

Summary of Thesis for PhD degree

by Patrick A Crookes

on

Personal Bereavement and Registered General Nurses.

1996.

The purpose of the study was to 'examine the idea that the processes of normal grieving can be impaired or complicated by virtue of an individual being a nurse or midwife'.

A mixed methodology was utilised to allow data to be collected at both exploratory and descriptive levels, and to provide reinforcement via the triangulation of data relating to key concepts, derived from a variety of methods.

At the exploratory level, the study examined the incidence of factors said to predispose towards complicated grief (Murray-Parkes 1972), within a population of nurses and midwives. This alongside consideration of factors within the socialising environment of hospital nurse/midwifery, which might engender or reinforce certain personality traits. The study also investigated the respondents' views on their role within their family.

Interviews with bereaved nurses and midwives, then explored the implications of these traits and norms of behaviour, for those who had actually experienced the death of a loved one. This provided data at the level of description, as relationships between identified concepts were examined.

In the event, the data suggested that certain predisposing factors to complicated grief: a 'coper' self-concept; a strong sense of personal independence from others; and a perceived lack of functional social support, both at home and at work, were prevalent within the group studied. They also indicated a range of difficulties which may arise when nurses and midwives become consumers of the services they usually provide, and the related problem(s) of being the 'family nurse'. Interviews with bereaved nurses and midwives, then identified how one or more of these issues can impact upon the experience of family hospitalisation, and ensuing bereavement, to the detriment of individual nurses and midwives - particularly by predisposing them to delayed onset of their grief, perhaps for months or even years.

THE UNIVERSITY OF HULL

Personal Bereavement and Registered General Nurses.

being a Thesis submitted for the Degree of PhD

in the University of Hull

by Patrick Austin Crookes. BSc (Nursing) (Leeds)

(January 1996)

Acknowledgments.

My thanks are extended to the many people who have helped me in my work over the past eight years, most notably Professor Margaret Clarke; Ian Gibbs; Eugene Chekaluk; and more recently Sue Davies.

I am also forever indebted to my wife Kay who always believed in me, and my family who willed me to complete what I had set out to do.

Dedications.

To William A Crookes (Bill), a father I never got to know until I was a man, and then all too briefly. If you had not died I would probably never have had the desire to study in this area. I wish you were here to see this now Dad, I would give it all away for that to be so.

To Lucy, Ellie and Amy. You are my sunshine.

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Chapter One

Introduction to the Study

"Very few conspiracies, Smiley once remarked, survive contact with reality. And so it was with the conspiracy that I had made with myself to let my mother's death slip past me as a timely and necessary release from pain. I had not taken into my calculations that the pain could be my own".

'Ned' - the "Secret Pilgrim" - John Le Carre (1991)

Carper (1978) refers to empirical knowledge as being "factual, descriptive and ultimately aimed at developing abstract and theoretical explanations". She goes on to assert that "It is exemplary, discursively formulated and publicly verifiable". This in a nutshell, identifies the necessity for researchers not only to follow a rigorous process whilst undertaking a study, but also the importance of being able to present this to the 'audience' for scrutiny and evaluation. The present researcher's attempts to do this were hampered to a degree, by the fact that the more established formats for doing so failed to capture the processes undertaken by the researcher in carrying out this study. This was particularly so because it was decided at the outset that both inductive and deductive approaches would be necessary to explore the issues in question and that a mixed methodology would be used to facilitate triangulation within what is a very large study.

Also due to the constraints of part-time study, the project took place over a number of years and so much of what was read regarding the study was post-data collection and it was thus difficult at times to recollect when an issue became apparent. Initially it was decided to limit the literature review presented, to the period preceding the time of data collection (1989) as this reflected the basis on which the study was undertaken. This was not satisfactory and so pertinent literature which has become available to the researcher post - 1989 is included in the literature review.

Background to the Study.

The possibility that the fact of someone being a nurse or midwife might complicate things when they become bereaved, became apparent when the researcher's father died. Most notable, was a difficulty in "acknowledging the irreversibility of the loss" (Worden 1983) on an emotional level (cognitively there was no problem - one 'understood' the pathology involved); and the guilt felt for not 'doing more'. Fears of being insane, or at least 'odd' were engendered. However, on discussing such feelings with other nurses who had been bereaved it became apparent that there were similarities between these

feelings, and those of others. Furthermore, for some people other problems were identified, particularly that during the hospitalisation of their relative they were expected to act as the 'seeker of information' for their family which often made them feel very uncomfortable. Also that many of them were expected to be stoic and in control in the face of their grievous loss, while the rest of their family took time to grieve.

This role of the 'family nurse' took on further shape and form, with true stories such as the student nurse who said that within three weeks of commencing her training, she had been informed that she should now take responsibility for administering her father's insulin regime, which up to that point he had controlled himself for 10 years. Finally a meeting with the chief counsellor for the Royal College of Nursing's counselling service (CHAT) namely Penny Crawley, reinforced the meaningfulness of a study into this area as a whole. During this meeting she asserted that over the years she had seen a significant number of nurses at the centre of disciplinary proceedings for professional misconduct, because of problems related to unresolved grief, and/or the difficulties of living up to the ideal image of the nurse.

It was at this point that the researcher turned to the literature, to identify if anyone else had examined the issue of personal bereavement in nurses and midwives; and to explore any related literature which could be utilised to underpin and inform the study. In the event, it became apparent that there was little literature (research-based or anecdotal) on this subject, although there were a few articles on the reactions of nurses to the death of patients. The work of Colin Murray-Parkes (1972, 1975) on factors predisposing individuals to pathological grieving, provided much food for inductive thought, as did that of Worden (1983) who discusses ways in which normal grief can be complicated. There was also a sizeable body of literature on the treatment of relatives, which included numerous anecdotal accounts written by nurses and midwives in which they recounted their experiences (usually bad) at the hands of other nurses, midwives, or health care 'institutions'. This literature was seen

as pertinent, as was that relating to the process and outcomes, both intentional and unintentional, of professional nursing socialisation, and the issue of social support and nurses.

This introductory foray into the literature provided the wherewithal to develop a formative aim for the study as well as a plan for a more structured and formalised literature review, which in turn facilitated the identification of a number of concepts considered to be related together.

The aim devised at this point was:-

'To examine the idea that the processes of normal grieving can be impaired or complicated by virtue of an individual being a nurse or midwife'.

It was intended to do this by quantifying the presence of factors thought to predispose to pathological grief (after Murray-Parkes 1972, 1975) within a population of nurses and midwives; examining the role nurses and midwives may play in their family (i.e. the 'family nurse'); and, considering possible ramifications of professional socialisation for the grieving processes of nurses and midwives.

Significance of the study.

The study is significant for nursing and midwifery because for the first time, the nature of the prevailing culture of hospitals, and societal expectations of 'professional copers' were systematically examined, along with consideration of implications for professional nurses and midwives experiencing personal bereavement. In time it is hoped that tangible benefits will be achieved, as a result of identifying how the contemporary environment in hospitals can be seen to be detrimental in some cases to patients and staff alike, and offering possible solutions to remedy this.

Also apparently for the first time the role of the 'family nurse', and the implications for people occupying that role during a family bereavement were systematically examined. It is hoped that in identifying that such a role exists for many nurses and documenting the expectations of people when in that role, that a greater awareness of the need of 'professional copers' like nurses to be able to be 'human' when bereaved is achieved. This awareness being in nurses and midwives themselves, their families and in work colleagues.

As will be seen in the data presented and discussed later, no discernible differences were identified between the nurses and midwives, with regards to the issues examined in this study. For ease of reading therefore, 'nurse' will henceforth be used to refer to both nurses and midwives.

Chapter 2.

Literature Review:

Pathological or complicated grief

The treatment of hospital visitors
in western society

Socialisation into professional
nursing culture

Professional socialisation and
'professional coping'

Social support and nursing

The 'family nurse'

Five areas of particular interest are examined in this literature review, namely: pathological (or complicated) grief and factors which may predispose towards it; the treatment of visitors to hospitals (including the needs of relatives and whether they are typically met); the professional socialisation of nurses (including 'professional coping'); the issue of social support and its availability to nurses; and, the role(s) played by nurses in their family.

Finally it is reiterated here, that data collection for this study took place in 1989, however reading pertinent literature obviously continued after that time. The reader therefore should appreciate that literature available to the researcher after 1989 could not and did not contribute to the study design. However, literature which has become available since 1989 is included in the review and data from the study were obviously considered in the light of all available literature.

Pathological or Complicated Grief.

Before one can carry out a meaningful examination of complicated grief, it is necessary to explore the concept of "normal" grief. According to Engel, grief is the "characteristic response to the loss of a valued object, be it a loved person, a cherished possession, a job, status, home, country, an ideal, part of the body..." (1961). Mourning is the process (with both physical and psychological aspects) through which grieving people must pass to re-establish a "state of health and well-being", the trauma of the loss having been overcome. In other words, grief is the response to loss, while mourning is a process by which the loss is resolved. Here the author intends to concentrate ostensibly on the grief reactions and resolution in those faced with the loss due to death, of a relative or close friend.

In his seminal text on grief and grief counselling, Worden (1983) points out that death is a part of life, a sobering but nevertheless unavoidable truth, thus grieving and mourning are also components of everyday life. Brantner's observation that only people who avoid love can avoid grief (in Worden 1983),

is a salient one here, as it reinforces the fact that sooner or later most of us are touched by death and grief. The resolution of grief through the process of mourning has been examined and documented by many over the years:- in terms of the behaviours typically manifested; the reasons postulated for that behaviour; and the phases of the recovery (or mourning process).

Questions have also arisen over whether grief is an illness or a natural response to loss. Both Freud (1917, cited in Engel 1961) and Bowlby (1980) have put forward psychological explanations for the symptoms manifested in grief. Freud suggested grief is the "struggle between opposing impulses ...to realise the loss or to retain the love object", whilst Bowlby relates it to his theories of attachment believing that good parenting in early life develops attachment with the child to fulfil security and safety needs. In childhood, if the object of security disappears (eg parent) then intense anxiety occurs - resulting in crying, shouting, tantrums etc - all of which are aimed at bringing the love object back (typically it does - quickly!) Bowlby extrapolates from this behaviour by saying that loss in adult life leads to re-identification with these early mechanisms for recalling love objects - hence the manifestation of intense anxiety in all its forms in the grieving person, they are a subconscious attempt to recall the loved one. The re-utilisation of child-like coping mechanisms also explains the ego-centrism of grieving people eg. "What will I do now?" and "How can I go on?".

Parkes and Weiss (1983) believe that behaviour such as crying in adults, also evokes the sympathy response in others in the group thus allowing the affected group member to opt out of responsibility for a while. They also point out that the group may, for a time, also allow bad behaviour eg. tantrums or outbursts of anger to occur without censure.

Together these three perspectives of the nature of grief, provide some explanation of the psychological and somatic symptoms often manifested by grieving people, eg feelings of numbness, guilt, anger, self-reproach, intense yearning, helplessness, feelings of emptiness, insomnia, sighing and anorexia.

In his book "Bereavement" Parkes (1972/1993) makes the point that data can be obtained from detailed studies of a few people or from statistical studies of larger samples. He goes on to say that the two should complement each other, so that generalisations can be made from studying large numbers of people and by intensively studying a few, the significance of the mathematics of the many can be evaluated. It was with viewpoint that he based his work on the bereaved, combining numerous longitudinal studies following the experiences of bereaved people, with case-note analyses of bereaved psychiatric patients, over a 30 year period, both here and in the USA (see Parkes 1972, p. 137 and related appendices, for details of these studies).

From this work, Parkes categorised the various symptoms of grieving and arranged them into the stages of the mourning process:- numbness; yearning; disorganisation; and, reorganisation (1972; 1975), each stage being interlinked and overlapping.

From his grief therapy work, psychiatrist William Worden (1983) views these phases as 'tasks', pointing out that they do not evolve passively but indeed need to be worked at.

Task one:- To accept the reality of the loss.

When a death occurs, even if expected, there is always a sense of "It hasn't happened," therefore the first task is to face this reality. Symptom manifestations in this phase, can be related to Bowlby's work, in that the bereaved may search for the loved one (literally); talk to them and act as if they were still there. This can also be seen (in the short term) as an effective coping strategy in that it can prevent flooding of the emotions and thus minimises the risk of the bereaved being totally overwhelmed by their loss. Parkes and Weiss (1983) take this on further and put forward the view that grief is a type of psychosocial transition - a situation in which a person is faced with the need to adapt to a new view of the world. This is akin to a situation where for years one has walked through the same door to the kitchen, to find that one day it

leads to the living room, or even nowhere. Much the same thing happens in this stage of grieving, in that the bereaved are constantly brought up short by reminders that the person is dead, until finally they can accept the fact, and move on (perhaps to slide back in some cases.)

People may attempt to avoid these 'reminders' however, particularly by using some form of denial mechanism, eg.

- . Denial of the facts - keeping rooms unchanged etc;
- . Denial of the meaning of the loss - trivialising the relationship;
- . Denial of the irreversibility of the loss, eg. by spiritualism.

These may work as a protection against doing the 'grief work' but as will be discussed later, there is a possibility that they will resurface problematically at some later stage.

Task 2: To experience the pain of grief.

It is impossible to avoid the pain of grief, it must be worked through otherwise it will manifest as some other form of aberrant behaviour later on (Worden 1983). The completion of this task can be complicated in various ways, for example, the relationship between mourner and society.

People in western society are often uncomfortable with the mourner's feeling. Death is taboo for many reasons, including a failure of modern science; the fact that considering death makes us consider our own mortality; and the fact that a sanitisation of death has occurred by diverting the care of the dying, from the family to professionals. The result is that the bereaved may be given the message "Don't grieve...he wouldn't have wanted you to cry". Such pressure may then be internalised by the bereaved as "I don't need to grieve" - a denial situation. Gorer (1965) identified this as an illustration that in western society giving way to grief is stigmatised as morbid, unhealthy and demoralising, the proper action of a friend and well-wisher seeming to be perceived as acting as a distraction from a person's grief.

Task 3: To adjust to the environment in which the deceased is missing.

The ability to do this and the rate at which it is achieved is obviously linked to the relationship between the deceased and the bereaved. The closer the interdependence (close marriage, age-old mentor, etc) the greater the vacuum left. This may be further complicated because roles fulfilled by the deceased may have gone unrecognised, leading to problems as the bereaved now has to fulfil those roles personally (or rely on someone else) requiring the development of new skills.

Some may attempt to abort task 3 - by portraying helplessness and/or withdrawal. This is not adapting to the loss and will inevitably lead to problems when helpers start to retreat to get on with their own lives. Most do not do this however, rather like the phoenix from the ashes, they rise to the challenge of new roles and grow as a person as a result. Indeed this can be seen as a positive component of death and bereavement, whereby from disaster comes new growth and insight.

Task 4: To withdraw emotional energy and reinvest it in other relationships.

Worden sees this task of mourning as detaching the survivor's memories and hopes from the deceased (1983). The researcher can identify with one aspect of this, notably, that future hopes and aspirations of the bereaved need not be considered relevant to the deceased. However it must be contended that the memories of the deceased should not be discouraged, indeed the contention is that the ability to remember the deceased, without remorse or pain, is a sign that the task of grieving is over. This can be a difficult stage however, as the withdrawal of emotional attachment to the deceased is often seen by onlookers (and the bereaved) as dishonouring their memory, particularly in societies where formal mourning periods no longer apply.

The investment of emotion into new relationships is also often avoided for fear of having to face up to further loss. This has been identified by Janis (1962) as the "Old Sergeant's Syndrome", in which battle weary soldiers tend not to

cultivate new friends, due to the risk of them dying soon. They therefore tend to isolate themselves to avoid the pain of loss. It may also partly explain why some bereaved spouses will spend large amounts of time and emotion with grand-children - believing that they will not die before them, instead of forging new friendships with people of their own age.

Looking at common manifestations of grief, and the tasks to be worked at to resolve it, brings us to the question "Is grief a disease?" Simos (1979) sees grief and illness as being similar in that both may be self-limiting or require intervention by others. In both, recovery can range from a complete return to the previous state of health and well-being, to partial recovery to improved growth and creativity, and both can inflict permanent damage, progressive decline and even death. Engel (1961) takes this line on even further, likening the loss of a loved one to physical trauma, in that it the hurt takes time to heal and there are ideal conditions in which it will do so. Furthermore, Deutsch (1937) states that whilst grief causes somatic symptoms and could therefore be termed an illness, essentially it is not because "grief is a normal accompaniment to loss". For Deutsch, the **absence** of a grief reaction is seen as an illusion, and as stated earlier could be seen as pathological in itself. This leads to the conclusion that mourning is healthy and necessary for well-being (in the bereaved) and failure to mourn manifests in a way akin to the child who fails to work through developmental milestones, ie she is impaired when trying to complete tasks at the next level.

From this it is apparent that mourning is essentially normal, there are tasks to be worked at to achieve resolution and as in the care of traumatic injury, healing will take place unaided if the conditions are favourable. If they are unfavourable, however, then help and intervention by others is necessary. So what conditions are unfavourable to grief resolution in the bereaved, and how these can be avoided, minimised or dealt with?

From the aforementioned studies, Parkes (1972; 1975) also identified pre-

determinants of pathological grief. They are extensions and complications of 'normal' reactions to loss and the presence of one (or more) of these factors can predispose the bereaved to complicated or pathological grief. This is seen by Horowitz et al (1980) and Worden (1983) as intensification of grief to a point where the person is overwhelmed, resorts to maladaptive behaviour or remains interminably in a state of grief, without discernible progression through the mourning process.

Parkes' main pre-determinants are presented here, along with other work which affirms the points made:-

Relational Factors: If the relationship has been an ambivalent one (eg. between a cruel man and his spouse/child), in such cases, residues of anger and guilt can hinder resolution of the loss (Raphael 1984). Those in highly dependent relationships are also at risk, because of the huge space left in their life by their loss (Horowitz et al 1980). The existence of a narcissistic relationship (where the deceased is viewed idealistically) also complicates grief, this because the deceased represents an extension of self (actual or desired) and therefore to accept the loss also requires an acceptance of their own mortality (Worden 1983). Perhaps this is why the death of a grown-up child is felt so hard by parents (Stedeford 1984).

Circumstantial factors: These are at work when the circumstances surrounding the loss are uncertain eg. a soldier missing in action, or a child who disappears and is presumed the victim of a murderer. The lack of firm evidence of death eg. a body (Lazare 1979), seemingly providing opportunity for subconscious, if not conscious, denial of the death (Simpson 1979).

Historical factors: Previous experience of complicated grief usually predisposes the bereaved person to further experience the phenomenon. Pincus (1974) identifies people who lose loved ones (parents etc) in early life, as being in this category, perhaps as a consequence of safety and security needs being unmet

to some degree (Bowlby 1980).

Personality factors: Certain personality types are identified as being 'at risk' including those who are unable to tolerate extremes of emotion and/or have difficulty expressing their feelings to others; and those who do not tolerate feelings of dependency on others (Worden 1983). The former group is self-explanatory, while the latter is interpreted by Simos (1979) as being because the resolution of grief demands the universal experience of feeling helpless and out of control. If the individual builds their defences around the avoidance of feelings of helplessness, then they may be among those most likely to have dysfunctional reactions to grief. Thus the individuals who normally perform most competently on the surface may be the very ones more heavily affected by a major loss as it strikes at the core of their defensive systems.

Self-concept factors: Certain aspects of a person's self concept have been identified as potentially leading to problems with grieving (Parkes 1972, 1975; Bowlby 1980). This is particularly the case with a self-concept of 'I am a copier'. This is said to be potentially problematic because such a person will typically be an individual who is (or at least appears to be) relatively unaffected by their bereavement, and acts as a 'tower of strength'. Stedeford refers to such a person as the "practical copier" (1984 p. 147), saying that they support their family and others within the wider social circle affected by the loss, as they 'fall apart' and actively grieve. This role may be naturally accepted because the individuals self-concept dictates it to be correct, or it may be forced upon them by social pressures (eg. being the eldest, the manager) or a combination of the two. Whatever the motivation, typically such people do not allow themselves to experience the feelings required for an adequate resolution of the loss (Lazare 1979). Deutsch (1937) said that "the death of a beloved person must produce reactive expression of feelings in the normal course of events"; that "omission of such reactive responses is considered just as much a variation, as excess in time and intensity"; and finally, that "unmanifested grief will be found expressed to the full in some way or other". Thus the 'tower of

strength' could be in danger of such a situation, if the onset of their grieving is delayed excessively. From the literature (eg. Stedeford 1984; Worden 1983/1991; Parkes 1972/1993) this would appear to be anything longer than 2 weeks from the time of the death.

Social Factors: These affect grieving according to the circumstances surrounding the death. For example when loss is socially unspeakable perhaps due to suicide or AIDS (Oerlemans-Bunn 1988); when the loss is socially negated, which relates to situations such as when the deceased has been disowned from the family for some reason (Lazare 1979); when it is a parent who has deserted spouse and child (perhaps this is related to relationship ambivalence); or when the deceased is a partner in a homosexual relationship, where the remaining partner is often ostracised from family and even overt mourning (Worden 1991; Jones 1988).

Problems may also occur when social support is lacking (Vachon et al 1982; Vachon and Stylianos 1988). This is common in those who move to new areas on retiring, often many miles from old friends, family and other social networks. It is also a complication when the bereaved try to deal with the loss by moving away 'to start afresh'. It can also occur when the person's role in society precludes them from easily seeking help and social support, that is, they are the ones who usually provide it. It is this aspect of 'social support' that is considered most salient to this study as being a nurse may place an individual in such a position.

The complicated grief reactions, arising as a result of one or more of these factors, can usually be categorised under one of four headings:-

Chronic grief - Time scales for the grieving process are meaningless, asking how long it takes is akin to asking how high is up. In typical grief however (as described earlier) the pangs of realisation of loss gradually become less frequent with time, perhaps rearing up temporarily on 'special' days, such as

anniversaries and birthdays. Chronic grief not only goes on longer than expected, but it is also more severe, and even years after the loss, the person displays the features of recent bereavement (Stedeford 1984). The grief determinants typically predisposing to this form of 'pathological grief' are relational (ambivalence towards the deceased etc) and circumstantial (especially with regard to sudden and unexpected death).

Delayed Grief - Sometimes, reactions to loss are delayed, suppressed or postponed. Such a reaction is said to have occurred if more than two weeks elapse before grieving begins. Grief determinants related to this include, narcissistic relationships, and perhaps more commonly, personality factors. If the bereaved is in the position (assumed or enforced) of the 'coper', then typically they will delay their grief reaction until everyone else affected appears to have recovered. This delay may be so prolonged as to prevent the open manifestation of feelings (a necessary occurrence for resolution) indefinitely. This may be due to the fact that so much time elapses after the death occurred, that the bereaved person does not feel able to begin to overtly grieve. It may also be because the bereaved person occupies a position in society which militates against it (e.g. managers and professional copers such as nurses, doctors and counsellors). The result of this is that the feelings are submerged, potentially to resurface (as predicted by Deutsch 1937) in some way at a later stage. Typically in such cases it manifests as an over-reaction to a more 'minor' loss eg. death of a pet or even a response to loss portrayed in a book, film or play, many months or even years later. Recurrent over-reaction to emotional situations is also a possibility.

Exaggerated grief - Here there is an open and obvious connection between the death event and the grief reaction. However the reaction is so severe that help may be sought, eg. it may manifest as a phobia (often to germs, illness, or death); as a prolonged feeling of helplessness and despair; it may also lead to exaggeration of previously non-problematic behaviour, eg. exacerbation of previous drinking habits towards alcoholism.

Masked grief - People with such grief reactions often experience symptoms and/or behaviours which cause difficulty, but do not relate them (at least consciously) to their loss. These may include experiencing symptoms related to those which caused the death (headaches, chest pains, etc).

Affective disorders may also arise and complicate grieving processes, most notably depression, sometimes leading to suicidal thoughts or attempts, due either to a wish to join the deceased, or because of a view that life is no longer worth living. Mania may also occur (Stedeford 1984), although this is rarely prolonged and is usually followed by depression and the development of more typical reactions to loss.

Somatic disorders are also common. Evidence for this includes increased morbidity and mortality rates in the recently bereaved as compared with their peer group average, usually from diseases accelerated by increased stress, eg. ulcerative colitis and cardio-vascular diseases. Thus, as Stedeford puts it, complicated grief reactions are either "variants of the typical process [of grieving] ... where grief is delayed, inhibited or prolonged ..." or "problems that may accompany the grief reaction and partly obscure or replace it" (ibid p. 157).

The predisposing factors to pathological grief identified in the literature, have thus been identified and discussed, most notably with regards to Parkes determinants of pathological grief model. It was from reflection on this model, that the possibility that nurses (along with other 'professional copers) may be at risk of pathological grief reactions. This was because three of them ('independent' personality traits, a self-concept of a copers and lack of social support) appeared to the researcher to be rather common amongst nurses, having been in the nursing profession for over 10 years. This was therefore the basis for the study, the intention being to examine the incidence of these predisposing factors, alongside ways in which their development could be seen to be encouraged within nurses, and why.

An aspect of the on-going reading related to the present study, has been the analysis of available texts on grief and bereavement published since 1989, including revised editions of seminal texts, e.g. Parkes (1993), Raphael (1992) and Worden (1991). The main points to raise of relevance to this study from this reading, are firstly, that the revised texts contained little new pertinent material. In fact the chapters of most relevance, i.e. on the nature of grief and how it may be complicated (Raphael; Parkes), and 'care of the counsellor' (Worden) were unchanged. This seems to suggest that these authorities are satisfied that such concepts have been adequately examined, allowing them to concentrate more on supporting and treating those identified as suffering from complicated grief. This conclusion is supported by the fact that journal articles in this area have essentially been literature reviews re-working much that is in this review (Carter 1989; Jacob 1993; Cowles et al 1991).

Secondly, almost without fail, the issue of the needs of professional carers/copers was ignored. Littlewood (1992) for example, in her text 'Aspects of Grief' did not mention this issue in spite of a chapter on 'caring for the carers', while Penson (1990), in a book which runs to 165 pages, refers to the difficulties nurses may have in bereavement on page 164. This is in spite of the fact that the text is 'a guide for nurses' to bereavement. Meanwhile Davidhizar failed to mention personal bereavement in an article entitled "When the Nurse Faces Separation and Loss" (1991). Neither of the above texts, nor those by Shapiro (1994), Marris (1993), or Stroebe and Stroebe (1989) provided any further update on the literature in the field of grief and bereavement and its resolution, than that provided in the original literature review of this study. However the latter text 'Bereavement and Health' does contain an excellent overview of the literature on 'normal and pathological grief'. Furthermore, in chapter 8 (pp168-221) they examine risk factors and bereavement outcomes and conclude that on balance, the research literature supports the view that the presence and interaction of others appears to ameliorate the negative aspects of bereavement, most notably depressive symptoms and somatic complaints. This reinforces points made later (in the

social support section) of this review.

The text 'A Handbook of Bereavement' edited by Stroebe et al (1993) was different to those above, in that it did include material from the 1990's, much of which was research based and provided by world authorities in the field (incl. Parkes, Raphael and Vachon). Within the text were literature reviews on topics very pertinent to this study, most notably the nature of 'normal' and 'pathological' grief, and the role of social support in bereavement.

The main point to come out of the 'grief' section in this text, was the fact that an area of pathological grief that is widely accepted is that "where delayed grief patterns predominate" (p 50). Again it is perhaps worthy of note that in a text of almost 500 pages crammed with data relating to the field of grief and bereavement, there was only one (cursory) reference to the needs of 'supporters of the supporters', that was by Parkes (p 100). In this case it was no different to the texts discussed already, and demonstrates the lack of emphasis on this issue, as well as underlining the potential importance of the present study.

In the final chapter of their text, Stroebe et al (1993) survey the research and development in this area and conclude that key areas of on-going and future research are essentially the nature of grief, and interventions to help the bereaved. This perhaps explains the lack of consideration of the needs of professionals.

Having considered grief and how it can be complicated by various circumstances, the review will now turn to areas which may impinge upon the experiences of grieving for relatives, particularly those who are also nurses.

The treatment of hospital visitors in western society.

This issue was examined because the present study intended to consider ways in which hospital visiting might affect nurses, particularly whilst enacting the

role of the family representative (see 'family nurse section later). The role of relatives in the care of the sick has been paramount throughout the ages. Hawker noted in her historical perspective of the role and treatment of hospital visitors, that it was in the home that doctors found the resources needed for their patients - "relatives to provide nursing care, food and shelter" (1984). She also believed that the idea of separating sick people from their relatives "arose in the context of the first hospitals" (ibid) having introduced the concept of visiting times in an attempt to control the 'problem' of relatives which centred around issues of access to the patient and the actual behaviour of the relatives while in the hospital (Darbyshire 1987). Darbyshire went on to discuss how, over time, access to sick relatives became even more limited, to the degree, in some cases, of the introduction of ticket systems to limit the attendance of visitors. All this was said to be for "the good of the patients" - not the institution.

The separation of sick people from their families is thus a feature of westernised culture, which has grown up over the past 200 years. Eldar and Eldar (1984) attributed this to our greater acceptance of "professional care in sickness than there is in developing countries", leading to a belief that highly trained personnel are required to deal with even the everyday aspects of caring for the sick, and thus requiring the restriction of access to patients by their relatives, so as not to interfere with the work of the professional staff (Eldar and Eldar ibid). They went on to point out that in many parts of the world, the role of the family in health care is still central, and that there is no 'problem' with relatives. Indeed they reflect that in some societies, the view that it is the family's responsibility to care for its sick members "is so deeply rooted...that relatives will not leave a sick person when he is admitted to hospital" (ibid), a situation accepted by the authorities involved.

The role of relatives.

We therefore have a situation common in many hospitals today, where relatives' access to the sick continues to be restricted along the lines of 19th century

institutions. Furthermore the most 'appropriate' role would seem to be that of the 'visitor', i.e. someone who provides a "great deal of emotional support... ..from regular visits" (Rosenthal et al 1973 p 100), this role being both helpful and necessary if "the patient is to derive the fullest benefit from hospital care" (Rosenthal et al ibid) (irony intended). This can be seen to reflect the 'passive' visitors role, identified by Fox, who having been a hospital visitor herself, asserted that visitors are made to feel that they should stay out of the way of staff; not ask questions that cannot be answered or which staff do not want to answer; and above all, do not complain either on behalf of themselves or their relative (the patient) (1985).

Rosenthal et al (ibid) meanwhile referred to another role - that of the worker, which they characterised as doing patient-centred tasks for the nursing staff. They argue that this often renders relatives "less likely to complain...because helping makes them feel less anxious and helpless" (p101). They also claim that this assumption of some responsibility, renders such relatives a part of the team under the normative control of the staff. This ensures that they then act in particular ways and play particular roles, comfortable to the staff. Furthermore they were of the view that should they (visitors) slip out of the 'passive' visitor role, then they may be given the role of worker (see above).

Alternatively they may be assigned a patient role, where the staff rationalise the behaviour of the relative (e.g. anxiety, distress) in terms of a sick-role, and hence can be viewed as pathological and so 'treatable' with "counselling.. ..comfort...(and) even sedation" (Glaser and Strauss 1966 p105) . Roth (1972) points out that the control of relatives to shape their behaviour so as to 'perform' the preferred roles is not necessarily pre-planned, but that circumstances conspire towards it, with both parties acknowledging norms of behaviour for their respective roles and an apparent awareness of the sanctions which may be invoked for not abiding by them. Thus, whatever the means used, a passive or conciliatory stance from relatives is encouraged.

The needs of relatives.

Molter (1979) surveyed the perceived needs of relatives of critically ill patients, by asking them to rank a list of needs (1-60) from most important to least important. She found that the major perceived needs were "to have hope...to feel hospital personnel cared about the patient...to be called at home about the changes in condition of the patient...to know the prognosis...and...to have questions answered honestly". Eldar and Eldar, are of the view that the freedom to be with sick relatives and to share in their care "helps alleviate worries and makes them feel more useful" (1984). They also believe that such an involvement facilitates a smoother transition from hospital to home life on recovery. There is also a need for families to know their relative is being 'well looked after', Hayter (1982) for example examined the perceived needs of relatives, and reported that families had less enjoyable visits when the patient was dishevelled. This has been considered to be partly attributable to guilt felt by some families who have to admit sick relatives to hospital, thus leaving their care to someone else (Sheldon 1982).

Most nurses would presumably claim to 'know' about such needs, perhaps even claiming to do so 'intuitively' or because it is 'common sense'. There may be a question however, as to whether relatives do actually receive such care. To paraphrase Nightingale, even the best plans are not self-executing, and several studies have found that when the needs of families and visitors are identified by nurses, in reality these needs are not always fulfilled (Daley 1984; Stilwell 1984). This is an example of cognitive awareness coupled with behavioural denial. It has also been found that nurses have a tendency **not** to view caring for families as a **realistic** (my emphasis) expectation of their role (Yoder and Jones 1982; Robinson and Thorne 1984) due to pressure of work, lack of time and lack of staff. Dyer (1991) has produced a paper which coherently argues the importance of caring for relatives, along with suggestions for how to best going about meeting their needs.

The need for information.

The need for effective communications between nurses and relatives was rated very highly by respondents in Molter's study (1979). Indeed it was seen as being vital for satisfaction of the relatives. Wiancko et al (1986) found that if staff failed to demonstrate to relatives that they were being listened to, then what would normally constitute small issues would mushroom into big problems. On reflection this is readily understandable, for as Dewis (1986) points out, having canvassed the views of spouses of demented patients being cared for in hospitals, "how can a nurse, even with all her assessment and interactional skills know a person better than a spouse or relative of many years standing?".

Of all the needs of relatives identified therefore, the lack of information would seem to be the most common source of dissatisfaction amongst both patients and relatives (Nyamanthi 1987; Whalley 1988). Indeed having considered the range of complaints to the Health Ombudsman, Walton labelled it a perennial problem (1986). But why is this?

It has been said that nurses are wary of giving information, and various reasons have been put forward as to why, for example:- fears of being found out as 'inadequate' (Larson 1987 - 'Helper Secrets'); to be not actually working all the time (Melia 1987) or not achieving the ideal level of care (Smythe 1984); a poor professional self-image, low self-esteem and an attendant lack of confidence in their own abilities (James 1989; Melia 1987; Roberts 1983); and, to avoid feeling 'uneasy' because of close personal involvement (Menziés 1961; Jourard 1971) perhaps due to inadequate preparation in this area. Smith (1992) for example examined the emotional realities of nursing and in particular how nurses come to be prepared (or not as appeared to be the case) for dealing with the emotional side of their work. She did this via interviews with and observation of, student nurses and their teachers when such material was covered in nurse training (if indeed it was). Strong parallels are apparent between Smith's work, and data from the present study, regarding both the

preparation of nurses for dealing with the dying and their relatives, and for mechanisms nurses use to minimise the emotional impact of their job, upon themselves.

It also has to be acknowledged that some perceived needs of relatives cannot realistically be met in the hurly burly of modern hospitals, for example, the 'need' to speak to a doctor every day about their sick relative's condition. It has to be agreed however that doctors should regularly meet concerned relatives, not least because as Molter (1979) points out, relatives frequently hold the view that nurses won't do for this task. This has been put forward as a major factor in occupational stress felt by nurses, because they have to bear the brunt of the situation ie making up excuses for doctors, deciding what to tell, how much to tell and to whom (Beaton 1980). In such cases, the frustration of the relatives can be equalled by that of the nurses involved and one can see how in such circumstances the tactic of avoiding the issue with relatives is understandably utilised. This can further be complicated in the situation where the physician invokes the power of his position and unilaterally orders what the patient and his family will know and the nurses have to live with all the problems associated with the closed awareness context of care (Glaser and Strauss 1966).

In such circumstances it is obvious that there would also be problems in the evolution of a successful relationship along the lines put forward by Robinson and Thorne (1984). They postulated that relatives of sick people in hospital tend go through stages in relationships with health professionals. Initially they describe "naive trusting", characterised by "compliant behaviour as they wait for the professionals... to fulfil their responsibilities". This is shaken (sooner rather than later) when relatives realise the mismatch between the professional's focus (diagnosis and treatment of disease) and their own (the experience of the illness and how it causes day-to-day problems in their lives). If this occurs, the relatives are said to be at the stage of disenchantment, where they recognise that positivity is wasted and perhaps overtly show

dissatisfaction with the care being provided. At this time health professionals typically note relatives as being as "demanding...imperious...and, over-anxious" (Robinson and Thorne *ibid*). This is a distressing time for both relatives and staff, not least because the relatives usually attempt to tread a fine line between demanding the best care possible for their relative and not upsetting staff so much as to jeopardise the care of their sick family member by alienating the health professionals.

Progression to the third stage - guarded alliance, is therefore desirable. Here the family recognise and acknowledge the strengths and limitations of the health care providers and a degree of trust is re-established. It can never return to naive trusting again however. In recognising that professional health care providers are human and fallible the chance of mutually negotiating satisfying care for the patient is enhanced. Families who were perceived to have reached this stage were interviewed by Robinson and Thorne, who found that such relatives had often given gifts to staff and used jokes to put the health providers at ease. Both of which had made the relationship become more personalised, meaning that there was more room for negotiation (*ibid*).

No doubt many nurses would identify other needs of relatives that they would consider unrealistic, giving lack of time or staff as the reason, much as they do when explaining why such things as humanistic care, individualised care and the nursing process are problematic 'in reality'. This was again reflected in the study by Yoder and Jones (1982) who on surveying the attitudes of casualty staff to relatives, found that almost half the nurses saw families as "at least potentially troublesome ie. demanding, meddlesome or overreactive". This reaffirms the belief that nurses may often fail to appreciate the needs and feelings of relatives and come to perceive them as intrusions and obstacles to the effective performance of their duties.

Person-centred care approaches may therefore be rejected by staff (as seen above there may be cognitive acceptance but behavioural denial of such

approaches in nursing), perhaps on the grounds of lack of time and staff. This may act as a further source of dissatisfaction to relatives, who in essence would like to believe that nurses look after patients (especially their relatives) as if they were one of their own kin (Wiancko 1986). There can be no doubt that the individualisation of care, with its emphasis on meeting individual patients needs, is often more time-consuming than the task allocation system (where staff are allocated certain jobs, often based on their seniority, e.g. bed-pans, bed-making, drug administration) simply because task allocation often fails to discover and provide for those individual needs. There is a growing belief however, that the time involved in giving individualised care is less than was originally believed and that with the development and practice of organisational and care-planning skills, any deficiencies can be resolved (Ashworth 1980). The alternative to patient-centred approaches to care provision, is one where staff base their care prescription on the basis of what any patient with a similar medical condition requires e.g. care of the 'asthmatic' or 'bronchitic'. This is therefore based upon a medical model of care. Such a model of care has been said to be attractive to many nurses because it extends the alliance of themselves and physicians and affords them a degree of power in health care, helping them to justify the care chosen and provided by them, the professionals, as being in the patient's interest (Lovell 1980). The resulting attitude of "we know best" may serve to promote further, an adversarial relationship with families who question or criticise.

There are other reasons which have been given for the patient-centred approaches to care being difficult to implement in practice (Menzies 1961; Jourard 1971; Crow 1977)). It is Crow's (1977) view for example, that in using such approaches nurses expose themselves to an unacceptable level of interaction with patients and their relatives. This in turn could engender potentially negative consequences for the nurse should, for example, the patient die. Menzies (1961), Jourard (1971) and more recently MacDonald (1983), have all identified self protection via the avoidance of the anxiety of getting too close to patients and relatives, as a reason for the professional distance that

nurses adopt. Such distancing obviously has great implications for relatives, whose perceived task is to get as good care for the patient as possible (Dewis 1986), as well as obtaining good quality information to help them to deal with their own anxieties. Interestingly, some health professionals see this distancing as being of positive benefit to patients (and relatives by proxy). For example, one physician, quoted by Vachon and Pakes, believed "as your involvement with patients is increasingly superficial, the more you can afford to go deeper ... the ultimate achievement is to break open a chest and put in a valve" (sic) (1985 p.158).

There is some evidence that distancing not only protects nurses from the anxiety of too close an emotional contact with people in their care, but also from anxieties within, which spawn from feelings of inadequacy and fear of making mistakes. As noted to earlier, Larson studied the disclosure of "Helper Secrets" (1987) in a group of American critical nurses. She did so by examining feelings related to their work, which they felt they could not express to peers. She found the most commonly occurring secret feeling to be one of 'I am incompetent' or 'I am inadequate'. These feelings were said to stem from such beliefs as:- "I feel I can't keep up with the fast pace of change in medicine"; "I feel I've really fooled the world, that I'm in this position and people think well of me". "I've fooled them! I'm not that great"; and, "I fear I may be found out". As Larson points out, these fears are not surprising given the many challenges facing today's nurse "not the least of which are staying current with rapidly changing medical techniques" (Larson *ibid*). This is true not only for nurses in critical care areas where a mistake could be life or death, but anywhere in a service where litigation can be brought as much for acts of omission as commission. Thus fears of making mistakes are very powerful stressors.

The feeling that professional responsibility often extends beyond an individual's competence, was also found in a study by Schmidt (1977). Furthermore, he noted that when this was the case, this acted as much of a stressor to the

nurse concerned as workload. It also had implications for patients' ultimate outcome. This could therefore be another reason why nurses at times, distance themselves from relatives (and patients) fearing perhaps sub-consciously that they will make a mistake and/or be found out as un-professional or a charlatan. No examination of why 'something is so' in nursing is complete without considering ritualised custom and practice. Ritual has been, and unfortunately will continue to be for some time yet, a legitimation for many practices prevalent in nursing (Walsh and Ford 1989; Darbyshire 1989). The treatment of relatives is an example of the continuation of questionable practices said to be inculcated via socialisation processes. Frost (1970) encapsulated this view in her award winning article, when she pointed out that the view of relatives as nuisances is as much a result of assimilation of institutional values (i.e. those of the senior nurses) as it is based on personal experience of nursing staff. Indeed, the people who deal most sympathetically with relatives, are often said to be those newest to the profession.

Even when wariness is not present, and there is a stated commitment towards keeping relatives informed, all may not be well. The shortcomings of nurse-patients/relatives communications have been well researched and documented (Harrison et al 1990; Faulkner 1980; Macleod Clark 1981), including communications with the dying and their relatives (Knight and Field 1981; Wallis 1987; Lyall 1990; Wilkinson 1991).

Wallis (1987) for example found that as a result of having difficulty with their own grief, there was a tendency for some nurses to avoid such people. Meanwhile both Eastham (1990) and Kawamoto (1992) were of the view that nurses find it hard to discuss their feelings (particularly about death) with others, and may indeed prefer to bury their feelings and just get on with things. Lyall describes a 'cycle of evasion' in dealings between health professionals and patients with cancer (1990). Finally, a small-scale study by Hoyle found that ICU nurses who had been bereaved were actually the least facilitative of staff in terms of allowing access to critically ill patients (1991).

These shortcomings have in turn been associated with the educational preparation of nurses, which is seen as inadequate both in terms of interpersonal skills and preparation for dealing with the dying and their relatives (Hockley 1989; Wright et al 1989; Field and Kitson 1986; Simms 1985).

Mis-matches between the information relatives actually want and what nurses are willing/able to give, have also been identified. It is quite possible of course that the two will match, particularly if the staff gave information based on a holistic assessment of perceived need, however there is evidence that such assessments are not routine. Boykoff reported that the family is often left out because nurses have focussed the majority of their time on patients (1986). Also it is not uncommon for nurses (and indeed other health care workers), to claim that they 'know' what relatives want to know for a variety of reasons:- because they know it 'empathically' (Allen 1987); because of experience derived in other similar circumstances; perhaps because it is what they perceive they themselves would want to know if they were in the same situation; or even that it is simpler and more economical of effort (Secord and Backman 1964) to stereotype people (including patients and relatives) and so avoid having to assess them at all.

Rodgers (1983) stated that when nurses do intervene with family members, then the interactions are usually brief and based upon what nurses perceive the relatives' needs to be, which may not necessarily be correct, a view shared by both Stilwell (1984) and Murphy et al (1992). Brown (1965) was even more blunt, when he claimed that the main reason for differences in perception between nurses and relatives, is the paucity of conversation [between patients/relatives and staff] other than on medical matters and surface issues, such as the weather. More instructive and constructive perhaps, was the view of Freidson and Lorber (1972) that "the chances of the staff members' perception of the needs of relatives being correct is low, because the two do not share the same phenomenological meanings, assumptions or concepts. Illness never means the same thing to the client and to the professional"

(p. 202). This means that many nurses spend much of their time giving relatives information regarding treatments and machinery at the expense of meeting their emotional needs (Murphy et al 1992). Irwin and Meier (1975) pointed out that this means nurses expend energy to cope with inaccurate or non-existent needs. It may also allow staff to avoid feeling dissonant, by enabling them to feel informative, even though they are not meeting the needs identified by relatives themselves.

Following all this discussion of what are essentially reasons why nurses often appear to have problems meeting the needs of relatives (and particularly the need for information), it is interesting to note that sociological texts which have focussed on nursing, such as Skevington (1984) and Dingwall et al (1977) have tended to apportion much of the blame for poor communications on medical staff, rather than on nurses. They do so both in terms of describing their (doctors) shortcomings as communicators and the functional uncertainty they are said to utilise to retain a sense of mystique and awe in patients. They are also critical of the control doctors have historically exerted over other health professionals in this regard. Unfortunately such texts are rarely research based with regards to control over 'colleagues', but their arguments are very convincing to anyone with experience within the health service. This however illustrates the importance of study in this area, as the identification of the true reasons of any problem and its successful resolution, can only be achieved by systematic evaluation and study.

Of the empirical studies on the quality of interaction which have been conducted, relatively little has been done regarding the effect on the reception of information and messages, by other channels of communication open during interactions. Such studies would examine for example, the transmission of attitudes, thoughts, and feelings via voice inflection and non-verbal cues, at the same time as the explicit message. Freeman et al (1971) did find that being approachable and pleasant enhanced satisfaction and compliance among patients and their relatives. Complaints to the Health Service Ombudsman over

the years suggest that such approaches are not universal. Walton (1986) reports that the most common complaints in the area of nurses' relationships with patients and relatives have been:- "un-sympathetic staff attitudes and failure to offer waiting patients and relatives reassurance or explanation for delays; failure to give relatives adequate or timely information; and failure to ... facilitate meetings between relatives and medical staff". Meanwhile Molter found that while the relatives she studied felt that most of their needs were met, there were still some areas lacking - "the need to talk to a doctor once a day...the need to be told about chaplaincy services...the need to have a place to be alone while in the hospital, and...the need to have someone to help with financial problems" (1979).

It is apparent therefore that the perceived needs of relatives, in particular the need for information, are in many cases not being met, and that a systematic examination of possible reasons for this, both within and without the direct sphere of influence of nurses, is overdue.

The treatment of hospital visitors who are also nurses.

The previous section of the review considered the needs of hospital visitors. At the time of data collection, no evidence of a systematic study of the needs relatives who are also nurses could be found. There were however, a number of anecdotal accounts of 'victims' of the system. In their own way, these were no less important however, as in spite of their lack of empirical credibility, they made powerful reading by affording the insight that only personal narratives can provide. Furthermore, most of them were written by nurses (Ferguson 1988; McKenzie 1989) a fact which fuels the belief that nurse-relatives can become casualties of the system.

Most of these accounts recounted the search for information (as highlighted by Bond 1982). Typically they were characterised by relatives being given inadequate information and being frequently regarded as an unwelcome hindrance by staff, and in becoming a relative who is "frustrated and frightened

at the end of an abortive search for information" (ibid). Sinclair, discussed the course of events surrounding her brother's admission and subsequent diagnosis of cancer. Her narrative account is one long tale of misinformation and misunderstanding which culminated with a 'showdown' with the staff involved, in the process of which she was told that "she should have known better (sic) than to query the existence of the team concept in the unit". She was later greeted by the surgeon involved in the case with "who are you? Are you the one who's been giving my staff stick?" (1984). Her parting comment states the view that "in nurse/doctor relationships, nothing has changed in the last thirty years" (ibid).

This search for information was identified as the task for relatives of critically ill patients from the initial uncertainty of admission, through the diagnostic process to the possibilities of the various prognoses (Dewis 1986). Throughout this time he believes, the relatives continually search for information to help make sense of the situation and if this is not forthcoming from staff, then more unconventional methods will be used, such as eavesdropping at the nurses' station. This reinforces the need for nurses to be actively involved in meaningful and honest dialogue with relatives. Brown (1986) reflected on the importance of nurses' attitudes to relatives, recounting how when she visited her mother out of working hours, the nurses who were giving out lunches totally ignored her. Her belief was that her mother's medical treatment was adequate, but her perception of the care both for her mother and herself left a lot to be desired, reiterating Bolger's observation that nurses could learn from the 'have a nice day' approach of McDonald's, ie. "it may not alter the quality of the food, but you don't complain about the service" (1986).

Other anecdotal and insightful articles, describe the lack of humanistic care provided for a grandmother (Hughes 1982); the treatment received by a regular visitor to a geriatric ward (Fox 1984); and the negative learning experience of observing how not to deal with relatives, of a student nurse (Frost 1970). All of these being characterised by a sense of the nurse-relative being on the

'outside looking in'.

Having insights into 'the system' would presumably make the development of the nurse-relative relationship as perceived by Robinson and Thorne (1984) very difficult. It is doubtful for instance that 'naive trusting' would ever be possible in a nurse-relative. Even if the relative was of the task allocation school of thought, the chances are they would want a humanistic and individualised approach to the care of their relative. Sheldon's view (1982) that relatives feel guilty about leaving their sick loved ones in the care of others is particularly salient here, as the relative in such cases is a nurse and therefore potentially capable of carrying out the care personally.

The area of quality of interaction, is another fraught with possible problems for the nurse relative. As discussed earlier, the transmission of attitudes and thoughts *via voice inflection and non-verbal signs*, are as important as the explicit message. The fact that nurses may be more aware than the general public (*via communication skills training, experience, etc*) means that this is potentially an area for misunderstanding and anxiety. Malcolm (1985) for instance recalls that her work as a health visitor had made her sceptical of what doctors said, but everything the consultant said during consultations seemed to be loaded with significance. As far as the presentation of an approachable and pleasant face to relatives, Knight (1985) was of the view that nurses find it difficult to deal with patients who have nurses in the family and often have "phobias towards the relative".

Difficulties for nurse-relatives can also be foreseen, when considered in the context of Dewis's tasks (1986) for the relatives of the seriously ill - the main one typically being to get information. It would seem reasonable to presume that nurse-relatives by virtue of the knowledge, insight and influence they are perceived to possess by their relatives would be put into this role, and hence run the risk of being viewed by staff as nosy, interfering and troublesome.

The other side of the 'equation' must also be fertile ground for problems to develop, i.e. for 'working nurses' dealing with nurse-relatives. The presence of someone, possibly scrutinising and assessing the care being provided, may encourage the attending nurses to minimise contact with that person. This is particularly the case if they feel the care they are being required to give is at, or beyond, the limits of their competence, and they therefore are in danger of being 'found out'. Both these 'sides' would therefore seem to be worthy of investigation in this study. This issue will also be returned to later in the 'family nurse' section of the review.

The 'typical' relationship between nurses and relatives was therefore characterised in the literature as being one where relatives tend to play certain roles, which minimise their threat to staff. Furthermore, relatives who exceeded certain, seemingly unwritten, rules of how to behave, and about just how much they should ask, were considered to be problematic to staff. It was also seen that the needs of relatives, and in particular their access to information, were not considered to be adequately met within hospitals. In the main this was seen to be associated with the one-way movement of communication and information, usually derived from what staff perceive to be necessary, valid and perhaps 'allowed' for relatives to know. It was an intention of this study therefore, to explore these points empirically, not least because it would seem reasonable to presume that nurse-relatives would tend to 'break' any such rules very easily. A systematic examination of the reasons for the apparent unwillingness of nurses to provide information to relatives and whether the difficulties envisaged for nurse-relatives were to be found in fact, was thus important for the study.

Socialisation into professional nursing culture.

A culture has been defined as "a complex of more or less shared ideas about what is known, how things ought to be, and how things ought to be done, which can be transmitted from one generation to the next" (Waters and Crooks 1990 p 61). Within professions such as nursing, that which is 'transmitted

from one generation of nurses to the next', occurs not only by means of the 'official', but also the 'hidden' curriculum. Indeed in the opinion of many (e.g. Kramer 1974; Green 1988; Melia 1987), the latter is the more effective of the two as a means of passing on the rules and requirements of the culture, even though 'participants' may be consciously unaware that they are affected by such a process. Hence the reason why both curricula are of pertinence to this study, particularly with regards to: the care of the dying and their relatives; the issue of 'professional coping'; the social mores of nurses' involvement with patients and relatives; and, the nature of relationships between nurses.

Feldman (1977) argues that the first stage of the socialisation process encompasses all the learning which occurs before the recruit enters the organisation, and involves the individual in forming expectations about the 'job' in hand. Although no satisfactory description has ever been developed for the 'role of the nurse', Henderson's (1966) is perhaps the best regarded, that is:- "the unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the recovery strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible".

From this it is obvious that a major aspect of the nurse's role is one of helper to the dependent and a support to the needy. People recognise this as a worthwhile and laudable vocation/occupation and hence enter nursing, realising that they will be a person relied upon by dependent others. Indeed during most interviews for nurse training, there will be some mention of the desire to 'help other people' by the applicant. Thereby there is a system of selection at work in which people with the desire to be depended upon are drawn into the nursing profession.

Once in the profession - albeit as a 'novice', initiates are then subject to the professionalisation process (McGuire 1969; Lamond 1974; French 1973;

Anderson 1973; Davis 1975;) which serves to teach and instil within them the knowledge, skills and (most relevant in this case) attitudes, deemed necessary to function as a professional nurse, both by education, and perhaps more strongly, by example. During this time, the individual sees what the organisation is actually like and either attempts to become a participating member of it, via the processes of accommodation and resolution, or leaves because the reality of the job is so incongruent with what they expected it to be (Davis 1975). Perhaps those who leave do so because they come to recognise that the stated objectives of hospitals (helping people to get well or die peacefully, within a patient-centred environment) are not necessarily reflected in reality (Handy 1986).

Dingwall termed this assimilation process as acculturation into the nursing profession, seeing it as the means "by which newcomers to a group, work to make sense of their surroundings and come to acquire the kinds of knowledge which enables them to produce conduct which allows established members of that group to recognise them as competent" (1977 pp 12-13). In other words, via both the official and hidden curricula, newcomers are initiated into the 'culture' of nursing, with its attendant values, social mores and meaning systems which are passed from generation to generation. Furthermore, upon reading literature from other countries, eg the USA (Leininger (1978), Australia (Speedy 1987) and South Africa (Mellish 1988), one can see that aspects of this culture are international in nature.

Professional socialisation of nurses has been said to lead to a tendency amongst most initiates, to adopt a "bureaucratic orientation" to their work (Corwin et al 1962; Green 1988) whereby decisions are made very much with the rules and regulations of the employing institution in mind, and designed to minimise the risk of contravening 'policy' or custom and practice. This is opposed to legitimising actions and decisions from a "service" perspective (where the emphasis is on the dignity and humanity of the patient) or a "professional" perspective (where the emphasis is on occupational standards, transcending

institutional policies and practices). The fact that such orientations could/would affect relationships between providers and 'customers' is obvious. How they might affect them, particularly if the customer was usually a provider (i.e. a nurse) would seem to be worthy of examination, in a study which seeks to consider factors which could affect the bereavement experiences of nurses.

Smith's work apart (1992) on the preparation nurses receive for the emotional aspects of their role (discussed earlier), little 'new' work has apparently been done in the area of 'the professional socialisation of nurses' since the original review was written.

Professional socialisation and 'professional coping'.

It is important to recognise that the professional socialisation of nurses begins prior to admission into nurse training. For example via media portrayal and personal experience of hospitalisation. It is also important to acknowledge that traits and behaviours said to be valued and emphasised by the profession, for example dependability, physical endurance and a 'caring' nature, may be present in large numbers of those entering training. This is both because nursing attracts applicants with such 'qualities', as well as a result of such people being targeted in the selection process (Child 1993). A combination of these factors - dependable personality type and the initiation into "professional nursing" (Kitson 1987) may thereby predispose to nurses graduating from their educational programmes, who believe that their role is to be an independent practical copier (Stedeford 1984). Such an individual would expect herself, and be expected by others, to be capable of dealing with any eventuality or stressor, be it physical, psychosocial or social, personal or someone else's. There are indications that some nurses concur with this view. Kunkler and Whittick (1991) for example reported that nurses working within general hospitals viewed feeling stress as being indicative of doing a good job, and not a sign of weakness, while Phillips (1993) was of the view that many nurses do not see themselves as needing care or support themselves.

In a sense these may be operational examples of 'mind games' which enable people to function under threat. Stedeford (1984) for example has identified that the "existential denial" of the certainty of their own death, allows nurses to deal on an almost daily basis with the death of patients. Lerner et al meanwhile put forward the "just world theory" (1978) where individuals distance themselves from misfortunes such as illness, injury and death, by allowing themselves to think that they only happen to 'other people'. In nursing this manifests as a subconscious acknowledgment that illness and death are things that only happen to other people and their families. Possession of either or both of these outlooks, will allow nurses to continue caring for the sick and dying, without being constantly affected by the inevitability that it will happen to them and/or their family. Menzies (1961) described nurses as having a coping with anything mentality characterised by a "pull yourself together" attitude, which she claimed many nurses display towards colleagues who are upset, based upon the belief that nurses should always cope.

The point to be made here however, is that the processes of how these things happen, if indeed they do, have not been empirically examined before, hence the potential importance of this study.

The development of such an orientation under the influence of nursing professionalisation would be even more problematic if the individual developed the types of coping mechanisms identified by Menzies (1961), Jourard (1971) and MacDonald (1983) as being traditional defences against anxiety amongst nurses, and still apparently being utilised in contemporary nursing (Hurtig and Sterwin 1990). Essentially these refer to the erection of barriers to protect 'self' (nurse) from over-involvement with others (patients and relatives). For example splitting up the nurse-patient relationship by task division; depersonalising of patients and nurses by using numbers, surnames and uniforms; the denial of, and detachment from, emotional stress caused by relationships with patients; and, by ritualised task performance, irrespective of an individual's needs. These are said to arise and evolve with time, from initial

innocence on entering the profession, when the 'novice' is often prepared to invest personal time and emotions into relationships with patients, only to find they are incapable of controlling their feelings when a death occurs (ie they grieve). This is then followed by a situation where, by trial and error, and perhaps using behaviours role-modelled by peers and supervisors, the nurse begins to minimise truly personal involvement with patients so as to protect herself from further anguish. Perhaps this manifests as a brusque manner (Stedeford 1984), and as "always looking busy" (Melia 1987). This is effective (for nurses) in that it may protect the nurse emotionally. Unfortunately it also minimises the chances of patients and relatives, receiving the psychological support they require.

It would also be problematic when the dying or dead person was not a stranger - a patient, or a client, but a relative. In such a case, the nurse could neither realistically assume an air of busy-ness or hide behind the uniform (Menziez 1961), nor evade or ignore questions (Sinclair 1984; Crawley 1984). It would also be virtually impossible for her to medicalise/intellectualise, to remain aloof, or ignore the problem because it won't just 'go away' in the way that the deaths of other patients tend to. In turn this could be further complicated by the high value said by Dewe (1987) to be placed upon "direct action" or problem-orientated strategies by nurses, with a potential for over-reliance on such mechanisms, to the exclusion of others when attempting to deal with stress (Bond 1986) .

