shame prone individuals. The primary reason for this difficulty is these individuals shut down or cover up their shame.

For this reason the investigator conducted a pilot study the purpose of which was: to see if individuals "shut down", to provide insights into better ways to handle certain questions (Gay, 1991), to determine whether data collected in the interviews could be analyzed in the intended manner (Gay, 1991), and to determine an appropriate time frame to adequately gather information but not unduly fatigue respondents.

Three individuals with whom the investigator has a close personal relationship agreed to be members of the pilot study. These individuals were within the selected sample. The investigator has discussed personal histories with these individuals through the years. The investigator believed there was a strong likelihood these individuals were persons with a shame prone identity or had families of origin that were shame bound family systems. The interviewer felt the trust within these relationships provided a safe atmosphere for the respondents to be open and honest with their responses.

The results of the pilot study revealed the time frame of the interviews was appropriate. The creation of the individual's genogram proved useful to: "break the ice", familiarize the respondents with questioning involved in the ethnographic interview, and develop

rapport. Data from the pilot study was incorporated into the main body of information.

Data Collection

The pilot study and remaining interviews were conducted over a two month period. All interviews were tape recorded. Notes were taken during the interview for observations of non-verbal clues of shame and to make clear the complexities of relationships on genograms.

Interviews were designed to last an hour. Interviews of individuals without families of procreation were briefer. Three interviews lasted two hours. Six individuals brought forth more information after the conclusion of the interview. As the researcher exited the interviewee's home, the respondent would bring up memories of events he/she thought important to the research. The researcher made additional notes at the earliest moment.

Compilation of Data

Recorded interviews were coded using key words entered into a DbaseIII data program. Samples of coding were checked by a registered nurse familiar with the family system perspective and a graduate student in Marriage and Family Therapy for descriptive accuracy.

Key words were organized into sets sharing a commonality, i.e., domains. As domains were examined, themes emerged, forming images germane to the central concepts of this research.

The author recognizes the presence of ambiguity in describing levels at which intimacy, dependency, and accountability needs are met. In assessing the family systems of respondents, the researcher relied upon participants' perceptions and their descriptions of how these needs were met. These perceptions are relative to others describing a similar situation. An event experienced by one individual may be described as harsh. A similar event experienced by another individual may be perceived as acceptable. These differing perceptions can be considered ambiguous.

Recognizing the presence of ambiguity, the researcher assessed genograms and responses from the ethnographic interviews for processes involving interactive patterns of relationships, generational transmission processes involving cohesion and adaptability, and interactive patterns. Responses and genograms were evaluated for affirmation processes. Again, domains emerged. From an analysis of these domains, the researcher noted emerging themes which served as the core of the findings.

CHAPTER FOUR

COMMENTARIES

A dBase software program was used to sort more than 2175 comments which were direct quotations taken from the ethnographic interviews. These quotations served to provide the rich description used in this qualitative research and to illustrate the themes developed from an analysis of this information.

All participants willingly and freely shared in providing intimate details of their lives. No non-verbal signs of shame were noted despite the emotional involvement and difficult situations that were being shared by the respondents. Eye contact was direct. The single sign of shame noted was in the modulation of the voice when relating traumatic events. This has been noted when particular quotations are cited.

Parenthetical remarks have been inserted within respondents' comments to clarify relationships or circumstances. The use of (---) rather than a name has been used to maintain confidentiality. Remarks of individuals are differentiated by double spaces between

commentaries. Individuals' perceptions have been identified by two letters. These markers have been carried throughout the presentation of the data to enable the reader to follow the commentaries of the respondents.

Assessment of Families

Close examination of the data revealed several processes of interactive patterns affecting adaptability and cohesion in respondents' family systems. An analysis of respondents' statements revealed three levels of family systems based on concepts of Olson's Circumplex Model which were discussed in Chapter Two. Four individuals' families of origin fell in the balanced family system range (two flexibly connected, two structurally connected), six within the mid-range of family systems (all structurally connected), and 18 family systems were identified as within the extreme range (12 chaotically enmeshed, one chaotically disengaged, and five rigidly enmeshed).

To provide an overview of the atmosphere of respondents' families of origin and to share in their realities, the author proffers their perceptions. These perceptions were obtained from the genogram and the answers to the first question, "What was it like

growing up in this family?" Guidelines were not offered to the respondents on "where to begin". Occasionally, additional questions were asked to clarify certain aspects of relationships or particular events being discussed by the respondents. Respondents' perceptions have been categorized and presented using Olson's three levels of family systems.

Balanced Families

Structurally Connected Famil System

> CA I don't know how my mother did it. We had no water or electricity. She did all the wash by hand, we had the pump in the front yard, and the kids carried the water and heated it on the stove. When you watched my mother and father work, you would feel guilty if you didn't pitch in. In the depression, my father had a hard time getting work. He shoveled snow all night for two dollars a night.
>
> The house had three bedrooms. Kid sister slept in the same room as my mother and father. Two sisters and I had another room and three brothers in the other bedroom. When my grandfather came to live with us, he slept with the boys.
>
> We were very close. We talked a lot with each other, made ice cream in the living room with the old creamer. I didn't know any different. You don't miss anything if you don't have it.
>
> Mother was the matriarch, she was the boss of the house. That was O.K. with everybody. Mother wouldn't back any of us, never had a favorite. When we had a spat (amongst the siblings) we were put in a room

until we could work things out and if you came out with a grumpy face you went right back in.

When I look back, I wonder how she did it. She never felt burdened by her family.

My father always told us that we could do anything we wanted to do if we worked hard enough at it. He set the example. We were the poor ones. My father said, "You go to school with clean clothes, you're being raised properly so don't worry about if they look down on you".

Flexibly Connected Family System

KM Big family. Lotta boys, parents were immigrants from another country. We had a real close knit family, I think. I think in Europe, the focus of family life is different. There aren't as many external influences. They didn't allow much of that. We did things as a family. We skied, we hiked, we camped, that was pretty important. We had family prayer group in the evening. Did a lot of cultural things that are more European than American that we didn't always like. It was difficult at times growing up with parents that didn't understand American ways of doing things. But overall, we're still very good friends, all of us. We still like to do a lot of things together.

My parents are real different personalities, but they have blended pretty well. Dad is optimistic, sees the good in everyone. Mom is more of an introvert, very artistic.

Sometimes I thought she was going to Warm Springs, so much commotion. She's one that if she'd had a choice, wouldn't have had so many kids.

The sense of family was so important to my parents. We were all included. That came first.