There have been a number of studies on nurses and coping in the last few years. However they have in the main, concentrated on the measurement of certain coping processes and their moderating effects against burnout, typically utilising measurement scales in an attempt to quantify such issues in the nurses involved, and usually examining critical care nurses. Such work essentially focuses upon stressors within the workplace (Lewis et al 1990; Robinson et al 1992; Bargagliotti et al 1987; Boyle et al 1991). They do have some relevance to this study however, in that invariably they reveal the reliance of nurses on

problem solving behaviours, and the retention of feelings of control (associated with 'hardiness' - McCranie et al 1987) to ameliorate stress. Furthermore, in the case of preventing burnout due to work related stress, such behaviours are considered positive protectors (Boyle et al 1991; Cesta 1989). This therefore affiliates with some contentions of this study in that as a result of such behaviours affording protection against burnout, nurses may have a tendency to (over)value them, leading them to problems in grieving should they try to 'problem-solve (irrelevant in grieving) or exercise control over events or their own affect (obstructive in grieving).

Two other studies of obvious relevance to this study, are those carried out by Lippman (1990) in which she examined 'stress, coping and professional supports as predictors of burnout, in bereavement therapists', and by Spencer (1994) which examined the ways in which nurses in Intensive Care Units (I.C.U.) deal with the grief related to the death of patients.

In her study, Lippman surveyed 100 bereavement therapists using Pines and Aronson's Burnout Inventory, and Folkman and Lazarus's Ways of Coping Checklist, along with a questionnaire designed to assess the work pressures and environment in which the therapists worked, including perceived support from colleagues and supervisors. There are obvious parallels between Lippmann's study and the present one. However, once again her study focussed on work-related stressors (in this case counselling the bereaved) and therefore the two have no direct relationship. Notwithstanding this however, she did find that those with satisfactory levels of support and supervision (when requested) scored significantly lower on the burnout scale, while those who utilised escape and avoidance techniques for 'coping' had a tendency to 'burnout', both of which are of relevance to this study.

A final point to make from Lippman's study is the shortcomings of the Ways of Coping Questionnaire, for her specific needs, particularly with regards to it not encompassing ego-defensive mechanisms for coping. The sense that it did not

fulfil the needs of the present study, led the researcher to develop a tool based on the work of Dewe (1987, 1989), as discussed in the methods chapter.

Spencer (1994) meanwhile, employed an anonymous survey approach, to explore how nurses working within an I.C.U. dealt with their grief on the death of a patient, along with their perceptions of support available to them at such times. She then followed this up with interviews in order to give the nurses an opportunity to explore their feelings further, and also to gain more detailed information.

As alluded to earlier in this review, official curricula have also been criticised with regards their content, on knowledge and skills related to caring for the dying and their relatives. Typically this criticism can be categorised under two headings:- the lack of such content *per se* (Smith 1992; Maguire 1988; Bird 1987; Calnan 1983); and the view that what is taught often is not translated into practice (Brooking 1986; Hughes 1982; Lamond 1973). It has also been suggested that education in interpersonal skills, including those related to communicating with the dying and their relatives, may lead to somatic and psychological problems. Llewelyn et al (1984) for example assert that such problems can occur as a result of nurses being encouraged to become involved on an emotional level with patients and relatives, if they have not also been adequately prepared for the realities of such involvement, and if adequate support services like counselling or post-incident de-briefing are not available.

It was an aim of the study at the outset therefore, to examine the idea that an amalgamation of both official and hidden curricula, facilitates the assimilation of neophytes into nursing culture and practice, and that one of the results of this process is a shared perception of what constitutes a 'good nurse - including the need (or otherwise) to be a 'coper' and 'in control'. It was also an intention to consider the possibility that such perceptions may affect such nurses' experiences of bereavement, along with the levels of social support they perceive to be available to them in an environment governed by nursing culture.

Social Support and nurses.

In a sense, social support can be seen as a variable which may affect an individual's adaptation to stressful life events - including bereavement.

Most writers on the general subject of social support begin with some reference to Cobb's definition:- "information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligation" (1976). They then typically expand upon their perception of this relatively simple conceptualisation of what is in practice, a very complex issue.

Rook (1985) for example, claims that the historical roots of social support research converge as an interest in the "help-providing functions of social ties" and although researchers have conceptualised and operationalised social support in many ways, a concern with how help provided by one's social network ameliorates the effects of life stress is a recurring theme (ibid). Vachon (1986) points out that one of the major debates in life-events literature is the exact role social support may play in mediating responses to stressful life events. In other words there is as yet, no agreed, all-encompassing definition of this complex concept, no agreed single mechanism as to **how** it moderates life-stress, nor any consensus regarding how to measure it. According to both Norbeck (1981) and Stewart (1989), this has led to the myriad of measurement scales developed over the years - almost as many as there are studies on the subject.

A major figure in social support research over the last two decades, has been James House. He offers the opinion that the social support concept entails a number of component characteristics, and he sub-divides support into four categories, namely:- emotional support, which involves caring, understanding, trust and empathy; instrumental support, which means helping in a practical sense, for example physically assisting with a difficult task; informational support, which relates to providing a person with information that the person can use in coping with personal or environmental problems; and, appraisal support; which involves helping to evaluate personal performance (1981). He

summarises by stating that social support is "a flow of emotional concern, instrumental aid, information, and/or appraisal (information relevant to self evaluation) between people" (p. 26).

In the context of this study, this conceptualisation along with operational examples of supportive behaviours provided by House (1981) and Gottlieb (1978), have the combined benefits of discrete description of each form of support, along with the relevance of each form of support to both the home and work environment.

Pinneau (1975) suggests that such social support processes have three potential effects:- 1) directly on the source(s) of stress (prevention); 2) directly on measures of strain or well-being (therapeutic); and, 3) a moderating effect on the stress-strain relationship itself (buffering). The buffering or moderating role of social support is, according to House, "implicitly or explicitly central to most of the major writings on social support" (1981. p. 33). Indeed he goes as far as to suggest that "buffering is virtually the only way in which social support affects health" (ibid). In other words this is the area which most people, observe, consider and write about, when examining social support and its effects on ameliorating life stress. Cohen and Hoberman (1981) illustrate this point with their view that although often they are often inconclusive, studies using measures of perceived availability of social support, provide data consistent with the buffering hypothesis. These include those examining the effects of social support on the processes of grieving (e.g. Glick et al 1974; Vachon and Stylianos 1988; Raphael 1984; de Keijser et al 1991), all of which confirm positive correlations between social support and reduced bereavement morbidity.

It should also be acknowledged that work has been done in the area of 'social dis-support', which refers to "relationships that hurt or hinder progress, adaptation, personal growth and/or materially consume one's resources" (Malone 1988). Malone highlights the fact that Cobb's (1976) definition cited

earlier, fails to recognise the impact of negative information or influences that hinder one's growth or promote disintegration. It was envisaged that this could be an area worthy of consideration in this study, given the later discussion of the nature of 'supportive' relationships between nurses.

A final point to make here, is that little appears to be known about the links between different types of coping with loss and social support. Furthermore, House (1981) points out the importance of recognising that the effect of social support, is directly affected by the focal person's willingness or ability to accept it. That is, no matter how much one's spouse or supervisor feels or acts towards you, there will be little effect on you unless you in fact, perceive them as sympathetic. The fact that this is an issue in nursing and midwifery is perhaps best illustrated by the results of the 1992 survey undertaken by the Nursing Times, which found that the majority of nurses do not (and would not) take advantage of counselling services, even when they are available. Also that the members of the Royal College of Midwives voted against the introduction of a service for midwives on the grounds of cost (approximately £25 per member per year).

This study sought to consider all these issues. Firstly by examining the coping strategies valued/used by nurses, and secondly by exploring the possibility that perceived social support and its effectiveness in moderating the effects of life-stresses (such as bereavement) for nurses, is as much a function of nurses' willingness to accept such support, as it is its actual existence. It was intended to do these whilst exploring the issue of institutionalised social dis-support within nursing.

It was perceived as being necessary to explore social dis-support amongst nurses because to quote Bond "the climate in the nursing culture with respect to mutual support is decidedly chilly" (1986 p. 134). MacDonald (1983) and Bleazard (1984) both report that nurses are somehow made to feel un-professional, inadequate and self-indulgent, should they present themselves to

peers and supervisors for help with personal problems. Whitehouse (1991) goes as far as to say that such people are often made to feel failures and are persecuted by peers and superiors as a result. Bond continues in this vein by reflecting that while they are seen as being caring towards patients, they seem to be uncaring towards each other. She also cites Hillier who likens nursing culture with the 'shame' cultures of some North American Indian tribes (1981 p. 135), because it "inhibits the development of personal and supportive ties amongst nurses" via the use of shame and ridicule. Bond concluded that nurses have a poor reputation for giving each other support. It should be acknowledged however that certain studies examining nurses' perceived support following the deaths of patients (Charnock 1985; Adey 1987; Spencer 1994), have identified that some nurses felt able to talk **informally** about their feelings to colleagues, at such times.

At the same time there also appears to be a problem with nurses receiving support. Bond suggests that this is associated with a difficulty of nurses allowing themselves to be vulnerable enough to receive support. Furthermore, when they do allow themselves the indulgence of vulnerability, they are met with expressions of "surprise, dismay or even contempt, from colleagues, family or friends" (1986). They may also feel painfully dissonant within when they do so, as they fail to live up to their own ideal of perfection, inculcated and/or reinforced by a professional socialisation process. This includes what Smythe refers to as an 'everything nurses do has life-or-death consequences' message being drilled into initiates to the profession (1984), and a potential for 'punishment' should they be found wanting in this regard.

Finally Bond (1986) suggests that the image of an 'all-giving' professional carer may result in care and support actually being denied to nurses, by keeping potential supporters at bay. This is done either by them not asking for support in the first instance, or by rejecting it when offered, in such a manner that will ensure that person will not offer it again.

This essentially anecdotal, yet compelling final summary of social support in nursing, encapsulates much of what this study was intended to 'quantify', regarding nursing culture, and its effects on the giving and receiving of social support by such professionals - both by professional colleagues, and personal sources such as family and friends. The fact that much that has been written is authoritative, yet nonetheless anecdotal in nature, reinforces the importance of systematic study in this area.

Further review of the literature in this area since 1989 reveals that this is still the case. Callaghan and Morrissey (1993) reviewed the literature published on social support and health between January 1984 and February 1991, using the CD-ROM system and found that 4247 papers had been published on the subject in medical and social science journals - an average of almost 600 per year. Examination of the period 1991 to present (mid-1995) on research relevant to social support and bereavement, would seem to suggest that this interest has continued.

Callaghan and Morrissey (1993) also make interesting points in their conclusion, regarding which research needs to be done in the area of social support. Included within this is the need to explore the extent to which an individual's needs for affection, approval, belonging and security, are met by those they consider to be playing a significant part in their life. This was something attempted in this study, as the nurses' and midwives' views on the support available to them from personal and work related sources were examined.

The majority of the articles on social support in the last five years, reflect the observations by Stroebe et al (1993) outlined earlier regarding grief and bereavement research. In the case of social support there appears to have been a concentration on its conceptualisation and measurement, and how it can best be provided to help patients and/or their carers (incl. the bereaved) by professionals, for example via counselling or family therapy.

A small number have examined the issue of social support and its effects on the outcomes of grieving. De Keijser et al clinical psychologists in Utrecht, Holland for example have undertaken a whole range of projects with the bereaved, including an examination of the effects of social support on post-bereavement morbidity (1991), sex-differences in ways of coming to terms with the death of a spouse (1990), and 'leave-taking' rituals for bereaved individuals. (1991).

Unfortunately (for nurses at least), little has been published on the provision of support for nurses, other than occasional 'opinion' based articles such as those by Ngasurian (1992) and Harvey (1992), usually related to the setting up of support groups, and how to maximise their effectiveness (Bond 1991). Also articles in journals such as the Nursing Times on the need for such professionals to be more supportive of one another (Crumbie 1992; Stoter 1992).

An exception to this is the work of Boyle et al (1991) who examined the effects of social support on the prevalence of burnout amongst critical care nurses. They found that both work-related and non-work-related social support mitigated against burnout due to work related stresses. Unfortunately, this has minimal relevance to this study, as it failed to consider the effects of such support on non-work related issues, such as personal bereavement.

The Family Nurse.

One of the intentions at the outset of this study, was to examine the idea that professionals such as nurses may enact particular roles in their family/social groups, and that this may be problematic to them should a relative/friend be admitted to hospital. Malcolm (1985) was of the view that many nurses feel that their training has been a preparation for health crises in the family as well as at work, and that their relatives often believe that the nurse of the family will sort things out. The review of the literature produced little other information in this area. Of particular interest however, was literature from counsellors who had dealt with nurses via the Royal College of Nursing counselling service (CHAT). In the main this comprised anecdotal, but insightful, reflections of their

dealings with nurses who were experiencing problems because they had become ill themselves (Crawley 1983), or because they were in the midst of an unresolved grief reaction (Collinson 1986; Crawley 1985).

Further work by Crawley (1984) was related to individuals playing the role of 'family nurse' (although she termed them 'family health professionals'), a role viewed as potentially problematic by both Crawley (ibid) and Olivet et al (1991) because it can lead to role-conflict (both attending nurse and nurse relatives are unsure how to approach each other); removes traditional defences against anxiety (discussed in depth earlier); and promotes projection and identification within the attending nurse (thus undermining any 'coping' based upon the nurses' existential denial of death and/or a belief in a 'just world').

The idea that the desire (need) to be depended upon, and to be a 'coper' and in control, may be present in individuals even before they enter professions like nursing, was discussed at some length earlier. They may have shown themselves to be dependable within their family and social circle for example, perhaps by enacting particular roles in their family or perhaps leading sports teams. However, entry into nursing is said to reinforce the role and shape it into that of "the family health professional" (Crawley 1984). This means that whenever a family member is ill (especially if admitted to hospital) they are expected to act as intermediary, find out what is happening, ask questions and deliver complaints, as well as translate everything that is said and done (ibid). Calkins (1972) adds to this discussion of "shouldering the burden" by stating that the person does so as a result of a perception that "there is no other way to manage the situation" (ibid). Presumably in the family with a "family health professional" (Crawley 1984), this obligation would typically and unquestioningly fall to that person.

Harrari (1981) illustrated how this may happen in a small-scale study of grief reactions in doctors wives (the majority of whom were nurses). After their husband's death they fulfilled the role of coper, identifying themselves as

"capable to do so by possessing such attributes as showing little or no emotion, exercising self-control, and the ability to hold rational discussion". At the same time others - for example professional and non-professional friends, told them they were "lucky, as their training meant they wouldn't be affected by their husband's death" (sic). As a result of such attitudes, these widows felt they were "prevented from expressing grief due to self-expectation and the perceived attitudes and expectations of others" (ibid). Both Slater (1988) and Stoter (1992) would presumably agree with this, being of the view that there is an assumption within society that health care workers are able to provide emotional support to bereaved relatives with no cost to their own emotions. It is as if there is a perception that health care workers are somehow better at dealing with situations like personal bereavement than 'ordinary' people. Both Canton (1978) and Deutsch (1937) have stressed the importance, and indeed the necessity, of expressing emotions when bereaved, if the loss is to be resolved. It appears plain therefore that professionals such as nurses, may be prevented from meaningfully expressing their grief at the relevant time (ie immediately after the loss) by virtue of their self-concept as a 'coper', and because of pressures from their family and friends. This in turn may be complicated by a lack of social support (actual or perceived).

Therefore if one takes on board the assertions made about the reinforcement of dependability traits in nurses by professionalisation and associate the development of such traits with the role expectations of the family health professional, then the ground for sowing the seeds of complicated grief reactions is fertile. If then the person's role in society is such that they find it difficult to seek and receive help eg. nurses, midwives, managers, (as discussed in the social support section), and perhaps others such as police officers and fire fighters, then the chances of problems arising are presumably even greater.

There is of course the possibility that being amongst the above list of professionals means that an individual is better prepared for personal

bereavement than the general public. It would seem reasonable to suggest for example, that a theoretical and practical understanding of grief could make grieving easier rather than harder, for bereaved nurses. The question of whether nurses actually have such a theoretical and practical understanding of grief arises however, hence its position as a key area of this study.

The belief that nurses should be seen to be able to cope has already been discussed, along with the problems that can arise should the mechanisms for coping be unsuitable for personal grief. The concepts of "existential denial" (Stedeford 1984) and the "just world theory" (Lerner et al 1978) were also discussed. A problem could arise however when sickness does affect the family as intense anxiety can occur (Lerner et al *ibid*) in the individual who has previously effectively denied the mortality of themselves and those close to them. This was highlighted by Franks et al (1978) in their description of a nurse's aide who suddenly became hysterical about her mother's cardiomyopathy condition, when she was overcome by reality and started to demand more tests and information, thus making her unpopular with staff. Crawley (1984) and Olivet et al (1991) would presumably believe that this unpopularity would be compounded by the fact that this person was now in the position of having one foot in the professional camp, and one in the lay person's camp, thereby making it difficult for staff to know how to approach her.

The dearth of material related to identifying and meeting any 'special' needs of health care professionals referred to earlier, could also reflect a 'just world' perception in psychologists, psychiatrists and researchers in this field, and that their work therefore focuses on the situations and problems of 'other people'. This was encapsulated in the personal account of a G.P.'s experiences during and after the Hillsborough disaster, presented in a collection of case-studies, essays and poems about death, edited by Dickenson and Johnson (1993). He discusses how he felt inadequate when trying to come to terms with his experiences as a front-line helper on the day and the horrific things he saw, and admits that "I know all the theory but I can't get it together for myself - the

plight of the modern professional" (Heller 1993, p. 100). In a sense this returns to the earlier point about whether knowledge 'about' grief serves to protect or complicate matters for bereaved health care professionals.

A number of potential problems associated with being the 'family nurse' have already been discussed. A major reason that they rely upon such a person is that as a nurse, the chances are that they will know more than the rest of their family about pathology and drugs for example. They therefore occupy the role of 'knowledgeable intermediary'. This role not only brings with it the stress of having one's knowledge regularly scrutinised, but also that engendered by virtue of experience, knowledge and/or information, into their relatives medical condition. In other words they may be privy to insights, about their sick relative that may affect the family negatively (Shields 1984). Doyle (1985) discussed the cycles of despair and relief encountered by relatives of those with a terminal disease characterised by relapse and remission. For those who understand the nature of such diseases (eg nurses) there may be an added personal anguish in knowing that a remission is only temporary, whilst feeling unable to discuss it with other family members for fear of upsetting them. Worden discussed the question of knowledge about impending death, stating that complicated grief reactions are less likely in those who are able to anticipate their bereavement, than those for whom loss was sudden and unexpected (1983). However, in the case of the nurse, there is the possibility that their knowledge may allow anticipation of impending death earlier than others in the family, again potentially encouraging them to feel that they have to keep the 'secret' to themselves. This is obviously distressing in itself, but even more so in the light of Stedeford's contention that people relate things to their own experience (1984). Hence if the nurse's common experience of cancer is pain and a poor quality of life, then that is what they will expect for their relative - potentially leading to even greater distress, about which they cannot talk to their family, and a greater degree of guilt should the person require hospitalisation.

It was thus a contention of the researcher from early on in this study, that

occupying the role of the 'family nurse' might place an individual at risk of emotional discomfort, role conflict and guilt, and that either or both may negatively effect that individual's ability to grieve effectively when they are personally bereaved. Furthermore, as a result of a relative lack of previous examination of this potentially important concept, the empirical examination of the 'family nurse' role became one of the major objectives of this study, as it is this which clearly adds to the existing body of knowledge. It was intended to do this by systematically:- confirming the existence of such a role and what it entails; examining respondents' satisfaction with it; and exploring the potential benefits and conflicts of being the 'family nurse', particularly when a family bereavement occurs.

The concepts discussed within the 'conceptual framework' section and the possible relationships between them, were derived from this literature review and reflections upon it in the light of experience within the nursing profession.

No hypotheses were identified however, as although causal relationships between pertinent concepts were examined in the study, it was not an intention to test them.

Chapter 3.

Conceptual Framework for the Study.

Newman (1979), describes a conceptual framework as an organisation or matrix of concepts, that provides a focus for enquiry. Such frameworks are developed by linking concepts selected from theories, experience and/or studies (Burns and Grove 1987). The relationships between the concepts then often become the focus for further study. It is intended that a theoretical framework will be developed from this study, having conceptually defined concepts and propositions that can be tested in subsequent research projects.

Another function of a frame of reference, is to allow abstract conceptualisations to be shared with others. This is obviously an important function in any study, as it is necessary that others apart from those directly involved, can understand the findings and consider their relevance to themselves. However, this function is of even more importance in this study, as the significance of its findings are potentially magnified when considered in the context of nursing culture. That is, if one is ignorant of the nuances and mores of this culture, then the impact of certain findings may be lessened, as without an understanding of the realities of that culture on the part of the reader, much impact will be lost.

It should be noted however, that this is not a suggestion that only nurses will truly understand the study and its underlying theories and realities. Indeed it has been asserted publicly that the "true nature of the culture of nursing may even be hidden from those within it, until such time as circumstances may change" (Crookes 1991) e.g. when a nurse becomes a patient him/herself. In other words this study, may not only inform non-nurses/midwives about the issue of the effects of personal bereavement on such professionals and how their occupational culture(s) affect it, but also these professionals themselves.

The frame of reference itself.

The concepts included in the framework and the relationships between them, were all derived from 'real life' experiences of bereaved nurses, and subsequently developed by reference to the literature. Furthermore, the presence of a single one of the factors described, has been identified by Parkes

(1972; 1975) as being enough to predispose to complicated grief.

The frame of reference is labelled 'potential causal routes of complicated grief amongst nurses and midwives' because within the concepts identified, there are a myriad of factors which in certain circumstances could mitigate towards complicated grief reactions - most notably a delayed reaction, amongst individual nurses and midwives.

A diagrammatic representation of the conceptual framework is provided overleaf.

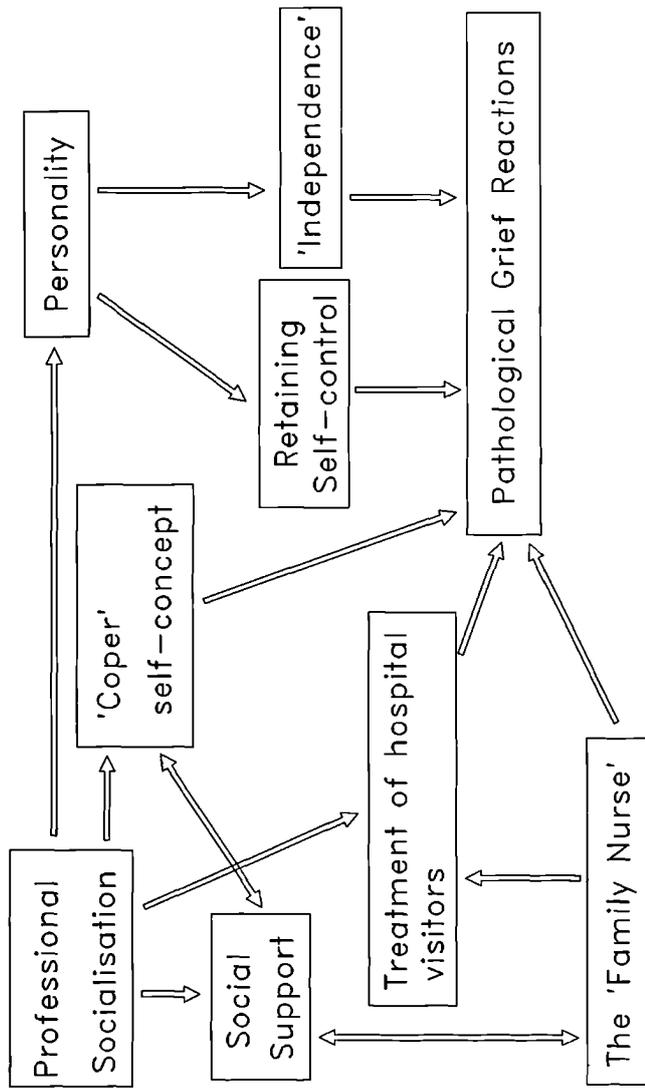


Figure 3.0 Potential causal routes of complicated grief reactions in nurses and midwives.

Concept 1. The Professional Socialisation of nurses.

Professional socialisation can be seen to be an example of "acculturation" (Dingwall 1978), a process by which newcomers to a group, work to make sense of their surroundings and come to acquire the kinds of knowledge which will allow them to behave in such a way as to allow other members of that group to recognise them as competent. In the current study, professional socialisation was considered in terms of the 'official' and 'hidden' curricula, and concentrated particularly on aspects of nursing culture which could impinge upon the care of the dying and their relatives - including those relatives who are also nurses. The aspects of culture of particular interest were:- perceptions of 'Ideal' traits for nurses; and the expectations of such professionals regarding coping and being 'in control', held by self, the nursing profession and by wider society.

Concept 2. Social Support.

House's view of social support as being "a flow of emotional concern, instrumental aid, information and/or appraisal (information relevant to self-evaluation between people" (1981 p. 26), was utilised for this study. Several facets of social support were examined in the study, most notably the perceived levels of support available from personal (ie family, friends) and work (ie co-workers, supervisors) sources; the possible efficacy of support from various sources; and aspects of nursing culture which may mitigate against effective peer/supervisor support. All of these may effect the availability (real or perceived) of social support from both sources, to nurses, when they are bereaved.

Concept 3. The treatment of hospital visitors.

For the purposes of this study, a hospital visitor was defined as anyone with a vested or personal interest in the welfare of a person who has been hospitalised, and who visits them whilst they are in hospital. The expectations of how they should behave when doing so, and the treatment of visitors who are also nurses, were of particular interest to this study.

Concept 4. Complicated or Pathological Grief Reactions.

Several factors or sets of circumstances, have been put forward as potentially having a negative effect on an individual's ability to grieve 'successfully' (Parkes 1972; Worden 1983; Lazare 1979), that is, they are said to lead to complicated or pathological grief reactions. Horowitz (1980) defines pathological grief as "the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behaviours, or remains interminably in the state of grief without progression of the mourning process towards completion...[It]... involves processes that do not move progressively towards assimilation or accommodation, but instead leads to stereotyped repetitions or expensive interruptions to healing" (p 1157). The manifestations of pathological grief are therefore many and varied. Deutsch (1937) however postulated that the absence of a grief reaction was in itself pathological. It is this 'reaction' that is considered most salient to this study.

Concept 5. The 'family nurse' role.

'Role' is essentially a set of expectations applied to the incumbent of a particular position (Brief et al 1979). For the purposes of this study therefore, the 'family nurse' role was defined as the set of expectations applied to nurses, by their families and other social groups, by virtue of their being a nurse. Of particular interest to this study, were the potential conflicts for the individual nurse when attempting to fulfil this role, when a family member or close friend becomes seriously ill or dies.

Concept 6. Nurses as 'professional copers'.

Lazarus and Folkman (1984) identified that there are many definitions of 'coping', but that all share a central theme, namely the struggle with external and internal demands, conflicts and distressing emotions. A 'professional copier' was therefore defined, for the purposes of this study, as 'a person whose occupation or profession carries with it, an expectation that its members are able to deal with the particular struggles associated with it's function (eg nurses and doctors - the sick and dying; police officers - violence etc), and to do

so whilst epitomising ideals of rational, controlled and neutrally affective behaviour. Furthermore, that such expectations are not only held within the professional group, but also by wider society. Of particular interest to this study was the reality of this concept within nursing (i.e. can nurses be seen as 'professional copers?'); if yes, what expectations are held of them?; how do they manage to fulfil the role?; and, is there any overlap of this professional persona into other parts of their life? All these questions were pertinent due to the intention of examining the implications (if any) of these issues for the grieving processes of bereaved nurses.

Concept 7. Retaining self-control.

Self-control can be defined as to be in control of one's emotions, desires, or actions by one's own will. It is a concept closely related to the 'coper' concept, but is worthy of separate treatment in this study. This is because a person whose positive perception of self depends upon their ability to retain control of themselves and situations, is someone who has been identified as being at risk of complicated grief when personally bereaved (Parkes 1972, 1975). For the purposes of this study therefore, self-control was defined as a cognitive state where individuals highly value, thrive upon, and perhaps even need, to feel that they are in control of their affect at all times, to retain a positive sense of self. Indicators of such perceptions within the study included the investigation of respondents' views on 'losing control', as well as the socialising effects of nursing culture with regards to the expectations of self-control amongst such professionals.

Concept 8. Independence, Dependence and Dependability.

To be independent is to be self-reliant, not seeking or relying on help or guidance from others. Dependence is defined as "the state of being dependent, especially for support or help" (Collins Concise Dictionary 1992), whilst being dependable refers to "being able to be depended or relied upon" (ibid), typically connoting self-reliance and control of one's own destiny. An outcome of 'dependability' can be a perception on the part of an individual, that they are so

self-reliant as to be functionally independent from anyone else, ie they perceive that they need no-one. Indeed they may actually tolerate dependency on others very badly, and will avoid it wherever possible. Such a perception has been identified as predisposing such a person, to complicated grief (Murray-Parkes 1972; 1975). Indicators of such perceptions within this study, included questioning the willingness of respondents to seek support from others, both via questionnaires and in interviews.

The relationships of particular interest were:-

The impact of professional socialisation, via both the explicit and hidden curricula, on the reinforcement and/or development of certain personality traits and patterns of behaviour, which have been identified as predisposing to pathological grief. In particular, over-independence; the need to retain self control; and a 'coper' self-concept in both the personal and professional domains. This as well as a tendency to develop and over-utilise cognitive and ego-defensive coping strategies, at the expense of others.

The relationship between the personal and professional personae of nurses, i.e. is there a tendency to be a nurse (incl. professional coper), 24 hours a day?

The realities of being the 'family nurse' when a family member or close friend is hospitalised and/or dies, both for feelings of guilt that they did not do more; for feelings of unease when cast in the role of customer of the service that they usually provide, not least because of their insight into the 'rules' of information control in hospitals, the preferred role of the hospital visitor; and the predisposition to pathological grief that this may lead to.

The realities of social support for nurses, i.e. is it available to them? If it is, would they accept it, given feelings of independence? What is the impact of a professional culture which is said to eschew support for colleagues? What are the implications for potential pathological grief reactions, for those nurses who

do not perceive themselves to have, or perhaps indeed need, social support.

These can be seen to be an extension of the aim of the study identified in the introductory chapter, namely:-

'To examine the idea that the processes of normal grieving can be impaired or complicated by virtue of an individual being a nurse or midwife'.

Chapter 4.
Methods of Enquiry.

It was acknowledged from the outset that this was a complex subject, as there are so many factors that may interconnect or overlap to affect a person's grieving processes. This is because the study was intended to examine not only the incidence of the factors thought to predispose to complicated grief (Parkes 1972, 1975), but also the culture within 'nursing' and its interplay with the family and indeed broader western society. This complexity was further compounded by the dearth of measurement scales directly related to the study (social support, self-concept and particular personality traits, most notably 'independence' and the need to feel 'in control' emotionally at all times); by the issue of social desirability factors present in all research utilising self-reporting techniques; and by the very nature of the culture it sought to explore and explain (making members wary of exposure).

The intention of the study therefore, was not to attempt to establish causal relationships between factors in nurses, nursing, and society (intra and interpersonal, professional and societal) with the incidence or severity of complicated grief reactions amongst nurses. Rather it was to identify and describe such factors more clearly within these groups and to explore relationships between them. This can be seen to be "essential groundwork" (Burns and Grove 1987 P.26) for further studies that will focus more on "explanation, prediction and control" (ibid) of the phenomenon in question, ie. complicated or pathological grieving amongst nurses.

It was apparent from the review of the literature, the content of numerous informal discussions with other nurses and the personal experience of the researcher, that there were several possible lines of enquiry to follow, if a holistic view of professional nurses and their personal bereavements was to be achieved. As a result, an integrated approach was utilised, in an attempt to facilitate triangulation between data pertaining to the same phenomenon, derived from a variety of tools and items spread throughout the study as a whole. In practice, attempts at triangulation can be seen to have provided

"convergent validity" to findings (DePoy et al 1994) in this study. This is because "convergent validity of a finding is achieved by bringing together information collected, tested or analysed through more than one method", in this case "across methodological strategies" (ibid) as there was the opportunity to compare findings across a range of methods.

Such triangulation also offers a "completeness function" (ibid), particularly within the realms of naturalistic enquiry. In such cases, different methods are chosen to assess different aspects of the issue under study, so as to reveal additional pieces of the puzzle, or to uncover varied dimensions of one (or more) phenomenon. In this study, this 'function' was achieved by the fact that for example, multiple facets of 'coping' expectations for the nurses and midwives involved, were examined in a variety of ways.

The following diagram provides an overview of the methods used to achieve this.

Part 2.

Part 1.

Questionnaire 1.

Survey of RGN's and SCM's within two DGH's, using a quantitatively orientated questionnaire. n = 85, this from a response rate of 61%.



Examination of the presence of factors predisposing to complicated grief within this group. Also aspects of hospital 'culture' which may affect the experiences of nurses and midwives, when visiting in hospitals.

Questionnaire 2.

Survey of RGN's and SCM's within two DGH's, using an open-ended questionnaire. n = 116, this from a response rate of 77%.



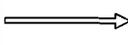
Examination of views of the socialising environment of hospitals. Particularly regarding the treatment of relatives (incl. nurse-relatives) Also, respondents' educational preparation for caring for the dying.

Semi-structured interviews with a sample of the respondents to questionnaire 1. n = 11, i.e. 15% of respondents.



To allow meaningful expansion of answers to questionnaire 1.

Interviews with bereaved nurses and midwives. n = 22.



Examination of actual experiences of nurses and midwives, as hospital visitors and as bereaved people.

Overview of the Study.

N.B. RGN = Registered General Nurse; SCM = State Certified Midwife; DGH = District General Hospital

This mixture of data collection and data analysis techniques, was intended to strengthen the study in various ways.

The use of 'postal' surveys provides access to relatively large numbers of respondents. In this case it was also intended to provide data of both a qualitative and quantitative nature, often regarding similar or related issues (see above discussion on triangulation). As it was intended that extrapolations from this study, be made for nurses and midwives in general, the benefit of a reasonable volume of respondents is obvious. It is acknowledged however that such extrapolations can only be speculative in nature in this case, given the fact that a convenience sample was utilised, and the sample was limited in size (approximately 100 for each questionnaire).

Alongside this quantity orientated data collection, semi-structured interviews relating to the concepts examined in questionnaire 1 (essentially a series of structured, closed question tools) were carried out on a number of respondents to that questionnaire (n = 11: approx. 15%). This was intended to provide not only validation that the respondents had understood the questions and answered them as they truly intended, but also an opportunity for them to expand on their replies, thus potentially enriching the data.

There was also an expectation that such a combination of approaches might highlight contradictory, or paradoxical patterns of replies, perhaps as a result of social desirability, cognitive awareness but behavioural denial, or in circumstances where respondents were consciously unaware of factors influencing their answers. The latter is very much akin to Leininger's concept of cultural blindness (1991), where an individual is unable to identify the degree to which their beliefs, attitudes and actions are governed by their background and culture, in this case the 'culture' of hospital nursing.

Finally, it was considered that interviewing bereaved nurses in some depth, was the only way to realistically provide a 'gestalt' for the study, as they allow some

consideration of the phenomena of grieving amongst a number of nurses and midwives. In some ways this could be seen as a second study, as the questionnaires and semi-structured interviews were at the level of exploration, while the interviews with bereaved nurses and midwives were at a more 'descriptive' level, as relationships between concepts would be able to be identified and explored (Brink et al 1988).

It would have been beneficial to have undertaken observation of respondents whilst they were interacting with patients, relatives (including those who were also nurses) and also with medical personnel, so as to allow comparison of their self-reporting answers to the questionnaires with their actual behaviour. This was considered at the time, unfortunately time constraints, and an unwillingness on the part of managers to allow this precluded such activities. The researcher also considers that the chances of a number of nurses and midwives agreeing to be 'watched' in this way were very slim, not least because of the 'helper secrets' and 'fear of being watched' issues examined in the study itself.

As a complete alternative to the study undertaken, un-structured interviews, perhaps using a grounded-theory approach and a larger sample of bereaved nurses and midwives, could have been utilised. This would perhaps have been more in line with the reality of the level of knowledge which existed at the time (which has not changed greatly in the interim) and led to this being an exploratory study. It should be recognised however that the conceptual and data-collection phases of this study took place at a time when such approaches were not as well 'accepted' as they are today. In point of fact, the Director of Nursing of one major teaching hospital, refused access to his staff for the study, because he felt parts of the tools used were *"too unstructured and would be difficult to code"*. It should also be acknowledged that this was during an earlier part of the researcher's development and knowledge, and when the methodological intricacies of such an approach could be considered to be even more within the domain of "tacit knowledge" (Meerabeau 1992) than is

currently the case.

In the remainder of this chapter, the methods employed in the study are described. Considered in turn are the samples and the sampling procedures; the instruments used and how they were developed; and the methods of data analysis utilised. It should be noted here that two sets of subjects were used in the study, one for the questionnaires 1 and 2 and semi-structured interviews, and another for the interviews with bereaved nurses and midwives. However there were some subjects who participated in both, though they cannot be identified due to the anonymous nature of the process.

Population and Sample - Questionnaire 1, related semi-structured interviews, and Questionnaire 2.

Registered General Nurses (RGN) and State Certified Midwives (SCM), employed at grades D, E and F (i.e. staff nurses and staff midwives), in two District General Hospitals (DGH), in the north of England were asked to respond to the two questionnaires. Questionnaire 1 contained a section asking for volunteers to participate in follow-up interviews based on their replies.

Access to the hospitals and staff therein, was approved by the respective Director of Nursing on each site (see later discussion regarding ethical approval for the study). A third large hospital - a university teaching centre for both Nursing and Medicine, was also approached for inclusion in the study, but the Director of Nursing Services declined to participate. Ward sisters and above were omitted to enhance the homogeneity of the sample. Enrolled nurses were omitted for the same reason. Thus the parent population which both samples came from was the same (i.e the RGN's and SCM's at the two DGH's surveyed).

Sampling Method.

A convenience sample was utilised for both questionnaires. The researcher approached nurses and midwives directly at the two hospitals, during the

months of February to May 1989. The hospitals were some 10 (ten) miles apart. To avoid confusion questionnaire 1 was circulated amongst hospital A staff during February and March, while questionnaire 2 was circulated amongst staff from hospital B. The opposite then took place during April and May. This was also an attempt to maximise the return of both questionnaires, by emphasising that there was a difference between the two.

Initially, only hospital based registered nurses were canvassed because grades D, E and F constituted the largest section of nurses of the same grade and training; socialisation is said to be strongest in hospital settings. Enrolled nurses undertake a different training, and therefore their inclusion could have introduced an extraneous variable. The same could also be said regarding nurses from the psychiatric and mental handicap fields. However, midwives were quickly added, both to boost numbers and to examine the variable of further (i.e. on top of general nursing) professional training in an area of distinct expertise.

Subjects were self-selecting in that the researcher visited the wards and departments of the hospitals, explaining the nature and purpose of the study whilst distributing questionnaires. The aim of the study was said to be an attempt to examine the factors affecting grieving and mourning in nurses and midwives. The researcher indicated approximate times needed for completing the questionnaires, this being based upon feedback from a 'pilot' group, and as time went on, actual respondents. Subjects were assured of anonymity, unless of course they indicated on their form, that they were willing to be interviewed later. The only identifying marks were code numbers to identify the ward that groups of respondents belonged to. This was to allow targeting of areas of poor return by the researcher, so as to encourage their completion and to receive feedback about content or reasons for non-completion. Respondents were asked to return the completed forms to the researcher via the internal mailing system, or by hand on a subsequent visit to the area. Further discussion was avoided whenever possible, so as to minimise bias. Follow-up visits were

made to the clinical areas involved to encourage potential respondents to complete their questionnaires, but not directly to individuals.

One hundred and forty (140) copies of questionnaire 1, and one hundred and fifty (150) of questionnaire 2 were circulated across the two sites. This difference was due to the simple fact that these were the numbers seen in the time available for data collection. Of these, 85 (61%) responded to the more 'psychometric' questionnaire (1), while 116 (77%) replied to the open-ended questionnaire (2). Given that some respondents fed back that they had taken up to two hours to complete the forms (typically because "*it made me think*" [Sic]), it can be seen that there was a high degree of cooperation on the part of respondents to the study as a whole.

The number of responses to the two questionnaires was proportional to the relative size of the two hospitals, i.e. one was somewhat larger than the other, but the response rates to both questionnaires were virtually the same, i.e. approx. 60% and 75%. The volunteers for the semi-structured interviews were also evenly spread across the sites. The anonymous nature of the exercise means that individuals may have completed both questionnaires, but one cannot be sure who they were.

Study Part 1 - Description and discussion of the instruments used within Questionnaire 1. (actual copies are presented in appendix 1.

Section A. Demographic data and whether an individual had ever been bereaved.

These items were based on previous work by Crookes (1986) and Green (1988). The data sought were straightforward, unambiguous and therefore suitable for closed-ended questions. This was considered to be beneficial both in terms of time (completion and scoring) and data analysis (allowed pre-coding). All were scored using a system whereby the respondents were asked to circle the response relevant to them.

1) AGE.

This was classified into 5 (five) year groups from 21 (twenty-one) years (the youngest possible age for an RGN in England), to 40 (forty) years. Forty-one (41) years and over was considered to be a potentially small group - based on the aforementioned study by Crookes (1986), and the view that most hospital based RGN's/SCM's of this age are ward sister level or above.

The responses to this item can be considered to be both fixed and stable and, owing to the anonymous nature of the questionnaire, reliable. This variable was seen as a potentially important variable, given the perceived socialisation profiles of nursing and midwifery, and how they have changed over the years, i.e. from unquestioning doctors handmaiden, to the knowledgeable doers within the "new nursing" (Salvage 1990).

2) SEX. i.e. male or female.

Again considered unequivocal and reliable.

Examined to see if gender affected a respondent's replies.

3), 4) & 5) RANK and GRADE, LENGTH OF TIME IN NURSING, LENGTH OF TIME IN PRESENT POSITION.

Unequivocal and reliable. These were included to give some insight into the seniority of the respondent, and their exposure to hospital socialisation, customs and practices.

6) & 7) PROFESSIONAL QUALIFICATIONS/STUDYING FOR FURTHER QUALIFICATIONS.

Stable and reliable. Considered necessary for 3 (three) reasons:- to ascertain that the respondent was indeed an RGN; to identify those who were also SCM's; to identify those who had already completed, or were in the process of completing other qualifications. Of particular interest were those in possession of, or undertaking degrees and/or diplomas in nursing, as these qualifications are perceived to have a decidedly humanistic orientation (Salvage 1990), and

therefore might provide interesting results.

8) PRIMARY TYPE OF PATIENT CARED FOR.

Again stable and reliable. Included to examine whether nursing speciality affects response, e.g. Was there a different outlook for nurses and midwives?

Another major reason these items were included, was to ascertain whether the sample group could be considered in any way, representative of the nursing and midwifery populations as a whole.

Expert advice in the field of questionnaire design was sought prior to embarking on the data collection phase (Dr. I. Gibbs, an experienced social scientist at the University of York). His feedback resulted in several modifications to the questionnaires, most notably suggestions on making the items more accessible to post coding, and the substitution of the question "have you ever been bereaved?" with a definition of grief and mourning (Engel 1961), and the questions "given these definitions, would you say that you have ever grieved and been through a mourning process?" (**Question 9**) and, "If yes, who or what was your loss? (**Question 10**). such changes being an attempt to clarify terms and minimise semantic misconceptions for respondents.

It was decided to leave the response to question 9 as a yes/no, then enquire as to who or what was their loss (Q 10), so as to allow the respondents to decide whether they had mourned a loss, without prompting from the questionnaire itself. This allowed for the inclusion of the multitude of possible precursors to the grieving process, given Engel's definition of grief (see literature review). It also meant that the decision about whether they felt they had grieved or not was their own, as opposed to the value-judgement necessary had they been asked to identify their loss from a list devised by the researcher. Such questions were considered relevant as Stedeford (1984) talks of nurses using existential denial of the certainty of their mortality, so as to be able to function. While the researcher believes that the experience of bereavement for nurses,

may engender a catharsis both personally and professionally, not unlike the experience of a nurse becoming a patient and being given nursing care, and thus personally exposed to patient norm expectations. In essence, it was believed that previous experience of bereavement might impact on the views of respondents, and was therefore an important variable to consider.

In the event, the replies of those who had 'mourned' could be 'post - coded' under 6 (six) headings:- Spouse/Parent; other close family/relative; friend; colleague; pet; and other, plus the possibility of not having suffered a grievous loss.

Section B . Role Models in Nursing.

This was intended to examine the ideal role-model perceptions of the respondents. The tool was extrapolated from work by Green (1988), who in turn was undertaking a slightly modified replication of an earlier study of work orientation amongst graduate nurses in the USA. (Corwin et al 1962). The aim in this case, was to provide an 'open-ended' mechanism for identifying the attributes of the 'ideal' nurse or midwife, and in doing so, generate evidence of aspects of the socialising atmosphere present in the working environments of the sample. That is, of the way that information about "how things ought to be, and how things ought to be done are passed from one generation to the next" (Crooks and Waters 1990) within their culture, and the effects of such conditioning on the processes of 'role-taking' and 'role-making (Hardy and Conway 1978) of and by these nurses and midwives. It was also possible that these questions, along with 'professional orientation' (Corwin and Taves *ibid*) items in sections E and F, would afford some insight into the said orientations of respondents within this sample.

Questions 1 (One) and 2 (Two) of this section were essentially intended to highlight any differences between the respondents' views of who **was** and who **should be** their main role-model, the view being that the processes of role-taking are enhanced if the person being observed is capable of providing assistance and instruction on how the role is to be fulfilled (Mayer 1983). The question of

whether such a person is commonly available to neophyte nurses, was however questioned by Riggan (1982) because of what was seen as a dearth of **consistent** role models available (my emphasis).

Question 3 (Three) consisted of a request to describe the assets a good nurse role-model should possess, and then to say which was the most important. This again was to allow triangulation with other aspects of the survey, most notably the expectations of the 'ideal nurse'. Such expectations may represent aspects of the socialisation process regarding key (in this study) issues such as self-concept; desirable personality traits (for the role of a nurse); and the need for virtues such as reliability and dependability 'under pressure'. Again, to avoid charges of prompting, and the problems of social desirability, respondents were asked to identify their own 'ideal' factors, rather than choose from a list provided by the author. Nevertheless, the replies could essentially be post-coded into 4 (four) categories:- Possession of various humanistic values (eg caring, kind); standards/experience/knowledge; capable/organised; and, being approachable.

There was also a code for no reply, and for answers that defied classification for reason of lack of numbers or because they were rather esoteric. The fact that there were no obvious misunderstandings, and that the replies were capable of such post-coding, suggests that there was face validity to this section. To further enhance the rigour of the coding of replies, the data were categorised by a group of raters. They did this individually at first, then agreed a final categorisation as a group.

Section C. Preferred Coping Strategies for RGN's and SCM's.

This section was derived from work carried out by Dewe (1987; 1989), which identified the strategies nurses use to cope with work stress. This work was considered to be of particular value because it sought to "investigate and identify the coping strategies nurses **themselves** say that **they** use to cope with stress" (Dewe 1987), rather than requiring forced answers to coping questions

derived from established instruments. Essentially therefore, the tool was based on valid research findings rather than on purely theoretical grounds. This was considered important for two particular reasons:- It would make the tool more valid and reliable, as it was related to actual perceptions of nurses and midwives; and, as the nursing profession is noted for the concrete operations level that many of its members are considered to operate at (Burns and Grove 1987 p7), any aspect of the questionnaire based upon tangible rather than abstract notions, was considered to be more relevant, reliable, and thus desirable.

Dewe's work itself was based, at least in part, on conceptual work undertaken by others. That of Lazarus (1975) seems to essentially underpin the aforementioned work in that he (Lazarus), differentiates between direct action techniques of coping (solving problems or mastering the situation), and palliative techniques (reducing the feelings of emotional discomfort, rather than altering the source of that discomfort) (Dewe 1987, p491).

Dewe's work, and therefore the present research, is closely associated with such concepts. Not least because as Dewe points out, much of what is stressful to nurses, has its source in situations beyond their control. Certain palliative strategies that attempt to minimise emotional discomfort (particularly ego-defensive techniques), would therefore seem to be an important part of coping for nurses (Dewe 1989). This along with the 'direct' strategies enumerated above. The researcher was therefore utilising this work partly because of its perceived credibility and validity; partly to empiricise preferred coping strategies amongst nurses; and partly because it examined coping strategies offered by nurses themselves. This meant that they were presented in a form capable of being understood reliably and repeatedly, even if the respondent was at the concrete operations level.

There were negative aspects in using this work as the basis for the tool however. The researcher wished to explore the range of coping or dealing with

stress, including the use of particular forms of palliative mechanisms - most notably distancing, evasion and intellectualisation. Unfortunately however, the research literature rarely, if ever, clearly extricates these particular ego-defensive mechanisms for reducing emotional discomfort, from the wider range of palliative methods, hence there was no existing model for clearly examining the use of such mechanisms. Furthermore, Dewe (1987) points out that self-report methodologies cannot identify strategies which an individual is not aware of using, which would presumably be the case for ego-defensive mechanisms such as those referred to above, and expanded upon greatly by the work of Menzies (1961). Nonetheless, items referring to such behaviours as 'distancing oneself from patients and relatives' were included as they are derived and thus reflect, the work of both Dewe and Lazarus - both acknowledged authorities in this field. It was recognised however, that responses to such items would have to be considered in the light of a possible lack of self-awareness in this area, whilst also acknowledging the potential for social un-desirability of nurses and midwives admitting to themselves and others, that they avoid the development of meaningful communication with patients and relatives. As a result of these points, it was expected that the most meaningful data on the use of such mechanisms, would come from the semi-structured interviews and the open-ended questionnaire (2), whilst 'direct' strategies would be clearly dealt with in this section (C).

It was envisaged that the results of section C. would not only provide a profile of preferred coping strategies amongst nurses, but again also allow triangulation with other aspects of the study. Notably the question of whether nurses perceive the more 'direct' (typically intellectual/problem solving) methods of dealing with stressors, to be more effective or desirable (one cannot realistically separate the two using self-reporting techniques), than passive methods - particularly encompassing the expression of feelings.

Further triangulation was also intended. For example the examination of perceived 'unhealthy' (Parkes 1972, 1975) personality traits, particularly

keeping control of one's emotions (or internalising); being 'independent'; and the possibility that the socialisation of nurses and midwives may be so 'complete' and they identify so strongly with direct/intellectual coping strategies and emotional distancing as techniques for dealing with or reducing stress, that their use dominates dealing with stress in all aspects of their lives. The above issues are of relevance to this study, as neither direct (Dewe 1989) nor ego-defensive strategies, are of any practical use to an individual when working through the emotional work which constitutes the tasks of grieving (Worden 1983). Also an integral part of successful grieving is said to be giving vent to one's emotions (Deutsch 1937) preferably whilst supported by someone else. Finally it should be recognised that the results of this section were not only expected to reflect preferred styles of coping with work related stress, but life stresses (including bereavement) in general.

Dewe (1989) identified six components of coping behaviours, from a large scale survey of nurses ($n > 1500$), and their preferred strategies for coping with stress. The components he identified were:-

Component 1 - Involving problem solving/orientated behaviours;

Component 2 - Involving trying to unwind and put things into perspective;

Component 3 - Involving the overt expression of feelings, emotions and frustrations;

Component 4 - Involving the internalisation of the problem, i.e. 'keeping it to oneself';

Component 5 - Involving accepting situations and 'getting on with things';

Component 6 - Involving 'passive' behaviours such as smoking, drinking alcohol, and taking time off work.

A scale was developed for the present study based on these components of coping. It comprised of 4 (four) 'concrete' examples for each of the 6 (six) coping components, i.e. 24 (twenty-four) items in all. Each item described a method of dealing with a difficult situation or stressor. Respondents were asked to grade, on a scale of one to five (not true at all - very true), each of the

24 items in terms of the degree to which it described their attitudes and/or responses to stress.

Overall therefore, the intention of this part of the study was to examine the pattern of expressed preferences of the nurses and midwives, for strategies for dealing with difficulties and stress. It was envisaged that respondents would tend to value and hence claim to use "direct" mechanisms (Dewe 1987) such as being organised, in control and problem solving, and/or cognitively based ego-defensive strategies (as previously discussed), this as opposed to more 'passive' means of coping, as also found by Dewe (1987), or by overt expressions of feelings, emotions and anxieties. If this was found to be the case, then it would give credence to the view that nurses highly value direct or 'cognitive' strategies, and that whether they actually succeed in being 'in control' or not, the desirability of it is so strong that it may manifest as a compulsion to try to emulate it whilst in the 'professional' or work setting. Included in those who would wish to emulate it, would be newcomers to the profession, eager to 'fit in' (Melia 1987) with this aspect of the 'ideal nurse' concept, which in turn could increase the chances that they will come to rely on them at all times - personally and professionally. Indeed it could be expected of them - by self and others.

Section D. Social Support Questionnaire.

This section was intended to identify the sources (work and non-work), and levels of social support, that respondents perceived they could expect from the people around them. The presence of social support is said to "ameliorate stress; improve health; or buffer the relationship between stress and [ill] health" (House 1981 p.14). Furthermore, its presence is said to ameliorate or even protect against post-bereavement morbidity (Raphael 1984; Vachon and Stylianos 1988). Meanwhile a lack of social support (actual or perceived) is perceived to be a predisposing factor towards pathological grief (Parkes 1972; 1975).

As stated in the literature review, this study utilised the work of authorities in the area - James S House along with Gottlieb, as they provided "specific and concrete illustrations of what is meant by social support" (House 1981. p18). That is, they provided useful examples and clarification of what constitutes social support, which makes the development of concrete or tangible examples of situations where social support is helpful/needed, much easier for the researcher. House (1981) and Gottlieb (1978) together, provided credible, research based foundations, on which to build a social support assessment tool, providing as they do, information on sources of social support, and the ways in which it can manifest or be provided.

According to House (ibid), two approaches have typically been used by other researchers when attempting to assess available social support. One requires respondents to identify sources of social support, and to say how and when they would be supportive. This is then post-coded and analysed. The other is more structured, and examines social support offered by individuals and/or groups identified by the researcher. This latter method was seen as preferable, allowing as it does for the researcher to examine support offered/provided by individuals/groups of particular interest; and providing actual situations for respondents to reply to. Such a method can also be seen to provide more concrete, and therefore less ambiguous examples of the concepts in question - an important consideration in a postal questionnaire.

Both the approaches are essentially self-reporting, i.e. respondents are asked to rate how much support they are receiving from others. Thus, resulting answers are termed "subjective or perceived support" (House ibid p.27). House perceives these methods to be the easiest and most appropriate ways of examining social support. In this study, easiest because the respondents were already answering a questionnaire, and appropriate because social support is likely to be effective, only to the extent that it is perceived to be available. That is, "no matter how much your spouse or supervisor feels or acts supportively towards you, there will be little effect on you unless you, in fact, perceive them

to be supportive" (House *ibid* p.27).

To obtain more 'objective' measures of support, this section of the study was also intended to triangulate with others, in an attempt to ascertain, amongst other things, whether the subjects:- perceived social support to exist; perceived it to be useful and necessary to them; and, perceived it was of a level that could be considered 'functional'.

Thus this section can be seen to have validity in that it was based on previous empirical work by Gottlieb (1978) and House (1981). House provides a further measure of validity to the tool used, when he suggests that "thorough measurement indicates **who gets how much of what kinds of support from whom, regarding which problems**" (his emphases) (p.69). The tool devised for this study sought to explore all these issues, for the nurses and midwives surveyed, particularly regarding support around the circumstances of personal bereavement.

It also sought to fulfil a requirement of "future research" (House *ibid* p.70)....the examination of how people come to perceive themselves as having social support available. That is, "what are the social, interpersonal and personal factors that promote or inhibit the development of a subjective perception of social support?" (House *ibid* p.85). He went on to make the point that this is necessary if effective applied programmes for enhancing social support are to be developed.

The methodology chosen, attempted to do this by examining both whether potentially supportive relationships existed for the respondents, as well as attempting qualitative assessment of how supportive these relationships were perceived to be.

This section therefore, was derived from work by Gottlieb (1978), and further refined by House (1981). The sixteen items in the scale in turn comprised of

four items for each 'type' of social support, i.e. appraisal; emotional; instrumental; and informational. An attempt was made to provide a mix of general and problem focussed means of support (Gottlieb *ibid*), so as to reflect the diverse nature, in terms of source and kind, of social support. In other words both 'direct' support and that which could be said to offer a 'buffer' against stress, were considered. For each item, the respondents were asked to give an assessment of the degree of support they would expect to receive from the various sources identified, these being:- Spouse/partner; Relatives; Friends; Work supervisor; Co-workers, and Other sources not mentioned (respondents were asked to identify such sources). They were asked to do so using a likert-type scale of one (no support at all/person doesn't exist) to five (a great deal).

Also considered was the fact that this study focussed heavily on the overlap of personal and professional lives in nurses. One must recognise that stressors (in this case bereavement in particular) do not typically exist in isolated spheres of life, but indeed impinge on them all. This study was intended to highlight the degree to which this unrealistic expectation may prevail within the population of hospital based nurses.

Overall, the aim of this tool was to identify if the nurses and midwives did perceive themselves as having social support available in the four described modes, at home and at work. Also whether it was perceived to be of a level that it could be said to be efficacious - either by direct effect or by buffering.

Section E. The 'Family Nurse', and The Socialising Contexts of Nursing and Midwifery. Section F. The 'Ideal' versus 'Actual' Questionnaire.

Essentially these sections, were devised to examine the reality of the 'Family Nurse' role for respondents, along with the pertinent pre-determinants for pathological grief - self-concept as a copier and problematic personality traits (Murray-Parkes 1972, 1975), and how the socialising context of nursing and midwifery (i.e. their cultures) might reinforce the assimilation and/or development of such traits. Initially, an attempt was made to produce a

personality scale/test that 'measured' these factors directly. It was quickly realised that this was in itself, a project worthy of a Ph.D. It was therefore decided to try to consider them more indirectly, and to concentrate particularly on the 'coper' self-concept, the need for self-control, and the 'independent' personality within the population used. How this was attempted is discussed below, along with the items which examined the 'professional orientation' of the respondents.

The 'professional orientation' items, and the overall format for this section were drawn from work by Corwin and Taves (1962), and Green (1988).

Respondents were asked to consider various statements associated with the above areas, and to identify, the degree to which they agreed or disagreed with them, using a five point likert-type scale). Certain of the items were phrased negatively to encourage respondents to consider each item on it's own merit.

Section E) was the simpler of the two. It gave 18 (eighteen) statements, and asked respondents to indicate their answers to the various items, from the point of view of nurses and nursing 'in general', rather than for **them** as an individual, eg. *'nurses are in an ideal position to act as the health care spokesperson for their family'*. This was intended to produce data that would throw light on several issues, notably:- the work orientation of nurses (i.e. bureaucratic etc.), which in turn informs of the prevailing socialising atmosphere for nurses (nine items from the work of Corwin and Taves *ibid* and Green *ibid*); the "ideal nurse" image of respondents, particularly with respect to the expectations of nurses to cope in any and every situation, and to be able to govern and manage their emotions in front of others especially the public (five items); the expectations of the families of nurses, on the nurses themselves (two items); the attitude of the respondents towards the issue of divulging information to patients and their relatives (two items).

Section F) though only having 14 (fourteen) items, was in fact more complex, in that it not only asked respondents to answer from a personal point of view eg

"as a nurse I am in an ideal position to act as the health care spokesperson for my family", but also to identify if there was a difference between actual and ideal situations. In other words if there was difference between how they would **actually** feel and act, and how they feel they would **ideally** like (or should be able) to feel and act, in the given situations. This was scored in the same way as section E.

The situations themselves again derived their structure from Corwin and Taves (1962) and Green (1988), and their content from observation of the culture of nursing in action by the author and nursing colleagues. They were drawn up to triangulate with aspects of the qualitatively orientated, second questionnaire.

Section F omitted items on work orientation, concentrating instead on the issues of:- the expectations of the nurse (by self, the public, and their profession/ professional colleagues) regarding coping and managing difficult situations, controlling the public display of their emotions, and the willingness of nurses to accept social support, particularly from professional sources i.e. counsellors; the expectations of the nurse (by self and their family) with regards their role during family health related crises (two items); and, nurses' attitudes towards divulging information to patients and relatives.

Together, sections E and F were intended to quantify the incidence and intensity of the relevant Parkes's grief determinants (i.e. personality, social support and self-concept), and the role of the 'family nurse', amongst the nurses and midwives surveyed.

Both sections were considered to have content and face validity, as the pilot (nurse tutor) group and the 'triangulation' semi-structured interview group (both discussed shortly), consistently provided coherent explanations as to why they had answered in the way they did and with similar trends in their replies. A Cronbach's Alpha analysis of internal reliability was also applied to the data in the sub-groups of these sections.

Section G. Self Concept, Personality and Perceptions of the Ideal Nurse.

This was the final instrument in this questionnaire, and comprised of two forms of the 'twenty statements test' (TST) devised by Kuhn and McParland in 1954.

The first, asked the respondents to complete the statement "I AM....". This was Kuhn and McParland's original tool, which they developed to "differentiate and measure the system of attitudes which defines the self as an object of experience" (Hocking et al 1976). In itself it is a relatively unstructured device which approaches the social self-concept directly.

The second, was Hartley's (1970) modification of the "I AM...." test, He extended the instrument so as to require respondents to describe social objects other than the self. In this case the social object replacing self, was 'a nurse'. Therefore the statement to complete became "A NURSE/MIDWIFE IS....". To allow easier differentiation between the two versions of the tool, the latter was called the objects contents test, or OCT.

Validity and reliability of both tests were published by Spritzer in 1970.

The intention was to elicit data that would reflect the respondents' perception of themselves (self), and of the 'nurse' or 'midwife' (potentially the 'ideal nurse or midwife', but not necessarily as the statement "A NURSE IS" is non-specific). It was also hoped that 'over-independent' aspects of personality might also manifest in the TST, thus triangulating with other sections of the questionnaire.

Identification of the categories to be used was not possible at the outset, essentially because such an open-ended tool requires post coding in the light of the responses received.

The categories used were not those of the original authors. This was because the categories did not appear to be relevant to this particular project, and so

more relevant categories were sought. Such a use of these tools (TST and OCT) was not unique, as this was also done by Hocking et al (1976), when they used the OCT to examine the willingness of staff nurses in psychiatry to undertake role extension. To do so they modified the test to allow the number of items that reflected a willingness to change and undertake new roles, to be calculated. Similarly the current project modified the scoring system to allow the same to be done for categories more relevant to the subject matter.

A copy of questionnaire 1 can be found as appendix 1.

'Piloting' of Questionnaire 1.

The input of Dr. Gibbs was discussed earlier. The instruments (A to G) were also given to 10 nurses of the same grade to be studied in the sample (D-F), who were not based at the hospitals surveyed, and so would not 'pollute' the sample group by contact and discussion. They reviewed the instruments for clarity, ease of understanding and brevity, by completing the questionnaires themselves.

The respondents reported no difficulty in completing the questionnaires in the desired manner, except for the negatively phrased items in the section adapted from Corwin and Taves (1961), and Green (1988). They were able to complete the items, but it "*took time*". Concern was also raised about the time taken to complete the exercises as a whole, i.e. no-one completed either of the questionnaires in under 20 (twenty) minutes. The cover sheets therefore had to be modified (the introductory paragraph had asked for 10 [ten] minutes of the respondents time!), and prospective respondents were therefore informed honestly of the time factor involved. It was decided that none of the scales could or should be omitted, because all were considered to be relevant, important, and integral to the study overall.

Semi-structured interviews associated with questionnaire 1.

As identified earlier in this chapter, respondents to questionnaire 1 were invited

to contact the researcher to expand upon their answers and so participate further in the study. In the event this equated to approximately 15% of the sample. This was an attempt to assess the reliability of the data, both by evaluating their understanding of the schedule, i.e. did they fill in the questionnaire correctly?; and by allowing opportunity for them to expand on their answers if they wished to. It was also intended that this exercise would offer some triangulation of answers given verbally and in written form, to questions posed about related subjects - again potentially enhancing the reliability and validity of the findings and any conclusions made.

These interviews were semi structured and took vastly varying amounts of time (20 to 90 minutes). An outline of the issues covered in them is provided as appendix 3.

It was decided to present the data from these interviews in two ways:- to refer to areas of triangulation where pertinent, throughout the discussions of results for the various sections of the questionnaire; and also by discussion of data derived from the interviews, not received from the questionnaire. This serendipitous data was relatively small in volume but of great relevance to the study overall.

Methods of Data Analysis - Questionnaire 1 and semi-structured questionnaire.

Section A - Biographical data and previous experience of bereavement.

This produced simple and straightforward descriptive data. Further analysis was not carried out on this data.

Section B - Ideal role models in nursing and midwifery.

This was analysed in two ways. As questions 1 and 2 asked respondents to identify the rank of 'typical' role-models, coding was straightforward. Question 3 however asked them to identify the trait possessed by the ideal role-model. It was necessary therefore, to code these replies 'post facto' - a task undertaken

by volunteers unconnected with the study, so as to enhance the validity of the categorisation process.

With the exception of the Twenty Statements and Objects Contents Tests, the rest of the data were analysed using the Statistics Package for the Social Sciences (SPSS) computer programme.

Section C - The Preferred Coping Strategies for RGN's.

The data from this instrument were examined at three levels:- those data arising from individual items; those arising within the six modes of coping behaviour (*problem solving, gaining perspective, expressing feelings, internalising feelings, accepting situations and passive mechanisms*), or intrascale data; and, those arising from comparisons between and across the scales, or interscale data. Such data stemmed from analysis of frequencies and a review of individual items, aimed at identifying significant results and notable trends in the data. Given the number of subjects and items, the risk of type 1 + 2 errors using multivariate analysis is quite high. A factor analysis was undertaken so as to fully explore the data, but caution was exercised in its interpretation.

A detailed analysis of each of the groups of 4 questions comprising the six scales (therefore 24 in all) was carried out. Subsequent to this, all the items were cross tabulated with the other items of this questionnaire, except for the Twenty Statements Test (T.S.T.) and the Objects Contents Test (O.C.T.), however this failed to identify any further meaningful patterns in the data.

Assessment of how positive or negative respondents' were towards each item, was examined in 2 ways, these being based upon the % of 4 + 5 answers (i.e. positive) and the mean scores of the various items. In actuality these two calculations produced virtually the same data in terms of ranking of coping strategies. It is acknowledged that the calculation of means from ordinal data is a contentious issue, however Burns and Grove (1987) point out that "the

criteria for classifying data as 'interval' has been relaxed". Furthermore although the data were of an 'ordinal' nature, it was considered acceptable to use the t-test in this context, as it is "generally held that it is relatively insensitive to differing population variances and lack of normality in the parent population" (Boneau 1960; Lewis 1965; Norton 1952), whilst Burns and Grove (1987) point out that of the parametric tests available, the t-test is the most "robust". Interestingly, in their 1993 edition, Burns and Grove state that it is now believed by 'pragmatists' that "with many measures taken at the ordinal level, such as scaling procedures, an underlying interval continuum is present that justifies the use of parametric statistics" (p338) It is because of such statements as this, and the fact that it was used only to explore the data more fully, that it was considered acceptable to use the t-test in a case such as this.

A Cronbach's Alpha analysis of internal reliability was applied to the results of each of the groups of questions (ie. each 'coping' sub-scale). This is a test which identifies whether certain questions are answered in the same way by the same respondents, and is therefore very useful when working with groups of conceptually related items.

Section D - Social Support.

The data from this questionnaire were also derived from three levels of analysis, i.e. the results of individual items; those results within the four sub-scales of social support, i.e. intrascale, and, those results arising from comparisons between the sub-scales (interscale).

The first step was an item by item analysis of frequency of responses for each of the values (1-5 or Not at all-A great deal). A '0' value (signifying no response) was added after initial analysis, this allowed the production of tables of frequency of response (expressed as a percentage of the overall responses), mean % of positive responses, mean values and the spread of the scores for each of the sources across the 16 items of the questionnaire, (a total of 80 variables overall). At this point the sixth column, i.e. 'other', was omitted as

the incidence of respondents using it was so low as to be negligible, perhaps a significant finding in itself, in that presumably the sources offered by the questionnaire covered the range of sources available to most people.

The individual items data were then re-computed in various ways (see results chapter for specific details) to allow intra- and inter-scale comparisons to be made, and thus provide insight into whom respondents perceived they could rely on for social support; what forms of support they perceived available to them; and whether what was available could be considered 'functional'. T-tests were used to compare group means, again this was considered reasonable, given the earlier discussion.

A test of internal consistency (Cronbach's Alpha) was not seen as relevant to the data from this section, as internal consistency cannot realistically be expected given the diverse nature of the modes of support within each scale. For example, "how much does this person make you feel respected or admired?" and "this person keeps me informed about how well I am functioning in my job" are both items in the 'appraisal' social support scale, however one can see they examine very different aspects of such support, not least because the latter is more obviously related to the world of work. This was however unavoidable given the constraints of time - to separate work from non-work would have extended the questionnaire even further, and it's effects on response rates potentially great. A factor analysis was attempted for 'thoroughness', but as could be expected, the number of variables led to a multitude of factors being identified. This exercise was therefore abandoned.

Section E - The socialising context of nursing and midwifery.

This instrument was analysed in four sections, by virtue of its content, i.e. coping/control items (5); expectations of families items (2); attitudes toward information giving items (2); and professional orientation items (9).

Certain items were negatively phrased in an attempt to control the tendency of

subjects to answer a series of questions the same way. This followed Corwin's original questionnaire and methodology. Due to this, a 'rule of thumb' for scoring responses was utilised, whereby a score of five was nominally attributed to the response that concurred with the research question/premise at issue in the item. For example, it has been asserted that a nurse's family may expect them to act as the family spokesperson for the family, therefore if a respondent strongly agreed that this was the case for them, they were allocated a score of 5 for that item. The degree of agreement/disagreement was then considered via a combination of examining tally scores and means.

Calculations of Cronbach's Alpha were undertaken for the groups of conceptually related items, within this tool.

Section F - Ideal versus Actual Questionnaire.

This questionnaire was also analysed in sections, nominally under the headings of copier, family expectations, and information giving, but also in pairs. The pairs arising from the fact that respondents were asked to answer each item twice, once for how they felt they **should** [be allowed to] act, and then again for how they **would** [be expected to] act.

'Ideal' answers were the odd items of each pair, e.g. S1, S3..; 'Actual' answers were the even items of each pair e.g. S2, S4..

Certain items in this section were negatively phrased, again in an attempt to control the tendency of subjects to answer a series of questions the same way. The above 'rule of thumb' for scoring replies to such items, was therefore again utilised.

The degree of agreement/disagreement was then considered via a combination of examining tally scores and means. Differences between 'ideal' and 'actual' ratings, were then examined using t-tests, this being considered reasonable in the light of the earlier discussion of levels of measurement, and the use of

parametric tests on non-parametric data. Cronbach's Alpha calculations were again undertaken for groups of conceptually related items.

Section G - Twenty Statements Test and Objects Content Test.

This section was analysed in the way recommended by the official scoring system, i.e. each individual reply item was assessed and categorised into various sections (this for both the T.S.T and O.C.T). However, the categories used were not those of the original authors, instead a content analysis was undertaken and 'new', more relevant categories developed. This was necessary because the original categories did not highlight the aspects of self-concept under scrutiny in this study.

The content analysis was performed by the researcher and a group of volunteers. The volunteer group consisted of 5 nurses, one psychology researcher and two non-nurses, so as to constitute a relative breadth of opinion. They were asked to examine the items 'en masse', and then to separate them into related groups, giving reasons why they did so. They did this separately and independently, so as to minimise bias and influence.

With some notable exceptions, they did this with a high degree of correlation. The main difficulty (apart from the tedium of such an exercise) was categorising the items into a reasonable number of sub-groups, i.e. most separated them into 9 or 10 groups. The author therefore utilised the feedback from the volunteers and devised the following categories. They were then discussed with the volunteers so as to make sure they concurred, which they did. The only category directly devised by the author therefore, was the 'coping' category. Most of the volunteers tended to group these together with items alluding to professional behaviours - a telling point in its own right. However, because a central theme of the research was the examination of the concept of professional coping, it was considered reasonable to separate such items.

After frequencies of response had been calculated, the scores for the two

scales were then computed to allow :- frequencies of item types/classes to be calculated; comparison of the incidence of similar items between the two scales, and the significance of their presence/absence in both tests; and, Identification of spread of responses and the implications of same. All this also allowed the possibility of the development of profiles for 'I AM and 'A NURSE IS' for each respondent, which could potentially be used fruitfully in on-going research, after the completion of this study.

Methods of Data Analysis for the Semi-structured interviews related to Questionnaire 1.

Having transcribed the taped interviews, the data were analysed using a 'concept matrix'. The nature of the interviews (structure provided as appendix 3) meant that the focus of some of the data was pre-determined to a degree, by having asked questions regarding subjects' views on nurses and coping; their perceptions about social support - including whether they felt it was available to them, and whether they would accept it if offered; and their views on their independence from, and/or dependence on, other people. However such questions were not typically asked in any particular order determined by the interviewer, neither were the focus of replies uniform. Each subject's interview was therefore examined for issues of particular salience for the study. These were then viewed together so as to identify common thoughts, feelings and experiences, apparently shared by the 'group'.

Description and discussion of Questionnaire 2 - 'Examining the socialising atmosphere and culture of hospital nursing and midwifery, using a qualitative approach' (copy provided as appendix 2).

This tool sought to examine the respondents' views of the social environment (i.e. was it humanistic? or therapeutic?) prevailing within hospitals; their views and experiences of patient's visitors; and their views and experiences (if any) of being hospital visitors themselves. These areas were felt to be important facets of the all-encompassing view referred to in the title. Together, they provided a

mechanism for quantifying, aspects of nursing and midwifery culture, which alongside the pathological grief determinant factors of Parkes (1972), may complicate the situation of a person who is also a nurse, being a hospital visitor/family spokesperson, and even more critically if they become bereaved. Thus the 'humanistic environment' aspect of the questionnaire was intended to examine issues such as whether the respondents felt that nurses in general, and themselves in particular, were adequately educated in the area of death and dying; and their attitude towards sharing information about patients, with patients and relatives, e.g. regarding prognosis and diagnosis.

The 'relatives' section of the questionnaire on the other hand, examined their attitudes towards visitors; their experiences in dealing with relatives, especially those who were also nurses; and their experiences of being a nurse-relative/visitor themselves.

The questionnaire was considered to have face validity in that the pilot group answered with obvious understanding, and trends were observable.

The semi-structured interviews discussed earlier also provided an opportunity to seek further insight into these areas. Both questionnaires 1 and 2 contained the same biographical data items, and the 'modified' question eight discussed earlier.

The actual tool can be found as appendix two

Attitudes towards meeting the needs of relatives - Questions 1 to 4.

Questions 1-3 were in many ways intended to lead into question 4, and as a whole sought to canvass the respondents' perceptions about the expectations to which they were subject, regarding dealings with relatives, and in particular, their giving information to patients and relatives. The questions did this by asking whether respondents saw caring for relatives as part of their job; whether they saw relatives as 'useful'; and what they perceived the needs of

relatives to be and whether they are typically met. Whilst question 4 asked if they were encouraged to be open and free with information to patients and relatives. The pertinence of such questions to this study being:-

The attitudes respondents' held regarding relatives and their involvement in care; the discomfort (if any) nurses may feel when asked about what they feel they cannot divulge, particularly when it is asked by 'informed people'; the discomfort nurse-relatives may feel when asking for information on behalf of their family, given that they have insight into how staff may be feeling and how they may react.

Such discomforts perhaps leading nurse-relatives to feel that they should assume a 'passive' role, with the possibility that should their relative die, they may feel that they did not do all that they should have done - thus providing ammunition for personal recrimination; or adopt an 'interfering' stance (Robinson and Thorne 1984), with its potential attendant sanctions for both them and their relative (the patient).

'Helper secrets' - Questions 5, 6, 7 and 8.

These items followed a similar pattern to the previous group, in that the first three (views on open visiting and feelings about being watched and/or helped by relatives to give nursing care) led onto the key issue being examined by the items, i.e. would there be any difference in their feelings and hence their replies, if the relative was also a nurse or midwife? (Question 8). Explicitly questions 5-7 were also an attempt to allow comparisons to be drawn between the perceptions of the respondents, with those from other studies quoted in the literature review.

There was also the opportunity for triangulation between these and the earlier questions, on meeting relatives' needs (including being involved in patient care), i.e. was there any match (or otherwise) between the numbers who claimed to be unperturbed by being watched by, or involving relatives, the experience

claimed in this regard, and whether this was perceived to be common practice.

It was anticipated that the claims of 'not minding being watched' and 'involving relatives in care', could be counterbalanced in some way by the questions tagged on to the end of these items, i.e any experience?' (of being watched), and 'is it common practice?' (for relatives to help care for patients).

Furthermore, it was envisaged that this would give some insight into whether the involvement of relatives was the 'norm'?; if they were involved were there any provisos?; and, who typically initiated such activities if and when they took place?

Finally, given the work of people like Brooking (1986) on the involvement of relatives in the care of patients, it could perhaps be expected that the item on open visiting (Q5) would produce a pattern of results with a majority claiming positive attitudes towards them, but with some proviso about 'how open is open?'. It was also hoped that the latter would identify any self-serving reasons for objecting to open visiting, along the lines identified by Larson, in her article on "helper secrets" (1987) (see literature review).

Nurses as recipients of the health care system - Questions 9 to 12.

Having essentially examined 'working' nurses' views on nurse-relatives by inference up to this point, questions 9 to 12 were intended to examine the same issues more explicitly.

These items were put in such a way, so as to attempt to identify the 'consumers' point of view (experiences as a nurse-relative and as a patient - Q's 9 and 12), and also to elicit material regarding the respondents' view of nurse-relatives, derived from both their own experience (Q 11) and from the observation of others (Q 10). It was felt that by asking these questions and considering the data together, then one would again be able to differentiate 'reality' (answers from experience) from supposition (answers based on what people think it would be like).

It was also anticipated that Q 10 in particular would inform further, about the 'cultural norms' associated with the treatment of nurse-relatives by staff, this being particularly of interest when considering how nurses might feel and act when in the position of relative, whom they may have seen being dealt with by other staff previously.

Questions 13 and 14 - views and strategies of professional distancing.

This area was examined by asking respondents to discuss the issue of the optimum level of involvement of nurses with patients and relatives, and whether nurses can become over involved with such people. A more hidden agenda was to elicit information about purposive efforts made by respondents, to establish meaningful nurse-patient/relatives relationships; and whether the psychological well-being of staff was considered whilst doing so, as recommended by such writers such as Worden (1983), Egan (1984) and Parsons (1964). Furthermore, to identify any conscious effort on the part of the nurses to 'distance' themselves from patients and relatives, as this is considered to be common amongst nurses as a means of protecting themselves from anxiety (Menzies 1960; Jourard 1971), yet becomes useless if contact with clients is prolonged and/or the nurse identifies with them for some reason.

It was intended that inferences would then be drawn regarding how these issues could be affected by the relative also being a nurse, and also whether such ego-defensive coping strategies were common or indeed predominant, for these respondents.

Triangulation with the responses to the 'coping' aspects of the first questionnaire was envisaged as distancing is said to be commonly used by nurses to minimise the anxiety of dealing (coping) with patients and relatives, and allows them to maintain a perception of a "just world" (Lerner et al 1978) where illness and injury are things that only happen to 'other people'. This provides a degree of protection to people in professions like nursing and medicine, as if one can blame victims, then one can reassure oneself that one

can avoid similar circumstances (Walster 1966). Such a perception is obviously not possible when a relative or the professional him/herself becomes ill, as it has not happened to 'other people'. Thus if distancing, evasion and/or intellectualisation as means of emotional defence, were seen to be common amongst the group then a coping strategy said to be used by many respondents, would be deemed unusable in the event that they or a relative were hospitalised.

Attitudes and issues in caring for the dying - Questions 18 to 20.

Question 18 was posed so as to elicit further data about the respondents' views and commitment towards patients' and relatives' freedom of access to information, in this case dying patients in particular. Question 19 followed this up by enquiring if there were any conflicts between how they as nurses want to act and how they are allowed to act, when caring for the dying. It was envisaged that these items would highlight if there was a **purposive** commitment on the part of the nurses and midwives, to "open awareness contexts" (Glaser and Strauss 1966), as opposed to purely cooperating with the decisions of 'others'. Also whether they felt dissonance in terms of how the apparent lack of autonomy for nurses and midwives with regards to patient information (as discussed earlier) affected the way they would **like** to be able to function. In a sense these items were also intended to re-visit the earlier question (Q 17) of whether respondents would welcome the responsibility and accountability of disclosing information in an autonomous way, as those who state that they are content with the status quo, would ipso facto be content with current levels of information giving and whoever controls it.

Question 20 enquired about what the respondents perceived the reaction would be if they, as a nurse, decided to tell a patient his diagnosis. This can be seen to associate with the previous two items and those earlier which referred to the control of information in hospitals, with the intention of quantifying the perceptions and insights of a group of nurses into the possible effects such an action would have. Perhaps more pertinent to this study, are the sanctions that

they perceived could/would be brought to bear on the individual nurse. It was considered at the outset, that the answers to this item would identify the reality of nurses giving information, and allow triangulation with respect to earlier items in this and the other questionnaire. Not least to highlight and perhaps mitigate against any tendency towards social desirability in responses. This item can therefore be seen to be the last of a number of questions designed to identify and quantify factors that may mitigate against nurses being open and meaningfully communicative with patients and relatives, and allow exploration of the possible implications of such factors for relatives who are also nurses.

Education and preparation for caring for the dying and their relatives - Questions 21 and 22.

Questions 21 and 22 were included in this questionnaire for a number of reasons, the most straightforward being to elicit information about the respondents' 'formal' preparation (if any) with regard to dealing with the needs of the dying and their relatives (Q21), and how well prepared they felt themselves to be to fulfil this role. It was envisaged that this would allow some exploration of the match between the nurses' actual level of knowledge and expertise and the level they are perceived to possess - by self and by others. This is of importance to this study both in terms of the 'family nurse' role (i.e. are they ideally placed and prepared to fulfil this role in situations of family bereavement?) and the role of "community educator" (Rawdon 1987). The 'family nurse' connotations could then be triangulated with items in section E and F in questionnaire 1, in terms of both the existence of this role, and the expectations held of those who find themselves playing it.

There were other reasons for asking such questions. Question 21 was quite deliberately phrased, so as to avoid being seen to be directly questioning the respondents' academic or theoretical background and preparation, which could have had social desirability connotations. It was envisaged that in asking about the relevance and applicability of education regarding caring for the dying and their relatives, respondents would not only provide answers directly to the

question, but also indicate what educational provision (if any) they had received.

On the other hand, question 22 appears to be a straightforward attempt to explore the respondents' 'preparedness' for dealing with the psychological and emotional problems of patients and relatives, especially in the case of terminal illness. However this was also phrased in this particular way so as to encourage further examination of the way respondents had been prepared for the roles they have to undertake - in this case the informal and experiential mechanisms adopted. As a pair, it was envisaged that these items would allow respondents' to expand upon how meaningfully they had been prepared to undertake a very difficult and stressful aspect of the nurse's role. In this sense it also triangulated with earlier items on this questionnaire on professional distancing and breaking bad news, as well as other studies on the inclusion of 'death and dying' content in nurse education programmes (Wright et al 1989).

Were responses a reflection of experience or idealised perception? - Question 23

This question was asked both to allow respondents to add any comments they felt pertinent to the issues covered in the questionnaire, and to provide insights into the sorts of experiences the nurses perceived meaningful to them. It was expected for example that the experience of personal bereavement would have had a major impact on their thoughts and feelings.

'Piloting' of Questionnaire 2.

This questionnaire was also given to the 10 (ten) nurses discussed earlier. Again they reviewed the instrument for clarity, ease of understanding and brevity, by completing the questionnaire themselves. They reported no difficulty in completing the questionnaire in the desired manner, although the time suggested for completion had again been under-estimated and so the cover sheets were amended. It was decided that none of the items could or should be omitted in an attempt to shorten the completion time, particularly because this questionnaire was in itself a distillation of a greater number and scope of

enquiries, arising from the literature, and the personal experiences, observations and reflections of the researcher.

Methods of Data Analysis - Questionnaire 2.

Initially the data from this questionnaire were collated in the form of the original questionnaire, i.e. under the respective question. This analysis required post-coding, given the open-ended nature of the 'follow-up' questions. This rather complex, but nonetheless fruitful task, was undertaken by the same group of volunteers described in the TST/OCT section. Again they sorted the data separately, then agreed final categorisations within the group. The outcome of this exercise was rather lengthy, and at times repetitive data - not unreasonably as many items overlapped in content with others. The data were therefore re-ordered in a more summarised form under headings of related content. As many verbatim examples of respondents answers as possible were included, in an effort to preserve the richness of the data, achieved by the questionnaire.

STUDY PART 2 - interviews with bereaved nurses and midwives.

Population.

Subjects were nurses and midwives who had been bereaved. Some had participated in other parts of the study, others did not work at either of the two hospitals. Rank was considered irrelevant in this part of the study - a decision in some ways reinforced by the need for subjects. As a result 22 were interviewed.

Sampling Method.

A 'snowball' technique of sampling was used to recruit subjects for these interviews. This was necessary as there is no mechanism for identifying people who have been bereaved. Also, for ethical reasons, no individual known to the researcher as having been bereaved was approached directly by the researcher. Most participants were obtained via approaches from the staff of the terminal care support team of one of the hospitals, who knew personally of bereaved

nurses, and by concerned friends who encouraged them to speak to the researcher. There were also a number of people who directly approached the researcher, volunteering to 'tell their story'. Often this occurred whilst the researcher was circulating the wards distributing questionnaires, and explaining the nature and purpose of the study to prospective respondents.

Method of data collection.

Interviewees were encouraged to talk about the circumstances of the death of their loved one, the researcher interjecting only when their 'flow' lapsed. A loose structure, based around their feelings of support from peers, supervisors and family at the time of their bereavement and subsequently; their feelings at the time and subsequently about the way they dealt with their loss; and any insights they felt they gained from the experience, was used to do this. As the study went on, at times considered pertinent, the researcher also asked questions similar to those posed in the semi-structured interviews discussed earlier.

Permission was sought from all subjects, to audio-tape the interviews. With the exception of two, this was granted. Tapes were then transcribed by a professional audio-typist, while field-study notes had to be written post-interview, for those who declined the tape recorder.

Method of data analysis and presentation.

In the event, large sections of the interviews were of little direct use to the study in hand. It was typical for example, for subjects to spend long periods of time re-visiting, often in very particular chronological order, the circumstances surrounding the death of their loved one.

It is the intention of the researcher at some time in the future, to re-analyse this data, perhaps using a grounded theory approach, at which time such data may be more relevant. This section of the study however, was an attempt to consolidate and integrate the disparate issues examined, and perhaps to

demonstrate possible relationships between them 'in reality', i.e. not to provide detailed data, from which to devise theory. As a result, it was decided to analyse the data using a data-matrix, akin to the one used for the semi-structured interviews, where respondents' replies or comments regarding issues or themes identified, were compared, contrasted and their possible implications for the study considered. Having done this, it was intended that passages of text could then be used to illustrate particular concepts 'in reality', and also to demonstrate possible relationships between them. The problem with this however, was that at times, in separating the data the implications of a certain event or remark was lost. It was decided therefore that where interviewees had discussed things 'in principal', then such data would be collated and presented in summary form. Whereas when the points they made were better illustrated by leaving the data in context, a 'narrative' approach to presentation was utilised.

Ethical considerations for the study overall.

The approval of an ethics committee was not sought prior to embarking on data collection at the two hospitals involved, this was simply because none existed on either site. The questionnaires developed did not go into the issues of grief and bereavement, other than to enquire whether respondents considered they had ever been bereaved and so could be considered essentially non-threatening to subjects.

As discussed earlier in this chapter, approval to approach staff was sought, and granted by the Director of Nursing on each site, after having examined the tools to be used, and discussed the aims of the study with the researcher. The approval of such 'managers' was not sought, regarding the interviews with bereaved nurses and midwives however. This was because not all were employed within their area of jurisdiction, and all interviews were carried out on volunteers and took place in their own time. The researcher recognised at the outset, the potential for the release of strong emotions during the interviews with bereaved nurses and midwives. Not only was he prepared to work through

such feelings with such people, but the support of a hospital chaplain and the head of a terminal care support team was also available as a back-up.

In the case of the questionnaires, anonymity was guaranteed for the subjects in this study, as their identity could not be linked, even by the researcher, to their responses. The only identifying mark on the questionnaires was a code number, allowing identification of the hospital and clinical area, of the respondents. The obvious exceptions to this, were those respondents who agreed to participate with the semi-structured interviews related to questionnaire 1. Both this group of individuals, and the bereaved nurses and midwives who agreed to the in-depth interviews, were given assurances that their identity would be kept secret from others, and that any information shared with the researcher would be confidential. To ensure this, audio-tapes were labelled numerically and not by name, and so not even the typist was aware of the identity of the subject. Furthermore, references to actual people and places in the transcribed interviews were altered to mask the identity of both the subject, and the people or institutions referred to. Finally, all respondents were assured that they could decide to withdraw their help at any time.

The mode of distributing questionnaires by hand, meant that any respondent was informed of assurances of anonymity and/or confidentiality (which was reiterated in writing on the questionnaires), as well as the background and reasons for undertaking the research. The fact that replies could be sent to the researcher by post, reinforced the non-coercive nature of the request to participate in the study. This also minimised the chances of accidental discovery of the identity of respondents, on the part of the researcher.

The aspect of the study with most obvious potential for ethical problems was that of interviewing bereaved people, in particular gaining access to them in the first instance. The above discussion under the heading 'sampling methods' highlights the ways in which this was approached.

To conclude this section, it is perhaps worthwhile to note here, that almost

without fail, subjects expressed positive feelings towards the researcher and the study at the conclusion of the interviews. While three went to the trouble of sending letters of thanks for spending time listening to 'their story'. For some, it was obviously the first time that they had been given such an opportunity, a significant finding in itself.

Chapter 5.

Treatment of Data and Results.

Section A:

Biographical Data of the Sample for Questionnaire 1 and the Semi-structured Interviews. Also data regarding respondents' previous experiences of bereavement.

The rationale for asking this range of questions in this section, were clearly enumerated in the methods section. Essentially they were intended to provide background data to allow consideration of factors which might affect a respondent's replies to various aspects of the study. This was particularly the case for the issues of the clinical area they worked in, and whether they had been personally bereaved.

Table A1.

Variable	Value	Number	Percent
Age			
	21-25 Years	40	47.1
	26-30 Years	18	21.2
	31-35 Years	5	5.9
	36-40 Years	10	11.8
	41 and over	12	4.1
	Total	85	100.0
<hr/>			
Sex			
	Male	5	5.9
	Female	80	94.1
	Total	85	100.0
<hr/>			
Rank and Grade			
	D Grade	31	36.5
	E Grade	32	37.6
	F Grade	21	24.9
	Total	85	100.0
<hr/>			
Length of Time			
in Present	7-12 months	10	11.8
Post	13-18 months	11	12.9
	19-23 months	7	8.2
	2-4 Years	11	12.9
	Over 4 years	17	20
	Total	85	100.0
<hr/>			
Length of Time			
in Nursing	0-6 months	11	12.9
	7-12 months	9	10.6
	13-18 months	6	7.1
	19-23 months	7	8.2
	2-4 years	17	20.0
	Over 4 years	35	41.2
	Total	85	100.0

Professional Qualifications.

All respondents (85 = 100%) were RGN/SRN (general nursing qualification).

Of these 16 (18.8%) had other qualifications:

13 (15.3%) were midwives i.e. SCM.

3 (3.6%) had orthopaedic nursing certificates

None of the respondents had a degree, nursing or otherwise.

Variable	Value	Number	Percent
Studying for Further Qual's	Degree in Nursing	1	1.2
	Other	10	11.8
	None	74	87.1
	Total	85	100.0
Primary Type of Patient Cared For	Medical	13	15.3
	Surgical	15	17.6
	Paediatrics	12	12.9
	Elderly	3	3.5
	Neuro	8	9.4
	Trauma	10	11.8
	ICU	6	7.1
	CCU	6	7.1
	Obstetrics	13	15.3
Total	85	100.0	
Have You Ever Grieved?	Yes	70	82.4
	No	15	17.6
	Total	85	100.0
Who Was Your Loss?	None	17	20.0
	Spouse or Parent	22	25.9
	Close rel\family	38	44.7
	Friend	6	7.1
	Other	2	2.4
	Total	85	100.0

Biographical data and previous experience of bereavement - summary and discussion of results.

1. **Age.** The results show that the sample had a spread of ages, with a predominant age of 21-25 years. This would seem to reflect the fact that many nurses leave the profession after a few years 'practice', for a variety of reasons,

hence the relative youth of the sample. They also highlight the relative inexperience of the nursing population studied. The fact is however, that at the time of data collection the nursing workforce turnover in England, was such that the nursing profession had to re-generate itself every three years. That is, an annual 'turn-over' rate of 33%. Thus, it would appear that the sample was representative of the wider population of nurses with regards to age.

2. Sex. This result reflects the female domination of nursing. The ratio seen, mirrors the wider population, hence the sample was representative for 'sex'.

3. Rank and grade. These results perhaps reflect those of item 1, in that D and E grades are 'junior' grades and hence are typically occupied by younger, more recently qualified people (the majority of nurses qualifying are still those who entered training from school). The majority of respondents therefore (over 75%) were RGN's in relatively 'junior' positions. These grades in turn make up the majority of the nursing and midwifery workforce, and this was the target group identified to sample. There were no ward sisters, nurses managers, or teachers as all of these were grade G or above at the time.

4. Length of time in present position. This item was interesting as it showed a fair spread throughout the age groups, and therefore enhanced the validity of the sample in terms of 'representativeness' and life experience. The relatively high numbers who had occupied their present position for less than six months (29:34.1%) may reflect the age and relative inexperience of the nurses surveyed. It may also reflect a practice common in nursing particularly - moving nursing staff on a regular basis, either by choice or decree. This is of pertinence to this study, as several of the interviewees mentioned that any social support they did perceive to have at work, was available from colleagues whom they had worked with for some time. This is obviously affected by such practices. Melia (1987) suggests that this leads nurses to be particularly prone to feeling it imperative to "fit in", while Coxon (1990) sees it is a method which nurse managers utilise to ensure feelings of uncertainty amongst staff, so as

to render them more 'manageable'.

5. *Length of time in nursing.* This item could be seen to reinforce the points made above, as over 60% (52) of respondents had been in nursing for over two years (35:41.2% >4 years), yet only 28 respondents (32.9%) had been in their present position for over two years. The possibility that this may affect the availability of peer support, which often builds over time (according to data from this study and that of Smith 1992) is again an issue to be noted.

6. *Professional qualifications.* This item showed all respondents to be SRN/RGN, therefore the target group was accessed. Of these, 13 (15.5%) were qualified midwives, all incidentally working as midwives (unexpected as a number of nurses qualify as midwives and return quickly to 'general' nursing). Another 3 had orthopaedic nursing certificates, this was to be expected as one of the hospitals ran such a course. The presence of a number of midwives was useful, so as to allow a comparison of answers from nurses and midwives (discussed later in this section). No-one in the sample was a graduate.

7. *Studying for further qualifications?* The results for this item show that only one of the sample was studying for a degree at the time of the study. Anecdotally, this can be seen to be reflective of the attitudes of the nursing hierarchies involved (at the time) towards supporting nursing staff regarding higher study. The ten respondents who were studying at the time, were all involved in hospital based, clinically orientated programmes (orthopaedics and neurology). The majority (over 87%) were not studying formally at the time of the study.

8. *Primary type of patient worked with?* The results of this item show that the respondents came from a variety of clinical areas, and hence represent a spectrum of views as well as being representative of the 'wider' nursing population. It was to be expected that general medicine and surgery would yield the greatest number of responses as these constitute the greater

proportion of clinical areas. Numbers received represented the profile of the clinical areas of the hospitals examined.

Cross-tabulations of all biographical data with findings from other sections of the study (such as coping styles, professional orientation etc) were carried out. Of particular interest was whether nurses and midwives would be shown to differ on any of the traits and behaviours studied, and if there was any major differences in the culture of the two 'professions'. In actuality, no such differences were identified. Perhaps this is not surprising, as at the time of the study 'direct entry' to midwifery was not available, and so all midwives would have undergone socialisation into nursing culture, having trained as nurses before going into midwifery. The culture of midwifery may therefore differ from that of nursing, but this was not apparent from this study, suggesting that many aspects of it are shared with nursing.

9. *Have you ever grieved?* This item showed that the vast majority of respondents - over 82%, believed that they had grieved.

10. *Who was your loss?* Of those who identified their loss, over 25% had lost a spouse or parent - losses seen as being particularly 'grievous' losses (Doyle 1983), while almost 45% had grieved for a close relative - typically grandparents. It could be therefore be expected that the majority of respondents would answer other parts of the questionnaire, based on personal experience.

The intentions of the questions were therefore fulfilled. Responses allowed cross-tabulation of this data with those from other sections of the questionnaire - though no meaningful relationships were found. There was also a fair degree of confirmation that this sample of nurses and midwives reflected wider biographical trends in the parent nursing and midwifery populations.

Chapter 5.

Treatment of Data and Results.

Section B:

Role models in Nursing

It was intended that this section would provide data about the views of respondents' key attributes of the 'ideal' nurse or midwife. It was considered important to elicit this information using an open-ended tool, rather than to ask respondents to choose from a list provided by the researcher. Data is tabulated in table B1:-

Table B1.

Variable	Value	Number	Percent
Personal Primary Role Model	Staff nurse	24	8.2
	Ward sister	44	51.8
	Nurse manager	4	4.7
	Nurse tutor	3	3.5
	C.N.S.	4	4.7
	Other	4	4.7
	No response	2	2.4
	Total	85	100.0
Who <u>Should</u> Act As Primary Role Model For Student Nurses?	Staff nurse	40	47.1
	Ward sister	25	29.4
	Nurse tutor	7	8.2
	C.N.S.	9	10.6
	Other	2	2.4
	No reply	2	2.4
Total	85	100.0	
Most <u>Important</u> Trait For A Role Model In Nursing?	Standards/ experience	40	47.1
	Capable/ organised	4	4.7
	Approachable	18	21
	Humanistic values	9	10.6
	Other	1	1.2
	No reply	13	15
	Total	85	100.0

Summary and discussion of results.

Personal Primary Role Model and Ideal Role Model.

The results of these two items were straightforward and provided the sort of

information envisaged. They were also interesting in that they seemed to suggest two things:- that nursing role models were typically seen to be in the next echelon of the hierarchy (student-RGN-ward sister etc.; and, that role-models in nursing were, and should be, clinically based. This result reflected the findings of Green (1988) on whose work this aspect of questionnaire 1 was based, in that 80% of her respondents chose clinically orientated/based role-models.

Another finding of note was that no-one identified nurse managers as ideal role models for students, though four respondents identified that their own role model was from this grade. When one examines the range of data regarding views on nurse managers throughout the study, it is perhaps not surprising that this group of nurses and midwives at least, did not see such people as providing an ideal role model for others to follow.

Most important attribute for a role model in nursing.

Considering that respondents could choose any attribute, the replies to this item were (perhaps) surprisingly similar, and therefore relatively easy to post-code. Furthermore, they were remarkably similar to those selected by respondents in Smith's study (1992) into the emotional labour of nursing, which was undertaken around the same time as data collection for this study.

Being experienced and knowledgeable rated highest (40:47%), followed by being approachable (18:21%). Displaying humanistic traits such as caring and empathy was chosen by 10% (9), with being capable and organised drawing 4.7% (4) respondents. Thirteen respondents did not answer this item. This means that the percentages are even higher when one calculates them as proportions of actual responses (72) rather than respondents (85):-
Experience/knowledge 55.5%; Being approachable 25%; Being caring/empathic 10%; Being capable/organised 5.5%

Overall therefore, the majority of respondents felt that the most important

attribute nursing role-models' should possess was experience, and the knowledge that this is perceived to engender. The responses for the seemingly related behaviours of being capable and organised therefore took this type of 'practical' or perhaps even pragmatic attribute (akin to Corwin's 'bureaucratic orientation' *ibid*), to over 60% of responses. This was while around 35% referred to more patient/client and caring centred behaviours. Green's (1988) study meanwhile, found this figure to be around 80% of nurses with a bureaucratic orientation. The fact that her sample constituted mainly of newly qualified graduates perhaps eager to please and to fit-in, may have affected this, along with the potential cultural differences in the ethos of nursing between the UK and the USA. That is, perhaps British nurses may tend to be more 'care' orientated than their American counterparts.

The findings of high levels of bureaucratic orientations amongst respondents also raises the possibility that should responses to other items on the questionnaires purport a patient-centred orientation, then this may be as a result of social desirability or cognitive awareness/behavioural denial, on the part of respondents.

Chapter 5.
Treatment of Data and Results.

Section C:

**Preferred Coping Strategies
Questionnaire.**

Essentially, the intention of this part of the study was to examine the pattern of expressed preference of nurses, with regards to their strategies for dealing with difficulties and stress.

The various coping mechanism question groups were as follows:-

Problem solving -- Questions 1, 9, 15 and 20.

Gaining perspective -- Questions 2, 10, 16 and 21.

Expressing ones feelings -- Questions 3, 11, 17 and 22.

Internalising ones feelings -- Questions 4, 12, 18, and 24.

Accepting the situation -- Questions 5, 7, 13 and 23.

Passive mechanisms -- Questions 6, 8, 14 and 19.

The items were rated 5 = very true [of me], 1 = not at all true [of me].

Assessment of how positive or negative respondents' were, was examined in 2 ways, these being based upon the % of 4 + 5 answers (i.e. positive) and the mean scores of the various items. In actuality these two calculations produced virtually the same data in terms of ranking of coping strategies. The ranking referred to throughout the section were derived from % 4 + 5 score calculations (i.e. +ve), while comparisons between groups of items utilised t-tests. This was considered acceptable, given the discussion of the treatment of ordinal data as interval data, and the use of t-tests on non-parametric data, provided within the methodology chapter.

1) Problem solving behaviours.

Figure C 1 A shows that almost 70% (79) perceived that they used this coping strategy. 2.4% (2) felt that it was not a very true description. No-one said that it was not at all true for them.

This item ranked 5 overall (out of the 24 items).

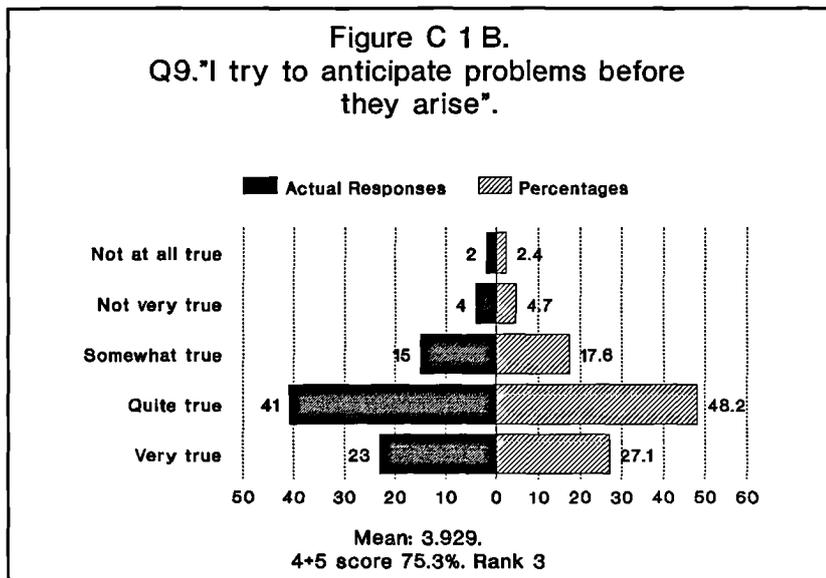
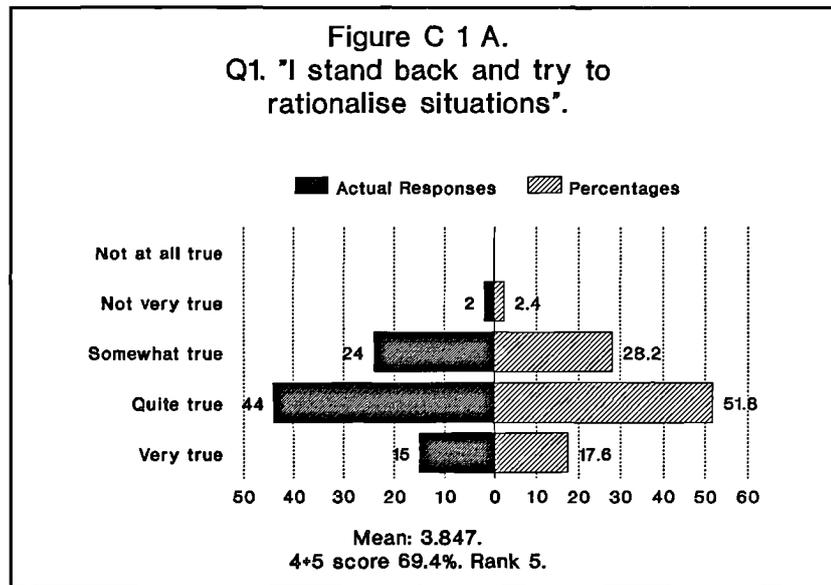


Figure C 1 B shows that over 75% (64) of respondents believed that they exhibited this behaviour.

7.1% (6) rated it 'negatively'.

This item ranked 3 overall.

Figure C 1 C shows that almost 65% (55) of respondents rated this behaviour 'positively', while 5.9% (5) rated it 'negatively'.

This item was ranked 6 overall.

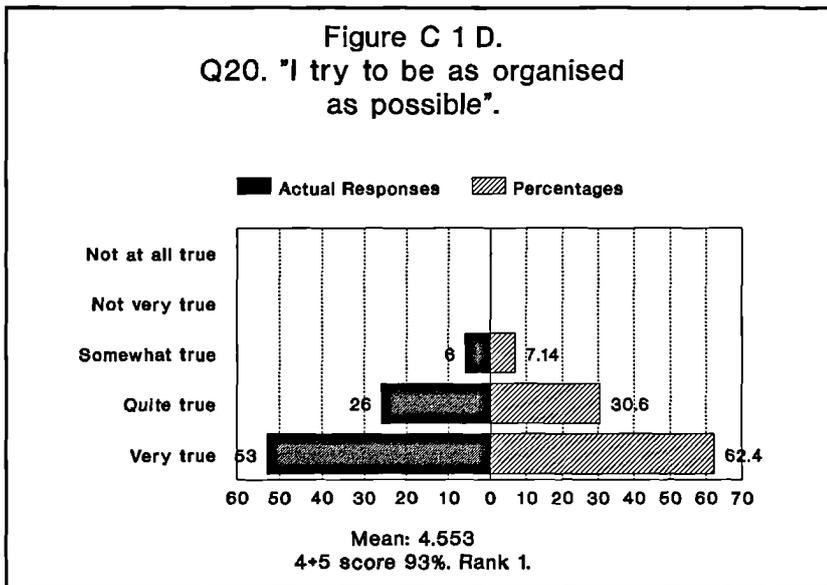
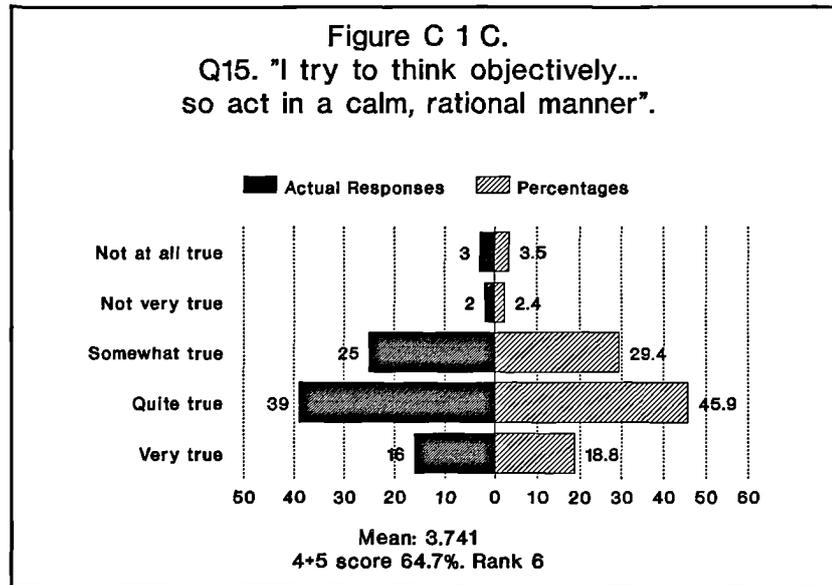


Figure C 1 D shows that 93% of respondents valued/displayed this behaviour, with over 62% (53) rating it at '5' (very true).

This item was rated 1 overall.

Mean % 4 + 5 Score = 75.5%.

Cronbach's alpha for this scale = 0.6209 *

Overall ranking of the items was 1, 3, 5 and 6.

Summary of problem solving behaviours sub-scale.

It is noteworthy that in this sub-scale, out of a possible 340 responses ($n = 85 \times 4 \text{ items} = 340$) there were only five responses of '1' (not at all true), and only eight responses of '2' (not very true). There were seventy (70) responses of '3' (somewhat true), therefore out of the 340 responses in this section, 257 asserted that it was true that they utilised such behaviour, 107 'strongly' so. Only 83 scored 3 (somewhat true) or less, and there were only 13 'low' responses for the problem solving scale overall.

Item 4 ("I try to be as organised as possible") was the highest scoring item through all the scales, with a mean score of 4.55 and a % 4 + 5 score of 93%. Over 60% of respondents rated this as 'very true' of their behaviour, and 7% 'somewhat true' (3), thus no respondent gave a score of less than three (3) for this item. Similar patterns were found in the other 3 items, i.e. over 60% perceiving the items as truly describing their behaviour. However, there was less polarity of the spread with approximately 5% claiming that the items were not truly descriptive of their behaviour.

There was little variability of answers in this sub-scale, as reflected by similar % 4 + 5 scores, and problem solving items occupied 4 out of the top six positions in the overall scale. The mean % 4 + 5 for this group of items (i.e. $69 + 75 + 65 + 93$ divided by 16) was 75.5%, making this the highest ranking sub-scale in terms of both % 4 + 5 and mean scores. The significant level of internal consistency (0.6209) shows that the items in this sub-scale tended to be answered in the same way by individual respondents, i.e. internal consistency was displayed. Therefore, the fact that the mean % 4 + 5 score was markedly > 50% combines with the above to suggest that these behaviours were seen as being highly desirable and/or commonly used by the majority of these nurses and midwives. That is, they do attempt to deal with life pressures by being as calm, rational and organised as possible, as well as acting as 'troubleshooters' attempting to anticipate problems before they arise.

B) Gaining perspective behaviours.

Figure C 1 E shows that almost 45% (38) of respondents valued/displayed this behaviour.

27% (23) scored it negatively.

The item ranked 7 overall.

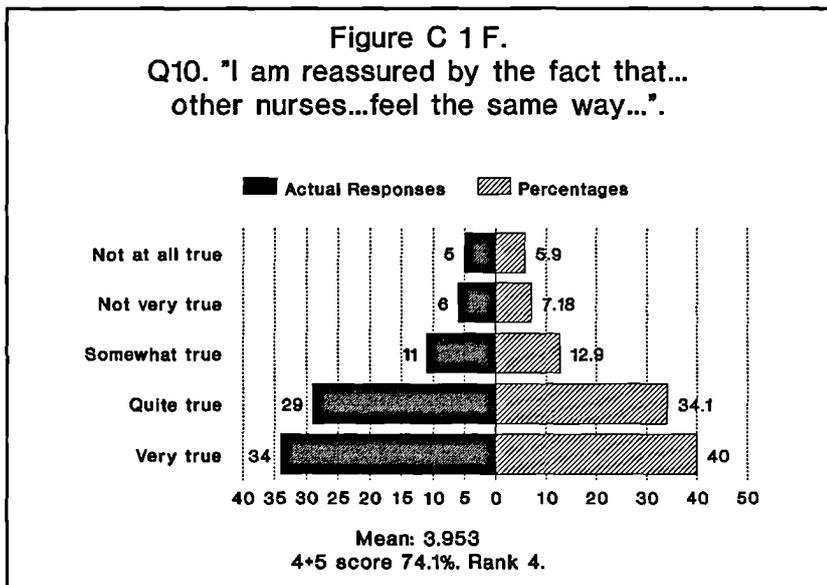
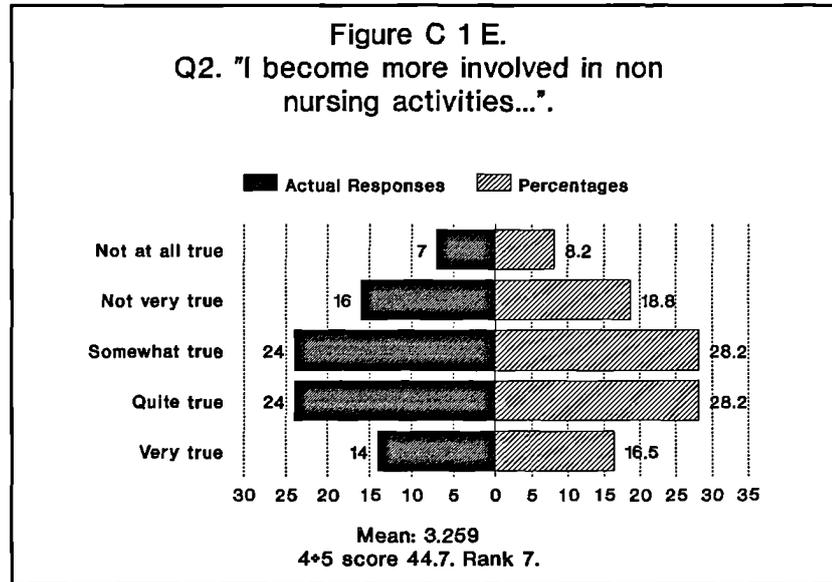


Figure C 1 F shows that almost 75% (63) of respondents scored this item positively, with 40% (34) scoring it a '5' (very true).

13% viewed it negatively.

The item was ranked 4 overall.

Figure C 1 G shows that over 90% (77) were negative about this item, and that almost 75% (63) were very negative (s = 1, not at all true).

3.5% (3) viewed it positively, though no-one gave a score of 5.

The item ranked 24 overall - the lowest possible position on the scale.

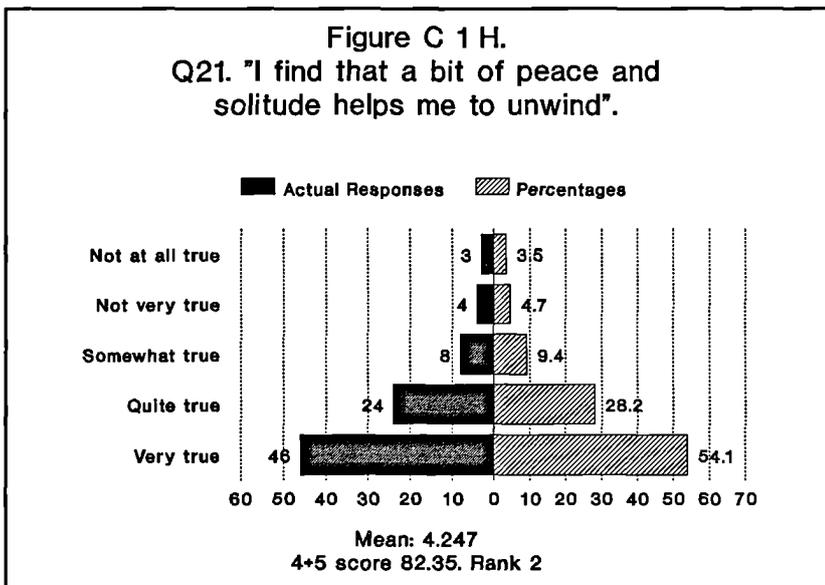
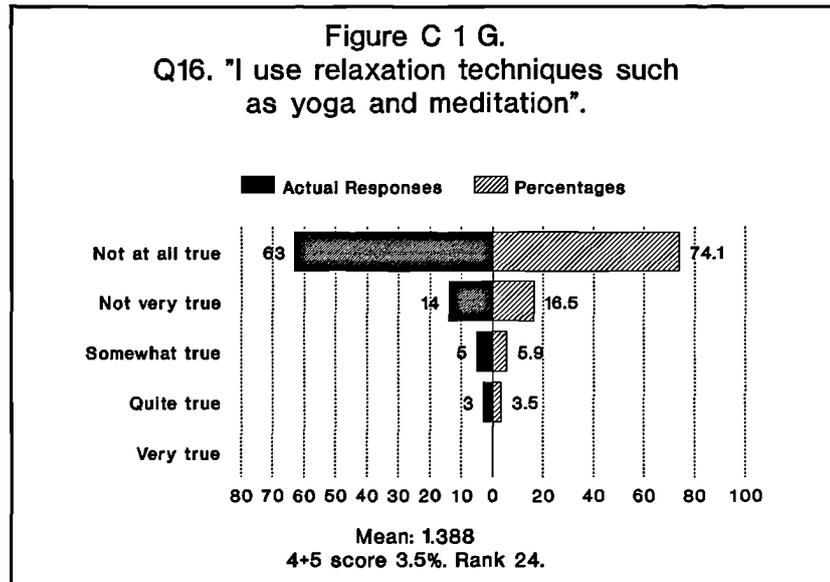


Figure C 1 H shows that over 80% (70) of the respondents valued/utilised this behaviour.

8.2% (7) rated the item negatively.

It was ranked 2 overall.

Mean % 4 + 5 score = 51%

Cronbach's alpha for this scale = 0.3104

Overall ranking of these items was 2, 4, 7 and 24.

Summary of gaining perspective behaviours sub-scale.

This group of items was interesting, in that it contained two out of the top three responses overall, namely 'peace and quiet helps me to unwind' (2), and 'feeling reassured that other nurses feel the same way'(4). However, the sub-scale also contained the lowest scoring item overall (24), i.e. 'using relaxation techniques such as yoga and meditation'. The other item was tenth overall, and pertained to hobbies and other non-nursing related leisure activities. The difference between the yoga and meditation item and the others, is underlined by the fact that while all the items received scores of '1' (not at all true) items 1,2 and 4 had 15 such scores in total, whereas item 3 had 63 such scores, and no '5's' (very true).

The mean % 4 + 5 score for this group of items was 51%, ranking it second overall. This, plus the mean scores, t-tests and the Cronbach's Alpha results for the sub-scale were all obviously affected by the results of item 3.

The results of this sub-scale make it notable therefore for the fact that three of the items rated highly (2 out of the top 3), yet the fourth item rated the lowest overall.

The fact that the mean % 4 + 5 score was > 50% would seem to suggest that such strategies were also valued/utilised by the respondents. That the 'rogue' item referred to the use of relaxation techniques such as yoga and meditation, is interesting and is re-visited in the discussion section.

Seen overall therefore 'gaining perspective' - by following hobbies, seeking peace and quiet, or feeling reassured that other nurses feel the same way, would appear to be coping strategies valued and/or utilised by this sample of nurses. Utilising relaxation techniques such as yoga and meditation most certainly were not.

C) Internalisation of feelings items.

Figure C 1 I shows that over 42% (36) respondents felt that they did this. 22.3% (19) perceived that they did not.

The modal score was '3' (somewhat true) with 35.3% (30) of the respondents.

The overall ranking of this item was 9.5.

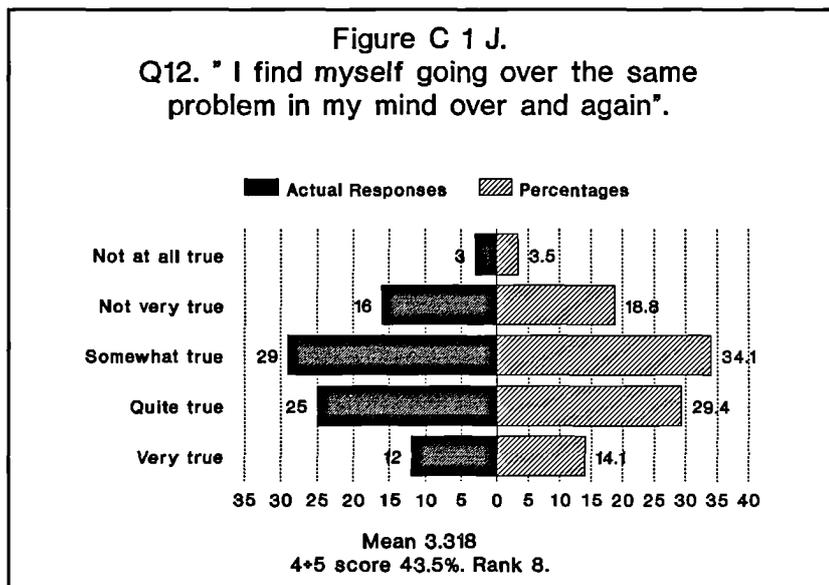
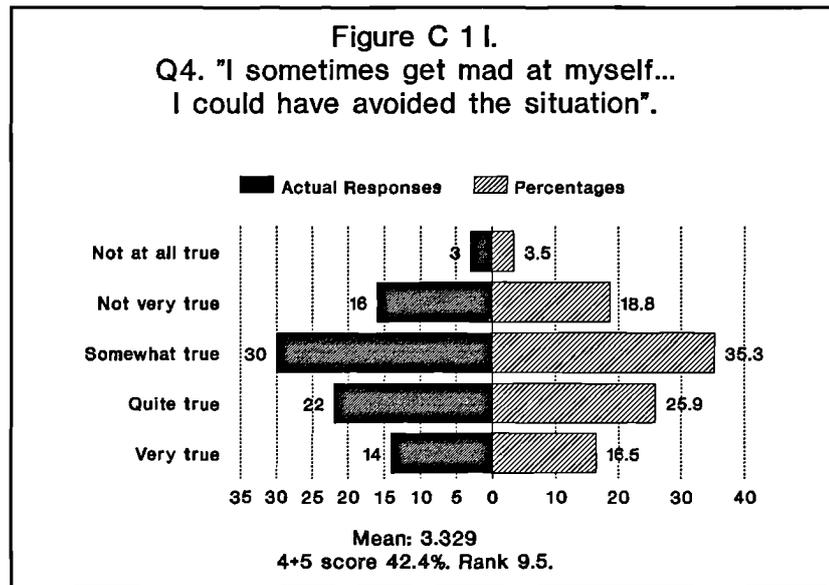


Figure C 1 J shows that over 43% (37) of the respondents viewed this item positively, and just over 22% (19) negatively.

Again the most frequent response was 3 (34.1%:29).

This item ranked 8 overall.

Figure C 1 k shows that just over 30% (27) of respondents believed they did this, while just over 20% (18) believed they did not. The modal score was again '3' (somewhat true) with 47.1% (40).

The overall rank for this item was 13.5.

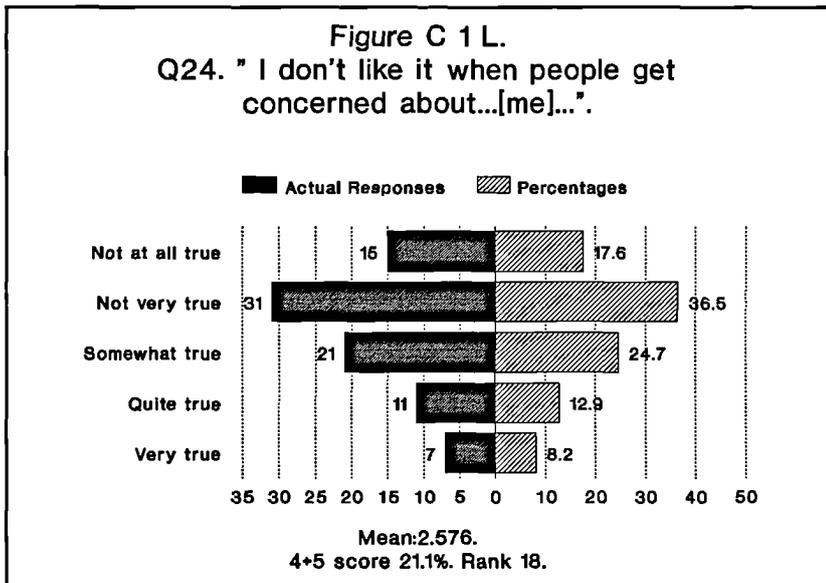
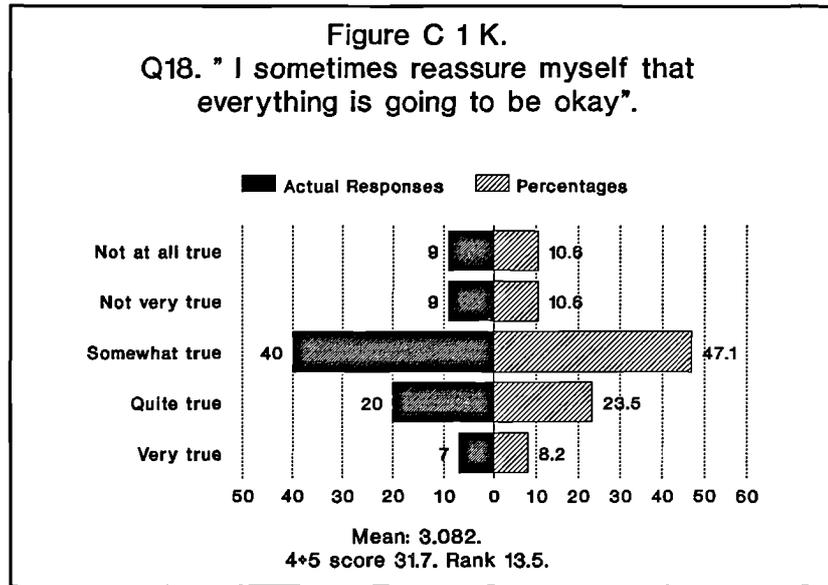


Figure C 1 L shows that almost 55% answered '1' or '2', and therefore viewed this to be untrue for them.

However, over 21% (18) said that they didn't like others to be concerned about them.

This item ranked 18 overall.

Mean % 4 + 5 score = 35%

Cronbach's alpha = 0.3655

Overall ranking of these items was 8, 9.5, 13.5 and 18.

Summary of results for internalisation of feelings sub-scale.

The pattern of responses was interesting in this sub-scale, in that three of the items (Q's 4, 12 and 18) displayed similar results - regarding spread of responses, mean, % 4+5 and modal scores and overall rank. The fourth item however (Q24 "I don't like it when people get concerned about the pressures I am under") did not match the others, it ranked lower overall and had a slightly different spread of response in that the grouped items had modal scores of 3, whereas Q24 had a score of 2 as its mode. 54.1% (45) of respondents rated it negatively (not at all/not very true), however, 21.1% (18) of respondents said that they **did not** like it when people get concerned for them.

Also noteworthy is the fact that on the continuum of 'most valued to least valued' modes of coping, the predominant score for 'internalising' was 3. Therefore it could be considered that such behaviours were at best 'neutrally' valued, by these nurses and midwives. The fact that the mean % 4+5 score was only 35% reinforces this view.

It would seem fair to say therefore, that 'internalising feelings' strategies (such as 'getting mad at oneself' and 'going over problems over and over again mentally') are seen as less attractive and/or perhaps less effective behaviours by the nurses, than those discussed already, and are therefore not reported as being used regularly.

D) 'Accepting behaviours' items.

Figure C 1 M shows that just under 26% (22) of respondents said that they forget work at the end of the day. 41.2% (35) said this was essentially untrue.

However, a score of '3' predominated (32.9%: 28)

Overall ranking was 15.

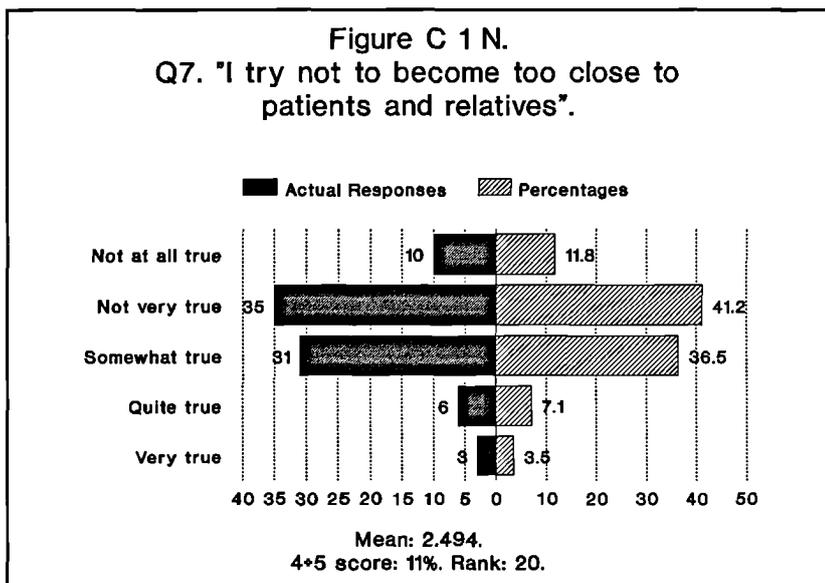
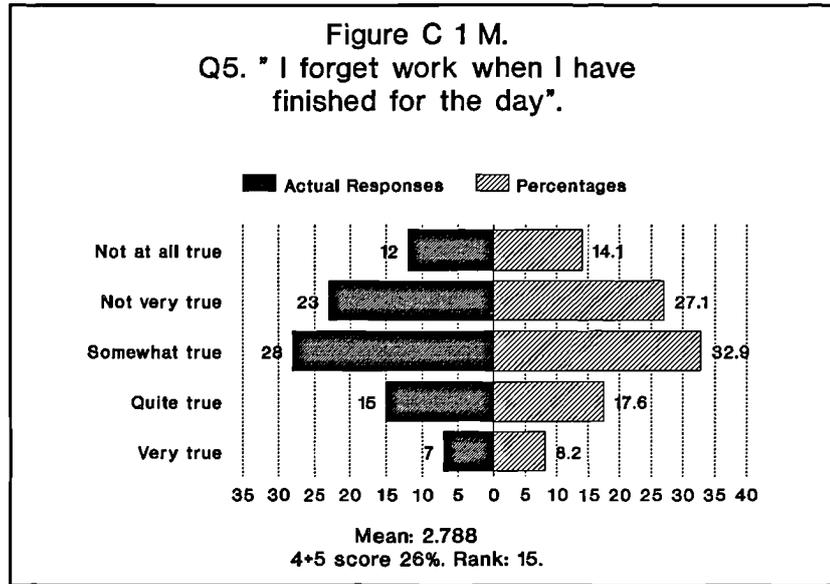


Table C 1 N shows that approximately 10% (9) of respondents said that they tried not to become 'too close' to patients and relatives.

The majority (53%:45) asserted this to be untrue of them.

Overall ranking 20

Figure C 1 O shows that just under 35% (29) of respondents claimed to 'just got on with the job'.

Over 45% (35) perceived this to be untrue for them.

The item ranked 11.5 overall.

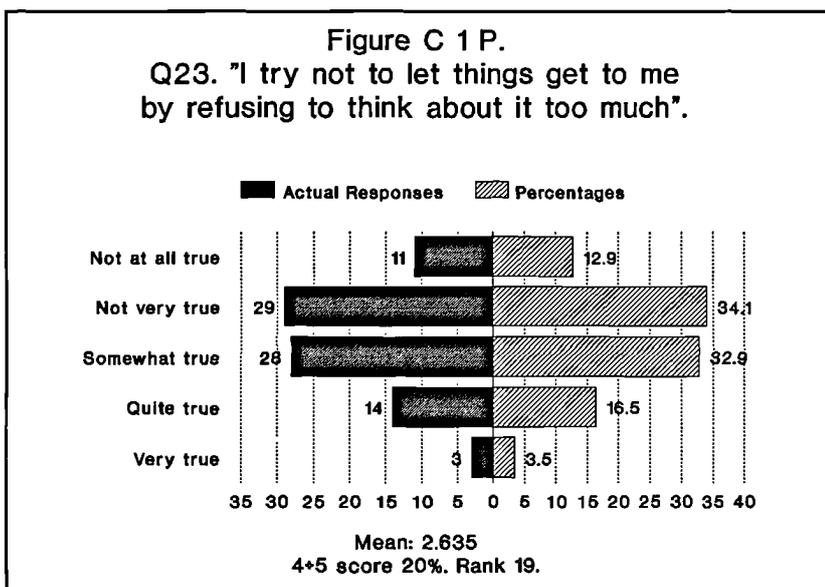
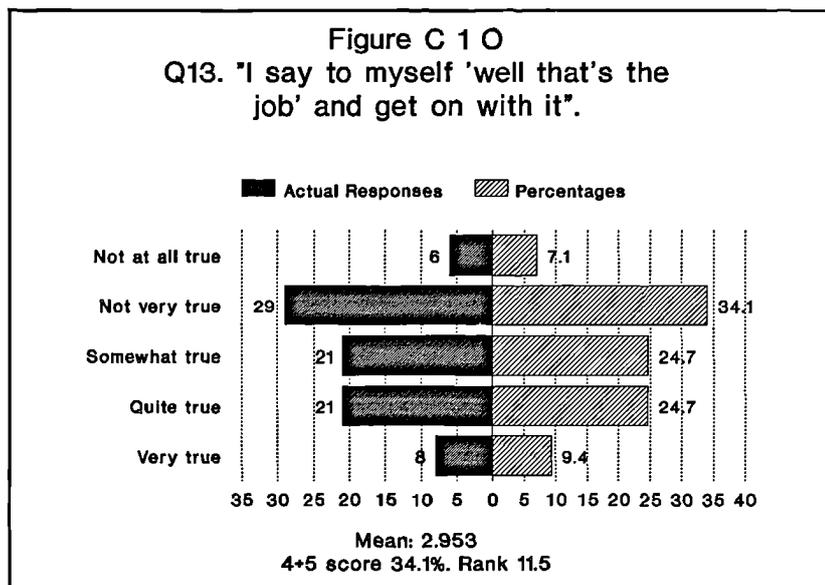


Figure C 1 P shows that 20% (17) of respondents claimed to do this.

However, 47% said that it was essentially untrue for them.

The item ranked 19 overall.

Mean % 4 + 5 score = 23%

Cronbach's alpha = 0.1961

Overall ranking of these items was 11.5, 15, 19 and 20.

Summary of results of accepting behaviours sub-scale.

These items were quite closely grouped in terms of overall ranking - despite a non-significant cronbach's alpha result.

The response to Q7 "I try not to become too close to patients and relatives" was of great interest within the remit of this study, with 53% of respondents denying that they do this. In fact only 10.6% (9) asserted it to be true of them. The majority of the nurses therefore denied 'distancing' themselves from patients and relatives, as a means of stress/anxiety reduction or avoidance.

Also noteworthy was the fact that Q5 varied from the others, in that the level of 'untrue' (1 + 2) responses was significantly lower for this item i.e. 14% as compared to an average of almost 47% for the other three. In itself this would seem to suggest that many of the respondents had 'difficulty in switching off at the end of the working day'.

The results also show that in the 'continuum' of sub-scales, this is where a modal score of '2-3' began to predominate. This, along with the mean % 4 + 5 score being markedly under 50% (i.e. 23%), and the 'negative' (1 + 2) response rate of almost 47% for three of the items, would seem to suggest that 'accepting' behaviours (at least those described in the sub-scale) would seem to be viewed as relatively unattractive, and not valued or commonly utilised by respondents.

E) Expressing feelings items.

Table C 1 Q shows that just over 30% (27) believed this to be true of their behaviour.

Over 40% however, believed it to untrue for them.

This item ranked 13.5 overall.

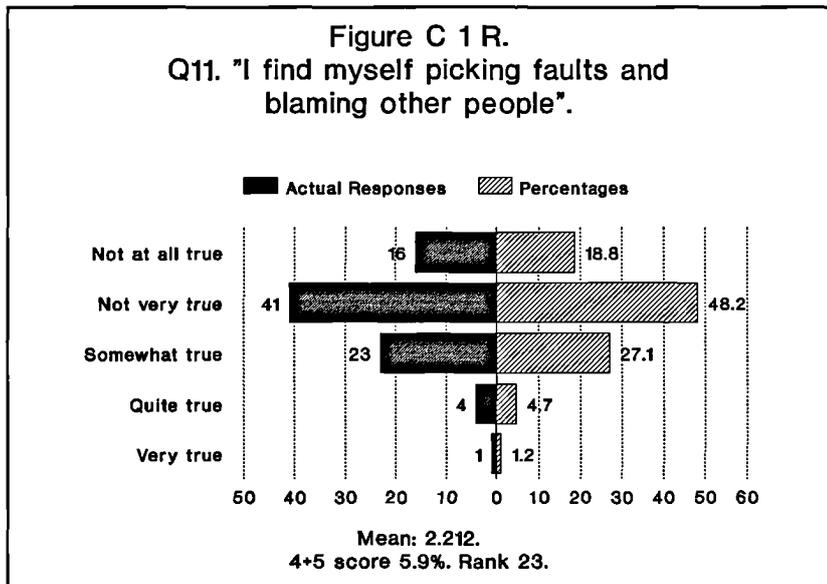
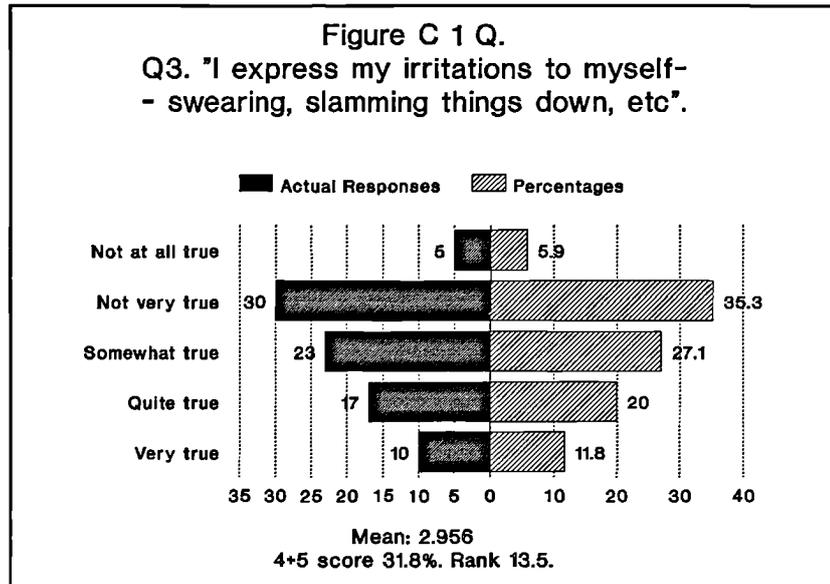


Table C 1 R shows that under 6% (5) respondents admitted to this behaviour. While 67% (57) said that it was untrue for them.

The item ranked 23 overall.

Figure C 1 S shows that just over 15% (13) of the respondents admitted to snapping at colleagues when under pressure.

Over 60% (58) said that this was untrue of them - almost 30% (25) saying that it was not at all true of them.

This item ranked 17 overall.

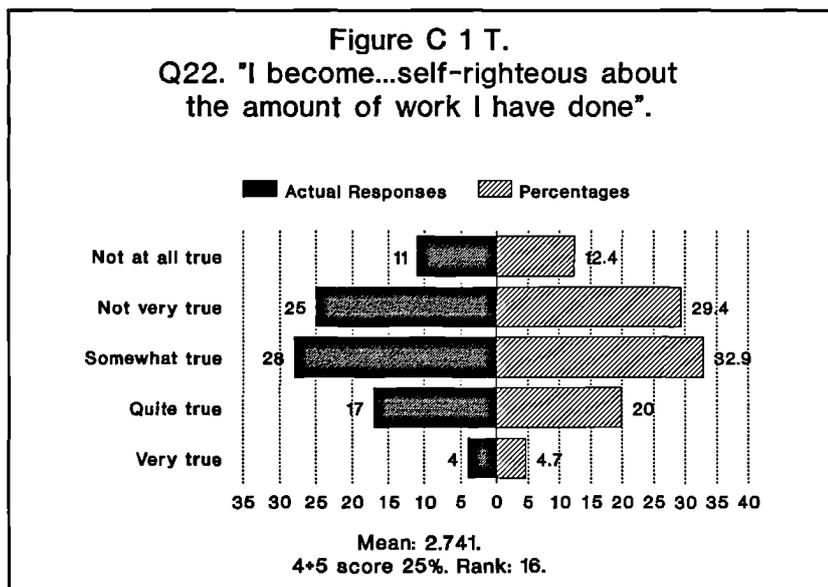
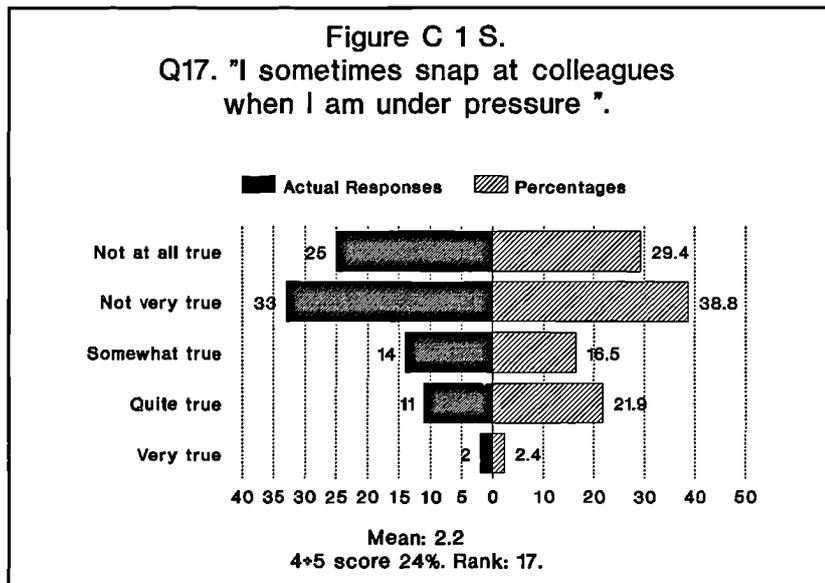


Figure C 1 T shows that almost 25% (21) of respondents viewed that this was descriptive of them.

Just over 42% (36) however, said that it was untrue of them.

Overall ranking for this item was 16.

Mean % 4 + 5 score = 21.75%

Cronbach's alpha score = 0.506 *

Overall ranking of these items was 13.5, 16, 17 and 23.

Summary of results for expressing feelings sub-scale.

The modal score for this sub-scale was 2, suggesting that these were also coping strategies viewed relatively negatively and hence ignored or minimally used by the majority of the nurses and midwives. This view is reinforced when one considers that the mean % 4 + 5 score for this scale was 21.75%, making it the lowest ranking sub-scale overall in terms of % 4 + 5 score, and 5th in terms of mean score.

The cronbach's alpha result (0.506) shows a high significant level of internal consistency within this sub-scale.

The lowest ranking item was question 11, which referred to picking faults and blaming co-workers. The issue of social desirability both in terms of everyday life and in nursing 'culture', is perhaps pertinent here, and will be expanded upon in the discussion section.

F) Passive mechanisms items.

Figure C 1 U shows that approximately 10% (9) of respondents agreed that they smoked more when they were under stress. However, over 82% (70) refuted the statement with 81.2% (69) saying it was not at all true.

This item ranked 21.5 overall.

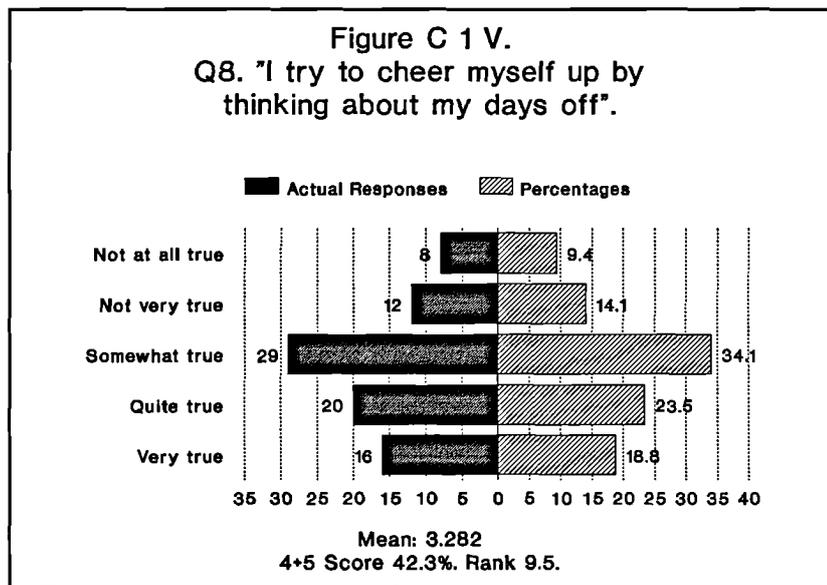
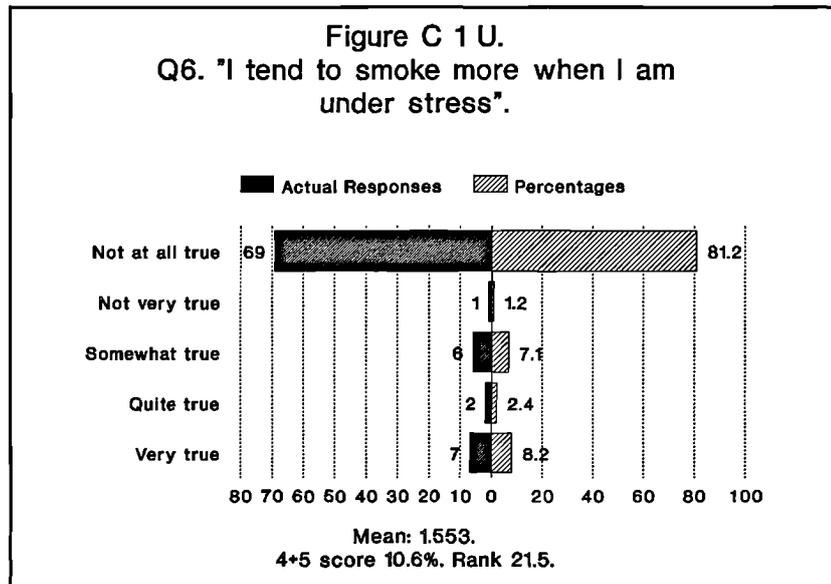


Figure C 1 V shows that over 42% (36) of respondents claimed to think about their days off in attempt to cheer themselves up.

23.5% (20) said that this was untrue for them.

The item ranked 9.5 overall.

Figure C 1 W shows that 35.3% (30) of respondents said that they did occasionally have a few drinks to help them unwind. 43.5% (37) said that this was untrue for them, 24.7% (21) saying that it was not at all true (s = 1).

This item ranked 11.5 overall.

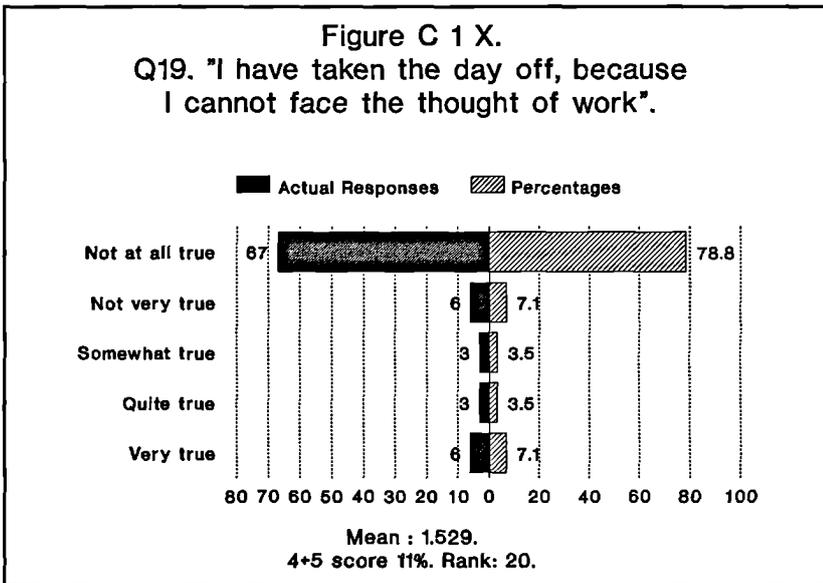
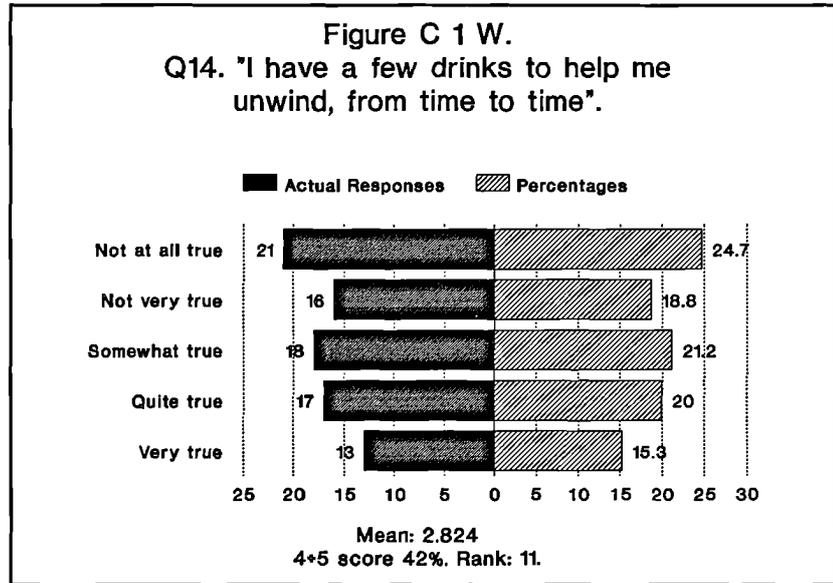


Table C 1 X shows that almost 86% (73) of respondents denied having taken the day off, because they could not face the thought of work. 78.8% (67) said it was 'not at all true'.

Less than 11% rated the item positively at all.

The item was ranked 20 overall.

Mean % 4 + 5 score = 24.75%

Cronbach's alpha score = 0.5881 *

Overall ranking for these items was 9.5, 11.5, 21.5 and 20.

Summary of results for passive mechanisms sub-scale.

This sub-scale also produced two groups of items in terms of pattern of response, mean and % 4 + 5 scores, and hence overall rank.

Items 8 and 14 (ranked 9.5 and 11.5 respectively) showed a fairly even spread of responses, though 14 ("I have a few drinks to help me unwind from time to time") was seemingly viewed more negatively than cheering oneself up by "thinking about..days off" (item 8) (% 4 + 5 = 42% and 35% respectively).

Items 6 and 19, were seemingly viewed extremely negatively, being ranked joint 21.5 overall. Both had '1' (not at all true) scores of over 75%, and '5' scores of approximately 7.5%. It is thus apparent that smoking more when under stress, and taking the day off work, were viewed extremely negatively by these nurses.

In summary then the main points to be discussed later regarding this sub-scale would seem to be:-

that 'thinking about one's day off' ranked fairly highly (9.5) but on the whole, passive mechanisms were not valued/utilised by these nurses and midwives; that 'smoking more when under stress' rated poorly, perhaps reflecting a health conscious population; and, that 'taking the day off' as a coping mechanism was viewed extremely negatively by these nurses and midwives.

FURTHER INTRA-SCALE ANALYSIS.

Table C 2 (i), shows median ranges, highest and lowest scores mean scores and the mean % 4 + 5 scores, for the six 'styles' of coping, ranked in order of mean for this sample.

STYLE	HIGH SCORE	LOW SCORE	MED.RANGE	MEAN % 4 + 5	MEAN
PROBSOL.	20	11	16-18	75.5%	16.07
PERSP.	19	5	11-14	51%	12.85
INTERN.	20	4	10-14	35%	12.31
ACCEPT.	16	6	9-12	23%	10.87
EXPRESS.	18	4	8-10	21.75%	10.12
PASSIVE.	20	4	7-9	24.75%	9.12

The histograms for these data all showed bell-shaped curves, but the 'probsol' curve was skewed towards the right, with a median range of 16-18. The others tended to have a balanced spread around a central median score of approximately 12.

The results in table C 2 (i) show that respondents placed problem-solving behaviours at the top of the list for coping behaviours, and that problem-solving and gaining perspective were the only coping behaviours examined which achieved mean % 4 + 5 scores of over 50%.

These patterns and their significance will be examined further in the inter-scale analysis section, and analysed in greater depth in the discussion chapter.

Reliability testing of the six sub-scales.

Cronbach's Alpha was applied to the data to identify the levels of internal consistency within each sub-scale). It is expressed on a scale of 0 - 1.

0 = low internal consistency; 1 = high internal consistency.

A high Cronbach's Alpha indicates that for example, if a respondent scored one of the problem solving items highly, then they would be likely to answer the other three items in the same way. A low Cronbach's Alpha would indicate the reverse, i.e. low internal consistency for that sub-scale.

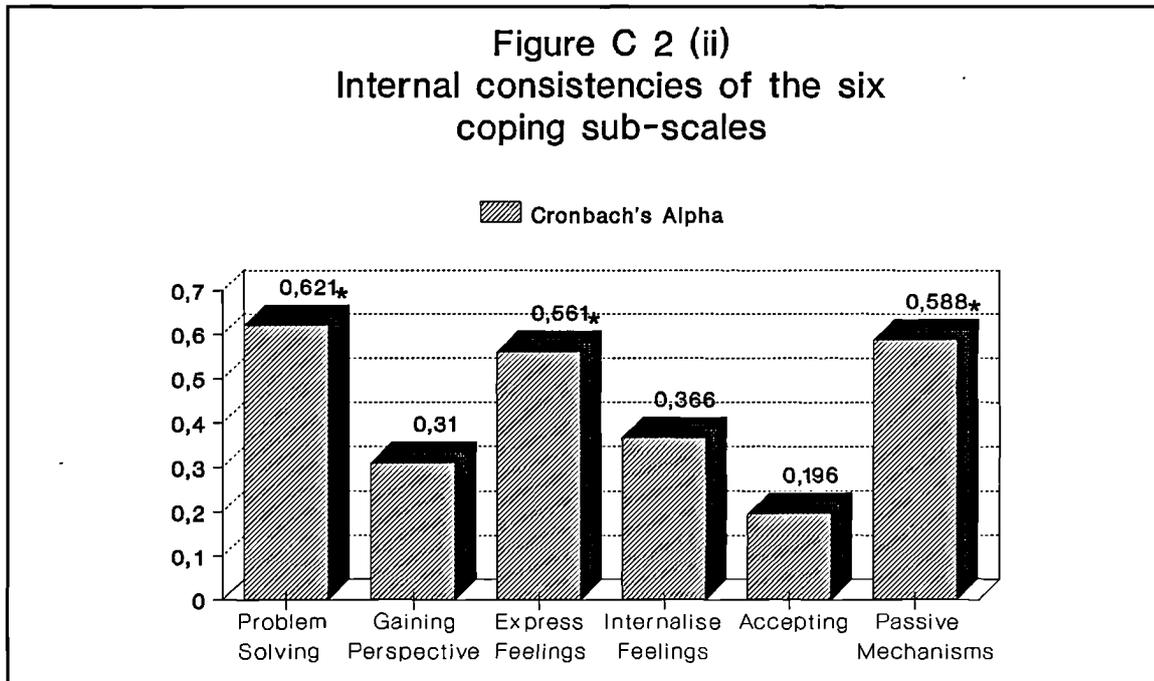


Figure C 2 (ii), shows Cronbach's Alpha values for the six sub-scales of preferred coping strategies for these RGN's and RM's. N.B. (*) = $p < 0.05$. Thus there was a significant level of internal consistency for the problem-solving, expressing feelings and passive behaviours sub-scales. That is, these items tended to be answered in the same way by the same people, and in such a way that suggests that they viewed problem-solving behaviours very highly, and expressing ones emotions, accepting behaviours and passive mechanisms very negatively. The implications and possible explanations for these levels of internal consistency will be put forward later, in the discussion section.

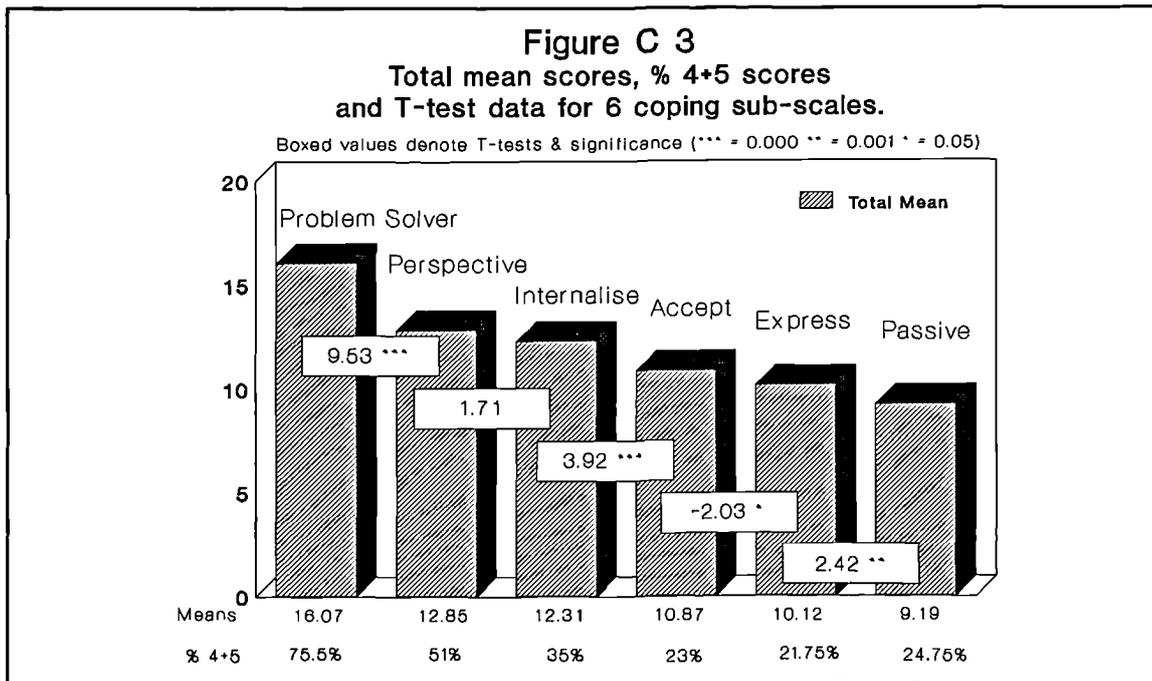
Summary of results for intra-scale analysis.

Further summary seems unnecessary for this section.

INTER-SCALE ANALYSIS.

T-tests were performed, to see if the differences between the six coping strategy sub-scales were significant.

Figure C 3 summarises total mean scores, mean % 4 + 5 scores and t-test data for the six coping sub-scales.



This shows that the differences between the ranked mean scores for the various types of coping strategies identified earlier in the intra-scale analysis were significant, with the exception of the t-test pair 'perspective' and 'internalising'. There was however a significant difference between 'perspective' and 'accepting' (T = 5.82. P = 0.000)

It should be noted that only the 'problem solving' and 'gaining perspective' sub-scales had mean % 4 + 5 scores above 50%, the latter just being so. Hence these were the t-test pairings of greatest interest to the study as a whole. The lowest three sub-scales (accepting, expressing and passive mechanisms) all appeared to be considered very negatively or were rarely used, by respondents.

Overall ranking of items.

The order of popularity (in terms of % 4 + 5 score) is shown by the following table (Table C 4).

ITEM	QUESTION	MEAN	% 4 + 5	Rank
Probsol 4	20	4.553	93%	1
Persp 4	21	4.247	82%	2
Probsol 2	9	3.929	75%	3
Persp 2	9	3.953	74%	4
Probsol 1	1	3.847	69%	5
Probsol 3	15	3.741	65%	6
Persp 1	2	3.259	45%	7
Intern 2	12	3.318	44%	8
Intern 1	4	3.329	44%	9
Passive 2	8	3.282	42%	9
Accept 3	13	2.953	42%	11
Passive 3	14	2.824	42%	11
Intern 3	18	3.082	32%	13
Express 1	3	2.965	32%	13
Accept 1	5	2.788	26%	15
Express 4	22	2.741	25%	16
Express 3	17	2.200	24%	17
Intern 4	24	2.576	21%	18
Accept 4	23	2.635	20%	19
Accept 2	7	2.494	11%	20
Passive 1	6	1.553	11%	20
Passive 4	19	1.529	11%	20
Express 2	11	2.212	6%	23
Persp 3	16	1.388	3%	24

The table reinforces the fact that 'problem solving' and 'gaining perspective' items took up the top six places overall, with all four problem solving items included in the top six.

The highest ranking item overall was "I try to be as organised as possible", both in terms of mean and % 4 + 5 scores. The lowest scoring items were two 'passive' items -- smoking more (m = 1.553. -ve score = 82.4%); and taking the day off (m = 1.529. -ve score = 85.9%); an 'expressing feelings' item "picking faults and blaming others" (m = 2.212, +ve score = 6%: -ve score = 67%); and a 'gaining perspective' item - using relaxation techniques such as yoga and meditation (m = 1.388. -ve score = 90.6%).

It is also interesting to reflect upon the position in the overall scale (1-24) where the scores could be said to evolve from a positive to a negative viewpoint, that is a % 4 + 5 score of < 50%. It could also be suggested that a % 4 + 5 score of between 26% and 49% could be considered 'ambivalent', and 25% or less 'negative'. This produces the following groupings:-

Positive = items ranked 1-6;
Ambivalent = items ranked 7-15;
Negative = items ranked 16-24.

Summary of results for inter-scale analysis.

The data in the first part of this section reinforced observations made earlier in this chapter, regarding the use and/or desirability of the various modes of 'coping' examined. Most notable was the significant level of importance assigned to the more intellectually focussed 'problem-solving' behaviours - a key issue in this study, and one which will be re-visited in detail in the discussions to come. As expected, ego-defensive mechanisms as covered in this tool - such as maintaining a 'distance' between self (nurse or midwife) and patients and relatives, were rated fairly negatively.

The second section also reinforced earlier findings to a degree, namely the

spectrum of modes of coping and their perceived relevance\usefulness to nurses. Possible explanations for why certain coping strategies were viewed more positively\utilised more than others will be put forward in the discussion section.

Factor analysis of responses from coping strategies questionnaire - results and summary.

The results from the 85 respondents for the 24 items in the scale were factor analysed. It was of particular interest to see if the factors identified, corresponded with the six coping sub-scales.

Initially, nine factors were identified. The factors which achieved eigen values of > 1 (4 in total) were then subjected to varimax rotation. These constituted 40.1% of the variance for the sample.

Table C 5 shows the results of the principal components analysis following varimax rotation.

Table C 5.

<u>Item</u>	I	II	III	IV	h2
Q1	-.230	.179	.699	.011	.574
Q2	.194	.094	.007	.559	.359
Q3	.355	.484	.224	.154	.435
Q4	.584	.317	.034	.325	.549
Q5	-.355	.099	.135	.555	.462
Q6	.094	.576	.152	.085	.371
Q7	-.193	.371	.008	-.016	.175
Q8	.262	.249	-.005	.496	.377
Q9	.100	.166	.692	-.271	.576
Q10	.180	-.309	.172	.481	.389
Q11	.624	.223	-.329	-.034	.549
Q12	.573	.070	.115	-.177	.379
Q13	.086	.199	.283	.122	.142
Q14	.119	.589	.109	-.079	.379
Q15	-.096	-.308	.504	.209	.402
Q16	-.150	.175	-.080	.294	.146
Q17	.460	.354	-.161	.020	.363
Q18	.105	-.223	.105	.649	.496
Q19	.169	.724	-.178	.022	.584
Q20	.092	-.017	.748	-.029	.570
Q21	.505	.117	.181	.074	.307
Q22	.601	-.119	-.050	.161	.404
Q23	-.308	.499	.035	.254	.410
Q24	-.041	.044	-.131	.431	.207

% of Variance 13.5% 9.8% 8.8% 8.8% Total = 40.1%

h 2 = communality. Rotated factor loadings which meet the requirements of the Burt-Banks formula are in italicised bold.

N.B. Two items - Q13 and Q16 ("I say to myself that's the job and get on with it" and "I use relaxation techniques such as yoga and meditation") had low loadings on all the factors, and so do not appear in a 'factor group'.

As stated earlier, four factors emerged from the analysis which between them accounted for 40.1% of the variance. After careful inspection of the pattern of the loadings the four factors were interpreted as follows:-

Factor 1 This group was made up of the following items:

'I sometimes get mad at myself...'
'I find myself picking faults and blaming others'
'I find myself going over the same problem in my mind over and again'
'I sometimes snap at colleagues when I am under pressure'
'I find that a bit of peace and solitude helps me to unwind'
'I sometimes become a little self-righteous about the amount of work I have done'.

No obvious thread seemed to run through this grouping. However, when the other factor groupings were analysed the issue of the overt display of emotions became apparent. This led to the view that this group could actually be bi-modal in nature, with three items referring to displaying emotions such as anger, frustration and being self-righteous, and three suggesting more internally orientated mechanisms i.e. getting mad at oneself; going over problems mentally over and again; and seeking peace and solitude to unwind.

Interestingly, this grouping also reflects the relative positions of the items on the overall scale of coping mechanisms, the former set occupying low positions (16,18 and 20), the latter appearing much higher (2,7 and 8).

This factor was labelled 'displays of emotion'

Factor 2 This group was made up of the following factors;

'I express my irritations and frustrations...swearing, slamming things down etc'.
'I tend to smoke more when I am under stress'.
'I try not to become too close to patients and relatives'.

'I say to myself, well that's the job, and get on with it'.
'I have a few drinks to help me to unwind from time to time'.
'I have taken the day off because I cannot face the thought of work'.
'I try not to let things get to me by refusing to think about it too much'.

It was considered that this grouping overall may have come about due to the issue of 'social desirability' of such behaviours for the respondents, i.e. they may not be acceptable within the prevailing culture of hospital nursing. It was presumed that the factor was 'negative' in nature, as it was noted that all of the items were in the lower reaches of the overall scale (12,14,17,19,22 and 23). Therefore it would seem that these items were grouped together as behaviours viewed at best ambivalently, and indeed more likely negatively, by respondents. It is worthy of note that all four 'accepting behaviours' were grouped in this 'factor'. Of all the items, these can be seen to most approximate with ego-defensive mechanisms for preventing overload from stress. This reinforces the point made in the 'methods' chapter regarding self-reporting methodologies, and the issues of social desirability and lack of self-awareness regarding the use of certain coping strategies.

This factor was labelled 'socio-cultural un-desirability'.

Factor 3 This group was made up of the four 'problem solving' behaviours items. This was seen as reinforcing the extremely positive attitude of respondents towards such behaviours, particularly as this group of items occupied four of the top six places in the overall scale.

This factor was labelled 'problem-solving techniques of coping'.

Factor 4 This group was made up of the following items:

'I become more involved in non-nursing activities - hobbies, leisure etc'.
'I forget work when I have finished for the day'.
'I try to cheer myself up by thinking about my days off'
'I am often reassured by the fact that other nurses are feeling the same way as am'.

'I sometimes reassure myself that everything will be okay'.
'I don't like it when other people get concerned about the pressure I am under'.

These items can all be seen to be things an individual may actually 'do' in response to stressors. With the exception of 'disliking others getting concerned...' they could all be considered 'positive responses' to stress. Also worthy of note is the possibility that they share an element of the individual retaining or exercising, some degree of control - of self, if not the situation. These items are spread fairly evenly through the overall scale (3-18) thus there is no evidence to identify anything other than the above relationships.

This factor was labelled 'compensatory techniques' after Hughes (1990)

As stated earlier, the other two items failed to load in to a factor at all. The factor analysis therefore seemed to add weight to the other data from this section, by identifying that controlling displays of emotion, social (un)desirability, problem-solving and compensatory techniques do play a part in the issue of coping strategies utilised and/or valued and aspired to by nurses and midwives, to some degree.

Possible explanations and implications for all these points are put forward in the following discussion.

Discussion - preferred coping strategies questionnaire.

This discussion follows the threads of the results section in that groups of items are examined first, followed by comparisons between sub-scales. Implications for the study are covered last, in an attempt to minimise fragmentation for the reader.

At the outset, it should be acknowledged that as the mode of investigation was one of self-reporting, one can only realistically talk in terms of what the respondents **perceived** to be true of their behaviour, not that they actually did

necessarily behave in the ways they claimed. The fact that they rated items highly or lowly, does however give some insight into what modes of coping they valued and perhaps aspired to, and hence are of great interest to this study. This is because it seeks to identify and quantify aspects of nursing culture that are aspired to - not just aspects of its reality. The difference between the two may have the potential for creating dissonance amongst its members, with people striving for an ideal level of performance that can never be achieved, and perhaps should never be aspired to in the first place.

The issue of valuing and aspiring to particular modes of coping also means that the issue of social desirability in the answering of the items was not really problematic here, as the ideal **aspired to** is of almost as much pertinence to the study as respondents' **actual** coping strategies. The issue of 'social undesirability' within nursing culture, for certain items has already been discussed at some length earlier, as has the fact that ego-defensive mechanisms will be explored more meaningfully, elsewhere in the study.

That said, the intention of this tool - to examine the pattern of expressed preference of nurses and midwives, with regards their strategies for dealing with difficulties and stress, was therefore achieved.

Problem solving sub-scale.

The responses to these items overwhelmingly pointed to this type of 'coping', as being the most popular and/or desirable to the nurses and midwives. That is, they did value/utilise problem-solving behaviours as characterised by the four items in the sub-scale, and they did so apparently to a significantly higher degree than for the other forms of behaviour examined. This can be seen to echo the findings of the studies of relationships between coping strategies of nurses and burnout discussed at length in the literature review (Lewis et al 1990; Robinson et al 1992; Bargagliotti et al 1987; Boyle et al 1991; McCranie et al 1987), they too have invariably identified problem-solving behaviours as being common amongst nurses. As discussed in the literature review, they

have identified positive connotations for such behaviours in terms of avoiding burnout. They have however been considering dealing with work-based stress while the present study is examining a very personal situation - personal bereavement. The fact that nurses do value such behaviours, and are perhaps encouraged to do so by copying the coping strategies of colleagues who are seen to be 'coping' with job stress, would suggest that they will come to be heavily relied upon by them.

As stated at the beginning of this section of the study, such a finding was envisaged because it has been the researcher's experience over many years in nursing, that behaviours such as appearing to be cool, calm and collected at all times, and having the ability to act as a 'troubleshooter' in anticipating 'problems' before they arise, are highly valued within nursing culture, and are aspired to within the profession. This is a view shared by Smith (1992) following her study of the development of 'caring skills' amongst nurses.

Some discussion of other aspects of these results regarding nurses and coping is also pertinent here. In an article on how hospice nurses come to cope with work stress, Fisher identifies that the "need to be strong and in control is emphasised and reinforced professionally" (1988), 'professionally' presumably referring to input from both the official and hidden curricula of professional training, which Maslach (1979) perceives to "reinforce distancing and emotional anxiety amongst nurses".

Such behaviours can also be seen to be desirable by wider western culture (Morris 1988), and thus particularly expected of society's 'professional copers' such as police officers (Skolnick 1975), fire-fighters, doctors (even their wives - Harrari 1981) and of course nurses and midwives. The result being immense socialising pressures being upon such professionals to fulfil such role expectations. According to Rippere et al (1985) this can be to the point that a "covert norm is internalised during health professional socialisation [whereby there is an] expectation of psychiatric invulnerability" inculcated by the "cultural

convention that emphasises the importance of personal strength in such jobs". This is a view shared by Burton (1991) based on her personal experience as a nurse suffering from depression.

Another interesting point raised by these data, is that the behaviours described within the sub-scale are considered to be archetypally male (Muff 1980; Farmer 1993). It would seem paradoxical therefore that the coping strategies seemingly most highly valued and aspired to by a group of nurses and midwives, are typically considered to be 'masculine'. It is not really a surprising result however, when considered in the light of the work of writers such as Owens and Glennerster (1990) who see nursing "moving towards the masculine". Also Roberts (1983) who is of the view that this has occurred because women and nurses can both be considered to be members of "oppressed groups" (nurses who are also female being doubly so), and as a result typically abide by the rules of the stronger more dominating forces in their lives (men and medicine) who keep them oppressed. Furthermore, she and others (Speedy 1987; Farmer 1993) are of the opinion that this leads many to aspire to the 'strengths' of their oppressors, and internalisation of their outlook, perceptions and behaviours, with a corresponding devaluation and rejection of their own. This because they believe that "to be like the oppressor will lead to power and control" (Roberts 1983).

In the case of nursing and medicine this has been said to lead to "a lack of autonomy, accountability and control [by nurses] over the nursing profession" (Freidson 1970); a denial of many of the 'attributes' of women and nurses (warmth, sensitivity, and being nurturing) - hence the difficulty in identifying exactly what nursing is (Roberts 1983); and over-identification with masculine, objective 'attributes' such as being rational and in control (Muff 1980), all to the detriment of 'caring'.

In part this identification of nurses with 'masculine' traits and behaviours, is seen to be due to the oppression of women as healers by the medical and

scientific fraternities over the last two centuries (Ehrenreich and English 1979) so as to allow them (doctors and scientists) to take centre stage in health care. Also because partly, this takeover has been so successful, that the rationale for doing so and the validity of this virtual monopoly continuing, have been internalised to the extent that it is unchallenged and perhaps even unchallengeable - the "medical hegemony" (Richman 1987).

This concept of oppression is re-visited in the social support section of this study, in which the relationship between rank and file nurses and midwives, and a range of possible sources of social support - including that between the said staff and their supervisors/managers are examined. For example, nurse managers are increasingly being viewed as aligning with the 'oppressors' (management - Heenan 1990, or doctors - Grissum and Spengler 1976) and thus becoming "marginalised" (Lewin 1948) in the process. Furthermore because of the rewards they receive such people do not feel animosity towards, nor seek to change a system which in essence mitigates against social support being offered by managers to nurses.

The data also runs parallel with the work of Menzies (1961) in that rating "direct" (Dewe 1987; Hughes 1990) or intellectual coping processes highly, and other more "compensatory, palliative or passive" (Hughes *ibid*) processes lower, suggests that many respondents used (or at least aspired to use) such mechanisms. Hence they would presumably attempt to cope with stressors by, for example: concentrating on the 'facts' of the situation, or "retreating into the details of test results and figures, rather than face patients - who often have unrealistic expectations of them" (Blacker 1987); by being 'objective' and rational; and perhaps by a tendency towards emotional distancing - suggested by Menzies (1961) to be a defence against anxiety. It should be acknowledged that such behaviour was not admitted to by these respondents in this instance. However data from interviews and the open-ended questionnaire discussed later, suggests that it may often be so. Certainly the literature suggests that it is often the case (Wallis 1987). It is also interesting to note that Boyle et al

(1991) made the suggestion that problem solving behaviours may have been developed in some of the nurses they studied, in response to burnout, i.e. they had 'learned' to use such strategies perhaps having burned out before.

All in all, the data seem to amount to a suggestion that nurses and midwives may rely heavily on problem-focused coping strategies to cope with stress, with an accompanying potential denial of, or distancing from, their own emotions. As a Nursing Times editorial points out "this may be a strength when helping others, but a weakness when coping with one's own problems" (1989 p. 1).

Gaining perspective sub-scale.

It would appear that this was the only other sub-scale of behaviours valued positively, in that in terms of % 4 + 5 score, two of its items ranked in the top four, with a third at number 7. This score was decreased substantially by the fourth item (utilising relaxation techniques such as yoga) which was rated lowest overall of the 24 items in the questionnaire. Therefore, gaining perspective on life by 'unwinding in peace and solitude'; 'feeling reassured that other nurses are feeling the same way'; and 'getting involved in non-nursing activities such as hobbies' were rated positively (if not highly) by the group.

In a sense such results are heartening for anyone concerned for the psychological well-being of nurses and midwives, in that mechanisms such as these have been said to afford some degree of palliation against stress (Altmann and Wohlfill 1983). This is said to be particularly so if the rule of thumb that an individual's mode of relaxation should be the opposite of their work, i.e. intellectual or thinking job - physical exercise for relaxation, is accepted.

The fact that relaxation exercises ranked the lowest was noteworthy, in that increasingly such mechanisms for reducing stress are being recommended by clinicians - including nurses and midwives, to a whole variety of client groups. Such mechanisms are also often referred to in the various texts (Bond 1986; Nicholls 1992) and articles (Mast and Urbanski 1987; Coburn and Manderino

1987) on stress reduction, usually along with deep breathing and imagery techniques. It is therefore interesting to find that these nurses and midwives rated such activities very low. Also that while it is acknowledged that such techniques have become more 'mainstream' in the time since data were collected and so may have been rated lower because of this, one could still be led to the conclusion that this is an area where professionals advocate one thing for their clients but another for themselves. Perhaps as 'professional copers' they feel they do not need it. It could of course also be that this was a very concrete example of a specific activity, leaving respondents no room for equivocation, i.e. they either personally use(d) relaxation techniques or not. Whatever the case, this group did not tend to rate such activities as 'being for them' at the time of data collection.

Internalisation of feelings sub-scale.

The main point regarding the data for this sub-scale, is the fact that again there was a clustering (in terms of mean and % 4 + 5 scores) of three of the items, with the fourth rated much lower (18th in this case). Considered as a group, the mean % 4 + 5 score and the mode of 3, would seem to suggest that these were examples of coping strategies and reactions to stress, that were viewed neutrally and/or not used as regularly as those discussed already. This would not give an absolutely true picture however, as two items (Q's 4 and 12 - referring to 'getting mad at oneself for not avoiding situations' and 'going over the same problem in my mind over and again') were rated 8th and joint 9th respectively. At the outset the researcher was not sure how the nurses and midwives would respond to the 'internalising' items (all 4 of them) as they were all fairly abstract in nature, and therefore some respondents may not have been consciously aware of doing such things. It was considered however, in the light of material about the low level of assertiveness amongst nurses (Bond 1986; Milauskas 1985) and their lack of autonomy and relative powerlessness (real or perceived) within the work-place (Freidson 1970; Brannon 1990; Gray 1989; Smith 1992), that nurses do often have to internalise their feelings because it is not always acceptable, possible or wise within nursing and health care culture,

to express them (Rosenthal et al 1970; Coxon 1990; Porter 1991; Smith 1992).

Questions 4 and 12 can also be seen to relate to the highly rated 'problem orientated' coping behaviours already discussed, thus affirming the conclusions regarding retaining control made there.

The item rated significantly lower than the others in this group (Q24 - I don't like it when people get concerned about me), perhaps did so because it is rather abstract in nature. In actual fact this item was included partly to allow comparison with data from other sections of the study, related to the respondents' sense of independence, i.e. do they consider themselves to be independent? and how do they view dependence on others? It is of note therefore that over 21% of respondents said that they did not like others to get concerned about them, while another 21 (24.7%) said that it was somewhat true of them. This point will be re-visited in the 'semi-structured interview' section, as all those interviewed said that they were independent. In point of fact they often prided themselves upon this, and furthermore they typically asserted their dislike of dependency on others - an outlook said to predispose towards complications in grieving.

Accepting behaviours sub-scale.

The relatively low ranking of individual 'accepting' items (11,15,19 and 21) and the sub-scale (5th out of 6 in terms of mean % 4 + 5 score), would seem to reflect the apparent unattractiveness of this group of behaviours for the majority of respondents. One hesitates to suggest that they are minimally used however, given the previous discussions of social desirability (for at least two of the items), and the possibility of a lack of self-awareness in this area of coping. For example, the majority denied distancing themselves from patients and relatives, i.e. only 9 (10.6%) admitted to doing this. However given the extensive literature on communications in nursing, and particularly nurses' use of evasion (discussed at length in the literature review), the researcher would

suggest that for some respondents, answers may have been due to a lack of awareness of the fact that they act in this way to patients and relatives. On the other hand perhaps they answered in the way they felt they **should**, as opposed to what they **actually did** - a case of cognitive awareness but behavioural denial.

Another point raised by the data, was the apparent difficulty these nurses and midwives had in switching off from work at the end of the day. This supports the view that the working life and associated roles of nurses and midwives, can often impinge into their personal lives. That is, they may find themselves playing the role of nurse 24 hours a day. Kovacs (1976) identified this when she examined the "dichotomising" of nurses' home and work life, and the difficulty many have in switching on and off between home and work. Melosh (1982) took this further, saying that "many professionals take their work identity into their private lives - to the point of being called doc, prof etc". This invasion of work into the private lives of nurses and midwives, is further examined in other sections of the study associated with the issues of the 'family nurse', and societal expectations of nurses and midwives.

Expressing feelings sub-scale.

Items in this sub-scale were also negatively/lowly valued and hence presumably used minimally.

The highest rated item - question 3 ('I express my irritations..to myself') was rated joint 13th overall. It is noteworthy that as stated, the expression of emotion would be inwardly focussed towards the individual nurse or midwife. Furthermore, questions 11, 17 and 22 ('I pick fault/blame others', 'I snap at colleagues' and 'I get a little self-righteous...') rated 23rd, 17th and 16th overall, and were therefore apparently more negatively viewed. These items refer more to expressing feelings out loud and at other people. Such behaviour is not typically viewed positively in nursing culture or wider contemporary society (Lowenburg 1976), and it is certainly not expected of 'professional

copers' such as nurses and midwives (Smith 1992). Parallels can therefore be drawn between these data and the earlier discussion regarding the 'internalisation of feelings' and the need for nurses and midwives to appear calm and collected at all times.

Such behaviours are therefore either truly not valued by the majority of the respondents, or they do not like to admit them, perhaps because to do so would suggest that they are somehow 'not coping' and/or un-professional and/or uncaring.

Passive behaviours sub-scale.

The items within this group produced interesting data also, in that as a whole the items rated very poorly. Most apparent was the negativity towards smoking - perhaps reflecting a health conscious population, and certainly at odds with the data one usually comes across regarding nurses and smoking (Knopf and Elkind 1988; Muir Gray 1980). Boothe and Faulkner (1986) however did find that nurses they surveyed also denied an increase in their cigarette consumption when under stress.

More pertinent to the study, was the fact that 'taking the day off' was viewed extremely negatively by these nurses and midwives, i.e. almost 80% denied having done this. This would seem to illustrate clearly the work ethic and level of commitment and dependability that they display - claimed to be to the point that they will go into work even if they cannot face the thought of it for some reason. This therefore further reinforces the strength of the vocational socialisation that nurses and midwives are exposed and apparently conform to.

Inter-scale analysis.

This analysis of the data i.e. comparison of individual items and sub-scale results also provided interesting findings. The most obvious and most pertinent of these would seem to be the trend of the problem-oriented/intellectually focussed behaviours sub-scale being viewed significantly more favourably than

the others. As discussed earlier, it could be considered that 'direct' strategies, could be used to the exclusion of other more 'palliative' approaches, by these (and other) nurses and midwives. This correlates closely with the work of Dewe (1987;1989), whose work provided the theoretical underpinning for this particular tool, as he also found a heavy reliance and high value placed upon cognitively focussed coping strategies amongst nurses.

This finding in this case, is of great relevance to this study as it would seem to support some of its major contentions including that these nurses and midwives seemed to rely heavily on cognitive coping mechanisms; that coping for such professionals connoted being cool, calm and in control in a crisis; and, that this was a 'role' often aspired to by members of the nursing culture, and expected of them by others (lay and professional). The findings of other studies on nurses and coping referred to earlier, would seem to suggest that the same could be said for the wider nursing population.

Conversely, the findings of the 'expressing feelings' and 'passive mechanisms' sub-scales, suggested that in the main these behaviours were not valued and hence not used by the nurses and midwives, because the more cognitive coping mechanisms are considered more effective. There is presumably little value in cultivating palliative strategies if the organisational structure is perceived as offering few, if any, opportunities for dealing with the emotional discomforts of nursing (Dewe 1987). Furthermore such behaviours go against the expectations of a professional in a culture in which one is expected to be cool, calm and in control, and where dependability and commitment to the role of 'nurse' or 'midwife' is vocational and almost sacrosanct (Smythe 1984; Mellish 1988).

The implication of this for the study therefore, is that the person who finds her/himself in the position of being personally bereaved, will often tend to utilise the coping strategies they use normally (Evans and Bartholome 1980), as they are "automatic, overlearned strategies" (Frese 1986). If the person is a nurse or

midwife (a 'professional coper') these will in all probability be intellectual or cognitive mechanisms, which require (amongst other things) rationality and emotional distance from the object of the stress to be effective. This along with a tendency to internalise emotions and anxieties rather than expressing them meaningfully. Thus the nurse may attempt to 'carry on' by using such mechanisms as 'intellectualising' the loss - for example by identifying the particular 'stage of grieving' they are 'at' or discussing the nuances of the pathology of the deceased. Indeed such a reaction may also be expected of them by others - an issue examined in more depth elsewhere in the study under social support and the concept of the 'family nurse'.

In the case of personal bereavement, the above would invariably lead to such mechanisms being overwhelmed, and so the nurse/midwife would find herself completely open to the deep emotion which results from grievous loss, without recourse to other means of dealing with it. In the longer term, this may also complicate her grieving process (Worden 1983) as she will have to resolve not only the loss of her loved one, but the loss of her self-concept as a 'coper' (Murray-Parkes 1972, 1975).

Another interesting issue raised by the data was the cognitive nature of the highly rated individual items (trying to unwind and gaining perspective, and keeping problems to oneself) along with the problem orientated behaviours already discussed. It may be the case that such a group of behaviours reflect a reality whereby problem solving (masculine) traits are used and/or aspired to by nurses and midwives. It may also be that often they find it necessary to internalise or seek to put things into a broader perspective, as they are the only mechanisms open to them in their work-place, given that nurses often have little autonomy in their work - for example in decision making regarding patient care (Dennis 1983; Coxon 1990). In a sense, this provides further evidence of "oppressed group behaviour" (Roberts 1983), as people in such groups are said to often subjugate themselves when in the company of their 'oppressor', and also highlights an aspect of the "emotional labour of nursing" (Smith 1992).

The data pertaining to internal consistency within the sub-scales becomes relevant here in that significant Cronbach's Alpha results were obtained for the problem oriented, expressing feelings and passive behaviours sub-scales. This enhances the significance of the findings for these sub-scales as they occupied the ends of the spectrum i.e. 'problem-solving' being rated the highest and expressing feelings/passive mechanisms amongst the lowest. Conversely, the sub-scales which did not show significant levels of internal consistency tended to occupy the 'middle ground', suggesting variation in terms of both spread of ratings and related items being answered seemingly without consistent pattern.

They also echo Dewe's view that given the nature of nursing already discussed, there may be few direct strategies which can be used and so they are frequently used by large numbers of nurses (1987). On the other hand the greater number of palliatives may result from the fact that such strategies are more likely to reflect the personality, background and environment of the nurse and so, while frequently used by individual nurses, they are not used frequently by a large number of nurses (ibid). In other words, the data from these sub-scales is that which could be expected, with problem oriented behaviours being rated highly and with internal consistency; others being rated with reasonable levels/value, but with no internal consistency; while respondents consistently viewed expressing feelings and passive mechanisms negatively because of the effects of nursing culture and the expectations of nurses and midwives (by self and others).

A factor analysis was carried out on the data, and in the event four factors were identified, namely:- displays of emotion; social un-desirability; problem-solving coping techniques; and, compensatory coping techniques. These can be seen to complement points derived from the rest of the data, in that the issues of overt expression versus the internalisation of feelings, the acceptability of certain behaviours within nursing culture, and problem oriented behaviours were corner-stones of the discussions to this point. Compensatory (or palliative) techniques have also been alluded to, furthermore this grouping expands the

point made earlier regarding the cognitive nature of the top 6 items, in that there may be another factor influencing the value placed on coping strategies by respondents, either over self or situations - that being the issue of control. Closer inspection of the top ranking items would seem to reinforce this view as they all relate to mechanisms of control, either of self or of situations. Thus, while any factor analysis with such a high number of items (24) as compared to respondents (84) should be viewed with great caution (Child 1990) particularly as the 4 factors identified only accounted for 40% of the variance, when considered alongside the other data this exercise provided an interesting new slant to the findings, that being the issue of control. Indeed this could be the issue, as if one considers the 24 items as a scale overall, the top 6 (positively perceived/valued) seem to offer control, while those at the bottom in the main offer little or none and were hence perhaps viewed less positively.

In summary then, this questionnaire seemingly went some way towards supporting and expanding upon the premise first offered by Dewe (1987) - that nurses rely heavily on 'direct' or cognitive strategies to cope with stress. Furthermore, the data supported the findings of other studies (Lewis et al 1990; Robinson et al 1992; Bargagliotti et al 1987; Boyle et al 1991; McCranie et al 1987) that nurses highly value such mechanisms, and it has been postulated that:-

- a) they do so because they reflect a persona of the 'ideal nurse' as the calm, collected, dependable 'professional' which many in nursing and midwifery aspire to, and perhaps perceive to be expected of them as an 'ideal' nurse or midwife;
- b) this may be at the expense of developing other methods of coping to any meaningful degree - potentially to their detriment should they be personally bereaved;
- c) the issue of control was apparently important, at least to these nurses and midwives;
- d) this may deprive bereaved nurses and midwives of a vital means of resolving their loss - overtly and unashamedly expressing their anguish.

The question of whether nurses and midwives may also follow such behaviour patterns in their personal lives, was raised and will be re-visited in later sections of the study which examine the family and societal expectations of nurses and midwives.

It should also be acknowledged however, that perhaps the most meaningful and potentially the most effective coping mechanisms i.e. related to receiving support from others, were not examined in this questionnaire. This was not due to an oversight, but a recognition that this would be attended to in the social support questionnaire.

Chapter 5.

Treatment of Data and Results.

Section D:

Social Support Questionnaire.

As stated in the literature review, social support is considered to be of great importance and value to a grieving person, whether it be the presence of a compassionate listener, or someone to take over for a while and perhaps offer the bereaved person the opportunity to withdraw temporarily from life's other responsibilities, so as to allow them the time and space needed to concentrate on the emotional 'tasks' of grieving (Vachon and Stylianos 1988; Parkes 1972; Worden 1983).

As previously discussed, this questionnaire was designed to provide some insight into both the potential sources of social support for nurses and midwives and the ways in which it is provided, as the absence (actual or perceived) of social support has been identified as a pre-determinant of "complicated grief" (Murray-Parkes 1972,1975). Furthermore, the items were constructed in such a way as to allow examination and comparison of levels and types of support, that respondents perceived to be available to them, in both their personal and professional lives. It was thus an attempt to highlight and discuss issues of where nurses and midwives perceived they could expect to get social support from should they be personally bereaved, and whether such support would be of any real use to them i.e. would it be 'functional'?

At the outset it was envisaged that the emotional and instrumental support items would be those of most pertinence to the study as a whole, since emotional support and practical help as described by the instrumental items would seem to be the most useful to a person who has been bereaved. In the event however the appraisal items raised important points for the study and so all individual results are discussed in relative detail as there were so few that did not have something of importance to reflect upon.

References to 'work' and 'personal' sources of support are made throughout. Work sources were seen as co-workers and supervisors, while personal sources were spouses/partners, relatives and friends.

The relevant results - frequencies of replies and means, are provided in tables D1 to D20. In an attempt to make the mass of data more manageable, and so facilitate easier comprehension and assimilation for the reader, the results have been tabulated in such a way that the responses 1-5 (plus 0 = no response) are provided so as to give some idea not only of actual responses (e.g. how many respondents gave a score of 5 for a certain item), but also of the trends of answers (e.g. numbers of respondents who could be said to be positive <4+5> or negative <1+2> for a certain item).

The scores are expressed as valid percentages of the total responses (score/100). S = SCORE. n = 85 throughout. The poles of the scale were 5 = a great deal of support and 1 = no support at all .

Emotional support items.

Item 1. "How much does this person make you feel liked or loved?"

Table D 1.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	74.1	9.4	83.5	10.6	2.44.	4.306
Rel's	42.4	1.2	81.2	2.4	1.2	4.165
Friend	11.8	2.4	51.8	5.9	2.4	3.482
Superv.	2.4	41.2	9.5	70.6	2.4	1.929
Co-w.	1.2	10.6	18.8	41.2	2.4	2.612

The trend of the means was downwards from spouse (m = 4.306; 83.5% = +ve.) to supervisor (m = 1.929; +ve = 9.5%). The negative scores varied in an inversely proportional manner (-ve = 70.6% for supervisors). Interestingly however the '1' score for spouses was 9.4% (1+2 = 10.6%). Supervisors and co-workers were rated very low for this item, with friends moderately so.

The results would seem to suggest that nurses felt that they could depend on spouses and relatives to make them feel liked or loved. This is not a surprising

result really, in that presumably many individuals do not rely on work-based contacts for such input. Nonetheless it is cause for concern that the figures were so low for co-workers and distinctly negative for supervisors (41.6% - not at all 'supportive' in this regard), especially as the item referred to liked as well as loved. Also noteworthy is that 9.4% of spouses were rated '1' (not at all supportive). This may either reflect a dissatisfied/unsupported group of respondents, or, (and perhaps more likely) a number of 'unattached' respondents.

Item 6. "I could trust this person with my secrets"

Table D 2.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	84.7	8.2	89.4	9.4	1.2	4.541
Rel's	60	4.7	82.4	5.9	2.4	4.247
Friend	32.9	4.7	65.8	9.4	2.4	3.776
Superv.	8.2	40	21.2	61.2	3.5	2.176
Co-w.	4.7	28.2	15.3	58.8	3.5	2.224

Again the trend existed of spouse (m = 4.541; 89.4% = +ve) through to supervisor (m = 2.176; 21.15% = +ve). An obvious gap existed between Spouse/Relatives/Friends and Supervisor/Co-Workers, i.e. Friends scored 9.4% at the 1 + 2 (-ve) level for this item, whereas supervisors and co-workers scored 61.2% (n = 52) and 58.8% (n = 50) respectively.

Respondents obviously felt that they could trust 'personal' sources more than 'work' sources with their secrets. Interestingly 8.2% rated their supervisors at '5' compared to only 4.7% of co-workers, perhaps reflecting very positive staff/supervisor relationships for a these respondents. However, 40% stated that they would not trust their supervisor(s) with their secrets 'at all'.

In the light of these results it would seem that these nurses and midwives:-

- a) only felt 'safe' trusting their secrets to spouses, relatives and perhaps friends; and
- b) would be loathe to trust their secrets to co-workers and supervisors.

Item 10. "Any advice given to me by this person is essentially helpful and constructive".

Table D 3.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	47.1	11.8	68.3	14.2	4.7	3.753
Rel's	34.1	3.5	73.5	9.4	3.5	3.741
Friend	17.6	3.5	54.1	12.9	4.7	3.412
Superv.	21.2	10.6	50.6	18.8	1.2	3.388
Co-w.	16.5	1.2	57.7	9.4	3.5	3.529

There was much less of a spread of values for this item (decreased polarity across the sources). Spouses again rated highest in terms of mean score ($m = 3.753$; +ve = 68.3%) although relatives had the highest 4 + 5 score (73.5%), while supervisors were rated lowest ($m = 3.388$; +ve = 50.6%). Over 80% of respondents gave a 3, 4, or 5 value for this item. Also noteworthy is the fact that only 47.1% of spouses/partners were rated at level 5 (a great deal).

Similar scores and means across sources can be seen for this item, furthermore, the results were essentially positive, i.e. approximately 50-60% = 4 + 5. Hence it would seem that a majority of respondents perceived that they had moderate support from all sources, regarding the provision of helpful and constructive advice. Nonetheless, the trend remains that supervisors were rated lowest. Also interesting was the figure of $S = 5 = 47.1\%$ for spouses. This would seem to suggest that there was an element of dissatisfaction amongst a number of respondents regarding the nature of advice they received from their spouse. This result is underlined by virtue of the fact that the mean score for this item

was considerably lower than for the other three in the sub-scale.

Item 12. "How much can you confide in this person".

Table D 4.

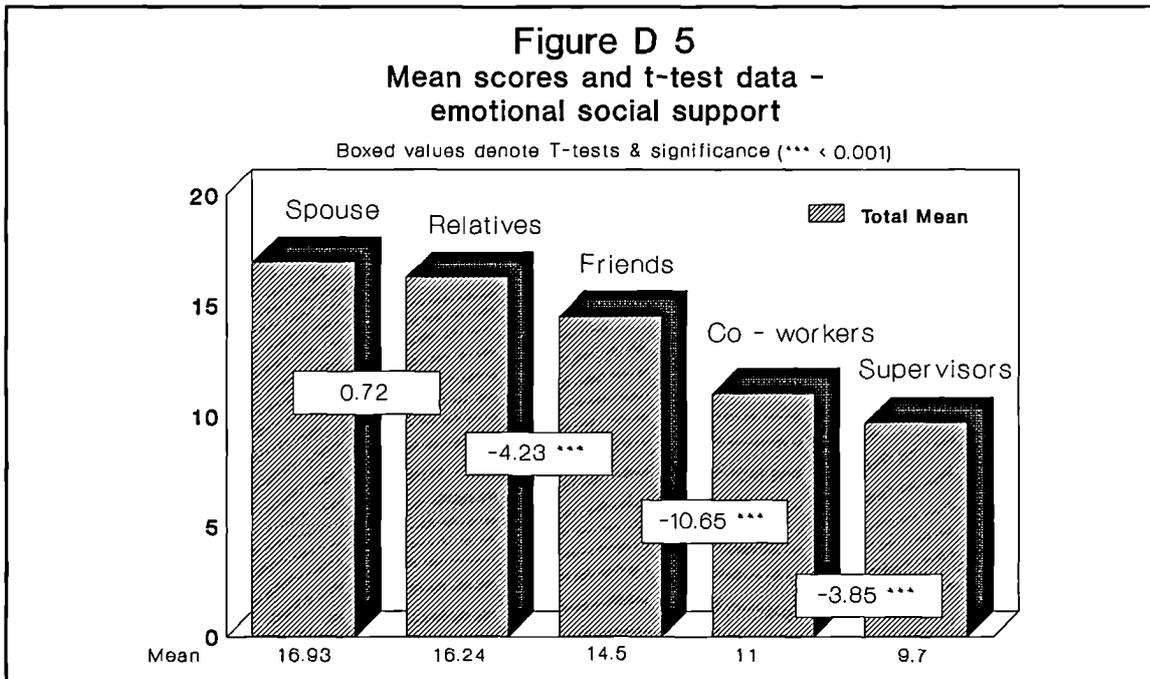
Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	75.3	11.8	85.9	13	1.2	4.329
Rel's	48.8	2.4	73.8	4.8	1.2	4.119
Friend	31.8	1.2	67.1	5.9	2.4	3.847
Superv.	5.9	32.9	13	61.1	1.2	2.212
Co-w.	3.5	10.6	20	42.4	2.4	2.635

A wide polarity of values was apparent for this item also. The gap between 'personal' and 'work' sources was again apparent. Spouses rated highest (m = 4.329; +ve = 85.9%) and supervisors lowest (m = 2.12; +ve = 13%). Indeed supervisors were seen negatively in that 61.1% = -ve, with 32.9% giving a score of 1 (not at all supportive).

The results for this item therefore show that most nurses felt unable to confide in both co-workers and supervisors, indeed almost 33% felt unable to confide in their supervisor.

Intra-scale analysis - Emotional Social Support.

The following diagram (Fig. D5) summarises a variety of findings, namely the sources of emotional social support placed in ranked order based on total mean score; the t-values of items compared; and the two-tailed probability level of significance.



The results show that t-test analyses for this sub-scale reinforce the conclusions reached earlier in this section, in that the trends observed there (personal sources being rated more supportive 'emotionally' than work sources) were found to be significant.

Calculations were also made of the mean % 4 + 5 scores for the various sources of support (spouses, relatives etc) across the emotional support sub-scale, in an attempt to establish whether any of them would provide support that was at a 'functional' level. It was decided that a mean % 4 + 5 score of > 50% would connote this. The results of such calculations were (see overleaf)

Mean % 4 + 5 score

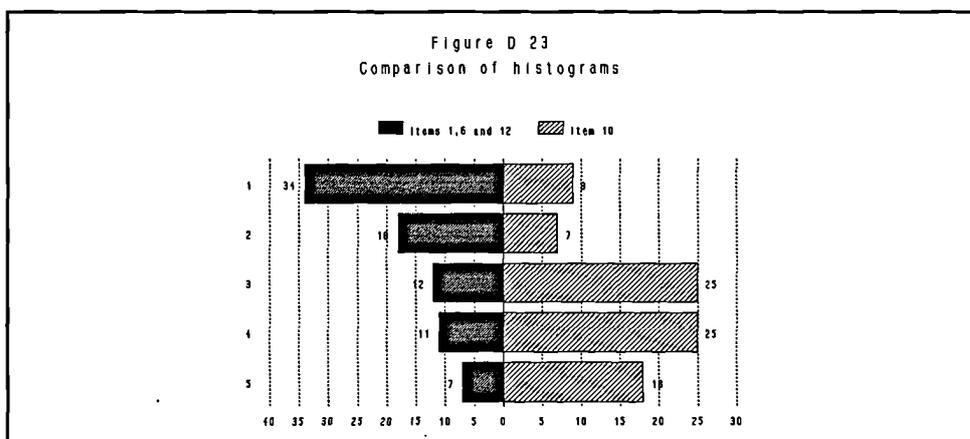
Spouse/Partner	81%	
Relatives	77%	i.e. +ve/functional
Friends	60%	

Supervisors	23%	
Co-workers	28%	i.e. -ve/not functional

Thus 'functional' emotional support was perceived to be available from personal sources however work sources, particularly supervisors, were deemed to be essentially unsupportive in this regard.

The exception to this was the item which referred to the issue of 'constructive and helpful advice' (item 10). If one examines the items in this sub-scale, one can see that they commonly alluded to the possibility of confiding in others and/or the development and maintenance of a positive self-image. Item 10, can be seen to vary from this in a sense, with 'constructive' perhaps being the key word.

Furthermore, it would appear to have had an effect on the spread of results for the various sources of support. Most notable in this were co-workers and supervisors, who for the 3 conceptually related emotional support items, tended to produce histograms similar to the pattern to the left of Figure D 23 :-



Whereas for item 10, the histograms were similar to the pattern to the right of this diagram. This would seem to reinforce both the view that the items are conceptually different, and that perhaps a key contributing factor is that item 10 can be seen to connote to the workplace more than the other three.

This further underlines the view that emotional support in the form of discussing personal problems, thoughts and feelings, was not perceived to be available to nurses and midwives in the workplace, by the respondents in this study.

However, there would seem to be a modicum of constructive advice available from all sources, including those in the work place. It would appear therefore that emotional social support for nurses and midwives (in most forms) was seen to be available, but it was seen as being in the domain of spouses, families and to a lesser extent, friends. However, the results from item 5, suggested that many respondents questioned whether personal sources of support could really understand work related problems.

An interesting side issue that arose from the data, was the small but significant number of respondents who asserted that they would not expect to get this type of support from their spouse or partner. This phenomenon was apparent throughout all the scales and will be examined in the duscussion.

Appraisal support items.

Item 2 "How much does this person make you feel respected or admired?"

Table D 6.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	56.5	10.6	80	14.1	2.4	4.04
Rel's	40	2.4	78.8	18.9	2.4	4.094
Friend	7.1	2.4	45.8	9.5	3.5	3.306
Superv.	1.2	35.3	11.8	65.9	3.5	2.012
Co-w.	1.2	7.1	16.5	42.4	4.7	2.541

Spouses/partners (m = 4.047; 80% = +ve) and relatives (m = 4.094; 78.8% = +ve) rated highest although the former was dragged down by the score = 1 score (very negative) which was 10.6% as compared to 2.4% for relatives. Again this probably reflected the 'unattached' respondents.

Supervisors were viewed very negatively for this item, with only 11.8% +ve, and a negative score of 65.9% (n = 46), of which 35.5% (n = 30) gave a value of 1 (not at all supportive).

The overall interpretation therefore is that most of the nurses and midwives did perceive that they had a source for such support - most notably spouse and family, and to an extent friends. However the majority did not perceive they were made to feel respected or admired by supervisors or co-workers.

Item 3. "This person keeps me informed about how well I am functioning in my job".

Table D 7.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	7.1	48.2	14.2	63.5	7.1	1.882
Rel's	3.5	52.9	4.7	78.8	5.9	1.588
Friend	3.5	43.5	10.6	63.7	7.1	1.847
Superv.	8.2	21.2	30.6	41.2	1.2	2.729
Co-w.	10.6	11.8	34.1	27.1	2.4	2.988

This item broke totally with the pattern of previous items, in that it almost inverted, i.e. co-workers and supervisors were viewed the most positively (34.1% and 30.6% respectively), while the 'personal' sources of support produced unipolar result spreads - heavily towards the -ve. Having said that, while scores for 'work' sources were more evenly spread, the means were still less than 3 and the percentages of +ve scores were less than 35%.

These results were both notable and interesting, notable in that this is the only item in the questionnaire which rated work sources of support the highest, interesting because of the fact that they 'topped the poll' with positive scores of 30.6% (supervisors) and 34.1% (co-workers), while 'personal' sources of support had positive scores of less than 15%. Furthermore over 20% perceived that they got no support at all, in this form, from their supervisor(s). It can be seen therefore that in general, most respondents did not perceive that they had anyone upon whom they could rely upon to keep them informed about how well they were doing their job.

Item 7. "This person lets me know exactly what is expected of me".

Table D 8.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	38.8	17.6	63.5	22.3	7.1	3.412
Rel's	21.2	10.6	50.6	22.4	4.7	3.247
Friend	7.1	9.4	38.9	22.3	7.1	2.929
Superv.	21.2	11.8	49.4	23.6	3.5	3.247
Co-w.	12.9	7.1	45.8	25.9	5.9	3.082

This item produced another new pattern in that there was a fairly even distribution of scores between the sources of social support. Spouses were once again viewed most positively (63.5% +ve: m = 3.412), friends ranked lowest (38.9%: m = 2.929), while supervisors (49.4%: m = 3.247) and co-workers (45.8%: m = 3.082) ranked third and fourth respectively. Again, the '5' score (very supportive) was low, the highest being for spouses (38.8%). Spouses and relatives were the only ones to score positively overall, i.e. 63.5% and 50.6% for 4 + 5 respectively.

Scores of '1' were relatively low, the highest level being 17.6% for spouses. This was reflected in a bipolar spread of results for spouses for this item.

These results also showed a constant level of negative scores for each source of support (approximately 23%). Furthermore, only spouses (63.5%) and relatives (50.6%) rated more than 50% positive score. The implications of these being that:- information about how well they were doing their job was typically not perceived as being available to the majority of nurses; and, those who did perceive it as being available, tended to see it as coming more from personal sources (but not friends) than from work sources.

The relative paucity of such social support may be expected from more personal sources, given the nature of life, in that many people do not set identified goals

for themselves or others. However, one would expect higher levels of this activity in the work setting given the modern day trends of management by objectives and staff appraisal. The perceived 'lack' of relevance to personal sources was perhaps reflected by the differing '0' (no answer) values. That is, for work related sources, these figures were 3.5% for supervisors and 5.9% for co-workers, while spouses were 7.1%, relatives 4.7% and friends 7.1%. A possible explanation for this variation is that supervisors and relatives (especially parents) are more often cast in the role of setting targets and having overt expectations of others.

Item 15 "I am regularly made to feel that I am doing a good job by this person".

Table D 9.

SOURCE	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
SPOUSE	44.7	20	64.7	23.5	7.1	3.447
REL's	35.3	12.9	58.5	15.3	5.9	3.529
FRIEND	25.9	11.8	50.6	20	7.1	3.235
SUP.	4.7	23.5	21.2	45.9	1.2	2.529
CO-W.	4.7	9.4	37.6	25.9	3.5	2.96

This item showed spouses and relatives to be considered the most supportive (m = 3.447: 64.7% +ve and m = 3.529: 58.5%), and supervisors the least supportive (m = 2.529:21.2%).

Interestingly these two groups were also scored the most negatively, i.e. 20.1% of spouses and 23.5% of supervisors scored a '1'. Co-workers scored 37.6% positive, and 9.4% = '1'. Relatives and friends had similar positive scores (58.5% and 50.6% respectively) to spouses, but both had '1' scores of less than 13%.

The results of this item show only moderate levels of perceived support and that only personal sources provided it to more than 50% of nurses. Only 21.1% rated supervisors positively for this item, the figure for co-workers being 37.6%. Furthermore, over 45% of respondents responded negatively, that is saying that they were not made to feel that they were doing a good job by supervisors (this figure being 25.9% amongst co-workers).

Also of note, is the fact that 20% rated spouses as a '1'. Again the unattached population accounts for a proportion of this, however it would appear that over 10% of respondents felt totally unsupported by their spouse, in terms of being made to feel they are doing a good job.

Overall therefore, it would appear that these nurses and midwives were not regularly made to feel that they were doing a good job at all, and if they were it was typically by spouses (some) or relatives. It is apparent that the respondents felt poorly supported by work sources, with regards to being told they were doing a good job.

Intra-Scale analysis - Appraisal Social Support.

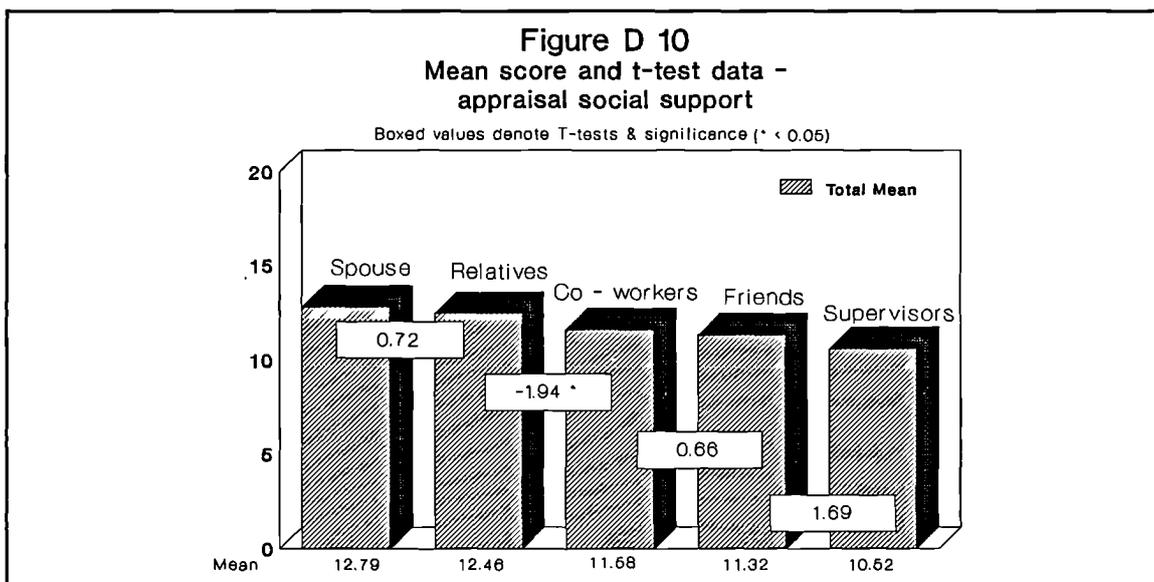


Figure D 10 shows that no statistically significant differences existed between paired mean values in the ranked order list. However, significant differences did exist within the scale, most notably:-

	T-VALUE
Appraisal Spouse vs Appraisal Friend	2.85* (p* < 0.05)
Appraisal Relative vs Appraisal Friend	-3.52**(P** < 0.001)
Appraisal Co-Worker vs Appraisal Superv'	-3.35**

N.B. more did exist, but the meaningful trend is clearly identified with these results.

Calculation of the mean % 4 + 5 scores for the items in the 'appraisal' sub-scale were as follows:- Mean % 4 + 5 score

Spouse/partner	55.6%	i.e. +ve/functional

Relatives	48.15%	
Friends	36.5%	
Supervisors	28.25%	i.e. -ve/not functional
Co-workers	33.5%	

These data therefore identified that **only** spouses/partners were rated at over 50%, and so perceived by respondents as providing 'functional' appraisal support. This was the case in spite of two of the items referring directly to the provision of constructive feedback on how well individuals performed in their jobs, and thus essentially work-related items. It is also a fact that with the exception of the 'being made to feel respected or admired' item, even personal sources scored quite poorly within this sub-scale, leaving it the lowest rated sub-scale overall (significantly so).

In a sense the work-relatedness of this sub-scale was apparent in that work sources were rated the 'most supportive' for one item (item 3). However this only amounted to positive scores being offered by around 35% of respondents (rather like the level of support described for the 'work related' emotional support item). The other items, for example referring to being made to feel

'respected or admired', and being 'made aware of what is expected of them', both tended to reflect negativity towards work-based sources of support, particularly towards supervisors.

The significance these results, particularly those for supervisors, have already been raised. However it would seem pertinent to reinforce the point that in the work-place, these nurses and midwives perceived appraisal support to be in short supply, and that when it is provided, it is typically by peers rather than managers. Furthermore, personal sources were seen to be the more supportive in this way, yet are essentially not usually in a position to actually provide realistic and meaningful appraisal support.

Informational support items.

Item 4 "This person will always show me how to do things if I don't know, without making me look stupid".

Table D 11.

Source	S = 5	S = 1	S = 4 + 5	S = 1 + 2	S = 0	MEAN
Spouse	40	20	55.3	29.4	8.2	3.212
Rel's	27.1	15.3	61.2	17.7	8.2	3.306
Friend	21.2	12.9	53	16.5	10.6	3.129
Superv.	20	15.3	42.4	25.9	2.4	3.141
Co-w.	20	7.1	62.4	14.2	3.5	3.506

This item received quite low marks throughout. The highest were for co-workers (m = 3.506: 62.4% +ve) and relatives, though spouses had the most frequent '5' score - 40% compared to 20% for co-workers (rated lowest). Supervisors were rated lowest in terms of both mean and 4 + 5 score (m = 3.141: 42.4% +ve) in fact they were rated negatively (25.9% -ve, 15.3% not at all supportive).

Without such a large negative score, spouses would have been on a par with co-workers and relatives. Again a relatively high positive score would be expected for spouses and relatives for such support, given that the item also referred to avoiding making the subject appear stupid - avoidance of this presumably being expected of kin. In this sense the '5' score for the personal sources was somewhat surprising. The fact of the high negative score for spouses again may be partially explained by the presence of respondents without a spouse or partner (1 = no support/does not exist). It may however, along with the other highly negative results for spouses in the questionnaire, reflect a number (albeit small) of respondents who had spouses who were very unsupportive. This perhaps reflects a chauvinistic (male) attitude of some men towards women, which may be characterised by undermining their wives

confidence and self-esteem.

The relatively low scores throughout suggested that many nurses and midwives felt they lacked this type of support. The most supportive sources were seen as co-workers and relatives (4 + 5 = 62.4% and 61.2% respectively). This was in spite of the highest '5' score being for spouses (40%), as the overall mean was brought down by them also having the highest level of '1' scores (20%). It is interesting that relatives and co-workers came out 'on top' for this item, both in terms of mean scores and % 4 + 5 scores. For co-workers, the result suggests that in an atmosphere generally lacking in support (hospital nursing) this was one of the more common means of support offered by work colleagues. The fact that nurses often rely on colleagues for ad-hoc information and updating, for example regarding equipment and clinical protocols, means that the only real surprise was that the positive co-worker score was not higher.

The relatively high negativity of supervisors re this item is perhaps pertinent to mention at this point, as it further underlines the lack of confidence the nurses and midwives had in their managers. Furthermore, such a result in this instance is of obvious concern if one accepts that an important role of any manager is to guide, teach and update subordinates.

The '0' values (i.e. no answer) for spouse, relatives and friends were considerably higher than those for supervisors and co-workers for this particular item (personal 9% : work 3%). This could perhaps be explained by a tendency to perceive such a mode of support to be more in the work domain than the personal.

Overall then, the perceived level of such support, by respondents, was relatively low and perhaps lower than would be expected given the nature of the item. Supervisors and spouses were viewed distinctly more negatively than the other sources, the ramifications being different and significant.

Item 8. "This person is willing and able to provide me with sound career advice".

Table D 12.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	9.4	34.1	21.2	50.6	5.9	2.282
Rel's	7.1	41.2	17.7	56.5	4.7	2.129
Friend	4.7	31.8	21.2	47.1	4.7	2.329
Superv.	28.2	14.1	51.8	29.4	2.4	3.294
Co-w.	17.6	15.3	36.4	23.5	3.5	3.047

This item was rated relatively 'negatively' throughout. The most positive sources being supervisors and co-workers, yet the figures were not overwhelming, that is 51.7% +ve: m = 3.294 and 36.4% +ve: m = 3.047 respectively. This was the only item in the questionnaire in which supervisors were rated highest. Personal sources all scored poorly for this item i.e. spouses (21.2% +ve: m = 2.282) relatives (17.7% +ve: m = 2.129) and friends (21.2% +ve: m = 2.329). Their negative scores are also noteworthy:-

Spouses 1 = 34.1% 1+2 = 50.6%
 Relatives 1 = 41.2% 1+2 = 56.5%
 Friends 1 = 31.8% 1+2 = 47.1%

The negative scores for supervisors and co-workers were 29.4% (1 = 14.1%) and 23.5% (15.3%) respectively.

These results were interesting in a number of ways. Perhaps most notable is that this was one of only three items in the scale in which supervisors were rated highest. They were followed by co-workers. However, the fact that the respective positive scores were 51.7% and 36.4% says something about the strength of this feeling.

The issue of the perceived work-relatedness of certain items can also be re-visited, with the personal sources achieving positive scores only just over 20%,

and negative scores of approximately 50%. That is, respondents tended to see this mode of support as more in the work than in the personal domain. That said, the negative score for co-workers and supervisors were also quite high at 23.5% and 29.4% = 1 + 2, respectively.

Thus overall, the nurses and midwives tended to perceive that on the whole there was a dearth of support (in terms of the provision of sound career advice) available to them.

For personal sources this was perhaps understandable given the need for insight into nursing to be able to provide such advice. For work sources however, in spite of being rated the highest, the magnitude of the support was rather underwhelming. The results indicate therefore that while many saw such support as being the remit of work colleagues and supervisors, little over 50% of respondents perceived it to be available from supervisors, and under 40% from colleagues. This, and the implication that such results may reflect ability and/or willingness to provide such support, will be discussed in the relevant discussion section.

Item 13. "I can talk confidentially and without fear to this person about work related problems".

Table D 13.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	70.2	13.1	78.8	15.5	2.4	4.131
Rel's	45.9	12.9	64.7	22.3	3.5	3.647
Friend	34.1	10.6	63.5	18.8	3.5	3.5786
Superv.	17.6	21.2	32.9	40	1.2	2.859
Co-w.	20	9.4	47.1	25.9	3.5	3.212

A pattern of results seen before re-emerged for this item, i.e. spouses being rated highest (78.8% = 4 + 5: m = 4.131), and the lowest being supervisors

(32.9% +ve: $m = 2.859$). Co-workers were also lowly rated (47.1% +ve: $m = 3.212$). Supervisors were again viewed negatively, with 40% of respondents rating them '1' or '2', of which 21.2% were '1' scores.

Given the nature of this item, i.e. nominally related to work but with emotional support undertones and the pattern of responses to this point, the results were perhaps not surprising, with personal sources of support being rated higher than work sources. Of particular significance to this study however, is the fact that the means for work sources, particularly supervisors, were markedly lower than for the personal sources of support. This was a result of a combination of low positive (4 + 5) and high negative (1 + 2) scores for work sources. The obvious interpretation for this, is that most respondents relied upon personal sources of support (spouses/partners in particular) with regards to discussing work-related problems in confidence. Conversely it was the nurses' and midwives' view that in the main, such confidences (indeed perhaps any confidence) would be avoided with work colleagues and supervisors. Thus the nurses and midwives may have perceived themselves as typically having such support, however the issue of whether persons not involved in the work situation can significantly modify work-based stress (in the form of work-related problems) is salient here, and will be discussed in the relevant discussion section.

Item 16. "This person is someone, other than myself, who I know shows interest in my future career prospects".

Table D 14.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	64.7	10.6	78.8	14.1	4.7	4.047
Rel's	56.5	2.4	81.2	8.3	3.5	4.165
Friend	22.4	4.7	53	16.5	4.7	3.4
Superv.	9.4	23.5	23.5	44.7	2.4	2.576
Co-w.	8.2	14.1	24.7	35.3	3.5	2.729

Relatives and spouses scored highest for this item (81.2% +ve: $m = 4.165$ and 78.8% +ve: $m = 4.047$ respectively). Lowest were supervisors (23.5% +ve: $m = 2.576$) and co-workers (24.7% +ve: $m = 2.729$).

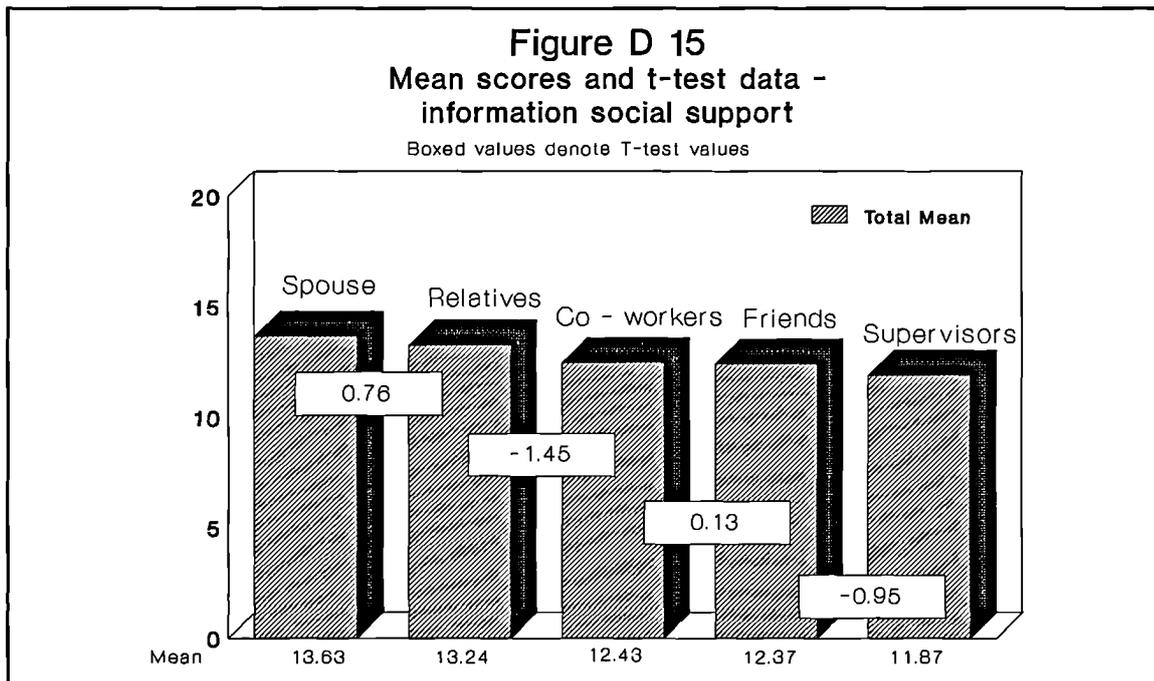
Supervisors were also viewed the most negatively in that 44.7% of the respondents scored them '1' or '2' (1 = 23.5%). Only 14.1% of co-workers were rated at '1'. 10.6% of spouses were also rated '1' (14.6% = 1 + 2).

Interestingly, relatives were (narrowly) in front of spouses for this item both in terms of mean and 4 + 5 scores, in spite of spouses having the highest S = 5 rating. This may again reflect the unattached respondent variable, or perhaps that one's relatives, especially parents, are traditionally unconditionally interested in the careers of family members - particularly offspring. It may also in part, reflect the relationships of certain respondents discussed earlier i.e. the impact of 'male chauvinism'- as indicated by the '1' score for spouse/partner of 10.6% and 1 + 2 = 14.6%, for this item.

The work related sources of support were again rated relatively lowly, both in terms of low positive (4 + 5) and high negative (1 + 2) scores. Indeed almost 45% of respondents rated their supervisor(s) negatively, with 23.5% rating them 'not at all supportive' (s = 1). Scores of '0' were constant across the item, suggesting that it was seen to have both personal and work connotations.

These nurses and midwives therefore, did not perceive co-workers or supervisors to be interested in their future careers. Spouses/partners, relatives and to a lesser degree friends, were seen to be interested and therefore supportive in this regard. The latter result could reasonably have been expected given the vested interest that families have for their members, yet it is disappointing in that co-workers and managers were perceived/rated so badly for this item. This is particularly the case for managers, who are typically seen to be the people who should motivate, encourage and advise subordinates to bigger and better things.

Intra-scale analysis - Information Social Support.



The significant differences across this scale were:-

T-VALUE

- 'INF SPOUSE' vs 'INF FRIEND' 2.33* (* = $p < 0.05$)
- 'INF SPOUSE' vs 'INF SUPER' -2.78*
- 'INF RELATIVE' vs 'INF FRIEND' -2.07*
- 'INF RELATIVE' vs 'INF SUPER' -2.17*

(N.B. 'Inf' refers to 'informational support')

Thus for informational social support, spouses and relatives were rated significantly higher than friends and supervisors. Therefore, trends identified earlier were found to be significant the most notable being the difference between spouses/partners and relatives, and friends and supervisors, as again the sub-scale items were identifiably applicable to the work setting, yet supervisors were again rated the lowest.

Calculation of the mean % 4 + 5 scores showed:-

Mean % 4 + 5 scores

Spouse/partners	58.4%
Relatives	56.2% i.e. +ve/functional

Friends	47.65%
Supervisors	37.625% i.e. -ve/not functional
Co-workers	42.65%

This suggests that respondents perceived a 'functional' level of informational support from their spouse/partner and their relatives, but not from the other sources examined.

A similar pattern, related to the work-relatedness of certain items, emerged for the informational support items as for those in the appraisal sub-scale. This is perhaps not surprising as again certain items were more obviously work related than others.

In the event, the item referring to the provision of career advice placed supervisors highest (supervisors 51.7%; co-workers 36.4%), whilst interestingly at the same time having quite high negative scores also (23.5% and 29.4% respectively).

For the other items, work related sources were again rated poorly in general, with the exception of co-workers who were seen to be willing to show colleagues how to do things. The negativity towards work related sources was again noted in the items referring to being able to 'talk confidentially about work related problems', and showing an interest in the future career of respondents.

The relatively positive views held by respondents, of personal sources for these items raise interesting but different points for discussion. These being the

issue of whether spouses and parents can significantly modify or influence work based stress; and the fact that relatives were at times, rated more highly than other sources - including spouses, with various interesting explanations possible.

The other issue of relevance to this study, was the observation that whilst such support (informational) was seen to be available from all sources (except supervisors), the mean % 4 + 5 scores placed all but spouses (58.4%) and relatives (56.2%) below 50%. This suggests that whilst this sub-scale seemed to be rated positively overall, it was not to a degree that would support a view that it was definitely functional, i.e. it would not be at a level that would do any good, for the majority of nurses and midwives.

Inter-scale analyses reinforce the above, showing that the mean % 4 + 5 score for the sub-scale was below 50% (48.54%) suggesting that the respondents' perceptions regarding this type of support was at best ambivalent, and leant marginally towards negativity.

Thus the results of the informational sub-scale seemed to be characterised by a perceived marginal availability on the part of respondents. Furthermore, where it is available its degree of efficacy may be questionable, and for such obviously work related items the 'showing' of co-workers and supervisors was notably poor. The analyses of all aspects of this sub-scale therefore points to a functional lack of such support by the nurses and midwives.

Instrumental support items.

Item 5. "If I was finding work particularly difficult for a time, I could expect this person to notice and agree that I should be re-assigned temporarily to a less demanding area for a while".

Table D 16.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	34.1	32.9	44.7	40	8.2	2.812
Rel's	9.4	40	29.4	49.4	10.6	2.176
Friend	1.2	29.4	16.5	52.9	10.6	2.035
Superv.	8.2	22.4	34.1	43.6	2.4	2.694
Co-w.	7.1	20	30.6	37.6	5.9	2.624

This item had low +ve scores for all sources of support. Spouses were rated highest (44.7% +ve: m = 2.812) and relatives the lowest (16.5% +ve: m = 2.035). All sources had '5' score response rates of less than 10%, except spouses (5 = 34.1%).

The negative scores were also interesting:-

Friends 52.9% -ve (1 = 29.4%)
 Relatives 49.4% -ve (1 = 40%)
 Supervisor 43.6% -ve (1 = 22.4%)
 Spouses 40% -ve (1 = 32.9%)
 Co-workers 37.6% -ve (1 = 20%).

Thus friends scored most negatively overall, but relatives and spouses had the larger '1' scores. It can be seen that all categories had high '1' scores for this item.

Amongst the spread of results for this item, the spouse and to a lesser degree, relatives responses were bipolar, i.e. both high '1' and '5' scores. It should also be noted that the positive scores for supervisors and co-workers were made up of:-

Co-workers 4+5 = 30.6% 5 = 7.1%;
 Supervisors 4+5 = 34.1% 5 = 8.2%

The '0' results for this item were noticeably higher for spouse, relatives and friends, than it was for supervisors and co-workers (Average 9% and 4% respectively). This item was perhaps most notable for the fact that it produced the lowest scores for the whole questionnaire. With the exception of spouses (34.1%), none of the sources had '5' scores of over 10%. It may therefore be presumed that this was not something that these nurses and midwives perceived commonly happens.

The bipolarity of the spouse and relatives' responses (high scores for both positive and negative) reveal interesting implications. That is, the 32.9% who said they would not receive such support 'at all' (i.e. $S = 1$) from their spouse may have reflected a number who felt that they had no relevance to the work setting, and/or those spouses who perceived that they (the respondents) should not be re-assigned (this figure was 40% for relatives). One would suspect that the former is the more likely reason, but one cannot be certain given the perceived supportiveness of some spouses in previous items. On the other hand, 34.1% of respondents said that their spouse would give a 'great deal' of support (relatives much less so this time). Thus for this item, respondents felt that their spouse would either be very supportive or not supportive at all, about their being temporarily re-assigned if necessary. In a sense this item can be seen as a microcosm of many of the issues pertaining to social support for nurses, as the 'positive' respondents could only receive 'moral' support from their spouse or partner, while the 'negative' respondents were presumably of the view that they could not talk to their spouses about work related problems because they don't understand the job.

The issue of how realistic the idea of nurses being temporarily re-assigned is, is discussed in the relevant discussion section.

Item 9. "If I didn't feel well, I could expect this person to be sympathetic and perhaps send me home".

Table D 17.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	27.1	42.4	35.3	43.6	12.9	2.376
Rel's	21.2	41.2	34.1	45.9	11.8	2.329
Friend	15.3	31.8	35.3	40	12.9	2.4
Superv.	22.4	11.8	49.4	28.3	1.2	3.282
Co-w.	23.5	7.1	54.1	14.2	4.7	3.424

The same pattern emerged as for the last item for spouse, relative and friend scores, i.e. a split between '1' and '5' scores, but modally favouring the '1' scores:-

Spouse 1 = 42.4% 5 = 27.1%
 Relatives 1 = 41.2% 5 = 21.2%
 Friends 1 = 31.8% 5 = 15.3%.

Co-workers were rated highest overall (54.1% +ve; 5 = 23.5%; m = 3.42), with supervisors second (49.5% +ve; 5 = 22.4%; m = 3.282) Relatives had the lowest mean score (m = 2.329) but this was very close to spouses (2.376) and friends (2.4). Thus there was a 'pairing' of the groups - work related and personal.

The fact that work sources were rated highest for this item was perhaps predictable given the phrasing of the item re: sending the respondent home, i.e. personal sources can obviously only agree that they should be sent home, not actually do it.

'0' scores varied across this scale, in that the figure was markedly higher in the spouse/relative/friend groups (average 12.7%) than in the supervisor/co-worker group (4.7% and 1.2%). This also seems to reflect the work orientation of this item, with personal sources being seen as either very supportive (5), or offering

no functional support at all (1).

In a sense, the results for this item reflect those for the informational support item 8 (referring to career advice and provision) in that work sources rated highest but in a range of relatively low scores overall. Only just over 54% of co-workers and less than 50% of supervisors were rated positively (4 + 5). It should be acknowledged however that the negative scores (1 + 2) for this item, were markedly lower for work than personal related sources, yet 28.3% still rated supervisors negatively.

Thus, the results of this item would seem to reflect its content as a work orientated issue, and therefore amenable to work source intervention. A (slight) majority would perceive this to be the case in practice and would expect to be sent home if they were sick. However the ramification of the higher 1 + 2 score for supervisors over co-workers is debatable, as typically it is the supervisor who has the power to decide who is actually sent home. In fact less than 50% of nurses perceived that their supervisor would indeed send them home (4 + 5 = 49.5%). Furthermore almost 12% felt that they would definitely not be sent home (1 = 11.8%).

Overall then, the question of whether a nurse or midwife who is sick, would expect to be sent home was not answered conclusively. However, there was enough 'negativity' present, to suggest that when a nurse is sick, a sympathetic ear and being sent home is neither the norm nor a foregone conclusion.

The significance of all these points will be examined in the relevant discussion sections.

Item 11. "If a close friend died, this person would agree that I should be allowed time off to attend the funeral".

Table D 18.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	76.5	11.8	80	13	7.1	4.118
Rel's	80	4.7	87.1	5.9	5.9	4.388
Friend	71.8	5.9	85.9	7.1	7.1	4.247
Superv.	35.3	14.1	54.1	23.5	1.2	3.482
Co-w.	50.6	3.5	75.3	7	3.5	4.047

This item was positively scored for all sources and was therefore different to the other 'instrumental scale' items. Furthermore, all had positive scores of greater than 50%.

The highest rated source was relatives (87.1%: m = 4.388) with friends and spouses (85.9% +ve: m = 4.247 and 80%: 4.118) second and third respectively. The mean for spouses was lowered by virtue of a slightly higher '1' score than the others (11.8% compared with approximately 5%).

The lowest rated source were supervisors, a function of the fact that while 54% rated them positively (m = 3.482) only 35.3% gave them a '5' score. For co-workers the figures were slightly higher i.e. 75.3% +ve (50.6% = 5: m = 4.047), and followed the results spread of the 'personal' sources of support.

The negative scores for the two work groups were:-

Supervisors 23.5% (1 = 14.1%)
 Co-workers 7% (1 = 3.5%)

i.e. almost 15% of respondents felt that supervisors would not agree to time off to attend a friends funeral.

The second highest '1' score was for spouses = 11.8%, compared to 4.7% for relatives and friends. This was taken to be reflective of the unattached respondent variable for this item.

The sources seemed to group again for this item, however this time co-workers tended more towards spouses/relatives and friends, with supervisors as a more polarised group on its own.

The results also show that all sources were rated positively (> 50% = 4 + 5) and therefore a 'majority would expect such support from all sources. However, personal sources were perceived to be much more supportive than work sources, this being particularly so when compared to supervisors (the person with the power to actually provide such support) in that less than 55% rated them positively. The next lowest group was co-workers with just over 75% = 4 + 5. Supervisors were also viewed the most negatively, with 23.5% = 1 + 2 and 14.1% rating them '1' (not at all supportive).

The practical implications are therefore:-

that the vast majority of nurses perceived that they would receive 'moral' instrumental support from personal sources; and, that co-workers would also tend to be supportive; but, for those with the power to actually sanction and provide such instrumental support - supervisors, just over 50% felt that they would receive it, and almost 15% of respondents felt that they definitely would not.

This item therefore reflected not only the central position held by nursing supervisors with regards to instrumental support for nurses, but also that many respondents did not believe that they would receive the most basic form of such support from their supervisor, if a close friend of theirs died.

The practical and theoretical implications of this will be dealt with in the relevant discussion section.

Item 14. "There would be no arguments from this person if I needed a little extra personal time off work".

Table D 19.

Source	S = 5	S = 1	S = 4+5	S = 1+2	S = 0	MEAN
Spouse	58.8	20	67	21.2	5.9	3.671
Rel's	42.4	18.8	61.2	20	5.9	3.471
Friend	28.2	15.3	45.3	18.8	7.1	3.282
Superv.	7.1	23.5	23.5	55.3	1.2	2.48
Co-w.	10.6	14.1	24.7	42.3	3.5	2.682

The most highly rated sources for this item were spouses (67% +ve: m = 3.671) and relatives (61.2% +ve: m = 3.471). The lowest rated were co-workers (24.7% +ve: M = 2.682) and supervisors ((23.5% +ve: m = 2.482). These also scored very lowly in terms of '5' scores i.e. 10.6% and 7.1% respectively. In this case friends were somewhere in the middle (45.3% +ve: m = 3.282).

The negative score results are also noteworthy, in that 55.3% of supervisors and 42.3% of co-workers were rated '1' or '2' by the respondents (23.5% and 14.1% gave scores of '1' respectively). This was while spouses (20%), relatives (18.8%) and friends (15.3%) were also rated '1'.

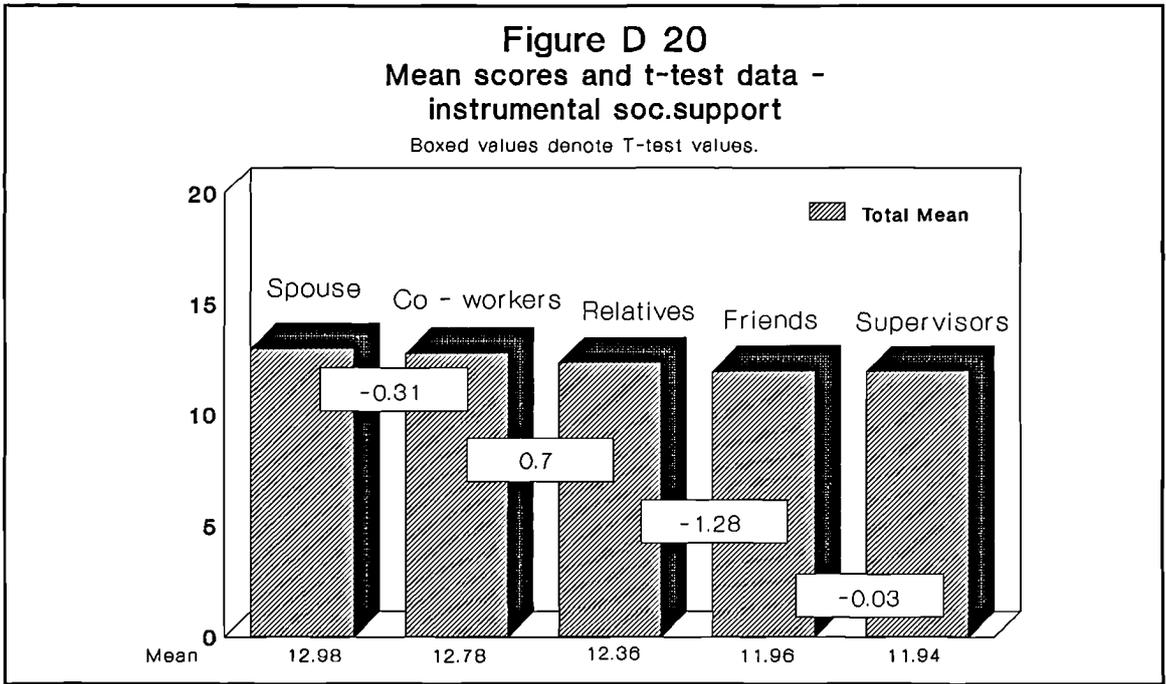
The spread of results for this item showed relatively high positive values for spouses and relatives. Friends showed more of an even spread, though still predominantly in the 4 and 5 range. Co-worker data showed more of a bell-shaped distribution skewed slightly to the negative, whereas supervisor results displayed a definite shift towards the negative (55% = 1 + 2)

The typical '0' pattern for more work related items appeared again for this item i.e. high values for 'personal' sources and relatively lower values for 'work' sources.

This item was therefore interesting for a number of reasons. Given previous results, it was perhaps not surprising that spouses and relatives rated highest, nor was it that work sources rated lowest. What was noteworthy was the fact that the negative scores were relatively high across all the sources, with scores being markedly higher for work sources. However '1' scores of 15-20% were collected for the personal sources also. This suggests that taking personal time off work was perceived by the majority of the nurses and midwives, to be viewed dimly by colleagues and supervisors alike, and that in spite of over 60% rating spouses and relatives positively, a small but significant number perceived they would not receive such support from such sources should they do this. Taking time off for 'personal reasons' was thus seen to be problematic to other professionals, and to a lesser degree by personal support sources. Again, the key results would seem to be for supervisors as they sanction/provide such support in actuality.

The above observations make this item of great importance to this study, as it reveals that what a person often needs to commence on a healthy grieving process - to take 'time out'- was not typically perceived by many of these nurses and midwives to be available to them.

Intra-Scale analysis - Instrumental Social Support.



No significant differences were found within this scale at all, thus all sources of support were viewed relatively equally - i.e. poorly.

However, the trend of:-
 Spouse/partner = 1
 Rel/Co-worker/friend = 2, 3 or 4
 Supervisor = 5

clearly identifiable in the other scales, was also present in this one. Mean % 4 + 5 score calculations were as follows:-

Mean % 4 + 5 score

Spouse/partner	56.75%	
Relatives	52.95%	i.e. +ve/functional

Friends	45.75%	
Supervisors	40.325%	i.e.- ve/not functional
Co-workers	46.175%	

These data suggest that respondents saw only spouses and relatives as potentially providing 'functional' instrumental social support, the reality of this

being questionable.

The mean % 4 + 5 score for all sources added together was 40%. It would seem reasonable to consider therefore that instrumental support was not perceived to be available at a functional level by these nurses and midwives, from any of the sources examined.

A significant issue raised by these data, is the fact that again the sub-scale items were obviously work-related, yet supervisors rated lowest overall. Also while co-workers were rated relatively highly (2nd overall), it was within a relatively low scoring sub-scale overall.

Given this obvious work-relatedness, it would have been **expected** that work sources would rate the highest, and **hoped** that it would be at a functional level. However neither was the case and thus the nurses and midwives did not perceive that they would be able to count on such support as examined in the scale. In actuality the idea of reassignment to other duties was the lowest rated item overall, thus very few respondents felt that anyone (perhaps including themselves) would expect this to happen for nurses and midwives.

The item referring to being sent home if feeling unwell reflected the others where work related sources were rated the highest, in that the degree of agreement was relatively low. That is, less than 50% of respondents rated supervisors positively, while almost 30% rated them negatively - suggesting an expectation of reluctance or perhaps even refusal on the part of supervisors, by many respondents to help in this way.

The issue of compassionate leave was examined within this sub-scale, with particular reference to the death of a friend. It was apparent that the majority of respondents perceived that they would receive across the board support for such a request, however almost 15% believed that it would be denied by their supervisor.

The final item in this sub-scale - referring to the views of others if the respondents needed 'personal time off' - was also interesting. This is because while the 'typical' pattern of personal > work sources persisted, overall there was an impression of negativity and that such action would be dimly viewed from all quarters (perhaps even themselves), but most particularly by supervisors.

A major issue to be raised here therefore, is that one would expect work sources to come into their own within this sub-scale, if any. As with the informational scale however, this failed to happen to any significant degree.

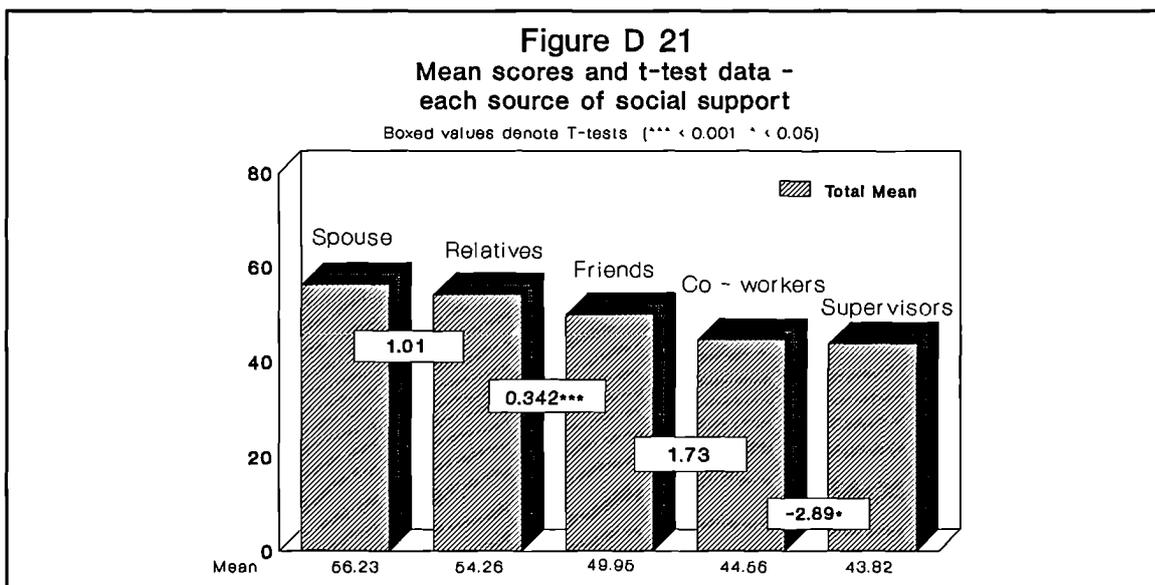
These nurses and midwives therefore, did not typically seem to perceive that they had any great source of functional instrumental social support, particularly if the problem was anything less 'concrete' than physical illness or attendance at a friend's funeral. If an issue of a more nebulous nature was problematic to them, perhaps leading them to need time off (though they were not sick) or re-assigned to a new area for a time, their expectation of sympathy and action was low.

Inter-scale results.

One should acknowledge that each of the various forms of social support, as identified by House (1981), cannot be fully assessed by four questions. Neither would it be useful (to the present study) to examine in detail only certain aspects of each of the four types of support. Instead, the questionnaire sought to cover the spectrum of social support both within (intrascale) and between (interscale) each form of support examined, whilst not leading to the 'social support tool being so long as to discourage respondents from completing it along with the others. One also has to acknowledge that some of the items were more work-related than others. As a result of these issues, internal consistency within sub-scales could not realistically be expected (i.e. each item within an identified scale did not necessarily examine the same aspect of for example, emotional or appraisal support, as another within the same scale) and hence Cronbach's Alpha was not calculated.

T-tests were performed to see if any of the sources of social support rated significantly higher than the others in terms of the level of overall support they could provide.

Pertinent data are summarised within figure D 21.



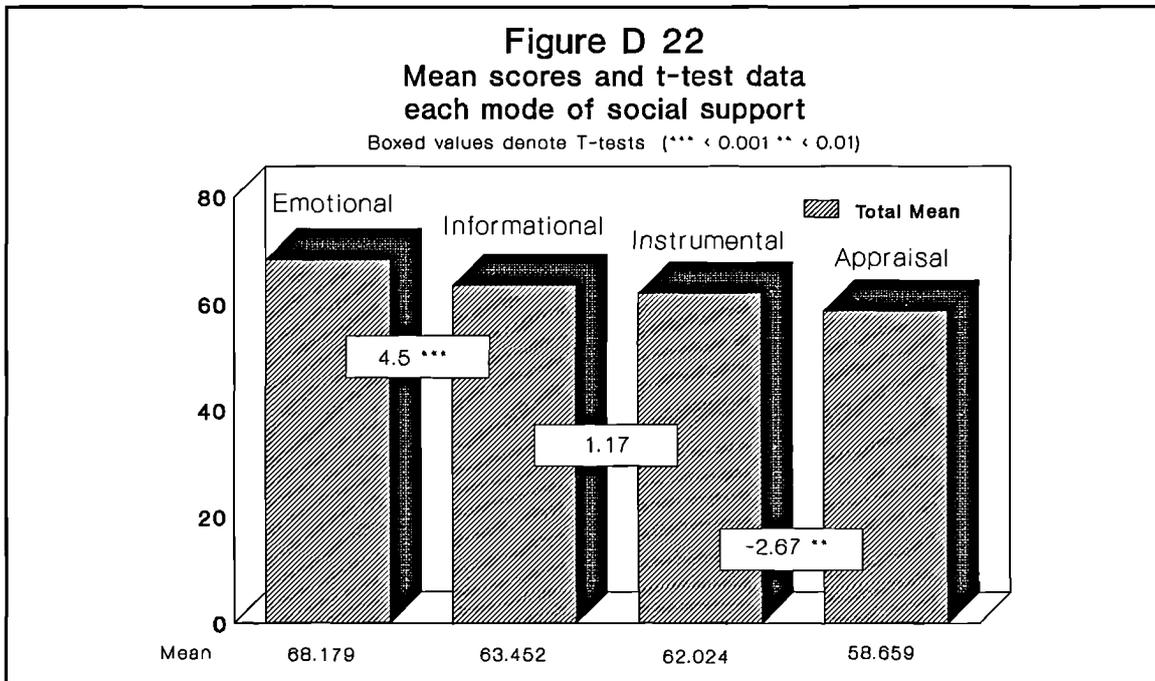
This table highlights the fact that a majority of the nurses and midwives perceived that they had a significantly greater degree of social support from their spouse/partner and their relatives, than from their friends and co-workers. Supervisors were seen as providing significantly less social support than all the other sources. Estimation of the 'functional' level of support available was also carried out, by calculating the % 4 + 5 score for each source of support for each item (80 variables in all), and then ranking them in order of this score. The mean % 4 + 5 scores for each of the sources of support (spouses, relatives etc) were then calculated. For example for spouses, all the % 4 + 5 scores (16 in all) were added together and then divided by 16 to give a mean % 4 + 5 score of 63.16%. The same calculations were then undertaken for the other four

sources of support :-	Mean % 4 + 5 score
Spouse/partner	63.16%
Relatives	64.83% i.e. +ve/functional

Friends	47.4%
Co-workers	37.75% i.e. -ve/not functional
Supervisors	32.44%

These figures suggest that 'functional' levels of social support were perceived to be available from spouses/partners and relatives, with friends just below 50% (47.25%). This reinforces the t-test results by showing that respondents perceived that spouses and relatives would provide support above a 'functional' point, while friends, co-workers and supervisors would not. It is also pertinent to point out here, that the decrease in perceived levels across the four support sub-scales, for the various sources of support was typically because of spouses and relatives being rated lower (than in the emotional support scale), rather than any increase in the ratings of the other sources. Given the work related nature of many of the items this is noteworthy as in many cases the support from personal sources can only ever be 'moral' in nature, when what is needed is 'actual' support - an issue highly pertinent to this study.

The four modes of social support were also examined, to elicit if any of them was rated significantly higher than the others in terms of the level of support respondents perceived they would get. Figure D 22, shows t-test data for the four modes of social support, along with their mean scores.



This indicates that respondents:- felt that they had significantly more emotional support, than they did informational, instrumental or appraisal; and, felt that they had significantly less appraisal support than the other types of social support.

Calculations of the mean % 4 + 5 scores were again undertaken to allow some consideration of the levels of 'functional' support that respondents perceived was available to them. This time all the % 4 + 5 scores for each mode of support were added together (4 x spouses, 4 x relatives etc = 20 items in all and then divided by 20), the results of these calculations were as follows:-

Mean % 4 + 5 score

Emotional Support	54.2%	i.e. +ve/functional

Informational Support	48.54%	
Instrumental Support	46.6%	i.e. -ve/not functional
Appraisal Support	40.4%	

Such data reinforced the assertions made earlier - that informational, instrumental and appraisal support were not perceived to be available at a functional level by these nurses and midwives. Also that when viewed from the perspective of all sources i.e. personal and work combined, only emotional support was perceived to be available to any functional degree.

Therefore, the accumulated results from all the analyses of this questionnaire (individual, intra-scale, and inter-scale) would seem to suggest that in general, these nurses and midwives viewed themselves to be poorly supported, rating personal sources of support significantly higher than work sources.

Furthermore, that all the forms of social support examined were functionally lacking for them, with the exception of a degree of emotional support provided by relatives and spouses, and typically related to them being able to trust and confide in them. Furthermore, in spite of the questionnaire having an obvious work-related 'bias', work-related sources, and supervisors in particular, were consistently viewed negatively with regards to the social support they were perceived to offer to their subordinates.

Social Support Questionnaire - Discussion.

Perhaps the main issue for discussion raised by the data, was the fact that the majority of these nurses appeared to be of the view that they did not believe that they would be able to count on functional social support from any source across the four sub-scales, with the exception of aspects of emotional support provided by their spouse/partner or relatives. This was considered to be the case because it was either rated at a low level and hence perceived unavailable, or because respondents were referring to support from personal sources for essentially work-related stressors, and who thus could only ever have a

buffering effect (House 1981) to stress. The efficacy of this may be questionable, particularly for work based stress (House 1981), as it may be impossible for them to provide because they are supportive actions open only to work-based sources.

As stated in the introduction to this questionnaire, emotional and instrumental support were considered to be of particular pertinence to a bereaved person, as they potentially provide both "early and later help" (Murray-Parkes 1972) towards coming to terms with their loss. These results suggest that these nurses and midwives at least, perceived that they would only be able to rely on their 'personal' sources for emotional support, and therefore if they needed to talk about their fears and feelings this would not be possible with people from work. In itself this is not particularly a problem, as long as the personal sources are indeed available and able to provide such support. However the results showed that this was not be the case for a significant number of respondents, including a small group who felt that sometimes they would not even be able to count on the support of their partner.

It may of course be the case that many non-nurses would feel the same way as these respondents about confiding in their managers or co-workers. Crucially for nurses however, is the question of whether their role in the family might preclude such support from being available to them. For example, if they are the 'family nurse' and thus responsible for health related matters, then they may not be in a position to access such support from personal sources as it is their 'job' to do that for the rest of the family during times of family ill-health or in this case, bereavement.

The data also indicated work sources (particularly supervisors) as being "socially dissupportive" in some cases, in that they seemed to "discourage the open expression of beliefs and feelings...and...discounted the appropriateness of a person's beliefs, interpretations and feelings" (Malone 1988). Nurses working in such environments would not see supervisors and co-workers as workable

alternative sources for the sharing of personal feelings and confidences. Therefore in the case of personal bereavement, who could/would a nurse turn to? The answer is probably no-one. Instead they would tend to internalise or suppress their feelings and emotions (Stedeford 1984; Engel 1962) with potentially serious implications for their health (Deutsch 1937; Malone 1988).

With regards to more practical 'instrumental' support, it would appear that again the nurse's needs may not be met unless what was required was a 'right' (in this case to sick or compassionate leave), and even then it would be offered with reluctance by some managers. However the invasion or overlap of private into professional life may be more subtle than this, a nurse may feel unable to deal with her typical patient group perhaps because they are of a similar age, or share a pathology with the deceased for example. Such a person might benefit from temporary reassignment, or perhaps even a few days to recover some composure. However little such help would appear to be either expected or forthcoming, the implication being that they would just have to get on with things as best they can, with a tacit acknowledgment that private issues should not be allowed to impinge into the work arena. As will be shown from the data from Questionnaire 2 and the interviews with bereaved nurses, any overlap which does occur, is typically from the 'professional' into the 'private'.

The negativity towards work sources and in particular supervisors, was most apparent from the sub-scale which an 'outsider' might expect to see them rated the highest source of support, i.e. appraisal, which referred to constructive feedback regarding respondents' job related performance and activity. An interesting point to consider here is why co-workers do not somehow try to make up for this apparent lack of support from supervisors.

Likert (1961) would presumably explain it as being by virtue of the supervisors not providing the lead in supportive behaviour for subordinates to emulate. It could also be due to some degree of competitiveness amongst the work force (Caplan et al 1975), or a manifestation of "horizontal violence" in an "oppressed

group" (Roberts 1983). It should be acknowledged also, that peer support was identified and positively viewed by **some** of the nurses interviewed in this study, as well as by those in other studies (Spencer 1994), though the practice of moving staff regularly (Coxon 1990) will obviously mitigate against this.

That said, given the perceived lack of appraisal support from all sources, it is not really surprising that people such as Larson (1987) have found that many nurses and midwives have "helper secrets", and as such are unwilling to share their fears and uncertainties about their practice; that nurses over-rate their abilities in respect of their work such as in communications, empathy (Murphy et al 1992) and Cardio Pulmonary Resuscitation (CPR) (Crunden 1991); and that they feel uncomfortable being watched, when they receive little or no constructive feedback regarding their performance. It may also go some way towards explaining why Brooking (1986) took the view that nurses spend their time "avoiding negative outcomes rather than promoting positive ones".

The issue of assertiveness skills, and their perceived lack amongst nurses (Milauskas 1985; Kilkus 1990) is also pertinent to mention at this juncture, as there is a belief that an outcome of not possessing such skills is that it can lead to difficulties in both receiving and giving constructive criticism, and thus goes some way towards explaining the phenomenon of work sources being rated so low. That is, it may not have been welcomed or encouraged, if offered.

The results from the more emotionally related items (N.B. not just those in that sub-scale) also highlighted that much may also be due to a perceived absence of confidentiality characterising typical nurse - manager relationships. The view that confidentiality is so questioned, is also made evident by the failure of some counselling services set up by managers, or those under the auspices of employers (e.g. occupational health departments). The fact is that they are not seen as independent, and nurses fear reprisals for perceived failure (Hughes and Vaughn 1989; Booth and Faulkner 1986). Such issues are behind many of the recommendations made by Bond (1991) in his guidance paper for people setting

up support groups for staff.

The fear of reprisals may also be relevant to the issue of 'being temporarily re-assigned' discussed earlier, in that nurses themselves would probably not consider this an option. This is because it would require them to admit 'weakness'. This in turn could be problematic because supervisors and managers would then be in a position in the future to reflect on such episodes when completing appraisals or references, and may do so negatively given the apparent 'cope at all times and at all costs' expectation of the prevailing professional culture. Interestingly in her study of the grieving processes of ICU nurses, for patients who have died, Spencer (1994) also found mistrust between staff and supervisors, and that it was a two way process, i.e. it was not only junior staff who were cautious of showing weakness in front of seniors, but vice versa, and this had to be considered when setting up meaningful discussion/support groups.

It may also be that negativity was exhibited by some as a result of conflicts between "segments" of the profession (Melia 1987) i.e. clinical nursing ('working' nurses) and nursing management. At the time of the data collection, nurse managers were typically seen to be aligning with 'general management' (a trend which has continued), particularly with the processes of clinical re-grading, and subsequently 'General Management' and the impact of 'Trust Status' of Hospitals. Hence they were seen to be following an agenda that did not have the interests of rank and file nurses at heart. The negativity may also have been a manifestation of oppressed group behaviour, as indeed might the often uncaring attitude of nurse managers towards subordinates appealing against what they considered to be degrading instead of re-grading.

Finally it should be acknowledged that managers may indeed have been (and continue to be) un-supportive of staff, but that this was not due entirely to the fact of their being nurses. The feedback from respondents may also have reflected a general malady in labour relations in this country, whereby managers

in general do not see 'pastoral care' of their subordinates as necessary or even important. There remains an irony however, that throughout all the above changes, nursing and midwifery staff have been exhorted to display a caring attitude towards their clients (Patients Charter, The Named Nurse, as well as locally planned initiatives) yet they have apparently not been afforded a caring attitude by their superiors at all levels. There also remains the axiomatic paradox of nursing - that the most caring of 'professions' does not appear to care for its own members (Meissner 1986; Roberts 1983) Furthermore, organisational stress has not been diminished (Dionne-Proulx 1993), and solutions to individual nurses' stress remain firmly with the individual and enhancing their 'fit' to the job, rather than any attempt at the converse.

The final issue to discuss from this data, is the fact that using self reported questionnaires rather than observation means that the data can only be used to identify that respondents **perceived** social support to be lacking, and not that this was actually the case in reality. This is of particular pertinence here, if considered along with data from other parts of the study, e.g. item 19 from the 'coping' questionnaire (I have taken the day off because I cannot face the thought of work). That is, the low level of perceived support may have been as much about the respondents' views on the 'ideal nurse', based upon their professional socialisation and the vocational work-ethic engendered therein, and, their (un)willingness to accept help when offered for fear of appearing weak, than it was necessarily a reflection of reality. Thus, it may be that some respondents would not consider being moved for a time if work was difficult, or take personal time off, for fear of being labelled unprofessional or a non-coper, while others would not even consider this because to do so would threaten their self-concept as a 'coper' too much.

This scale overall therefore met its intended aims, in that it provided insight into both the potential sources of social support for nurses and midwives, and the ways in which it is provided (or not). In doing so, it informed the wider study greatly as it provided information and insight into the key areas of:-

the perceived levels of the four modes of support, both in personal life and at work; the possible interaction between the private and working lives of nurses; the 'culture' of nursing regarding staff supporting each other; also (to a degree) the nature of male-female relationships. All of which could impinge upon and complicate the grieving processes of a bereaved nurse.

Chapter 5.

Treatment of Data and Results.

Section E:

**The socialising context of nursing
questionnaire**

This instrument was devised to explore aspects of nursing and midwifery culture, and the expectations that nurses and midwives feel they are governed by or measured against. Such expectations include self-expectations and those of the profession(s), society and the professional's family. As a result the questionnaire was analysed in four sections, by virtue of its content, ie. Coping/control items (5);
Expectations of families items (2);
Attitudes toward information giving items (2); and,
Professional orientation items (9).

As recommended by Green (1988), certain items were 'negatively' phrased so as to mitigate against subjects answering a series of questions the same way. The 'rule of thumb' for scoring items discussed in the methodology chapter (a score of five being nominally attributed to the response that concurred with the research question/premise at issue in the item) was used here. Therefore each item is written in full and the scoring system made clear throughout.

COPING BEHAVIOURS ITEMS.

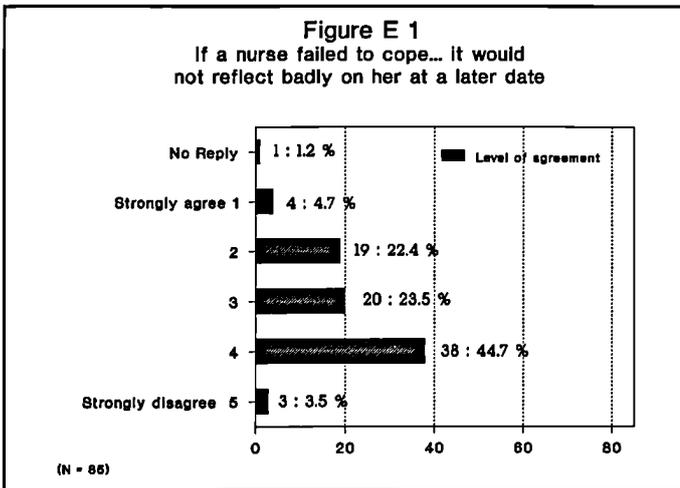
These were included so as to examine the 'ideal image' of nurses, particularly with regards to the expectations of them to cope at all times, and to be seen to do so by others - both personally and professionally.

See overleaf for items.

Coping 1. (Q.3).

"If a nurse failed to cope with a difficult situation, it would not reflect badly on her at a later date."

Negatively phrased question therefore scored
1 = strongly agree; 5 = strongly disagree.



Thus almost 50% of respondents felt that 'failing to cope' would be held against a nurse in the future, while 27% felt it would not. The fact that the results at the extremes of the scales were low is also noteworthy.

The mean = 3.16

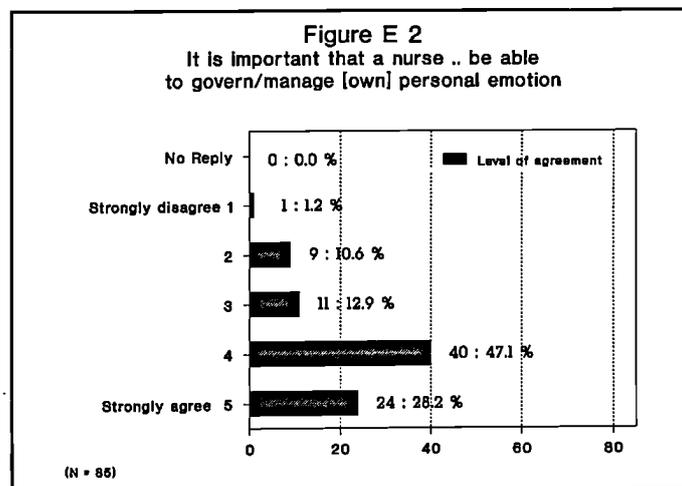
Coping 2. (Q12)

"It is important that a nurse/midwife is able to govern and manage disturbing personal emotions in herself".

Scored as 1 = strongly disagree; 5 = strongly agree.

This shows that over 75% of respondents agreed that nurses/midwives should be able to control their emotions, whilst just over 11% felt the opposite. Only one person strongly disagreed

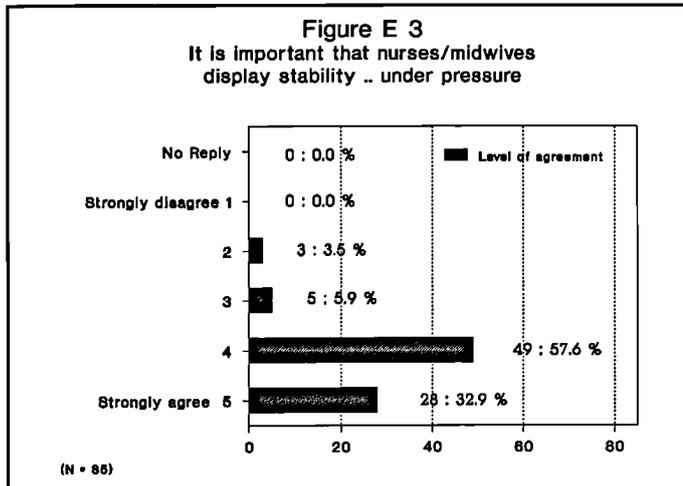
Mean = 3.165



Coping 3. (Q15)

"It is important that nurses and midwives display stability and endurance under pressure".

Scored as 5 = strongly agree; 1 = strongly disagree.



This shows that 90.5% of respondents perceived it to be important that nurses and midwives are 'stable' when under pressure.

Only 3.5% disagreed with this - none 'strongly'.

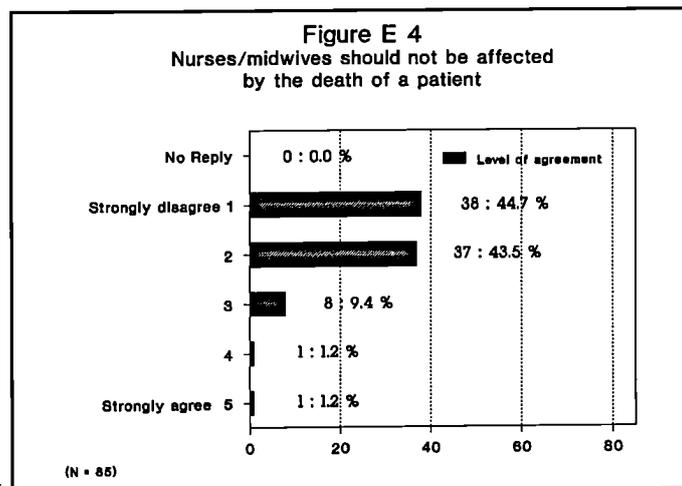
Mean = 4.2

Coping 4. Q16)

"Nurses/midwives should not be affected by the death of a patient".

Scored as 1 = strongly disagree; 5 = strongly agree.

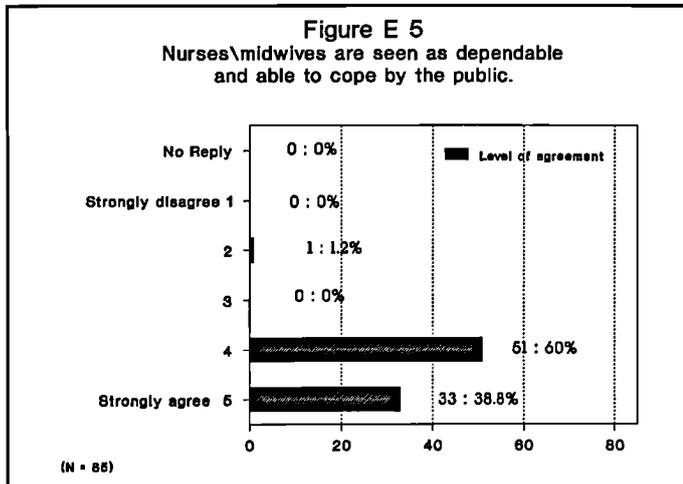
This shows that almost 90% of respondents felt it 'okay' for nurses and midwives to be affected by the death of a patient. Only 2.4% disagreed with this. Mean = 1.706



Coping 5. (Q18)

"Nurses and midwives are professionals seen as dependable and able to cope by the public".

Scored as 1 = strongly disagree; 5 = strongly agree.



Almost 100% of respondents agreed that this was the perception of nurses/midwives held by the public.

Mean = 4.365

All but one of the items within this subsection can be seen to have similar histograms - i.e. a modal score of 4 and similar spread of results. However, 'coping 4' was almost a mirror image of the others (modal score 2). The mean for this item was significantly lower than the rest, and the % 4 + 5 score was only 2.4%.

Cronbach's Alpha for these items = 0.0927, i.e. no significant internal consistency.

Coping behaviours items - summary and discussion of results.

With the exception of the item regarding nurses and midwives being affected by the death of patients, the results from this group of questions showed that these respondents saw it as necessary and important for nurses and midwives to be able to retain control of situations and their emotions, and to be 'stable' under pressure. Furthermore it seemed that this was expected of them by others. The items therefore successfully elicited the intended information, and in doing so affirmed results from the 'coping' questionnaire regarding the apparent desirability of nurses and midwives retaining personal control. They

also identified that this was an expectation of respondents, both by self and by wider society. Furthermore, the respondents had a tendency to perceive that should a nurse or midwife fail, at some time, to 'cope', then this could reflect badly on him/her at a later date, perhaps in terms of career prospects. This reinforces the view that 'coping' and being seen to cope, are also expectations of the profession(s), and that therefore the majority of these nurses and midwives were apparently in the position of 'professional coper'. These points were underlined by the histogram patterns and actual data provided in the pertinent tables (E1, 2, 3 and 5). Interestingly the other item (fig.4) had a histogram pattern that was almost a mirror image of the others, with over 90% disagreeing that nurses and midwives should not be affected by the death of patients. Unfortunately, the results did not allow discrimination between those who felt that it was 'okay' and would allow themselves to display reactions or condone it in others, and those who believed it **should** be the case yet would not do it themselves in actuality for some reason. This includes the possibility of a fear that they would be seen as a 'non-coper', with the potential sanctions this could entail. The responses to the same question in the 'Ideal v Actual Questionnaire' (results section F) are therefore of great relevance to this. The implication of these data for the wider study is therefore that given this degree of expectation from all quarters, it is not inconceivable that nurses perceive the 'ideal' professional to be calm, collected and displaying minimal affect, at **all** times - including when not on duty.

FAMILY EXPECTATIONS/ROLES ITEMS.

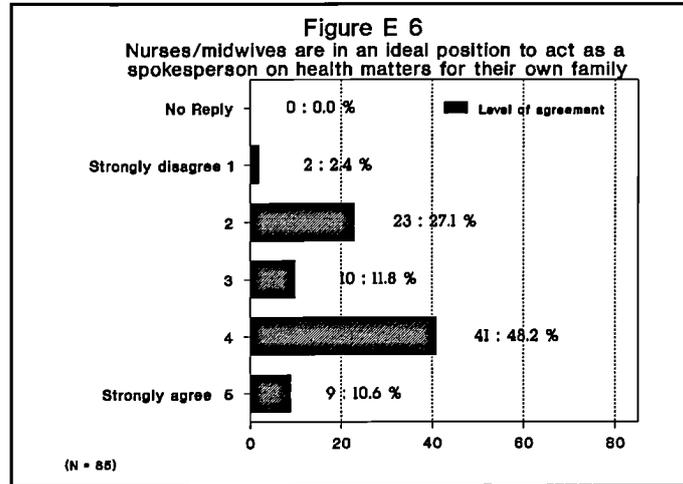
These items were included to examine the respondents' views of the sorts of roles nurses are expected to play in their family. Also to see how satisfied or comfortable they were in such roles. They were obviously designed to triangulate with data from section F, questionnaire 2, and both sets of interviews in this regard. n = 85 throughout. Items in this section were scored:- 5 = strongly agree; 1 = strongly disagree.

Family 1. (Q4)

"Nurses and midwives are in an ideal position to act as a spokesperson on health matters for their own family".

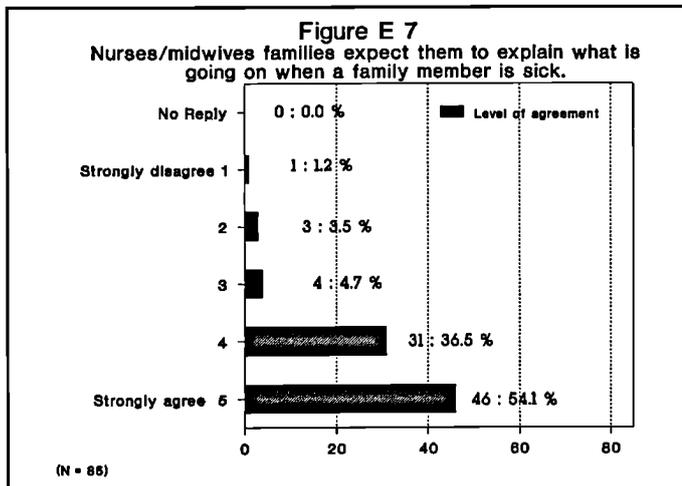
Almost 60% of respondents perceived nurses and midwives to be the ideal family health spokesperson. However almost 40% believe the opposite to be the case.

Mean = 3.376



Family 2. (Q14)

"Nurses/midwives families expect them to explain what is going on when a family member is sick".



From this it can be seen that over 90% of respondents' felt families expect nurses and midwives to explain what is going on during family sickness. Only 4.7% perceived that this was not the case.

Mean = 4.399

The results for this section were interesting in that they formed two distinct patterns, i.e. Family 1 has a bi-polar pattern, the two poles being score = 2 (27.1%), and score = 4 (48.2%). Family 2 however, is unipolar with the answers 4 + 5 being the most common (36.5% and 54.1% = 90.6% overall).

Cronbach's Alpha for these items = 0.4374

Summary and discussion of results - Family Expectations/Roles items.

The results for these items showed that the vast majority (over 90%) of respondents perceived that the families of nurses, do expect them to be the family spokesperson on health related matters. Furthermore almost 60% perceived that they were ideally suited for this role. However by implication, there were a significant number (approx. 30%) who believed that nurses do find themselves expected to fulfil such a family role, yet for some reason they are uncomfortable with it. Thus the items elicited the desired information.

Both these points are of interest to the study in that amongst both groups, there will be a number who may find the role of 'family nurse' problematic, when experiencing the hospitalisation and/or death, of a loved one. Perhaps because they are confronted by the difficulties of being a nurse-relative, and are surprised by them; or because they are expected to fulfil the family-nurse role when feeling less than happy to do so. This being so perhaps, because they know the 'role-uncertainty' (Olivet et al 1991) that may ensue, or because for a while at least, they want the right to be 'just a person', with feelings and emotions to express, rather than to be a calm, collected 'professional copier'.

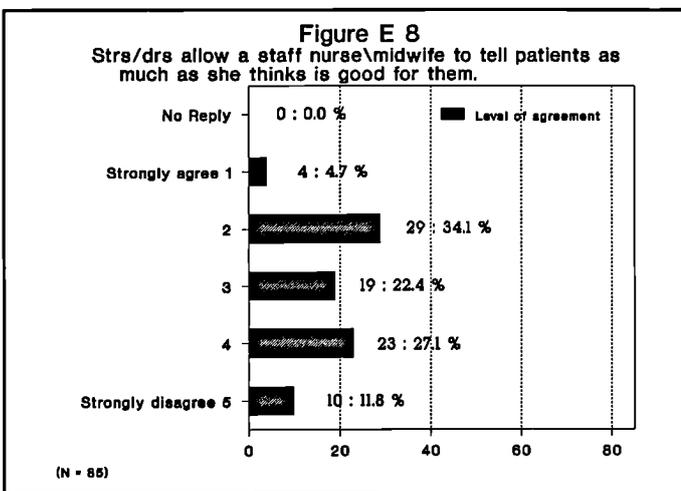
Whatever the cause of the problem, any of these scenarios could present possible obstacles to the normal grieving processes of the nurse involved, in that they would be expected to be the family 'tower of strength' at a time when they need to grieve as well. The data also identifies the probability that most of these nurses will find themselves expected to be a nurse 24 hours a day, when 'required'. This issue will be returned to in the next section of results.

DIVULGING INFORMATION ITEMS.

These items were included to examine the stated attitudes of respondents towards the issue of nurses autonomously giving information to patients and relatives. Items in this section were scored as:- 1 = Strongly Agree; 5 = Strongly Disagree.

Information 1. (Q7)

"Sisters and doctors allow staff nurses/midwives to tell patients (and relatives) as much about their physical and emotional condition as the nurse thinks is good for them".



This shows a bipolar pattern of answers, with almost exactly the same number of respondents being in agreement as disagreement (38%).

N.B. almost 25% were undecided (3) for this item.

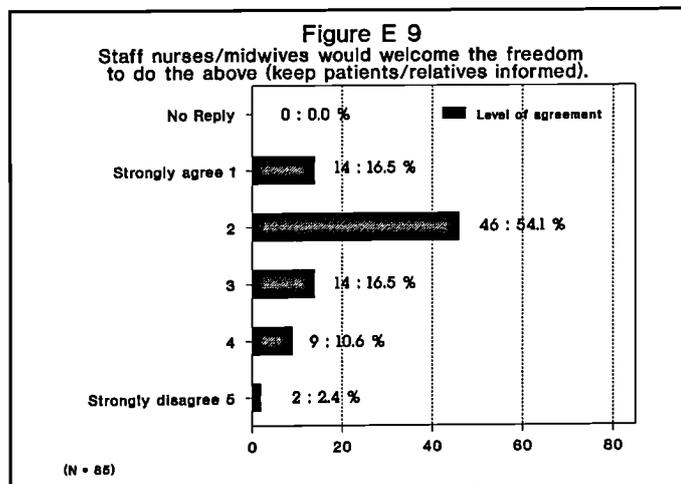
Mean = 3.07

Information 2. (Q8)

"Staff nurses/midwives would welcome the freedom to do the above".

Thus, over 70% of respondents perceived that nurses and midwives would like the freedom to give information to patients, just over 16% feeling this 'strongly'. Only 13% felt that they would not like this freedom. Mean = 2.282

Cronbach's Alpha for these items = 0.4064



Summary and discussion of results - information giving items.

The results for these items were perhaps less conclusive than the others in this section of the questionnaire, in that respondents tended to answer more within the middle ground of response options. This was particularly so for question 7 (fig.E8) where there were equal numbers agreeing and disagreeing about whether sisters and doctors allow more 'junior' nurses to give patients and relatives information, and almost a quarter were 'undecided' for the item.

This item was intended to question the respondents' perceived autonomy in information giving, i.e. not just the act of giving information sanctioned beforehand by higher authority and hence indicating low autonomy. It would appear from the responses that respondents interpreted correctly the fact that this item referred to nurses telling ...what she thinks is good for them, and therefore indicated that as such, for many their autonomy in information giving at least, was limited.

The issue of whether staff nurses (relatively junior grades in the hierarchy) would welcome the freedom to be autonomous, regarding giving information to patients and relatives, was more conclusively answered, as over 70% said that they would welcome such freedom. In actual fact, the main reason these items were included was to allow some exploration of the readiness of respondents to accept autonomy, with regards to providing information to patients and relatives, and hence if taken at face value the data would seem to suggest that the majority of respondents would have liked the autonomy to divulge information, but felt unable to do so.

PROFESSIONAL ORIENTATION ITEMS (after Corwin et al 1961).

N = 85 throughout.

Scored as:- 1 = Strongly agree; 5 = Strongly Disagree, unless identified.

The items in this scale, which sought to explore the work orientation of respondents, can be seen to fall into several categories:-

items 1, 2, 3 and 9 examined the perceptions nurses and midwives had regarding their role(s);

items 5 and 7 examined attitudes to the humanistic elements of nursing care;

items 6 and 8 referred to the relationships between nurses/midwives and 'authority' - namely doctors and 'hospital policies'.

Item 4 looked simply at the time nurses and midwives said they spent at the bedside.

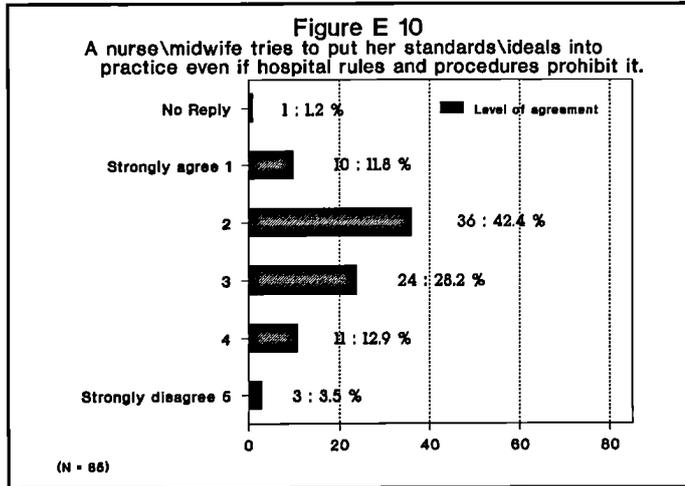
Together they were intended to quantify aspects of the prevailing socialising culture within nursing.

Calculation of Cronbach's Alpha showed insignificant levels of internal consistency for these sub-groups, however there was a significant Cronbach's Alpha for the items grouped together as a whole.

ROLE PERCEPTIONS.

Prof Or 1

"A nurse/midwife tries to put her standards and ideals about good nursing into practice, even if hospital rules and procedures prohibit it".



Thus just over 50% of respondents agreed that nurses and midwives would go against hospital policy.

Over 28% were 'undecided' and 16% disagreed.

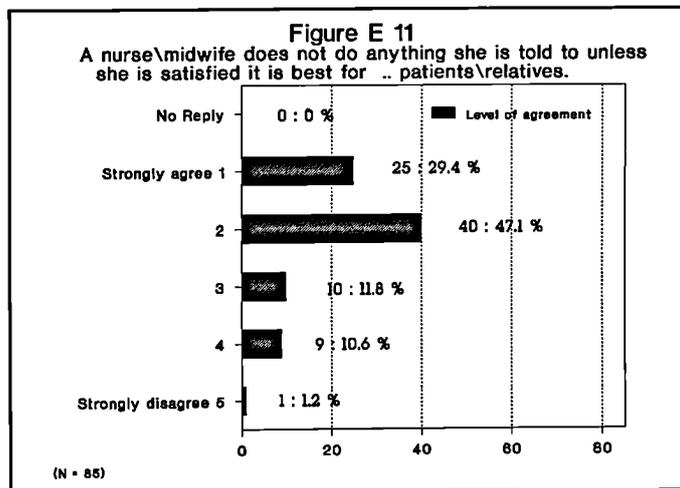
Mean = 2.506.

Prof Or 2. (Q2)

"A nurse/midwife does not do anything which she is told to do unless she is satisfied it is best for the welfare of the patients/relatives".

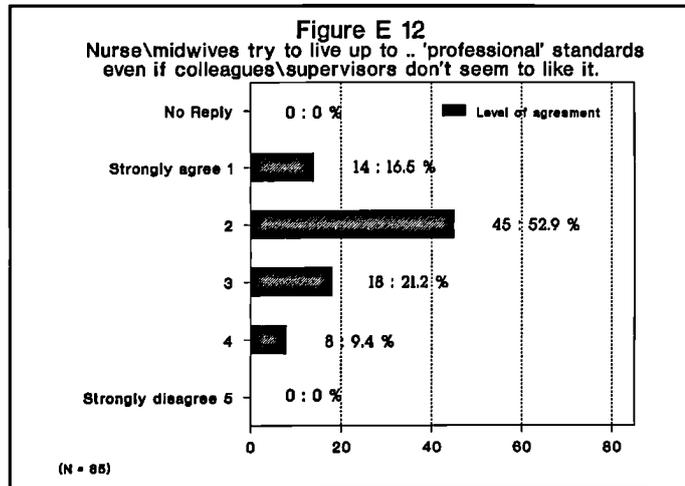
Therefore, over 75% asserted that the welfare of patients and relatives took priority over all other considerations.

Mean = 2.071



Prof Or 3. (Q5)

"Nurses and midwives try to live up to what they think are the standards of their profession even if colleagues or supervisors don't seem to like it".



Almost 70% of respondents asserted that nurses and midwives fulfilled 'professional' requirements even if it 'upset' other health professionals.

Mean = 2.235

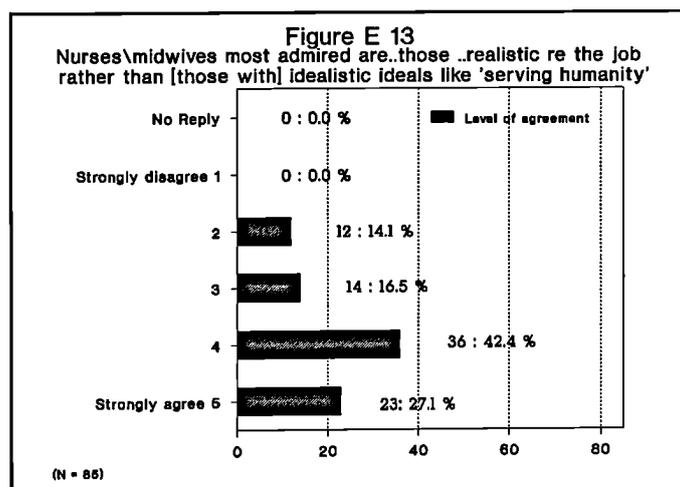
Prof Or 9. (Q17)

"The nurses and midwives who are most admired are the ones who are realistic about the job, rather than the ones who attempt to live according to idealistic principles about serving humanity".

N.B. This item scored 5 = strongly agree, 1 = strongly disagree.

Thus almost 70% of respondents agreed that those who were most admired are those who were 'realistic', rather than the nurses and midwives who followed idealistic, humanistic principles.

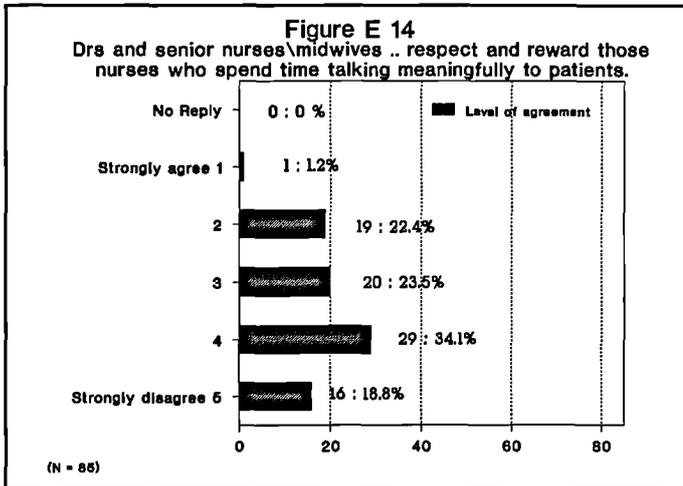
Mean = 3.824



HUMANISTIC ASPECTS OF CARE.

Prof Or 5. (Q9)

"Doctors and senior nurses/midwives at the hospital, respect and reward those who spend time talking to patients meaningfully".



Just over 23% agreed that talking to patients was rewarded by 'authority' figures.

Almost 25% disagreed with this, 18.8% strongly.

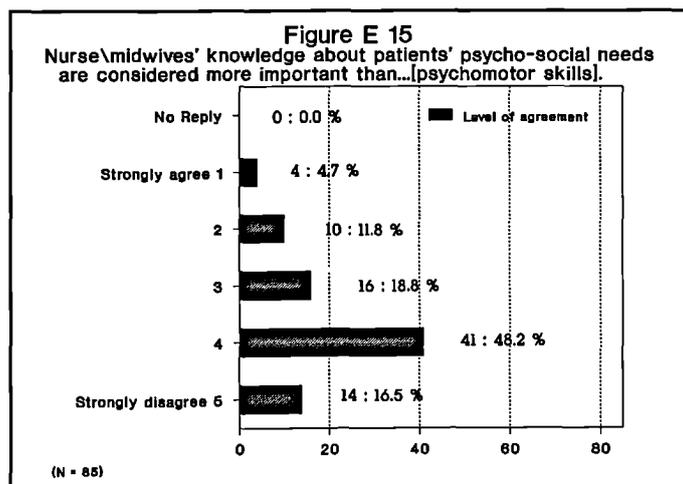
Mean = 3.471

Prof Or 7. (Q11)

"A nurse's/midwife's ability to understand the psychological and social factors in the patients background is regarded as more important than the knowledge of such skills as giving drugs, dressing wounds etc.".

Thus 16.5% of respondents perceived knowledge of psycho-social issues to be regarded as highly as psychomotor skills, almost 65% felt them to be regarded as less important, while almost 20% were 'undecided'.

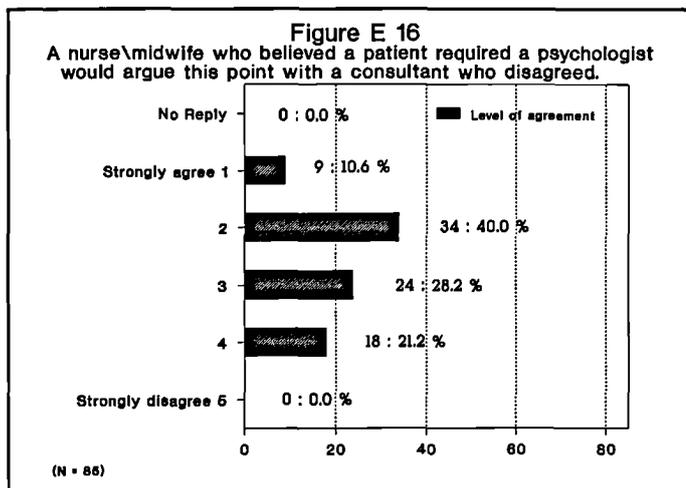
Mean = 3.6



NURSES, MIDWIVES AND 'AUTHORITY'.

Prof Or 6. (Q10)

"A nurse/midwife who believes that a patient ought to be referred to a psychologist would try to convince the consultant of this, even though he disagreed and made this very obvious".



Over 50% of respondents felt that nurses and midwives would 'clash' with a consultant in this way.

However over 21% felt that they would not (none 'strongly'), while almost 30% were undecided.

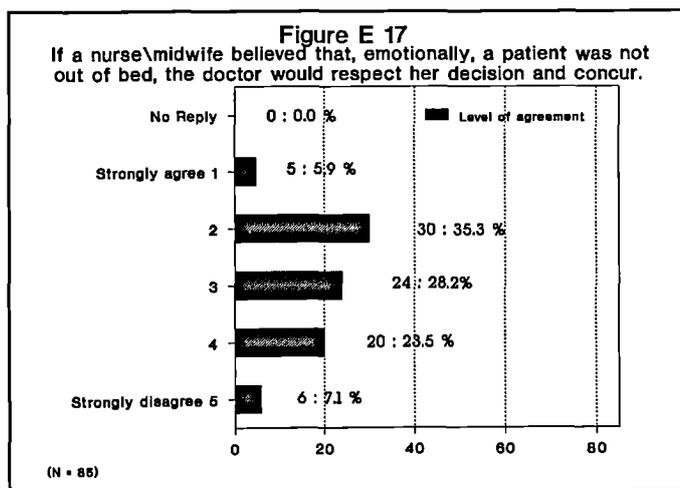
Mean = 2.6

Prof Or 8. (Q13)

"A doctor orders a patient to sit out in a chair twice a day, but a nurse /midwife believes he is not emotionally ready to do so, the doctor would respect her opinion and change the order.

Just over 40% agreed that a doctor would alter such an order based on 'her' say-so. Just over 30% felt that 'he' wouldn't. Almost 30% (28.2%) were undecided.

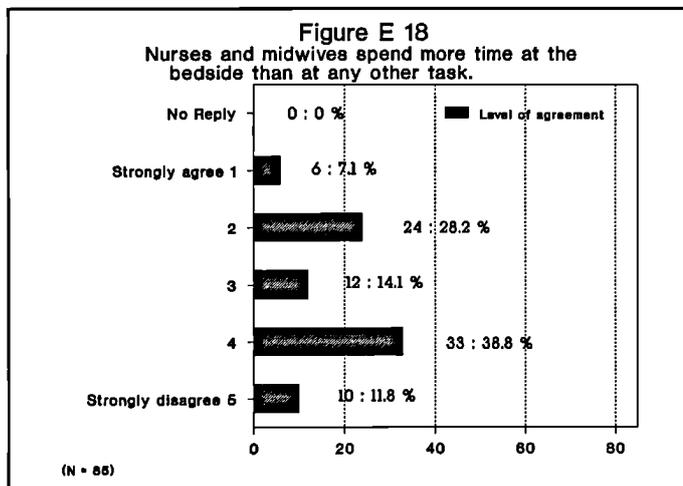
Mean = 2.906



PERCEPTION OF TIME SPENT AT THE BEDSIDE.

Prof Or 4. (Q6)

"Nurses and midwives spend more time at the bedside than any other task".



Over 50% disagreed with this statement (10% strongly).

Just over 35% asserted that it was the case.

Mean = 3.2

Cronbach's Alpha for these items = 0.5393*.

Summary and discussion of results - professional orientation items.

For the items referred to as 'professional orientation' (after Corwin and Taves 1961; Green 1988), it can be seen that the majority of respondents claimed that nurses and midwives utilised a "professional" or "service" (ibid) perspective when making decisions about patient care, this as opposed to a "bureaucratic" (ibid) perspective - when decisions are based upon hospital policy and procedure and/or custom and practice. This was said to be the case even if such 'behaviour' was unpopular or at odds with colleagues, superiors and authority.

The way that such views articulate with those put forward in response to the issue of nurses and midwives being 'realistic' as opposed to 'idealistic' if they are to be respected and admired was interesting, as it would seem that some contradictions existed. For example, being a 'realist' or pragmatist about how and what care is delivered would surely lead to a more bureaucratic orientation, with decisions being made for institutional rather than individual patient's benefits. These respondents said nurses and midwives who were respected

and admired were realistic or pragmatic, whilst also asserting that nurses and midwives in general are prepared to be unpopular or even go against hospital policy and procedures, if it is 'for the good of the patient'. Such points of view not only contradict each other, but also much of what is known and written about professional socialisation (Skevington 1984; Melia 1987; Smith 1992). Also the 'orientation' of professionals such as nurses, midwives and doctors (Corwin and Taves 1962; Green 1988; Brooking 1986). This therefore places the view espoused in this part of the study - that these nurses and midwives put the needs of patients and relatives above all other concerns, in some doubt. As does the data from Questionnaire 2, where the use of open-ended questions illustrates a reality of nurses and midwives being constrained in what they say to patients and relatives, by the rules and regulations of the institution and the diktats of doctors, rather than by professional concerns or the 'rights' of clients.

The items referred to as 'humanistic aspects of care' reinforced this contradiction and doubt. The impression was given that "taking time to talk to patients" and awareness of psychosocial aspects of their patients' background were **not** attributes viewed positively in nursing and midwifery - at least when compared with psychomotor skills and tasks. The above doubts were confirmed by data from the semi-structured interviews, in which interviewees invariably said that standing up for the rights and needs of patients and relatives **above all else** was neither common-place nor recommended, for nurses. This highlights yet again the benefits of triangulation in general, and the invaluable contribution of these interviews within this study.

The items referred to as 'nurses and authority' produced interesting data. Respondents again tended to put forward the view that nurses would put themselves in an 'advocate' role, even if this was obviously at odds with medical staff. Perhaps at this point, it would be pertinent to remember that this questionnaire referred to 'nurses and nursing' in general, not to the respondents themselves per se. This may have therefore affected the responses as they may have answered in terms of what they perceive nurses and midwives **should**

do, and not necessarily what they **would** do in actuality. The issue of social desirability is therefore obviously an issue here.

The final item in this section was there more as a 'distracter' than anything else. Interestingly however, more than 35% of respondents said that nurses and midwives spend more time at the bedside than any other task. However over 50% said that they don't. No significant correlation could be found between respondents putting forward this view and biographical data, i.e. it was not a function of age, rank, years of service or speciality. Anecdotally however this is one of the biggest complaints nurses particularly claim to have - that they are not allowed enough time at the bed-side due to paper-work, student supervision etc. Therefore either 35% of respondents were from areas where such obstacles had been circumvented, or they were answering in the 'ideal'.

Given these contradictions and paradoxes caution must be exercised when postulating any implication from the results of this tool. One is drawn to the conclusion however that social desirability was indeed an issue here, and that whilst not wishing to admit it (consciously or otherwise), a number of respondents gave answers which could be said to reflect a 'bureaucratic' orientation.

These items therefore succeeded in exploring the work orientation of respondents, and quantified aspects of nursing culture as intended. Data reflected the outcomes of similar studies in the past - Corwin et al (1962) and Green (1988) in particular, when they found that the majority of nurses they surveyed possessed a bureaucratic orientation to their work although they tended not to admit to this.

That said, implications for the study, are that a bureaucratic orientation tends to characterise and lead to, patient care provision which nurse-relatives may find difficult to accept for **their** relative. Also that what some respondents claimed,

for example regarding their attitudes towards relatives and their commitment to giving information more freely, may not necessarily be reflected in their practice. In other words cognitive awareness but behavioural denial may have been identified here, perhaps as a mechanism for resolving cognitive dissonance.

Chapter 5.

Treatment of Data and Results.

Section F:

The 'Ideal' versus 'Actual' Questionnaire

This questionnaire was also analysed in sections, nominally under the headings of coper, family expectations, and information giving, but also in pairs. The pairs arising from the fact that respondents were asked to answer each item twice, once for how they felt they **should** [be allowed to] act, and then again for how they felt they **would** [be expected to] act.

Ideal answers are the odd items of each pair, e.g. S1, S3..;

Actual answers are the even items of each pair e.g. S2, S4..

Certain items in this section were reverse scored in an attempt to control the tendency of subjects to answer a series of questions the same way. Due to this, the 'rule of thumb' discussed in the methodology chapter and used in section E was again followed.

The majority of the items in this instrument were 'coper' orientated, with various aspects of coping being examined, i.e. some were concerned with the expectations of the role of the nurse, and some related to the issue of personal control. Therefore the grouped 'coper' questions were:-

- a) Personal/professional role expectations, - Q's 1, 2, 6, 7,
and expectations of support - Q's 10, 12 and 14.
- b) Coping/Control - Q's 3, 8, 11 and 13.

Other item groups were 'Family expectations' (Q's 4 and 9) and 'Information giving' (Q 5). All items were intended to triangulate with related questions in the previous section of the questionnaire, and were posed for the same reasons.

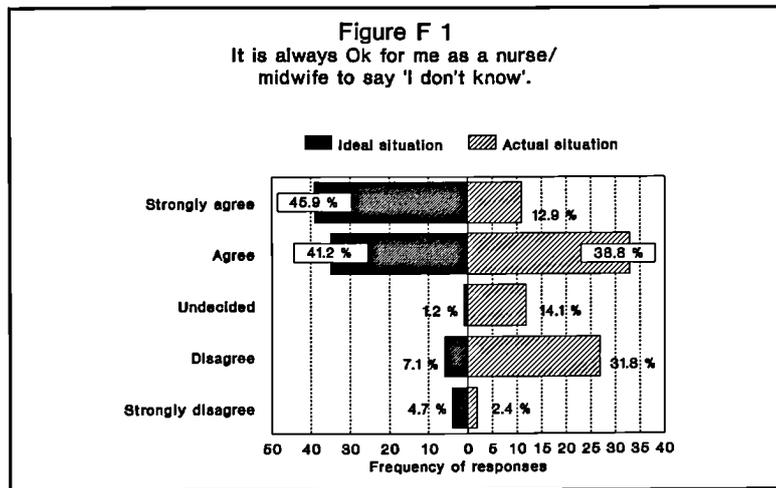
T-tests of the means for 'ideal' and 'actual' responses were carried out for each item - t-values and levels of probability are shown for each item (* = < .05 : *** = .001). Degrees of freedom for each was 84. n = 85 throughout. For reasons of easier assimilation of patterns within the results for the reader, the values shown in the diagrammatic representations of the data, are stated in percentage terms.

Personal and professional role expectations and expectation of support items:-

Question 1. (S1 + S2)

"It is always okay for me, as a nurse/midwife to say 'I don't know'"

1 = strongly agree, 5 = strongly disagree.

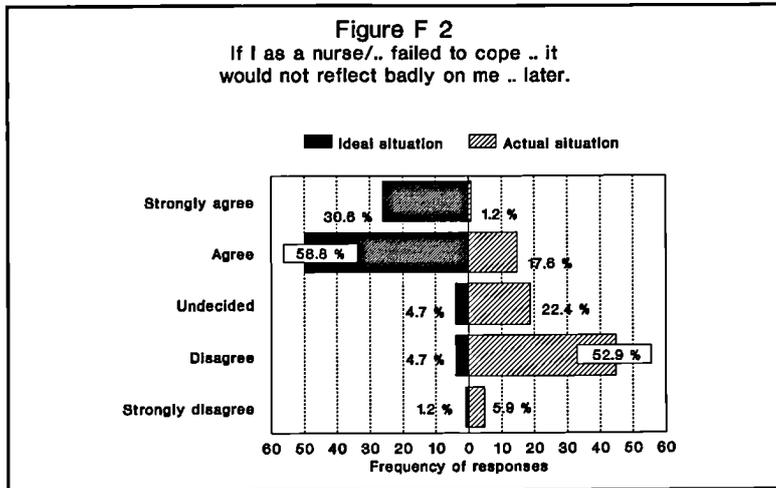


Means: Ideal 1.835. Actual 2.718. t-value = -5.92***

Thus almost 90% of respondents felt that it should be okay to admit it when they don't know something, whereas this dropped to around 50% in actuality. Furthermore, the degree of agreement/disagreement varied greatly - 46% and 13% 'strongly agreed' (S = 1) for Ideal and Actual respectively. The converse was true for 'disagreed (S = 4+5) as can be seen in figure F1. The most notable difference was that between the S = 1 and S = 4 scores. It should also be noted that only one person was 'undecided' (S = 3) for the ideal situation

Question 2. (S3 + S4) - "If I as a nurse/midwife, failed to cope with a difficult situation, it would not reflect badly on me at a later date".

1 = strongly agree, 5 = strongly disagree.



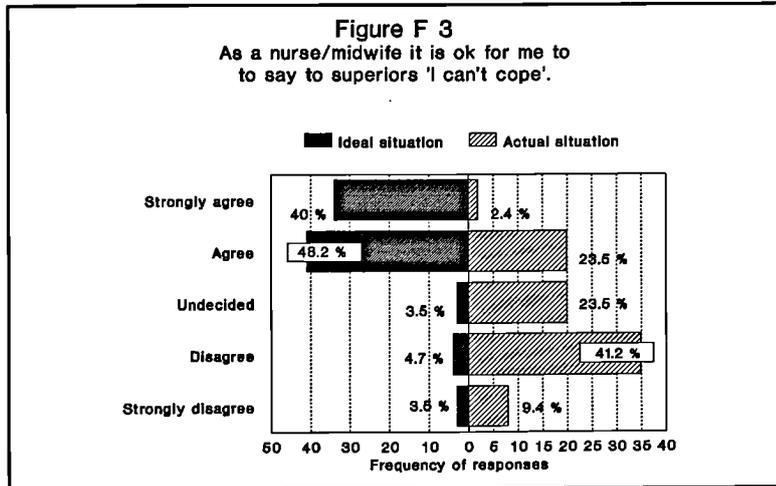
Means: Ideal 1.871. Actual 3.447. t-value = -11.65***

This shows that almost 90% of the nurse and midwives felt that 'ideally', failing to cope should not reflect badly upon them at a later date but in reality less than 20% expected that this would be the case. Almost 60% felt that it definitely would be held against them (s = 4 + 5). The 'undecided' figure rose from 4.7% for Ideal to 52.8% for actual. Only one respondent strongly disagreed that failing to cope would not be held against her as a nurse or midwife.

Question 6. (S11 + S12)

"As a nurse/midwife, it is okay for me to say to superiors 'I can't cope'."

1 = strongly agree, 5 = strongly disagree.



Means: Ideal 1.835. Actual 3.318. t-value = -9.15***

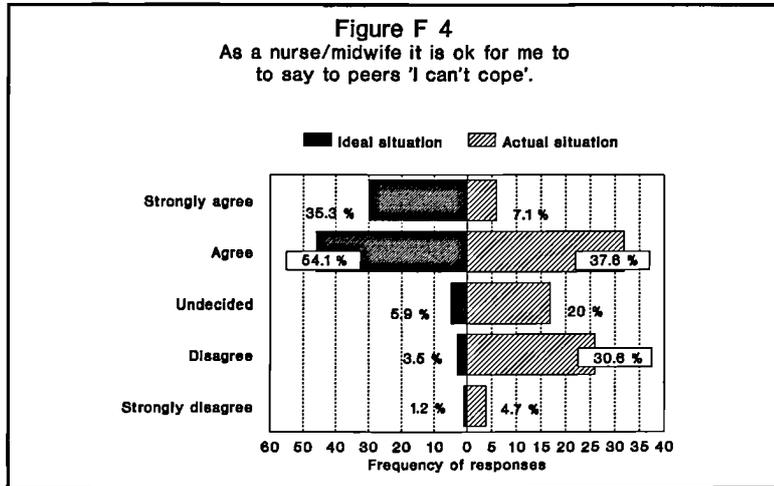
This shows that 90% of respondents believed that they **should** be able to confide in their supervisors when they can't cope, but only 25% felt that they actually could. The 'undecided' figure rose sharply from the Ideal to the Actual i.e. 3.5% to 23.5% respectively.

The s = 4 + 5 results reveal that 8.2% of respondents did not feel that admitting one can't cope to a supervisor was a correct thing to do - even in the 'ideal world'. In the 'actual' item, this figure had risen to over 50%.

Question 7. (S13 + S14).

"As a nurse/midwife, it is okay to say to peers 'I can't cope'."

1 = strongly agree, 5 = strongly disagree.



Means :- Ideal 1.812. Actual 2.882. t-value = -9.07***

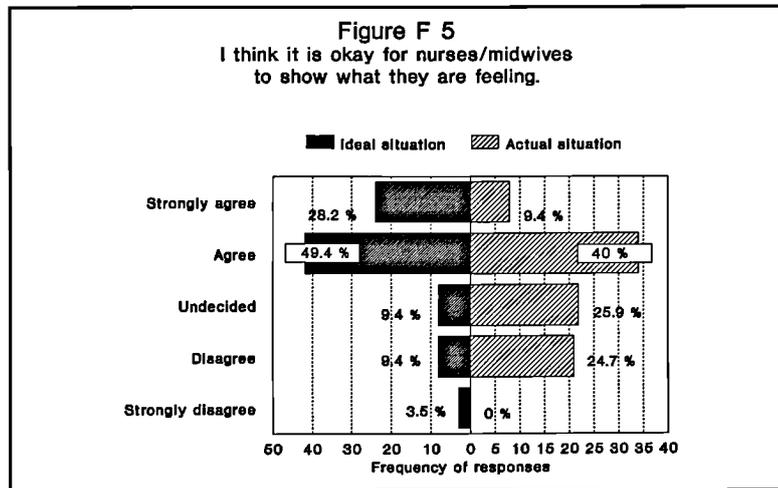
Again, the vast majority (89.4%) of respondents asserted that it **should** be okay for nurses and midwives to say that they can't cope - this time to peers. However, less than 45% felt that they actually could.

Over 35% 'disagreed' (s = 4 + 5) in 'actuality'. In the 'ideal' sense the 4 + 5 score was 4.7%.

Question 10. (S19 + S20).

"I think it is okay for nurses/midwives to show what they are feeling".

1 = strongly agree, 5 = strongly disagree.



Means:- Ideal 2.106. Actual 2.659. t-value = -4.60***

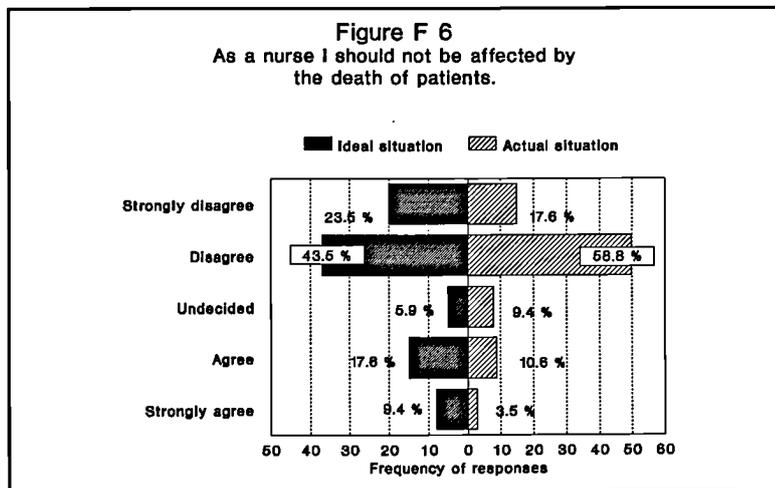
This shows that over 77% of respondents felt that **ideally** it should be okay for them as nurses or midwives to show what they are feeling. This figure dropped to 50% for 'actuality'.

Over 25% were undecided for the 'actual' aspect of this item, compared with less than 10% for the 'ideal'. Therefore, almost 25% of respondents seemed to be saying that they perceived it to be less acceptable/desirable in actuality, for nurses and midwives to show what they are feeling, than ideally. This histogram pattern came about as a result of the vast majority of respondents rating their 'actual' answer lower than their 'ideal', i.e. only 8 respondents bucked this trend for this item. For actual data on the I v A patterns for this item please see appendix 4.

Question 12. (S23 + S24).

"As a nurse/midwife I should not be affected by the death of patients".

1 = strongly disagree, 5 = strongly agree.



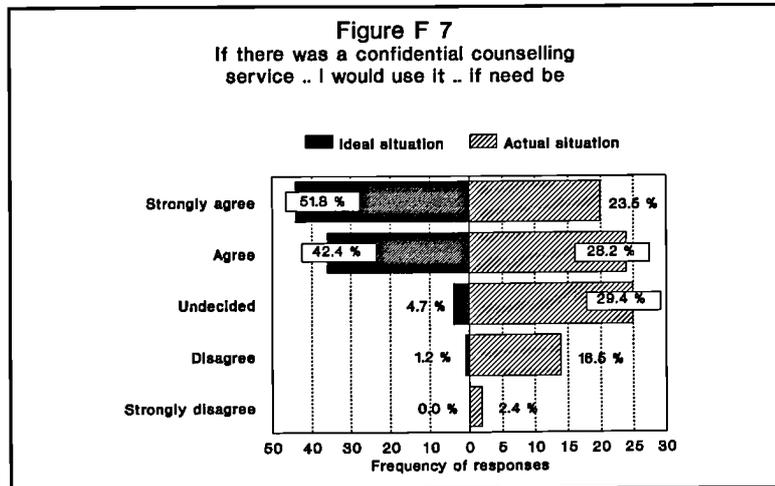
Means :- Ideal 2.459. Actual 2.235. t-value = 1.54

This table shows that approximately 70% of respondents disagreed that they, as a nurse or midwife, should not be affected by the death of patients - in both the ideal and actual domains. The 4 + 5 (agree) score for 'ideal' was almost twice that of the 'actual' (27.3% : 14.1%), thus there was a noticeable trend but no significant difference between the means for the ideal and actual. A comparison with the related item from section E is interesting, as the 4 + 5 score there was 2.4% (i.e. 2 people), with a comparable 'undecided' score (approx 9%). A comparison of the histograms however shows an increased tendency to perceive that nurses and midwives should not be affected by the death of patients, when respondents spoke of 'I' (not nurses in general), and when offered the 'Ideal and Actual' options.

Question 14. (S27 + S28).

"If there was a confidential counselling service available to all employees, I would use it if I felt the need".

1 = strongly agree, 5 = strongly disagree.



Means :- Ideal 1.553. Actual 2.459. t-value = -8.71***

This shows that almost 95% of nurses and midwives asked, said that in an ideal world, they would utilise a counselling service. This figure dropped to 51.8% (23.5% = 5) in actuality. The 'undecided' figure also altered significantly i.e. I = 4.7%, A = 29.4%

Table F 7(i) shows Cronbach's alpha values for the grouped 'coper' items.

Coper Items	Cronbach's Alpha
1,2,6,7,10,12,14	0.55*

* denotes significant level of internal consistency.

Thus the groups of items identified as having common content, were found to be answered in the same way by the same respondents i.e they were consistently of a similar view for related items.

Summary of results - personal and professional role expectations, and expectations of support

- Q's 1, 2, 6, 7, 10, 12 and 14.

This group of items produced a range of interesting and significant results. Furthermore, they reflected the intended outcome of posing the questions. Trends observable in the histogram patterns were found to be significant at the <0.001 level for almost all of these items, i.e. the differences between the Ideal and Actual mean scores were highly significant, the exception being item 12 which referred to being affected by the death of patients.

The results for question 1 showed that the vast majority ($>85\%$) of respondents felt that whilst they should be able to admit when they are unsure of things, in actuality many felt less able to do so, and attempted to show confidence and apparent knowledge when they didn't know something. Indeed they may even have felt that this was expected of them, and felt compelled to do so.

Question 2 showed that a majority (approx. 60%) of respondents perceived that failing to cope would somehow be held against them at a later date, a much larger majority (89%) felt that this should not be the case.

Questions 6 and 7 viewed together show that many respondents felt unsupported in their workplace, in that they believed admitting to both supervisors and peers that one can't cope, was less 'okay' in actuality than the majority would have liked it to be. This was to the point that over 50% of respondents felt that they could/would not confide in this way to their supervisor(s). Of the other 50%, half were 'undecided' ($S = 3$) compared with 3.6% in the Ideal. The figures for confiding in peers were less extreme, but followed the same trends i.e. 90% said that they should be able to confide in their peers in this way, yet under 45% felt they could/would. A further small, but notable group was the almost 10% who asserted that even ideally, they

wouldn't/ shouldn't admit that they couldn't cope.

These results are obviously of great interest in association with those from the social support questionnaire and Section E, as in many ways they triangulated with data from both tools.

The responses to question 10 (Fig. F5) suggested that 'showing one's feelings' whilst working as a nurse or midwife was acceptable to the majority in the Ideal sense, however in practice, a significant number became undecided (I = 9.4%; A = 26%) or disagreed (9.4%;25%). Visual examination of the response patterns (see appendix 4) shows that only 8 respondents went against the pattern of it being more acceptable/desirable for nurses and midwives to show their feelings in an ideal sense than in actuality.

Following on from this, it would seem that respondents rated the acceptability of being affected by the death of patients (Q 12) in a similar way, that is, it was acceptable to the majority. However, there was a significant minority (>25%) who disagreed with this view, some indeed viewing it even more negatively in the 'Ideal' sense than in actuality. Some people for example seemed feel that it was acceptable, yet questioned whether this should be so, while others may have perceived that they would like it to be the case that they didn't get upset, but they were unable to manage this.

The final question in this section (Q14) showed that there was an assertion made by many in the group, that both ideally and actually, they would utilise a counselling service if need be. However, the level of agreement dropped significantly from ideal to actual, suggesting that many of the nurses and midwives **would** use counselling services **ideally** (only 5 respondents did not 'agree'), but in actuality, for some reason, they would be less likely to do so.

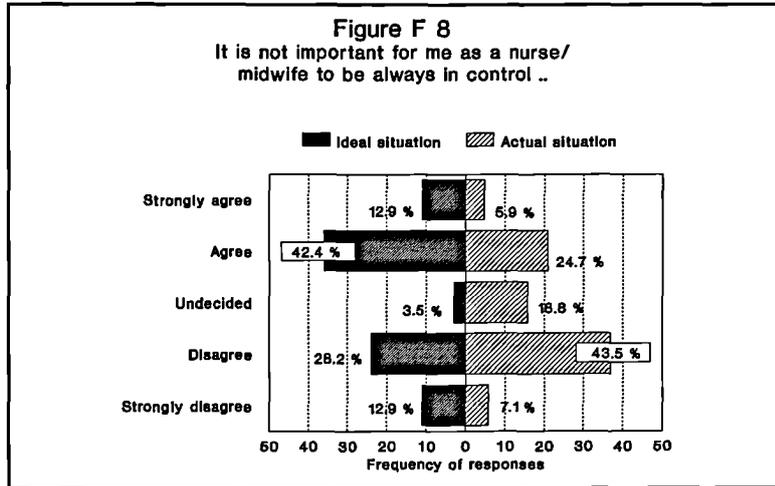
This group of questions seen alongside that from sections D and E, therefore yielded data which invariably showed that the nurses and midwives perceived

that there are high expectations on them to **be copers** and to **be seen** to be such - by peers, supervisors, the public and themselves. Also that they did not feel comfortable confiding in supervisors and peers, expressing their feelings, or with the idea of personally utilising the services of a counsellor. Furthermore, it would seem that whilst being affected by situations and circumstances (such as the death of patients) was perceived as being acceptable, there was a concern for a significant number that perhaps this should not be so.

Coping/control items:-

Question 3. (S5 + S6) - "It is not important for me as a nurse/midwife to be always in control of my thoughts, feelings and actions".

1 = strongly agree, 5 = strongly disagree.



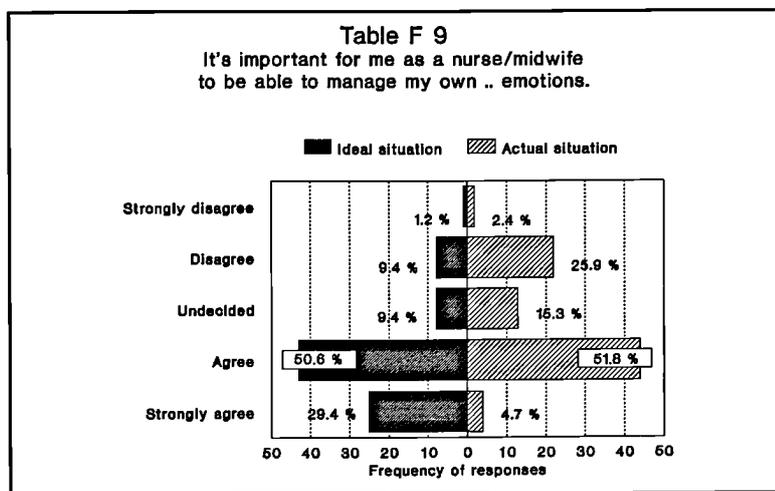
Means: Ideal 2.859. Actual 3.212. t-value = -1.96*

Thus 55% of respondents felt that 'ideally' they should be able to 'lose control' from time to time, whereas only 50% felt that it was actually okay to do so. However, over 40% felt that **ideally** they as nurses or midwives **should not** lose control (S = 4 + 5).

Visual examination of the actual questionnaires revealed that of this 40% (27 people), 14 changed from disagreement (4 or 5) to agreement (1 or 2); 6 remained in disagreement (5 to 4); while the other 7 altered to 'undecided' (3), the point being that the histogram pattern was due to respondents discerning actual differences between 'ideal and actual' - not due to artefact from computing data.

Question 8. (S15 + S16) "It is important for me as a nurse/midwife, to be able to manage my own disturbing emotions.

1 = strongly disagree; 5 = strongly agree.



Means :- Ideal 3.976. Actual 3.306. t-value = 4.71 ***

This shows that over 80% of respondents agreed that ideally, they as a nurse or midwife should be able to control their emotions. This figure dropped to 55% in 'actuality'.

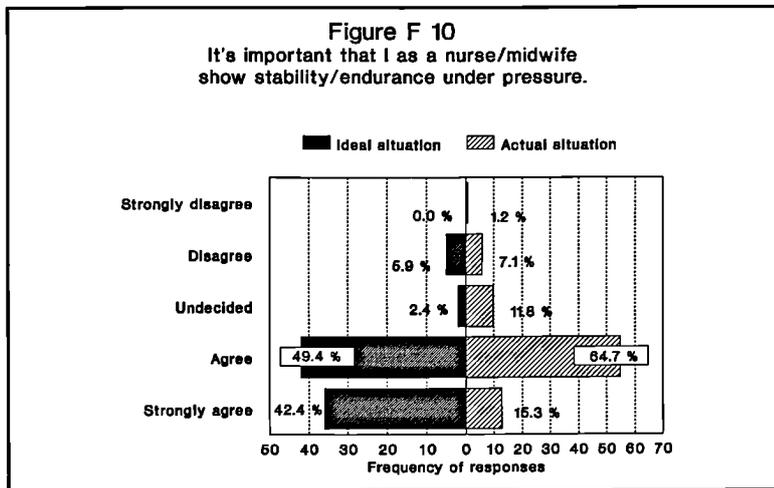
In the 'actual' sense, over 28% rated this item 1 or 2 (disagree), whilst almost 30% rated it as strongly agree (5), thus a bimodal histogram can be seen for this item.

This level of agreement for 'ideal' is even more notable for the fact that the equivalent score for 'actual' was 4.7%. Thus a marked shift towards lower expectations in actuality than ideally was observed. Visual examination of the original questionnaires (see appendix 4 for details), and the Cronbachs Alpha results, reinforce this view i.e. that the trends apparent from the histograms and t-tests are due to respondents identifying different levels of agreement for ideal and actual, and not due to statistical artefact. This is further underlined by the low level of respondents who rated 1 = A for this item.

Question 11. (S21 + S22).

"It is important that as a nurse/midwife I display stability and endurance under pressure".

1 = strongly disagree, 5 = strongly agree.



Means :- Ideal 4.282. Actual 3.859. t-value = 3.98***

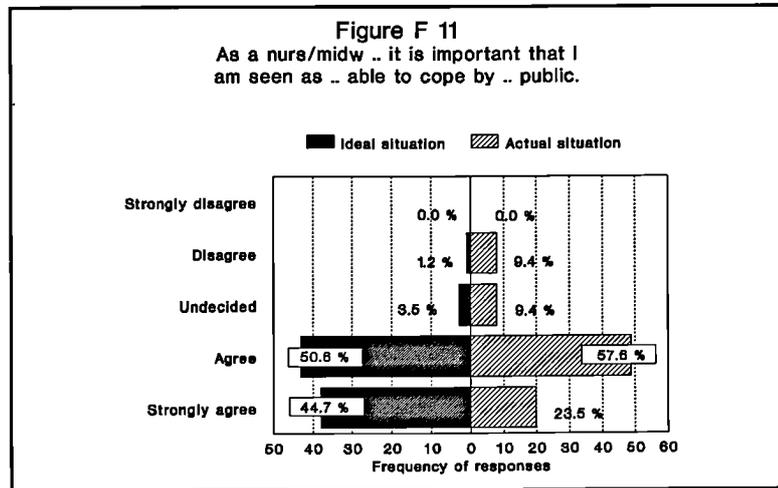
This shows that the nurses and midwives questioned perceived that it was important that they were stable under pressure - both ideally (91.8%) and actually (80%).

The fact that the strongly agree (5) score was significantly higher in the ideal than in the actual (42.4% : 15.3%) is also noteworthy.

Question 13. (S25 + S26).

"As a nurse/midwife and professional, it is important that I am seen as dependable and able to cope by the public".

1 = strongly disagree, 5 = strongly agree



Means :- Ideal 4.388. Actual 3.953. t-value = 4.57***

This table shows that 'being seen as dependable and able to cope by the public' was important to respondents, in both the ideal (4 + 5 = 95.3%) and actual (4 + 5 = 81.1%) domains. The degree of agreement differed however, with S = 5 (strongly agree) scores being Ideal = 44.7% : Actual = 23.5%.

Table F 11 (i) shows Cronbach's Alpha data for these items

Coper items	Cronbach's Alpha
3, 8, 11, 13	0.56*

N.B. Internal consistency was even greater for items 8, 11 and 13 i.e. Cronbach's Alpha = 0.6102*.

Summary of results - coping and personal control items.

i.e. Questions 3, 8, 11 and 13.

Data from question 3 seem to show that a majority of respondents (over 55%) felt that they should be able to lose control from time to time, this figure falling to 30% in actuality. In truth, it was expected that the majority of respondents would be of this view, i.e. that it **should** be okay to lose control from time to time, but in actuality in nursing it is not. Interestingly however over 40% felt that even ideally, they as a nurse should not lose control. This means that for a significant number there was an issue of acknowledging an ideal that is perhaps unattainable in reality with the potential for dissonance and a sense of failure. These results therefore provided insight into the culture of professional nursing as intended at the outset.

The spread of results also means that question 3 was one of only 3 in this section of the questionnaire, that failed to produce a significant t-test result when comparing mean scores for ideal and actual, although the patterns of the histograms were different.

Answers for question 8 continued in this vein with the majority (80%) agreeing that nurses and midwives should (ideally) be able to control their emotions - 56% perceiving that this was actually the case. This means that in general respondents were less sure of this in actuality than 'ideally', and indeed almost 30% disagreed ($s = 1 + 2$) as compared to 10% for the ideal. Thus the trend for this item was very much one of 'agreement' i.e. the nurses believed that it was important for them to be able to control their own emotions, both Ideally and Actually.

The issue of 'idealistic expectations' of coping and control was therefore again raised, with some respondents expecting more of themselves than they can actually do. This provides further insight into nursing culture and the expectations of those within it. It must also be acknowledged however, that

there were a number of respondents who perhaps recognised that it is not always desirable or even possible, to control one's emotions all the time.

The spread of results - shown as bimodality in figure F9 - resulted in question 8 also producing a non-significant t-test result, a pertinent finding when one considers the similarity of the items (3 and 8) and the results obtained. Such results gain even further significance in the light of the significant Cronbachs Alpha result for this group of items (expanded upon further later in this section).

A slightly different pattern was seen for question 11, in that the majority agreed that it was important that they as a nurse or midwife display stability and endurance under pressure - both Ideally (91.8%) and in actuality (80%). However, the histograms (Figure F10) again highlighted a drop (albeit slight) in the level of agreement between Ideal and Actual, i.e. the expectation to be stable under pressure was rated more highly in the ideal sense than in actuality - in this case the difference was significant at the <0.001 level ($t = 3.98$). This most certainly reinforces the cool, calm, collected vision of the 'ideal' professional nurse or midwife.

There was a high level of agreement between ideal and actual for question 13 also, where it was seen as important that the public see them (respondents) as nurses and midwives who are dependable and 'copers'. Again the level of agreement dropped from ideal to actual, more markedly in this case.

Cronbach's Alpha results and the breakdown of actual respondent patterns (see appendix 4) showed that these related items were indeed answered in the same way by the same respondents, and therefore trends identified were significant - both in terms of the typical $I > A$ patterns, and the respondents who bucked the trends for some reason. Both patterns were noteworthy, interesting and offer insights into the cultural and social mores of nursing and midwifery culture, and so will be re-visited in the discussion section.

Seen as a whole, this group of items produced data which suggested that with regards to coping and personal control, these nurses and midwives perceived that there was an expectation (by self and others) that they are copers, and that it is important that they be seen as such by the public.

Furthermore, for some, these expectations tended to be even higher in the ideal than the actual, suggesting the existence of 'unrealistic' expectations (again of self and by others) regarding coping and control, and thus the potential for dissonance. In turn this could possibly lead to feelings of negativity about self, and possibly stress and burnout, as found by O'Brien et al (1994) in their study of the relationship of 'perfectionism' and stress, in nurses.

For those for whom the expectations were lower in the ideal than the actual, there is the possibility that perhaps they either possessed a strength of character and resolve, which allowed them to assert their rights as a person as well as a professional, or that they questioned the modern 'trend' towards personalising or humanising the 'professional' nurse persona (Salvage 1990). It may be that there were examples of both attitudes in the responses, unfortunately this cannot be identified from the data.

Discussion - Coping and Personal Control items.

Perhaps the main point to make at the outset of this discussion, is that there were many significant differences between paired items (I v A), and that respondents did seem to discern real differences between Ideal and Actual expectations and presented them accordingly.

Regarding role expectations by self and others, it was very apparent that most respondents perceived there were high expectations on them, both to be 'copers' and to be seen to be so by peers, supervisors and the public. This manifested as a tendency of respondents to say that in 'actuality' they should be able to admit 'helper secrets' (Larson 1987) such as 'not knowing everything' and being able to show what they are feeling, and that many

(> 30%) were ambivalent about the idealistic (over-)expectations held of them regarding 'coping'. Furthermore, an assertion was made that failure to be a 'professional copier' would often reflect badly on a nurse or midwife at a later date - perhaps a reason for respondents not being willing to admit fallibility to peers and particularly supervisors.

The data also suggested that self-expectations to be a 'copier' were also very high. This was demonstrated by the fact that although the differences between Ideal and Actual ratings were usually significant, there were often large numbers of respondents who aligned themselves to the 'professional copier/always in control' position by altering a '5' score (strongly agree) to one of '4' (agree). Thus they followed the trend of I score > A score, but still remained 'positive' for such items. For approximately 10% of respondents, this perception was to the degree that even 'ideally' they asserted that they as a nurse or midwife should be a 'copier', in terms of **always** being in control and being stable under pressure. This would seem to reflect a number of people with extreme self-concepts as 'copiers' and/or those who had been completely indoctrinated by professional socialisation processes. The importance of being seen to be a 'professional copier' by the public was also strongly asserted.

Therefore, although there was a tendency for some respondents to be critical of the 'coping' expectations upon them, and that presumably many would like such expectations to be lower, there was an acknowledgment that in actuality they as nurses and midwives were expected to be copiers, by self, society and colleagues, and that should they allow it to be known that they are not, they may come to regret this in the future.

It is interesting to compare responses to the item which asked whether respondents' felt **they** should be affected by the death of patients (Q 12), with the related item from section E (Q 16) which referred to nurses and midwives **in general** being affected by the death of patients. The main point to observe is the fact that the mean scores for the I v A questionnaire item were both higher

than that from section E, i.e. $I = 2.459$; $A = 2.235$: $Q.16 = 1.706$. This difference was obviously affected by the fact that almost 90% disagreed ($S = 1 + 2$) for the item in section E, compared with approx. 70% for the Ideal and Actual items, and could either identify a lack of consistency on the part of the respondents, or again indicate that some respondents (i.e. 15-25%) had exceptionally high expectations of themselves.

There were therefore two particular issues of pertinence to this study. They being that all influences would seem to encourage nurses to develop a self-concept of a 'professional copier' (perhaps reinforcing personality traits that were present at the outset); and also that nurses would not tend to seek support from peers and/or supervisors, for fear of being seen as a non-coper, which could be held against them at a later date. Both are pertinent to the study as both could serve to complicate the grieving processes of a nurse. The corollary of this is that a bereaved nurse may neither seek help or support, nor perceive the need for it until it is too late.

The item on utilising counselling services shed further light on the issue of respondents' willingness to accept support, as almost 95% said that 'ideally' they would seek counselling - if it was needed, but only 51.8% said that they would 'actually' do so. Such a result could be explained as respondents acknowledging the importance of such services as counselling but a perception that they do not need it (Coper self-concept again), a position perhaps reflected by midwives' decision to scrap their Royal College's plans for a counselling service, albeit on the grounds of cost (approx. £25 pa). Alternatively it could also be that although the item referred to 'confidential' counselling services, the respondents replied whilst cognisant of the issues discussed in the social support questionnaire regarding the perceived confidentiality of hospital run counselling services, and the problems of nurse managers and tutors acting as staff counsellors - both identified as being of importance by Bond in his recommendations for setting up counselling services for nursing staff (1991).

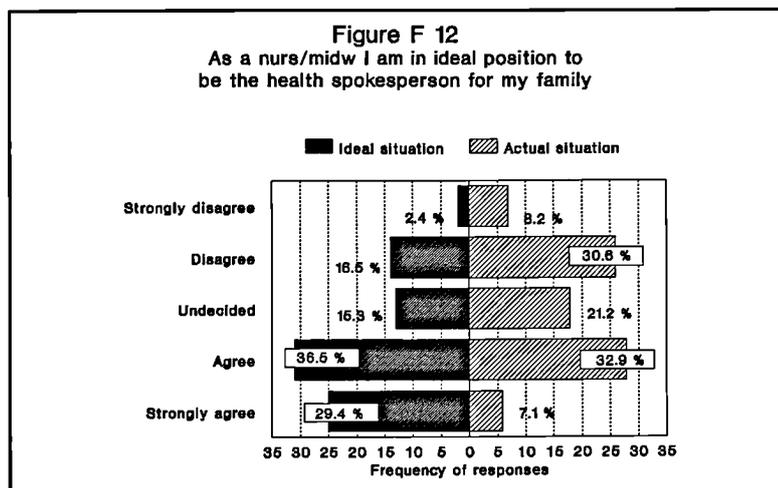
In conclusion then, the tool used was successful, as the data from the coping and personal control items were of pertinence to the study, identifying factors thought to predispose to complicated grief (Murray-Parkes 1972,1975) as being relatively common within this sample of nurses and midwives. This then allowed conjecture that their presence could be seen to be as a direct result of an individual being a nurse - namely a self-concept of a 'coper' and a potential lack of social support, both of which in turn were as a result of expectations of the 'ideal' nurse which was apparent as a cultural norm for this population.

Family related items:-

Question 4. (S7 + S8).

"As a nurse/midwife, I am in an ideal position to act as the spokesperson on health matters for my family".

1 = strongly disagree, 5 = strongly agree.



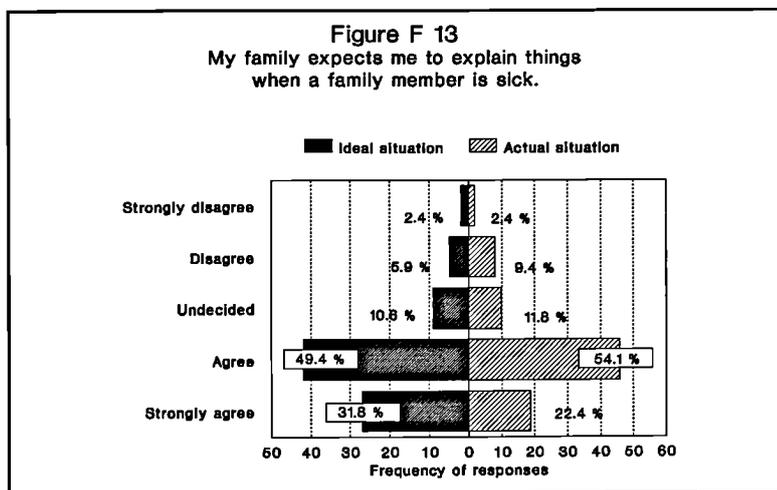
Means :- Ideal 3.741. Actual 3.0. t-value = 4.66***

This shows that over 65% of respondents agreed that in the 'ideal world' they were ideally placed to be the family spokesperson on health related matters, with almost 30% agreeing strongly (S = 5). Almost 19% disagreed (1 + 2 = 18.9%). In 'actuality', the level of agreement dropped to 4 + 5 = 40%, with only 7.1% 'strongly agreeing', while disagreement (1 + 2) rose to 38.8%. The degree of spread across the range led the author to undertake cross-tabulations (using Chi-square) of this item with age, rank, primary patient type cared for, length of time in nursing and having grieved, to see if any of these variables led respondents to particularly agree or disagree with being the family spokesperson on health. No significant relationships were found however. Visual examination of the original data (questionnaires) was also undertaken for this item because of the spread of replies (see appendix 4 for detailed analysis). This showed that there was a degree of ambivalence amongst these nurses and midwives with regards to undertaking this family role. Implications and explanations will be examined in the discussion chapter.

Question 9. (S17 + S18).

"My family expects me to explain what is going on when a family member is sick".

1 = strongly disagree, 5 = strongly agree



Means:- Ideal 4.024. Actual 3.847. t-value = 1.54

This shows that in both the ideal and actual domains, respondents perceived that their families expected them to fulfil this role - 4 + 5 scores = Ideal 81.2%; Actual 76.5%. This agreement between ideal and actual trends and means led to a non-significant result for the t-test.

Table F 13 (i) shows Cronbach's alpha values for the grouped family items.

Family Items.	Cronbach's Alpha
4 and 9.	0.61 (*).

Summary and Discussion of Results - family expectation items.

i.e. questions 4 and 9.

Data from question 4 were very interesting as along with questions 3 + 8, the

histogram patterns showed bimodality in the 'actual' domain. That is, over 65% agreed that ideally, they were in an ideal position to act as the health spokesperson for their family (the family nurse), but this figure dropped to 40% in actuality. This was due to respondents changing to 'undecided' or 'disagree' for the 'actual' aspect of the item, suggesting that 2/3rds of the sample would have liked to be the ideal 'family nurse', yet only 40% perceived themselves to be so. Furthermore, the disagree (1 + 2) figures, differed greatly i.e. I = 18.9%:

A = 38.8%. Therefore, twice as many felt they were **not** actually in the ideal position, than those who thought they **should** be.

The visual examination of the original questionnaires revealed another interesting point, as well as there being a group ($I > A$) who felt that they should be ideally placed to be the family nurse but who in practice are not (reasons unknown); there was another group ($I < A$) who felt uncomfortable with the role (again reasons unknown) yet felt they were expected to fulfil it - both potentially providing grounds for self recrimination for the 'family nurse'. These differences were marked enough to produce a significant t-test result at the < 0.001 level.

Question 9 produced very similar results for both Ideal and Actual, the slight difference being in the 'strongly agree' response rates, which were slightly lower for Actual. This level of agreement led to a non-significant t-test result.

It was apparent from the data therefore, that for the majority of respondents ($> 65\%$) the role of 'family nurse' was not perceived as problematic, as not only did their family expect it of them, but they also felt ideally placed to fulfil it. As for the others however there were some who for some reason did not feel happy with the role, yet felt that they were expected to fulfil it just the same; and others who perhaps felt that they **should** fulfil the role but for some reason (eg. time, geography) couldn't or wouldn't fulfil it.

All three groups are of pertinence to the overall study: the 'complementary' group because exposure to the reality of being the 'family nurse' during a family health/death crisis, may be problematic because of the expectations held of them (to be the coper/tower of strength and the spokesperson for the family) and the role-conflict this can entail (Crawley 1984; Olivet 1991); the 'unwilling' because they may quickly be swamped by the tasks they feel unprepared or unable to undertake; and the 'non-player' because of the potential for guilt and self-recrimination for not playing the part their training is perceived to have prepared them for.

The implication is therefore, that there is a potential for complicating the grieving processes of nurses and midwives, whichever group a nurse or midwife belongs to. Therefore it seems reasonable to assert that a corollary of being a nurse working within the existing nursing culture can be the presence of expectations within self and families, which could possibly lead to complications in grieving for nurses.

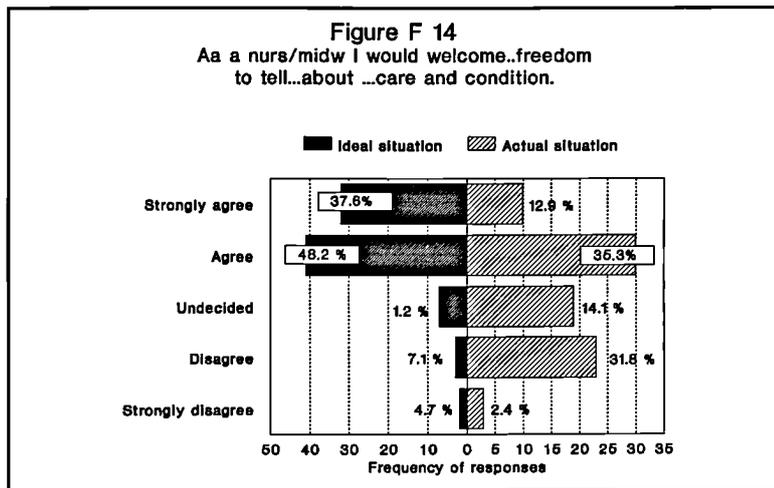
Furthermore, the data reinforces that from section E in that such expectations on the part of families, and a willingness on the part of nurses would seem to ensure that many 'family nurses' will most certainly see their professional role overlap constantly into their personal life, so as to be seen as a nurse 24 hours a day particularly, but not necessarily only, during times of family illness.

Information giving item:-

Question 5. (S9 + S10).

"As a nurse/midwife, I would welcome the freedom to tell patients (and relatives) about their care and condition".

1 = strongly agree, 5 = strongly disagree.



Means :- Ideal 1.847. Actual 2.753. t-value = -7.84***

This shows that in the 'ideal' domain, over 80% of respondents said that they would welcome the freedom to give information to patients and relatives. In the actual domain however, this figure (1 + 2) dropped to around 50%, and almost 35% disagreed (4 + 5).

Summary and Discussion - providing information item.

This item was interesting as it shows that while the majority (over 85%) of the nurse and midwives perceived that they would (or perhaps should) ideally welcome the freedom to give information to patients and relatives, in perceived actuality many have reservations. Indeed almost 35% said they would not like this 'freedom'. The trend was therefore to be more reticent in 'actuality' than in the 'ideal', about taking on such responsibility. Interestingly, the 'Ideal' data from this item reflected that from the related item from Section E, there the majority agreed that they would welcome the freedom to give information to

patients and relatives, however, in actuality a significant number said that they would not welcome such autonomy (and responsibility). The opportunity to answer in the 'Ideal and Actual' therefore presumably gave respondents the chance to distinguish between what they felt was expected of them, and what they feel comfortable with or competent to do. The decision to attempt to triangulate using Ideal and Actual, and 'A nurse' and 'Me as a nurse' was therefore vindicated.

The reasons for the differences between I and A, could be many-fold, ranging from fear of the unknown or an unwillingness to change (Wright 1989); to a lack of self-worth about levels of knowledge (Larson 1987); perhaps a fear of legal ramifications; or concern about reprisals or antagonism from medical colleagues (Rosenthal et al 1980; Richman 1987). Whatever the cause, it would seem reasonable to suggest an unwillingness exists on the part of many respondents, to divulge information to patients and relatives, and may therefore provide some explanation for the shortcomings of nurse - patient/relative interactions identified in other studies. That is, there must be something they are unsure or perhaps even frightened of, which prevents some nurses from being open and honest. This is an issue returned to in the discussion of the open-ended questionnaire.

Chapter 5.

Treatment of Data and Results.

Section G:

The Twenty Statements, and Objects Contents Tests.

As stated in the methodology section, this part of the study was an attempt to discern the respondents' self-concept, using an open-ended tool, so as to avoid leading them, and thus enhance the significance of any trends identified in the data.

The coding and analysis process for these data (a content analysis carried out by volunteers) was discussed in the methodology chapter.

The following headings/groupings were devised, having been chosen ostensibly for three reasons:- because they reflected the essence of the data; because in this form they allowed a degree of comparison between the two scales; and, because they reflected the aims and interests of the research project itself. The only category directly devised by the researcher, was the 'coping' category. Most of the volunteers tended to group such replies with items alluding to professional behaviours. However, because the research had the examination of the concept of professional coping as one of its central themes, it was considered reasonable to separate them.

It seems pertinent to assert here, that even though the 'score' for any particular category may appear relatively low, that category was nonetheless a significant aspect of the self and professional concepts of nurse and midwives who responded to the questionnaire. It should also be recognised that the percentages identified were proportions of all 'responses' i.e. including 'no response' (0), which means that in actuality the results were decreased in dimension by this factor.

Twenty statements test - headings identified and results
(N.B. tabulated data are presented at the end of the section).

Group 1) Personal descriptions.

This included such items as 'I AM...' blonde, tall, fat.

This category had the highest mean frequency of items score overall, i.e. 5.51

responses per respondent, therefore ranked category 1 overall. The range was also high (0-20).

Group 2) Altruistic, personal and humanistic traits.

This included such items as 'I AM....' caring, trusting, amiable, sympathetic, empathic. The items in this category were varied but nevertheless linked, in that they alluded to human (some would say feminine) traits, such as being caring, compassionate.

Mean frequency of response was 3.4 such items per respondent, the range being 0-9. Ranked category 2 overall.

Group 3) Professional/intellectual traits.

This included such items as 'I AM....' confident, trustworthy, conscientious, confidential, educated, eager to learn.

The mean frequency of responses was 1.65 such items per respondent. The range was 0-6 responses. Ranked category 4 overall.

Group 4) Practical traits.

This included such items as 'I AM....' hard-working, tidy, punctual.

This group, somewhat surprisingly ranked 7 overall, with a mean frequency of responses of 0.86 per respondent. The range was 0-7.

Group 5) Personal negative traits/issues.

This was sub-divided into three: Negative personal traits such as 'I AM' ...bossy, careless, impatient; personal weaknesses such as 'I AM....' forgetful, complacent, boring; negative aspects about 'life' such as 'I AM....' always tired, undervalued, worried. All such items were allocated to group 5.

The presence of this category was perhaps less surprising for its presence than for the level of response. It was ranked category 3 overall based on mean

frequency of response rates (mean = 2.54 such items per respondent).

As stated above, this group was made up of three sub-sections, namely negative personal traits, personal weaknesses and negative aspects about life. Of the 252 responses in this category, the actual breakdown of responses for each sub-section was:- 27% (62); 40% (101); and 33% (84) respectively. A fairly even spread. The range was 0-10.

Group 6) Items referring to coping, or referred to in the 'coping' questionnaire.

This included items such as 'I AM....' a copier, reliable, dependable.

In spite of this category being the (only) one identified *a priori* by the researcher, the number of responses in this vein merited its inclusion as a category in its own right. A mean frequency of response of 1.07 such items per respondent was derived for this category, thus ranking it 6 overall. The range was 0-6.

Group 7) Others.

Essentially this was made up of smaller groups of connected items, which had insufficient numbers to merit a group of their own, yet were of interest. This included items like:- professional titles such as 'I AM....' a nurse, a midwife, a manager; other work related/professional references such as 'I AM....' a member of a team, happy on my ward, well trained; being human/a person such as 'I AM....' an individual, vulnerable, not perfect; and, pertaining to health and fitness such as 'I AM....' healthy, fit, active. Of the 167 responses in this category:

- 42 (26%) referred to job titles;
- 57 (34%) made reference to their job;
- 22 (13%) were health related;
- 46 (27%) were 'human' related.

Thus, 60% of responses in this category were work related.

The mean frequency of such items was 1.39 per respondent. Being a composite of unrelated, though interesting items, the relatively high rank of 5 overall is perhaps understandable. The range was 0-8.

Group 8) Unclassified.

These were mainly single item responses, or answers that were ambiguous because the coders were unsure if the item was positive or negative, such as 'I AM....' emotional, a perfectionist, sensitive. By putting them in this section, some interesting items were therefore not lost in the masses of other data.

A score of 0 was allocated to 'no response' as this was felt to be a significant result/answer in its own right. For the TST, the mean response rate for '0' was 10.5 per respondent.

Tabulated data - Twenty Statements Test.

Table G1 shows mean values and range scores for categories 1-8 (plus 0), identified in the TST data.

Group	1	2	3	4	5	6	7	8	0
Mean	5.5	3.4	1.65	0.86	2.54	1.07	1.39	1	10.5
Range	0-20	0-9	0-6	0-7	0-10	0-6	0-8	0-5	0-20

Summary of TST results.

This tool therefore produced data, that in spite of its open-ended nature, allowed meaningful groupings of responses to be made.

By far the highest scoring category, was 'personal descriptions of self' (mean frequency = 5.5), followed by altruistic/humanistic traits (3.4). Personal negative traits (2.54); professional/intellectual traits (1.65); coping traits (1.07), and practical traits (0.86), were further behind. The respondents therefore tended to describe themselves in terms of being things like: caring, amiable and empathic; confident, trustworthy and conscientious; and, hard-working, tidy and punctual. Also to be reliable and a 'coper'. A small but notable number put forward their human-ness, i.e. I am ... "an individual; vulnerable; not perfect".

More prevalent (mean response rate = 2.54) were personal negative traits/issues. This group will be re-visited later in the summary, when comparisons between the TST and the OCT are made. As well as being the highest ranked, 'personal descriptions' was the category with the widest range (3 respondents gave 20/20). None of the other groups, with the exception of 0 = no replies at all, had this spread, their ranges being 0 to 5-10.

Two possible explanations spring readily to mind for this. One is that the respondents gave a large number of 'personal descriptions' because they reflect the stereotypical concrete operations nurse (Theodore 1971) and therefore found this exercise difficult. The other is that they were not prepared to self-disclose more personal aspects of self. From the data one cannot be certain if these, or any other reason explains the finding.

Another salient issue to raise from the responses to this section at least for this study, was the amount of professional/work related attributes and issues referred to within an exercise into self-perception. This reflects a degree of overlap between self and professional persona that will be discussed in detail later.

Objective Contents Test headings and results.

Group 1) Job descriptions, titles and positive roles of nurses.

Such as 'A NURSE IS..' a teacher, a counsellor, professional.

It was perhaps realistic to expect significant numbers of responses in this category (ranked 3 overall), as it is one of the easier ways to describe a professional, i.e. in terms of aspects of their job. It also reflects the wide range of roles that nurses perceive they undertake. The mean frequency of response of such items was 2.05 per respondent, the range was 0-11.

2) *Altruistic, personal and humanistic traits.*

Criteria as per TST group description.

Given the nature of nursing as a caring profession, then one could perhaps have envisaged this as a popular category. Indeed it ranked 1 overall with a mean response rate of 4.6 per respondent. The fact that most of the respondents were female and how this may have affected this result, will be discussed later. The range was 0-10.

3) *Positive professional traits and positive feelings about the profession.*

Criteria as per TST group.

This was a popular category. Again this is perhaps not surprising as the literature is full of material related to the issue of humanistic orientations in nursing, and also the issue of the standing of nursing as a profession. Aspects of professional behaviour are identified constantly in such works so it is no real surprise that respondents produced enough responses in this category to place it 2 overall. The mean frequency of response was 3.25 such items per respondent. The range was 0-9.

4) *Positive practical traits.*

Criteria as per TST group.

This category was ranked 6 overall (mean frequency of response being 1.35 per respondent), with a range of 0-6.

5) *Negative feelings about the profession.*

Such as 'A NURSE IS..' abused by patients, underestimated, a servant.

Again the level of 'negativity' was somewhat surprising (mean frequency of such responses = 1.79 - ranked 5 overall). The range of up to 11 responses in this vein is also noteworthy. The majority of negative feelings referred to the seemingly second class nature of nursing when compared to medicine. Also a

feeling that the expertise and effort of nurses are often unrecognised and/or unrewarded by other professionals (incl. other nurses) and the public.

Other responses reflected upon the fact that nurses are often expected to undertake tasks that are not part of an agreed job description - especially 'menial' jobs (cleaning, moving furniture) and filling in for other professionals (professional and/or ancillary). This was particularly the case for the nurses in the study. The fact that a major clinical re-grading exercise was going on at the time of the data collection phase may have acted as a focus for such thoughts and feelings.

A third sub-group were critical of nurse managers, particularly with respect to the level of support provided by them. This correlates highly with the results from other sections of the study.

6) *Items related to coping.*

Criteria as per TST.

The range for this category was 0-6. The mean frequency of responses was 1.88 such items per respondent - ranked 4 overall.

7) *Other.*

Again responses given by small numbers of respondents made up this group. Sub-groups of particular interest to this study were:- professional practicalities such as 'A NURSE IS..' a shift worker, a uniform wearer, accountable; nurses are human too such as 'A NURSE IS..' part of a family, human, fallible; negative traits of nurses such as 'A NURSE IS..' inconsiderate, strict, a bully.

As in the TST, this was a composite group. It was made up of 91 responses broken down into the 3 groups (above) as 29% (26); 19% (17); and 52% (48) respectively. These sub-groups were interesting as they identify that a number

(albeit small) of responses alluded to the fact that nurses and midwives are also 'people'.

This category had a range of 0-7, a mean frequency of response of 1.2 responses per respondent, and was ranked 7 overall.

8) Unclassified.

As per TST group.

This category had a mean frequency of response rate of 1.1 per respondent - ranked 8 overall. The range was 0-7.

As in the TST '0' was again allocated to 'no response'.

Tabulated data - Objective Contents Test.

Table G2 shows mean scores and range of scores for groups 1-8 in the OCT.

Group	1	2	3	4	5	6	7	8	0
Mean	2.05	4.6	3.25	1.35	1.79	1.88	1.2	1.1	11.6
Range	0-11	0-10	0-9	0-5	0-11	0-6	0-7	0-7	0-20

Summary of OCT results.

The responses for the OCT were similar in nature to the TST in many ways - including the presence of +ve and -ve aspects/traits, in this case of the nursing profession.

In the OCT however, the highest ranking category was altruistic/humanistic traits (mean = 4.6), followed by +ve professional traits (3.25); professional/job descriptions (2.05); coping traits (1.88); negative feelings towards the profession (1.79) and practical traits (1.35).

The ranges also differed. Only the 'no response = 0' category had a range of 0-20, all the others being between 0 and 5-11, with categories 1, 2 and 5 having the widest ranges (0-10/11). There was therefore a narrower band of ranges than the TST.

Therefore, if the responses were used to develop a profile of the perceptions of the respondents, one could say that they viewed nurses as being typically:- caring and empathic; confident, trustworthy and conscientious; and, punctual, tidy and hard-working. Also dependable and 'copers'. In fact, almost the same profile as for the TST results, although not necessarily to the same degree (see later in the summary).

The issue of 'negativity' was referred to in the results section. Three distinct areas of 'complaint' could be identified: the second class status of nurses and midwives as compared to doctors; the number of menial tasks they are required to undertake; and, the level of support given by nurse managers.

Another interesting finding was the small group of respondents who referred to the need for it to be acknowledged that nurses are also people.

A final point of note regarding the OCT is that there were a number of responses to " A nurse/midwife is.." followed by.. .."is expected to"...followed by a response which suggested that the person felt that they were always 'on show' - rather like Rawdon's (1987) "indirect" mode of teaching, where she alerts nurses to the fact that they are 'teaching' clients all the time via their behaviour and manner (e.g. smoking whilst a health promoter, and avoiding or closing difficult conversations).

Comparative analysis of TST and OCT data.

Although the scales, and categories within them were independent of each other, some were so similar in content (humanistic traits and practical coping traits for example) or connected in some way, that at least some attempt at

comparison seemed valid as well as interesting. T -tests were therefore undertaken comparing the mean scores for the numbers of groups of responses for comparable groups in the TST and OCT (e.g. Self and Nurse/Midwife :- humanistic traits; professional traits etc.). Data are presented in tabulated form overleaf.

Table G3 summarises the results of these calculations (n.b. *** = < 0.001; ** = < 0.01; * = < 0.05).

TST heading and rank	OCT heading and rank	T-test	Direction of difference
Personal description (1)	Job description (3)	6.6***	Self > Nurses/midwives
Humanistic traits (2)	Humanistic traits (1)	-4.85***	Self < Nurses/midwives
Professional traits (4)	Professional traits (2)	-7.35***	Self < Nurses/midwives
Practical traits (7)	Practical traits (6)	-3.27**	Self < Nurses/midwives
Negative aspects (3)	Negative aspects (5)	2.42*	Self > Nurses/midwives
Coping traits (6)	Coping traits (4)	-4.70***	Self < Nurses/midwives

(N.B. 'others' and 'unclassified' not included in this table).

Summary of comparative analysis of TST and OCT.

For all 'comparable' groups in the TST and OCT, significant differences were found to exist in terms of overall mean scores, between self perceptions and perceptions of professionals held by respondents. The direction of difference

varying from group to group, and with varying levels of significance.

It would appear that the respondents found it easier to meaningfully describe what a nurse or midwife is, than to describe themselves. This was made evident by the highest mean score overall being physical description of self, with an upper range score of 20.

What would also seem to be apparent, is that humanistic, practical, and copier traits were identified more regularly for 'nurses and midwives' than for self, significantly so in fact. How this articulates with the role model traits identified in section B is interesting, and will be examined in detail in the discussion of this section.

Also interesting was the fact that negative feelings about 'self' (mean = 2.54) appeared more often (significantly so) than negative feelings about the profession(s), yet both had similar ranges. This would seem to suggest that respondents tended to be more negative about themselves than their profession. The nature of the negativity seemed different however, with the negative feelings regarding self typically being self-deprecating and not serious flaws of character, whereas many of the feelings regarding the profession(s) were at times vitriolic, and seemed to underline truly negative aspects of nursing and midwifery picked up by the other questionnaires (see overall discussion section), as well as issues that can be seen as valid complaints about the way nursing was run, and the way nurse and midwives were treated - or at least perceived themselves to be.

A final point to make here, is to reiterate that as the responses were amenable to categorisation under very similar headings for both the TST and OCT, one could say that in spite of there being differences in the response rates between self and nurse/midwife, there were nonetheless great similarities between self and professional perceptions held by these respondents. Indeed as identified earlier, several respondents put the same descriptor for 'I am' and 'A

Nurse/Midwife' is ... suggesting the overlap of the professional persona into self concept, and vice-versa. This in turn identifies a correlation of the respondents views of themselves and 'the nurse/midwife', with Oakley's view (1984) that the "qualities of a 'good' woman are closely associated with those of the 'good' nurse". Furthermore, the expectation of 'nurse/midwife' in many ways can be seen as an enhancement of many of the positive aspects of self, and fewer of the negatives. The issue of the realistic nature of such expectations is explored further in the discussion.

TST and OCT - Discussion

In some ways it was reassuring to the researcher that there were few surprises in the results in that the sorts of responses expected were essentially those received, even though an open-ended tool was used to elicit the data. The value of having independent sorters is also underlined here, as had they not been used, one would have been laid open to criticism in terms of validity and bias. In the event, this methodology therefore essentially worked as intended and provided significant and relevant data regarding respondents self-concept, and their concept of 'the nurse/midwife'.

The fact that the responses of 85 people to such an open-ended tool, could be reasonably categorised into 8 groups suggests a fairly high level of homogeneity in terms of the self and professional concepts of the nurses and midwives studied. It could be said from these data therefore, that the nurses and midwives in the main, perceived themselves to be (in varying degrees) composites of the traits/descriptions identified.

The fact that many of the traits of the 'Ideal' role model put forward by respondents within section B, further reinforces this consensus of opinion about what nurses and midwives 'are', and what they do. There is the possibility however that some respondents found this the easiest thing to do.

An earlier user of the tool (Hartley 1970), pointed out that one would expect

people to include some reference to their job or role in society in their responses to a TST. Indeed "its omission may merit enquiry" (ibid). Furthermore earlier work by the same author suggested that "respondents whose replies fell modally within such a category...were responsive to the role requirements under which they find themselves" (McPartland et al 1961) i.e. they tend to fulfil the roles expected of them - a point of great relevance to a study such as this, which seeks to examine what roles nurses and midwives are expected to play, and how they may affect their ability to grieve successfully. The fact that some respondents referred to feelings of being watched all the time was testament to this perception of being 'on show' with regards to how well they fulfil such roles.

Another point pertinent to this study was whether the preponderance of such responses was due to an inability (e.g. concrete thinking, or lack of self awareness), or an unwillingness to share/explore self on the part of respondents, both of which would reflect their abilities in terms of interpersonal skills. The answer to this is of course pure conjecture but the simplest conclusion is that it was probably an amalgamation of both, to greater or lesser degrees for different respondents. Interestingly, a similar level of description and spread of results was also found in Marshall's study of the perceptions of Baccalaureate nursing students about nursing (1988), thus not only supporting these findings, but also identifying that many beliefs about the roles and functions of nurses cross international boundaries, and importantly for this study, suggest that its findings may have wider generalisability and applicability. There is also the possibility that such responses were so common because it is easier in general, to conceptualise a 'professional' entity such as 'a nurse or midwife' than it is to do so for 'self'.

That the latter was perhaps the case, is reinforced by the fact that the range of scores for the OCT were more constant across the categories than for the TST; that the top 6 response categories for the OCT were 'distinct' categories i.e. not composite groups; and, that a number of respondents put the same

attribute/trait for both self and nurse/midwife on the same line of the reply sheet.

Thus, similar levels of this type of response (i.e. relatively low level description of self and roles) were obtained in both the TST and the OCT. Such responses for the OCT may also reflect the perception amongst nurses in particular that nursing is an amalgamation of many roles, which they assume at varying times and to varying degrees depending on circumstances. The implication of this is that the perceived 'job' of nursing in particular, is to be a jack-of-all-trades which in turn can lead to being a master-of-none and an ensuing potential for lack of self-confidence in one's own ability and worth.

The level of such work related responses and their nature in this sample, along with those pertaining to professional and intellectual traits/behaviours within the TST, would also seem to support the assertion that there was a marked overlap of the 'job(s)' of nursing and midwifery - with their cultural expectations and social mores into the personal lives of nurses and midwives (good woman/good nurse - Oakley 1984).

Comparisons of the mean response rates for related groups, reinforce the presence of this 'overlap' between personal and professional lives and personae. These calculations produced results which if one accepts the proposition that such overlap existed, suggest that the professional persona was seen (at least by these respondents) to be somehow 'better' than the personal, i.e. more humanistic and caring, more intellectual, practical and better at coping and retaining control.

This informed the study in two ways. One in terms of the 'idealised', professional role(s) of nurses and midwives and thus the expected behaviours and socialising norms they are influenced by (behaviours and traits which incidentally were put forward in section B of the questionnaire, as being aspects of the 'ideal' professional role model for nurses and midwives). The other in

terms of the fact that, given the comparison of mean response rates, these respondents did not appear to feel that they matched that 'ideal', with the potential for role-conflict and negative self-concept. This therefore also reinforced the findings of the Ideal v Actual questionnaire, where some respondents appeared to feel intimidated by the expectations held of them by others.

All these assertions could be seen to be contradicted by the presence of a (small) number of items which refer to the respondent being 'human'. However, the fact is that they were low in number (46 in total), and furthermore included phrases like I am... .. "sometimes frustrated ... secure" and, "myself" and it is therefore apparent that not all the responses put into this category were assertions of the human-ness of nurses and midwives.

Nonetheless these responses could represent the views of a small group of respondents who could be said to be opposing the unrealistic expectations made of nurses and midwives (in terms of coping, being in control and being a professional all the time) for some reason, and thus disagree with the status quo. Whether they would still abide by the rules of the 'game' in spite of disagreeing is another matter, and will perhaps be more clear when these results are triangulated with other aspects of this study, and with the findings of others, later.

Such phrases may also be another indication of the societal expectations the respondents perceived they worked under, i.e. to be somehow 'super-human' or infallible, as reflected by the fact stated earlier - that several respondents either wrote the same response for both scales alongside each other, e.g. TST = a coper; OCT = a coper, or they wrote the exact opposite i.e. TST = fallible; OCT = infallible.

In truth, the types of response categorised as **humanistic traits** were expected to be 'popular', as a means of describing 'self', both because of social

desirability and because of their association with aspects of personality said to be typical of people who enter nursing and midwifery (Kaler et al 1989).

Therefore one would have expected many responses in this vein for the TST. Also given that the nature of nursing and midwifery is axiomatically said to be one of 'caring', humanism and self-sacrifice (Kaler et al *ibid*; Dingwall et al 1975; Mellish 1988), the 'popularity' of using such words as a means of describing nurses and midwives in the OCT could also be expected.

T-test results showed that the difference in the mean response rate for the TST and the OCT, for such traits and behaviours, were significant at the 0.001 level. This again illustrates both overlap of 'desirable' traits or behaviours, and the 'extra' perceived to be expected of nurses and midwives.

It should also be acknowledged that the fact that most of the respondents were female may also have been influential, as such traits and behaviours have been identified by various writers as being typically 'feminine' in nature, though not confined to (nor necessarily found in all) women. Whether such claims would have been found if observation had taken place concurrently with the surveys is of course open to conjecture, particularly given the views of writers such as Gordon (1991) and Muff (1988), both of whom bemoan the demise of 'feminine' traits amongst nurses over the years. They both hold the view that such traits have (and are) being replaced by more masculine orientated approaches tied up with technology, rationality and 'problem-solving' (amongst other things).

The descriptions associated with **coping and dependability** were of great interest to this study. Their presence alone as meaningful categories in such an open-ended exercise in personal and professional concepts, highlights the pertinence and importance of such behaviours to these nurses and midwives, in both their personal and professional lives. Furthermore, they concurred with aspects of the other questionnaires in that they allow statements to be made about the expectations that are made of nurses and midwives, regarding being 'copers',

retaining control of their emotions and being dependable - both at work and in their personal lives. The earlier issue of 'overlap' is therefore again pertinent here.

The results also lead to a further interesting discussion point, in that a significant number identified such behaviours to be expected or desirable for both the TST and the OCT, i.e. for self, and for nurses and midwives. Could it be that this also reflected the importance placed upon such behaviour in our society as a whole, with the expectations of nurses and midwives (and perhaps police officers, fire-fighters, the clergy etc) being extreme extensions of 'normality'. That there are 'professional copers' would seem to be irrefutable, as is the view that there is an expectation on them to be cool, calm and collected all the time.

Results which were less expected were those involving the 'practical' attributes of nurses and midwives, and the issue of negativity regarding self and their profession.

The level of response for those items categorised as '**practical traits**' was lower than expected'. In terms of the TST, it was low when one considers the work of people such as Theodore (1971) on entry characteristics of health professionals (including nurses). Nonetheless, it was a specifiable category and thus a typical aspect of the respondents' personal and professional self-concept.

For the OCT, it was surprising that such traits and behaviours were 'ranked' sixth because there is a tendency for nurses in particular, to describe themselves as being very practical, common-sense type people, and their work in terms of physical tasks to be 'got through' (Melia 1987; Clarke 1975; Dingwall et al 1975). Furthermore nurses have typically been described as being 'doers'. In the event, the mean response rate for such items was significantly higher for the OCT than for the TST, again reflecting both the 'overlap' and the higher expectations of professional nurses than 'private'

individuals, and it is this that is most pertinent to this study, along with the question of whether the emphasis of 'work' is more on physical care and 'tasks', than on care of a more psycho-social nature.

Negative responses both about self and the professions of nursing and midwifery were expected, but not to the degree that they occurred. The issue of greatest pertinence to the overall study was that the majority of negative responses in the OCT referred to the seemingly second class status of respondents in relation to medical colleagues. They were also characterised by the feeling that often their expertise and effort goes unrecognised by professionals (nursing and others) and the public alike.

Other responses reflected the fact that nurses particularly are often expected to undertake tasks that are not part of an agreed job description, and are either menial (e.g. cleaning), manual (e.g. moving furniture) or filling in for other people (professional and ancillary), and thus reflected a fairly negative and non-professional view of their work. This constitutes a similar finding to that of Kenny et al (1991) who found that nurses tended to view their profession very negatively when compared to other health related disciplines, and medicine in particular.

Another sub-group was critical of their clinical managers, particularly with regard to the level of support they are perceived to offer. This obviously accords with the results of the social support questionnaire in that in both cases nurse managers were said to be un-supportive or even obstructive towards staff nurses. In fairness however, it should be acknowledged that such ill-feeling may have been intensified by the re-grading process that was going on in the hospitals utilised during the data collection process.

Overall therefore, the T.S.T. and the O.C.T.'s raised several issues of pertinence to the overall study.

There was strong support for example, for the assertion that an overlap between self and professional lives and perceptions were both common and marked, for many of the respondents. Indeed often the same 'quality' was put forward for both the T.S.T. and the O.C.T.. This overlap was shown to include the concept of nurses as 'professional copers', an expectation which has already been discussed as a potential complication for such people when experiencing personal grief. This as a result both of its effect on their self-concept, and because of perceived availability of social support and their willingness (or otherwise) to accept it.

Notably, very few respondents provided statements 'opposing' such an expectation, or indeed any other which connoted the perfect and infallible nature of the 'ideal' professional nurse or midwife. Furthermore, the overlap was typically uni-directional, with the 'ideal' professional traits being transferred into the personal persona - not the converse. As one interviewee concisely put it *"nurses have to take off their own personality and hang it by the door when they start work for the day"*.

The 'jack-of-all-trades' perception and the relatively high level of negativity towards the nursing profession was also of interest, as both could be seen as de-motivators for nurses and midwives to be autonomous professionals. The corollary of this is that this will lead to the perpetuation of contemporary practices such as reticence in giving information and the provision of bureaucratically orientated care, which are identified elsewhere in the study as potentially leading to problems for nurses and midwives playing the role of 'family nurse', when a family member is hospitalised and/or dies.

The negative attitudes towards nurse managers were also noteworthy as they triangulated with, and re-affirmed findings from other sections of the study.

Finally it should be acknowledged that while these tools (T.S.T. and O.C.T.) shed light on several interesting and pertinent issues, relating to the personality

and self-concept of respondents and also their views of nursing/midwifery, the data produced included little direct information on the 'over-independent' aspects of personality identified as being deleterious to successful grieving. It was however identified that for many, aspects of the 'caring' professions that are associated with people relying and depending on them were attractive, perhaps even desirable, and therefore form part of their conception of what a 'good' nurse or midwife should be. The benefits of not leading respondents to certain answers by using such open-ended tools, would seem to have offset this however, because the categories that were devised were all the more meaningful for being generated 'post facto' from the raw data. Furthermore, this 'gap' was mitigated against by the insight into the respondents' perceptions of independence/dependence on others, provided by the data from the semi-structured interviews where this issue was addressed directly.

Chapter 5.

Treatment of Data and Results.

Section H:

**Semi-structured interviews related
to questionnaire 1.**

As stated in the methodology section, these interviews were carried out to expand upon issues examined in questionnaire 1, and to allow some further insight into the reliability of the instruments therein. The 'exercise' was successful in both regards. As well as this, they also provided pertinent information that was not forthcoming from other areas of the study - namely on the issue of respondents' views on dependence on, and independence from, other people.

Essentially this discussion covers the data of most interest to the central themes of the study, i.e. factors which are said to complicate grief (Murray-Parkes 1972,1975) plus roles and expectations of nurses. Sadly some of the richness of the data was inevitably lost, though this was compensated in part by the inclusion of data from these interviews within discussions of results in other sections, where relevant. What the interviews also offered therefore was a more 'holistic' view of the respondents' perceptions regarding issues like social support, 'coping' and their personal and professional self-concepts.

The role of the 'family nurse'

This was very much in existence amongst interviewees. In fact only two said that they weren't the family nurse, as they both had mothers who were also nurses and they tended to fulfil this role. Interestingly, one of them said that their neighbours tended to ask her 'medical' questions, and that with her friends she *"seemed to be a bit of an agony aunt"*. The other said she found that as she got older, she was *"taking over the role more and more"*, as if she was *"the staff nurse...[and her mother]...the sister"*.

Invariably what was expected of them related to knowledge of medical conditions, diagnostic skills, and being asked to intervene or intercede on others' behalf with hospital staff. This perhaps sheds some light on the data from the questionnaire which showed that some felt uncomfortable with this role. One nurse for example said *"they think you are a midwife, a doctor, a social worker and a psyche (sic) nurse and everything else thrown in. They*

think you just know". Some reflected on such expectations by stating that they asserted what their skills and knowledge were, and acted in a referral capacity (e.g. to GP's) while others tried to answer questions and fulfil the role fully. Both behaviours apparently caused feelings of inadequacy or guilt at times however.

Again invariably, such roles were nonetheless apparently readily accepted - even by the respondent who had had a very traumatic experience after an accident to her sister, in which the 'family nurse' role was obviously problematic to her. These problems were both in terms of the expectations of her family - "*I felt awful because I panicked (in casualty) and I wasn't there for them*" and "*I didn't want to ask questions or get involved, I just wanted to get away*"; and the expectations of professional peers who expected her to help out in the A/E department at the time because they were busy. As she stated "*they wouldn't ask somebody off the street to do that*". The impact of all this was encapsulated by the statement "*It were just an accident, but I coped terrible and I were really ashamed. I thought I coped awful. When I think about it now I get really, I get upset with myself, because I think I should have been there for everyone*" (sic).

Social support.

Interviewees reiterated answers for the social support questionnaire (i.e. emotional/moral support from parents and partners, little else from others), thus suggesting reliability of such responses and conclusions reached from them. When support from peers was said to be available, the degree was said to be a function of how long they had been working on a ward or not. This can be seen to relate to the work of Spencer, who also found that nurses valued informal support provided by colleagues (1994). The form that such support could/would take was not discussed at length, indeed all tended to talk in potential terms about this, and not how it had actually happened. Several spoke of the possibility of 'talking' to peers, though how this would work given the 'helper secrets' issue discussed elsewhere in the study, is unclear.

Presumably such interactions would only take place if a high degree of trust existed.

Supervisors tended not to be seen as supportive, again reflecting the data from the questionnaires. One sister put this as *"you only see your manager when something goes wrong...the complaints always come through...but no-one ever comes round and says 'well you had 200 ladies through here, and none of them has complained, everybody has been happy, haven't you been super'. You don't hear that"*. To be fair, it should be acknowledged that two of the eleven interviewees, said that their manager (ward sister) was supportive, and rated them so on the questionnaires appropriately. One said that this was because the Sister was of a similar age to herself, while the other was from a ward where the sister was a very caring, supportive person and manager, and was well known as such amongst patients and staff alike.

In terms of non-work based sources, support was seen as acting as an understanding sounding board for the relief of frustrations - which all respondents referred to. In other words a 'buffer' (House 1981). Two nurses identified shortcomings of this, particularly the point that non-nurses could not understand their problems. This was obviously not the case for the two people whose mothers were also nurses. An interesting further point to make is that the nurse whose sister had had the accident, confided later in the interview that as a result of the trauma of the time surrounding her sister's accident, she was still unable to discuss it with her family, even though her sister had by this time fully recovered. This would seem to reiterate points made in the social support discussion section regarding the efficacy of personal sources of support for nurses, when the problem is somehow work related.

This interviewee, along with another who had kept the long-term implications of her mother's Multiple Sclerosis a secret from her brother and wider family, highlighted another aspect of the 'family nurse' role, namely keeping insights to oneself - an issue returned to in the 'interviews with bereaved nurses' section.

Personal and professional self-concepts.

These were also covered in these interviews, focusing particularly on the subjects' views on nurses 'coping' and what was expected of them in this regard. Subjects tended to reflect their answers for the questionnaires again suggesting reliability, in that the need to **be a copier and to be seen to be so**, was underlined, e.g. *"It's that kind of job isn't it? You wouldn't get very far if you didn't"* and *"things can get on top of you, but you mask it - you don't want people to see you as a non-coper"* .

An extension of this was the need for self-control, which all of the subjects seemed to value. Examples included *"I try to be in control more or less all of the time"* (i.e. both at work and at home), and *"I try not to let people see me upset, even my husband"*. Several reiterated that personal feelings or problems should be set aside whilst at work, and prided themselves on *"always being the same at work"* no matter what had happened at home. One said that this neutral affect was expected, i.e. *"I don't think you are allowed to swing [moods] when you're working, you've got to stay this pleasant, confident and happy person. You're not allowed to be depressed or upset or mad at somebody"*. Furthermore, while this person said that this did not follow into her personal life, she did say *"I think there's only half a dozen people that's seen me go from one extreme to the other"*. Thus indicating more overlap than she perhaps acknowledged.

Overlap of professional personae into the personal lives of nurses.

From the above it can be seen that interviewees provided insight, into the degree of overlap of their professional and personal lives. It could be identified for example, that for some nurses the personal and professional 'face' were the same, while for others there was very much an idealised expectation of self, whilst acting out the role of nurse or midwife, which was far removed from their 'true' self. It is interesting to note here also, that two interviewees disclosed that the separation of their personal and professional personae was so marked as to be considered 'pathological'. Both these women reflected the

lifestyle of Wallace (1965) in her book 'Portrait of the Schizophrenic Nurse', in that when they were not working (weekends, holidays) they tended to lead the life of a reclusive; rarely ventured out (one considered herself an agoraphobic); spent long periods just lying in bed; and at times failed to maintain basic hygiene standards by not washing for days at a time. This at the same time as holding down senior positions in wards and units with no apparent complaint from the organisation or from patients. Indeed one of them was very highly regarded by her colleagues because of her unstinting support of them during difficult times - an attribute she carefully and explicitly nurtured, as she felt it was important to do this as a senior staff nurse. These two 'subjects' were among those who rated the 'Ideal' situation higher than the 'Actual', for several of the coping items in section F. This illustrates the benefit of such an exercise, as the data there suggested that such people were those who held overly-idealistic views of the professional nurse or midwife, when in fact there may have been others leading a 'double life', though one doubts that their number would be large.

All the subjects referred to 'helper secrets' to some degree, ranging from *"sometimes I'm not as confident as others think I am"*, to *"sometimes I feel inadequate"* e.g. when comparing self to newly qualified staff, and *"you think, I'm not telling anybody I don't know [because] they'll think I'm thick. Yes you do sometimes feel that everybody else is doing better than you"*. There was therefore a tendency to say that they felt that they had to be right all the time, that they could not say *'I don't know'*, and that in fact such existential infallibility was perhaps even expected of them. Furthermore, whilst arguing that this was not reasonable, they felt compelled to at least attempt to give this impression (rather like in the 'family nurse' scenario earlier) to colleagues and the public.

Expectation of self control.

The question of whether being a 'coper' and displaying self-control was expected of nurses and midwives was also definitively answered by all the

subjects, i.e. yes. They typically agreed that their training had reinforced and enhanced traits and roles that were already there, making them *"more confident"*. One said *"nursing has made me a stronger person"*, another suggested that *"nursing did intensify it"* [her self-concept as a copier]. Such data reflects Child's 'Nurse Selection Project' (1993) undertaken for the UKCC, in that he found that prospective nursing students often undertake work experience in nursing homes and hospitals. His subjects suggested that this enabled them to identify if they could "cope with the realities of nursing, such as emotional involvement or the squeamish features of the job" (ibid).

Interestingly the source of expectation that was referred to most commonly, was from 'people' i.e. the public. Subjects in the present study referred to an expectation of the public that *"you should be able to cope because you are a nurse"* and *"even people who don't know you, who find out you are a nurse, think you can cope with everything"*. How this could combine with entry behaviour and professional socialisation to produce a "metaperspective" for nurses (Skevington 1984) (that being a person's perspective of how others perceive them) was illustrated by the statement *"I think you are expected to be detached from the problem, and get on with the job, and think about it afterwards. I feel as though a lot more people are looking to me to make a decision...whereas before I wouldn't have been able to make a decision and tell people what to do"*. The 'nurse as copier' expectation, and the effects of socialisation were also confirmed by the person who said *"coming into nursing made me realise that I can cope in more difficult situations than I thought I could...when I first said I was going to be a nurse, I was a bit of a laughing stock...because I was too soft"*. It is not surprising therefore, that nurses and midwives not only see themselves as copiers but also feel that they have to be seen as such. Also that such expectations can reach the proportions that led one person to say *"if I didn't cope I'd feel guilty...not worth the uniform...everyone would talk about me being hopeless"*.

This therefore demonstrates the idealistic and overstated sense of personal

responsibility of nurses described by Smythe (1984), said by her to be inculcated by nurse training and socialisation. Such a failure to cope was said to be avoided by another because *"it could be held against you"*, and hence her reason for tending to muddle through when unsure of herself - *"because it's easier and safer than asking for help"*. This again triangulated with findings throughout the study, which suggested that some respondents were concerned about showing fallibility to peers and particularly supervisors, for fear of it coming back to haunt them at some time in the future.

Dependence/independence.

Being very independent and dependable, and tolerating dependence on others badly, has been suggested to predispose to problematic grieving, for reasons expounded in the literature review. As discussed in the methodology section, measuring such a 'trait' is very difficult, and in the absence of any straightforward psychometric test to do so it was decided to ask subjects outright, their views on the issue. It was hoped that the T.S.T. and O.C.T. would elicit information on the subject, but this was not the case to any degree - perhaps not surprisingly. The value of these interviews for this aspect of the study is then obvious. In the event, all those interviewed said that they were independent people, and that they liked feeling depended upon. For example *"I enjoy it [being depended upon] it's like people need me...I enjoy that"*; *"I get a real kick out of helping people. I love walking people across the road, and holding doors open for people..."*; and, *"It feels nice to be depended upon and that I can help others"*.

There was also a general feeling that this 'independence' was 'brought out' by working in nursing. These statements therefore concurred with findings in questionnaire 2 and the interviews with bereaved nurses, in that they identified a high degree of 'needing to be needed', and one would suspect a tendency to want to 'own' patients and perhaps exclude relatives from care. Three respondents went on to say unequivocally that they did not like to depend on others, one expanding to say *"I like people to lean on me but I don't like to lean*

on anybody else". Another went to the extreme of saying "I don't like dependence at all. I like to be financially independent. I like friends and I like to socialise but I wouldn't like to cling to any one person or rely on any one person for help...I would rather stay away from people than cause them [she corrected herself here] - rather than them see me during that period. She then went on to say that she preferred to "work things out in her own mind independently" and then go out and start seeing people again. Such views were balanced by the nurse who said that "you have to depend on others to survive" , and another who said that at times she "quite liked it " when her boyfriend said what they were going to do.

Therefore for a set of eleven interviewees there were five who overtly disliked thoughts of dependency, two who welcomed it (albeit within limits), and the rest covered various points in between. In a sense therefore, this was a microcosm of the study as a whole, in that it would be foolish to suggest that **all** people within an occupational group the size of nursing would have **all** the predisposing factors to complicated grief. However the fact would seem to be that **some** do, and that for some it is associated with them being a nurse.

As stated at the outset to this section therefore, these interviews provided further insight into the prevalence of factors said to predispose to complicated grief, amongst this population of nurses and midwives. It did this by reinforcing and at times validating, findings from elsewhere in the study regarding the roles of nurses and midwives and the expectations of them within their families and wider society; the sources and possible efficacy of social support for nurses during family health crises and/or death; and aspects of nurses' personal and professional self-concepts - particularly the need for self-control and independence from others. They were therefore a useful and indeed necessary part of the study.

Chapter 6.

Questionnaire two - Examining the socialising atmosphere and culture of hospital nursing and midwifery, using a qualitative approach -

Treatment and overview of salient results

As discussed in the methodology chapter, this questionnaire was designed to elicit information regarding the level of humanism within the environment prevailing in hospitals, particularly with regards the treatment of relatives, and nurse-relatives especially, when visiting patients in hospital. That done, it was expected that reasons for **why** they are treated in such ways would be made clearer, the suggestion having been made that such people are often in the awkward position of being viewed with suspicion and as a threat by ward staff (Crawley 1984), whilst also being expected to fulfil responsibilities to their family as the 'family nurse'.

Furthermore it was hoped that some examination of conflicts for nurses, between the ideal (lay approach) and the actual (professional) approach to care (Kitson 1987), that is reality would be possible, so as to identify any implications should a relative of theirs be hospitalised. Finally, it was also anticipated that an examination of the preparation of nurses for the role of caring for the dying and their relatives, would derive data regarding the coping strategies commonly used by nurses, including ego-defensive mechanisms such as evasion and distancing.

Altogether it was intended to provide insight into the socialisation of individuals into nursing culture, and how aspects of that culture may impinge on a nurse's ability to grieve 'normally'. This is a fundamental area within the wider study related to the possibility that being such a professional may in itself, potentially complicate the grieving processes of individual nurses.

It was identified in the literature review, that there has been little research undertaken regarding the treatment of nurse-relatives (although there are many anecdotal accounts). This reinforces the importance of a study such as this. It was hoped that the findings would support this literature, as well as other studies in the more general area of caring for relatives, so as to enhance the validity of this study and allow some measure of 'generaliseability'. As will be seen throughout, this has been achieved in many areas.

The tool used to generate these data has already been described and discussed in the instruments section of the methods chapter, a copy is presented as appendix 2. The data are presented here in summarised form.

The number of respondents was 116, however it should be remembered that not all the nurses responded to all aspects of the questions, and therefore numbers and percentages may seem to vary. Biographical data for the respondents are not included, as apart from the fact that some G grade personnel (ward sisters) responded, the biographical profile was much the same as for questionnaire 1 and the semi-structured interviews.

The questionnaire itself was nominally made up of three areas of questioning :- The nature and control of nurse-client relationships including the issue of "helper secrets" (Larson 1987) and the professional's discomfort when being watched; the control of information in hospitals; and, the theoretical preparation of nurses for dealing with all aspects of caring for the dying and their relatives. This division is artificial in many ways however as many issues overlap and interweave, it is hoped that this becomes apparent for the reader.

The nature and control of Nurse-client relationships.

The nurses' opinions were canvassed regarding the expectations of the nursing profession in nurses' dealings with relatives. This was sought by asking respondents whether they saw caring for relatives as part of their job; whether they saw relatives as 'useful'; and what they perceived the needs of relatives are and whether they are typically met. The pertinence of these issues to the overall study was that they can be seen to explore and inform about the attitudes nurses hold towards relatives and their involvement in patient care.

Essentially the respondents seemed to be saying that as nurses they did perceive caring for relatives as being important and indeed part of their job. Unfortunately many of the responses offered tended to be rather 'slogan-like' in nature, often one-word and typically 'socially desirable', e.g. things like "*being*

supportive...reassuring..and sympathetic" (46:44%), or doing practical things such as "organising accommodation" and "giving information" (24:22%).

The data from this study reflected the discussion of the 'role of relatives' in the literature review. Typically there was an overt assertion that the respondents perceived relatives to be 'useful' or 'helpful'. On the whole this tended to be considered in terms of how the relatives could help the nurses provide care eg. by giving background information and performing small tasks for the patient, although a number (23:20%) reflected on the benefits for patients such as improving their morale (13:11%), and for relatives (10:8.5%) in terms of allowing them to feel involved. The orientation of visitors as 'helpers' or 'workers' was shared by a further 46 respondents (40%) **but** with reservations - often regarding the impact that relatives helping and being involved may have on the staff. Thus it would seem that many respondents perceived relatives to be 'useful' if they fulfil a role acceptable to them, which Darbyshire (1987) suggested involved the avoidance of "hindering them in the performance of what they perceive to be their imperative daily tasks", as well as avoiding complaining on one's own behalf or that of the patient (Fox 1985).

In some ways this data also reflects the views of Gibbon (1988) and Kitson (1987), the latter suggesting that admission to hospital frequently means that the hospitalised patient is seen to 'belong' to health professionals, rather than to the family, in spite of the fact that very often the patient may have been cared for by family and relatives at home for some time before admission, and may be again after discharge. It can also be appreciated that this might be very difficult for a relative who is also a nurse to deal with, as they may be expected to ask questions on behalf of the family, and may also feel ambivalent or even guilty that the patient has had to be admitted - a view reinforced by the data from interviews with bereaved nurses discussed later in the study.

It is interesting to note that objections (approx.15:13%) to this 'professional takeover' tended to be voiced by respondents from paediatrics and spinal

injuries. The former group have for years espoused a philosophy of parental access, involvement and continuity of care, the views of the latter group were encapsulated by the statement by one respondent, a nurse from spinal injuries:- *"... without the family and relatives our job would be sometimes impossible...to do this, we lower the professional barrier and allow first name terms - as an example. We lose the status of nurse and allow relatives and patients an equal role. We allow them to teach us the way they prefer things to be done. Many nurses in other areas cannot accept this as they have been 'programmed', maybe to be in charge of the situation. Maybe it is this wrong image of themselves that makes it hard for them to deal with relatives and patients ... they are afraid to make mistakes in front of other people. We are used to making mistakes on here - I was a human being before I was a nurse!"* In other words the professional facade is dropped, in this case because long term care precludes the distancing techniques often said to be used by nursing staff in the past (Menzies 1961; Jourard 1971; MacDonald 1983) and apparently continue to do so (Lyll 1990).

The responses to this questionnaire can be therefore be seen to suggest that visitors were expected to fulfil one of two roles - worker or visitor. This provides a meaningful triangulation of findings with Rosenthal et al (1980) and Brooking (1986) in that respondents in all three studies have tended to see nurses 'placing' visitors in such roles.

Rosenthal et al (1980) expanded upon this "worker" role, saying that it rendered such relatives a part of the team and as such under the normative control of the staff, and so encouraged them to act in particular ways and play particular roles comfortable to the staff.

Identifying and meeting the needs of relatives.

There also seems to have been some congruence of the findings of this study and the other studies that have been undertaken on this topic over the last 20 years. Perhaps the most striking fact, is that the majority of respondents

(84/112:75%) said that typically the needs of relatives are not met. Of these, 58 said this unequivocally, the other 26 saying that they are met but "*time...or...lack of experience*" are factors which mitigate against it. In other words "*we try but it is not always possible*". This levelling of blame at 'lack of time' for not meeting needs, has been typically found in studies of this sort (Brooking 1986), but as Brown (1965) points out, other reasons based on the organisational structure of the hospital, and from values inculcated in professional training are not commonly considered by nurses to affect this. Indeed it may be that they are not consciously aware of possessing such values having assimilated them totally into their personal meaning systems via the processes of professional socialisation.

This theme of 'controlling the threat' to staff, was extended by the responses to items which examined respondents' views on open visiting and their feelings about being watched and/or helped by relatives. It was anticipated that any tendency to simply claim that individuals 'did not mind being watched' and 'involved relatives in care' for reasons of social desirability, would be counter-balanced in some way by the questions tagged on to the end of the items i.e. 'any experience?' (of being watched), and 'is it common practice?' (for relatives to help care for patients). In this way it was envisaged that insight would be gained into:- whether the involvement of relatives is the 'norm'; if they are involved are there any provisos; and, who typically initiates such activities when they take place?

In the event, most respondents did claim to favour open visiting, although 23 (20%) were overtly opposed - usually for reasons like "*they (relatives) get in the way*", or are critical of the care being given. One respondent just wrote "*Rubbish!*". Whether this was an example of cognitive awareness yet behavioural denial, whereby some nurses claim to be in favour of open access yet in actuality deny it, is again possible, as over half of the other respondents had some form of reservation - many the same as the replies as from those who were opposed. Furthermore, asking relatives to leave at times considered

necessary by the staff, was mentioned repeatedly. Scepticism about the reality of claims was further fuelled by responses like "*patients need rest and staff need time to do their job*".

As was envisaged, the majority of respondents claimed that they did not mind being watched whilst giving 'care'; that they were positive about involving visitors in giving care to their relatives; and that they had experience of the same. However, it was also at times paradoxical in that when asked if it was common for relatives to be so involved, 66% (73) responded in the negative. Furthermore, almost 50% seemed to take a dim view of being asked by relatives if they can stay, a finding shared by Brooking (1986) who also went on to say that nurses tend to over-estimate the level of participation that they organise, and that they rarely, if ever, invite participation.

It therefore appears that while many claimed to have involved relatives in care it cannot have been very often, and that while others may have agreed with the idea in principle they had rarely (if ever) seen it happen, a view reinforced by data from the semi-structured interviews. This reflects the point that the process of involving relatives is "neither smooth nor universal" (Rosenthal et al 1980), and that relatives' involvement is in the main neither expected nor encouraged, in theory or in practice. This was also a finding replicated by Brooking in her study of family participation in care. She also found that few areas had policies regarding patient and family participation, and that nurses reported that there was little taught about such issues during training (1986).

The dearth of policies for such activities was referred to by several respondents, typically going on to point out that as a result they would be cautious about what they allowed relatives to do for fear of the patient or the relative being hurt and the legal ramifications of such an occurrence. Instead as was discussed earlier, the 'preferred' action for relatives was seemingly for them to accept a passive 'visitor' role, or one supportive of the staff and the goals of care as identified by the staff, i.e. the role of worker or patient.

A variety of reasons were put forward to validate the limiting of access of relatives to patients. Fifty-eight (58 : 50%) referred to the needs or feelings of patients or relatives, many again reflecting the "benevolent paternalism" described by Bassford (1982). Interestingly however, some acknowledged that it may be as a result of the staff being made to feel intimidated or uncomfortable by the presence of relatives. The term "*wariness*" was used several times. Other researchers have attributed this to the fact that nurses' strategies for maintaining control over families, include "minimising, avoiding or channelling their interaction with family members" (Rosenthal et al *ibid*). These are techniques which are more difficult to employ when open visiting policies are in operation. They also give visitors an opportunity "to see exactly what and how much, nurses actually do" (Melia 1987) which may also be threatening to some nurses.

Eldar et al (1984) referred to the fact that the continued presence of relatives may be resented because nurses may have to entrust gratifying aspects of care to the relatives. Apart from one person who said that "*giving care is a profound human experience...encouraging relatives to assist in care is unfortunately not common practice - nurses guard their skills very well*", this was not referred to by respondents in this study. However it could be that the seeming 'possessiveness' expressed by some respondents may not necessarily have been about 'control', but in some cases be indicative of a need to be needed, and to feel useful. Indeed Abdallah (1960) asserted that "very often nurses make patients dependent upon them in an effort to meet their own needs". This perhaps may suggest the presence of co-dependent traits and behaviours (Hall et al 1989; Wolfelt 1990) within the sample.

Therefore the majority of respondents claimed to have involved relatives in care and to be unperturbed by being watched by them whilst giving care. However, it was also identified that involving relatives in care was not commonplace, and that when they are, many of the nurses like to feel that they are 'in control' of the arrangement - either to 'protect' the patient and/or to mitigate against

(staff) feelings of intimidation and unease elicited by the relatives being present. The fact would seem to be, that in general these nurses and midwives reflected those in other studies and literature, and found having relatives around and involved stressful, and where possible, mitigated against it.

The role of experience in ameliorating such fears was raised by a number of respondents. Explicitly this was in terms of how inexperience leads to uncertainty and hence wariness, for example *"inexperienced nurses tend to feel intimidated and frightened, should they be asked questions they are unable to answer"*. Perhaps more by inference, there was the view that with time one gets to know more and so the need to be right and not make mistakes diminishes somewhat. Brooking found 'experience' to be a significant factor in this regard in her study (1986), however she did not expand on what criteria she used to identify that someone was 'experienced'.

One can only presume that it was in terms of years of experience. In the present study respondents seemed to be alluding to such criteria, however this was not borne out by cross-tabulations, that is, years since qualification did not **necessarily** lead respondents to provide 'positive' answers in terms of dealing with relatives. What was found however was that those with the most positive attitudes towards relatives, who had least apparent problems about being watched (eg *"if you are doing the job correctly what does it matter?"*), and who could give actual examples of involving relatives in care, tended to come from respondents who were indeed relatively experienced in terms of years (> 2 years post-qualification). Perhaps more saliently however, they usually referred to personal experience as recipients of the system - either as a patient or visitor.

It should also be noted however, that there were respondents who also met these criteria, but who were not as obviously 'client-centred'. This identifies that 'experience' is a function of what one makes of it, for example it is possible for two people to be qualified for the same length of time - say five years, but one person may have five years experience, the other person, one

year five times over. This shows therefore that experiences leading to a particular point of view or behaviour, in this case dealing with relatives, are not linearly arranged, neither is there any one particular experience which can be identified as 'fundamental' or seminal.

Perhaps the same can be said of any 'experience' - bereavement and grieving included, as not all respondents who had been bereaved described client-centred attitudes. This concurs with the findings of a small study by Hoyle who found that not only did a large proportion of the nurses who had lost a close relative perceive that it had not affected their practice, but also that such nurses were found to be the most restrictive in terms of providing relatives access to, and information regarding, critically ill patients (1991).

In summary therefore, as referred to throughout, data regarding respondents' perceptions of identifying and meeting the needs of relatives/visitors, and how they are viewed, used and 'controlled', can be seen to concur closely with data from the semi-structured interviews and the work of others. This adds weight and validity to findings which basically identify that the treatment of relatives in hospital would seem to be characterised by "benevolent paternalism" (Bassford (1982) and a desire to direct relatives to play roles which do not threaten the 'professional' self-concept of the staff.

The control of information.

In terms of talking openly and freely to relatives and visitors, the majority of respondents seemed to be of the view that there was not a free market in information, this being seen typically to be blocked by real or perceived threats - most notably *'hospital policy, medical staff, the law and time'*.

In this study over 60 respondents (> 56%) said or gave the impression, that they as nurses were not encouraged to freely volunteer information to relatives and visitors (N.B. a further 10:8.5% did not reply to the question). It is almost axiomatic that nurses are not encouraged to be free with information, this

control often being exercised (overtly and covertly) by medical staff, and increasingly by hospital General Management (note the case of 'whistle-blower' Graham Pink [Turner 1990]). In turn this undoubtedly increases the use of evasion to avoid dissonance and anxiety.

The respondents seemed to be in no doubt about who actually controlled patient-related information. It would appear that invariably the decision and the responsibility typically rested with medical staff, and consultants in particular, as 60 respondents (52%) said this. A further 13 said "*doctors and nurses*", 26 referred to "*involving relatives*" and another 10 alluded to "*patients*" - but always along with doctors.

Subtly deferential attitudes to 'the system' were reinforced by 21 respondents who referred to "*team decisions*" regarding information giving, that is, it is not an individual nurses role - "*it is not up to me*" (7/21), and those who said they would not say such things because it is the responsibility of others i.e. "*doctors and/or more senior staff*".

In the main the majority of respondents did not seem to feel that they had any great input into what and indeed how, information was passed on to patients and relatives. A few (16:14%) did say that this input should be increased e.g. "*Nurses should have more say*" because "*nurses get closer than doctors*", while others referred to the fact that often they had to "*follow on from doctors, translating what they say into plain English*". In fact the adequacy of the communication skills of 'typical' doctors were questioned by many respondents - "*doctors tend to do a bad job [of giving such information]*", typically blaming this on their training (or lack thereof). By implication these respondents also seemed to be saying that they however possessed good communication skills.

There were a number (11) who asserted that even if a nurse did give information (in this case regarding their diagnosis or prognosis), patients and relatives would still want it to be confirmed by a doctor. This highlights a

pragmatic viewpoint on their behalf, and a recognition that they share Geary-Dean's rather sardonic view that "in spite of our [nurses] strong points - accountability, levels of responsibility, patient contact (50 hrs to drs 1 hr) judgement skills etc, the public perception remains at bedpan level" (1980 p. 156).

Of the others who said that this situation of medical staff controlling information should be changed (45:39%), 7 (6%) asserted the rights of patients as people, as their rationale for change. Three other interesting replies were the person who said "*why?* [should it be changed]"; the nurse who asked "*who could do it better?*"; and finally the person who was of the view that "*in practice, the nursing staff can often engineer disclosure by the medical staff to relatives and later the patient*". Twenty-two (22:19%) did not expand on their answer and so one cannot be sure of their rationale for wanting to change the apparent status quo, however all in all the desire did not seem to be that nurses should assume the role of gate-keeper of information, indeed the majority were either opposed to this or did not reply to the item (25 : 21.5% = no reply) suggesting a reticence in this regard. Rather they seemed to be saying that **they** should be more meaningfully involved than they are at present.

Also noteworthy was the fact that all respondents who spoke of increasing the input from clients were referring to relatives' and not patients' input. All this presents us with an interesting scenario, in that almost all those who desired a change (45) were complaining about the medical monopoly on information and their lack of input, while those who did not see a need to change (32) tended to be those who were relatively senior. There were however a number who felt reality was a team approach and/or those who asserted that patients and relatives are already included in the decision making process anyway. This fact, along with the earlier quote about '*engineering disclosure*', indicates the continued existence of the "doctor - nurse game" (Stein et al 1990) in the working environment of at least some of the respondents. It may also be the case that some nurses would not want the responsibility even if they had the

autonomy to do so, a point reinforced by the 'Ideal v Actual' questionnaire, and returned to later in this chapter.

Thirty-two people (32 : 27.5%) said that the status quo over control of information should not be changed. As already stated, almost without exception these were either nurses who identified that the status quo for them was medical control, or who were relatively senior nurses in the hierarchy. Of these 32, 12 made further comments:- seven (7) were of the view that doctors are in the best position to be so e.g. *"it is best from the consultant first then followed up by [nursing] staff"* and *"who else is qualified to assess the prognosis and to answer patients initial questions?"*; while the other 5 felt current practice should continue because they *"already had a say"*, the decision was *"reached by the team"*, or because *"there will always be someone else who wants to control it"*. Two respondents made the further point that such tasks *"should not be passed onto someone inexperienced "* and that any changes should only be considered after *"a great deal of thought and discussion"*.

Unfortunately there were few explanations proffered by those people who said that they did not want to see a change, but some at least seemed to be abiding by a "hegemony...the existence of sets of beliefs that operate to legitimate existing power relationships" (Richman 1987). In nursing this is said to happen because the beliefs and attitudes of nurses are shaped to the extent that they see their lack of autonomy, in this case in terms of the right to communicate medically significant information to patients and their relatives without the authorisation of a doctor, as being "right, natural, unchangeable or [even] beneficial" (Palmer et al 1989). As a result it can only be envisaged that decisions regarding the information given to patients and relatives (in this case prognosis and diagnosis) will continue to be staff rather than client-centred/directed, and hence leave much to be desired for patients and relatives.

The fact that several referred to the 'law' in the way that they did, e.g. one

needs to be careful involving relatives so that "*in the event of something going wrong, you are not held accountable for the care given*" suggests that many respondents based their answers as much on fear as on knowledge. This also supports Brooking's contention that "nurses are strongly motivated to avoid blame and criticism" (1986), this leading to a tendency for decisions about nursing practice to be made so as to avoid negative outcomes rather than to promote positive ones.

Other replies highlighted the pressures perceived to be applied to nurses to 'toe the party line' and to be frugal with information. With regards to the perceived reactions to nurses disclosing information to dying patients, it was apparent that there was a perception amongst respondents that it was against established custom and practice. That is, nurses giving information regarding patient diagnoses and/or prognoses would at best be viewed with surprise, and at worst could result in disciplinary action and even their dismissal.

Of the 31 who overtly responded regarding the reactions of other staff (several others responded implicitly), 26 spoke in negative terms e.g 13 said "*they would be shocked*" and/or "*horrified*", and 6 referred to disciplinary action e.g. "*you'd be sacked!*" and "*staff would not envy me!*". The other 5 did not envisage major problems, however they said things would "*depend on circumstances*". One nurse asserted that "*we are professional people and should be allowed to use our own judgement*", however she then went on to say that "*if the consultant agreed, I am sure patients, staff and relatives would be happy*" (sic).

Furthermore the data leads to the suggestion that a "bureaucratic" as opposed to a "professional or service" orientation (Corwin et al 1962; Green 1988) existed amongst respondents regarding information giving. This is because it seems likely that they would provide information whilst cognisant of the rules and regulations (written and otherwise) of the institution, rather than for reasons of professional ethics or the humanistic rights of patients and relatives

(as also postulated from data in Questionnaire 1).

In the event therefore, the data seemed to support points already made - that control over patient centred information was the domain of medical staff, and furthermore that these nurses were of the opinion that should they overstep the mark, serious sanctions could be brought to bear against them, either by colleagues, superiors, medical staff or by the institution. This was made more apparent by the fact that those who said that they would disclose such information, tended to be either relatively senior staff or gave the proviso that the decision to do so would have been made in conjunction and in agreement with 'other staff' such as "*where I work the consultant/sister allows us to do this*". This underlines the fact that this is not the perceived 'general rule' and that in such cases, nurses would again be cooperating within existing structures and guidelines, not as autonomous professionals.

If Melia (1987) is to be believed "nurses are aware from day one, that day to day life on the wards is made more comfortable if they obey the unwritten rules" and as a result respondents would have known for a long time that they should abide by the convention that they do not "communicate to patients or relatives, any information of medical significance without doctors' authorisation" (Rosenthal et al 1980, p 119).

Therefore, reticence regarding the imparting of information was acknowledged as reality. However it may not **just** be a function of nurses maintaining **their** power and image, or of them protecting themselves from the anxiety of dealing meaningfully with patients and relatives, **but** that they may be acting in such a way so as to protect their job which many felt uncertain about. This uncertainty is said by some to be cultivated and actively encouraged by managers to ensure a malleable workforce (Coxon 1990), and by doctors to maintain aesculapian authority and functional uncertainty - the mystique of professional omnipotence (Muff 1980).

Having asked about the 'person's right to know', and their views on the control of patient information, the most obvious comment to make is the presence of paternalistic attitudes in the majority of respondents. This was illustrated by the fact that 87% of respondents unequivocally asserted that they would want to know their own prognosis/diagnosis, whilst apparently having reservations for 'others' eg. patients, a finding shared with Cartwright et al (1973), and perhaps reflecting the 'coper' self-concept of some nurses, i.e. 'I can cope but you may not be able to'. This suggests that there was a belief amongst the respondents that there are some people ('I' typically being included) who can 'take it' while others cannot, and that those who can not constitute a relatively large number of people.

The fact that so many respondents were categorically in favour of themselves being in full possession and control of information pertaining to them, whilst holding reservations regarding the same for 'others', would also seem to suggest a perception of 'self' that is somehow different and apart from 'non-self'. Perhaps even a position of "I'm OK, you're not OK" (Berne 1967), which could allow cognitive and emotional distancing to be maintained between nurses and patients using the psychological buffering mechanism of viewing illness and death as happening to other people', via existential denial of their own mortality (Stedeford 1984), and/or a belief in a "just world" (Lerner et al 1978).

It should be acknowledged here that in themselves such buffers are not necessarily problematic. Indeed they may be vital for the mental well-being of professionals like nurses and doctors, (Egan 1983; McSweeney and Nyatanga 1989), at least in the absence of more positive strategies, such as effective support networks and an intention to use them. However, as will be seen from the discussion regarding the theoretical preparation of nurses in issues surrounding 'death and dying', what is an issue is the apparent lack of knowledge and preparation regarding the development of a professional distance which allows for the meeting of client need as well as being cognisant of the ongoing health and well-being of the professional. Instead it appears to be

based on approximation through trial and error, socialisation and myth. This is a viewpoint further reinforced by the interviews with bereaved nurses in this study, and a finding shared by Smith (1992) when investigating the "emotional labour of nursing".

Paternalism and an apparent lack of knowledge was also evident in the reservations put forward about giving patients information, in that they (nurses) said that **they** would have to assess the patient's ability to "*cope*" with the information, rather than it being a decision reached in collaboration with others - particularly the patient.

Actual mechanisms for assessing the individual's ability to 'take it' were not offered, however there were a number (34:30%) who were of the view that one can assess a persons desire for information by virtue of "*whether they ask for it or not*" and/or by basing assessment on the say-so of relatives. All this was further complicated by the fact that the majority of respondents said that information is typically controlled by medical staff, most certainly not by patients, suggesting that patients are left in the dark while they wait to be 'told', and staff wait to be approached by those who **really** want to know.

Several of the points made thus have pertinence to this study, the most obvious being that relatives will continue to have difficulty eliciting information. A number of possible reasons as to why nurses and other health professionals seek to control information were also considered, not least the hegemony of medical control of information in hospitals and the psychological buffering mechanism of staff seeing patients as somehow less of a person than 'self', which may serve to minimise their chances of identifying with patients and so mitigate against anxiety.

The final issue in this section is whether respondents would welcome the responsibility and accountability of disclosing information in an autonomous way, as those who stated that they were content with the status quo i.e "*no*

conflict" would presumably ipso facto, be content with current practices in dealing with the dying and their relatives, including levels of information giving and whoever controls it.

The majority (65/56%) felt that nursing patients who know they are terminally ill was preferable and 'easier' because there was no need to *"hide the truth"*. The relief of not having to lie to people was obvious and was overtly mentioned by several respondents. Many went on to discuss how this openness benefited patients and relatives - *"You can be more supportive"; "less subterfuge and pretence, which can lead to loss of trust" is necessary; "things are more relaxed"* and overall trying *"to meet the individualised needs of the terminally ill"* is facilitated.

Such responses also underlined the view held by some respondents, that patients 'knowing' also relieves the stress on nursing staff. Four nurses discussed such stress, two basically stating the view that it is reduced, one going on to postulate that it can ameliorate feelings of guilt when the patient dies. The other two referred to the emotional trauma for nurses when they have to nurse those who 'don't know', i.e. when they *"say things like what they are going to do when they get better"*, or when they (patients) set *"unreachable goals"*.

Many respondents spoke of how difficult it is to hide the truth from dying patients, a significant number also asserted that patients should 'know' - indeed only one respondent said that they shouldn't. However from the responses received it would appear that in spite of holding this particular view, many of the nurses regularly found themselves working with dying patients in a "closed awareness context" (Glaser et al 1966). This suggests that they either had no influence or were reluctant to exercise it for some reason. Perhaps talking to patients has a high priority professionally, but a low priority in the work place.

The same feeling of powerlessness can be seen to have been present in other

areas of 'conflict' for the nurses, in that 57 (49%) of respondents complained about things such as problems related to interactions and relationships with medical staff and the 'care-cure dilemma'. This was demonstrated in responses like *"doctors often don't want to tell patients and relatives"*; *doctors' "opposition to terminal care support teams"*; *"prolonged active treatment of terminally ill patients"*; and, *"inadequate pain relief"*; (13 responses).

At the same time another 13 were of the view that factors out of their control, typically *"time"* (11/13), had a deleterious effect on the care they would like to give. Another group (9) again highlighted the fact that it is not uncommon for patients to be 'kept in the dark', when they said that their conflict was being made to feel awkward when they *"have to pretend"*.

On the other hand, forty-four (44:38%) respondents intimated that they felt no conflict in how they were allowed to deal with the dying and their relatives. Unfortunately only 11 commented further. Of these, 4 said something to the effect that they *"do what they know is right regardless"*, while the others tended to echo points made earlier about passive cooperation and perceived powerlessness. For example *"I have been lucky, wherever I have worked other nurses have either given or allowed others to give a high standard of care to dying people"*; *"I find most people and relatives are aware of their diagnosis and then it is easier to care for them and relate to them"*; and, *"not generally [a conflict felt] but it is always more difficult when the patient doesn't know"*. In some ways therefore it is not surprising that so many respondents did not report a conflict as it can be seen that many respondents either did not seem to have strong views on the subject, or seemed to view such issues as being out of their control.

When one reflects upon the data from these items (eg question 16 in which respondents typically asserted **their** need to know about issues such as **their** diagnosis and prognosis), in the light of the literature regarding patients and relatives views on their information needs (particularly that the most common

cause for complaint remains the lack of meaningful information), one is tempted to say that both as people and as nurses, perhaps respondents should have had feelings if not intentions to act on this matter. This is not least because of the UKCC Code of Professional Conduct which states that all registered Nurses, Midwives and Health Visitors should act to "safeguard and promote the interests of individual patients and clients" at all times [their emphasis] (British Journal of Nursing 1992 p. 3).

The view that many nurses do not internalise and function at this level of moral reasoning is reinforced by Aroskar when she stated that of "staff and supervisory nurses...most are at the conventional level of moral reasoning i.e. obedient to authority, and needing harmonious relationships with institutions and authority figures" (1980). This perhaps reiterates further, the effects of the medical hegemony discussed earlier in that such perceptions may have been engendered by experience and socialisation over the years, to the point that for some it has become a situation of "learned helplessness" (Seligmann 1975) Furthermore that for many this has resulted in the development of a professional self-concept which makes autonomous nursing practice for some at least, a distant and not necessarily desirable (for them or their clients') goal .

A final point of interest comes from the small but not insignificant number of respondents (11), who referred to organisational and cultural norms that they perceived to exist, which served to put them in conflict with how they would like to care for the dying and their relatives. These included 'getting involved' which may be considered un-professional; and their being seen as weak and a 'non-coper' if they get upset, e.g. *"sometimes I am afraid that the emotions I want to show may be perceived as silly by relatives or junior staff i.e. weak"*.

Another interesting point is that the issue of emotional involvement was referred to by a number of respondents, including some who identified it as an important area of nursing care. However as will be discussed shortly, the data from other items highlighted an apparent dearth of knowledge about what could

be said to constitute an acceptable level of involvement and how helping relationships can be meaningfully and purposively developed. This highlights a situation of nurses having to work out these fundamentals of 'helping' for themselves.

Theoretical Preparation for Caring for the Dying and their Relatives.

The most obvious reason for exploring this area was to elicit information about the respondents' formal preparation, with regard to dealing with the needs of the dying and their relatives and how well prepared they felt to be able to fulfil this role. It was envisaged that this would allow some exploration of the match between the nurses' actual level of knowledge and expertise, and the level they are perceived to possess - by self and by others.

Both of these are of importance to this study in terms of the 'family nurse' role (i.e. are they ideally placed and prepared to fulfil this role in situations of family bereavement), and their role as a "community educator" (Rawdon 1987). Also a lack of meaningful and effective preparation into the social and psychological realities of death and dying and bereavement, will mean that a nurses will potentially be governed by 'popular belief', and thus prey to the same taboos and misconceptions of the rest of the population. Furthermore it was expected that further insights would be gained into the use of ego-defensive coping strategies by nurses .

On the face of it the data were encouraging (at least for nurse educators), as 50 respondents (47%) answered the question 'has education helped?' in the affirmative. There was also a perception by some, that more education would be helpful as their training had been lacking in this area, suggesting a positive view of the role of education in general.

Further examination of the responses however showed a less positive picture. Nine respondents made the realistic point that education had helped by "*facilitating insight, which could then be built upon by experience*"; another 5

spoke of the general benefits of education i.e. the opportunity *"to discuss issues"* and for *"personal growth"*; while 16 gave examples of content they found useful e.g. *"insights into the grieving process"* (7), and *"pain relief methods"* and other such practical care issues (8). On the other hand 8 initially acknowledged the role of education, yet seemed to minimise its importance and impact e.g. *"I think practical experience is better than reading about it"* and *"my education has been in the school of life"*. Thus it can be seen that many who were initially classed as positive towards educational preparation, also had reservations or provisos.

This of course may be a reflection on the material covered in nurse training, regarding death and dying and bereavement. The impression given by respondents (and indeed those in other studies on the subject) was that what is covered is typically 'factual' in nature, for example the 'stages of dying/grieving' and 'symptom control', while the emotional and practical realities remain untouched (as per Smith 1992 and Heller 1993).

This may in turn illustrate another facet of the 'hidden curriculum' regarding control of self and situations, in that material covered in such a way will reinforce a cognitive or knowledge-based view of the subject. Furthermore, this may promote the perception that 'knowing' about something (in this case stages of grieving and pain control) provides a degree of personal control over it. This may be acceptable, even desirable, when considering pathophysiology, yet be potentially problematic in the area of grief and bereavement. This is because a self-perception of being able to 'control' grief will typically lead to the painful realisation that one cannot do this, which in turn may complicate grief for the person involved. In essence then, this is another problem with cure-orientated curricula as they tend to cover content with the implicit rationale of allowing control via knowledge.

Forty-nine nurses (49:46%) were in the 'education has had no effect' group. Again, such a 'bald' figure does not adequately do justice to actual responses.

Six (6) people just wrote "no" - leaving it unclear as to whether they meant they had not received education in this area, or that such education had not helped. Three said that they *"weren't sure if it had helped"* because they were relatively newly qualified and had not had opportunity to find out. A further 9 seemed to be complaining that their education was lacking in this area - either in terms of content or indeed it's non-existence. Of these 9, 5 went on to say that this meant that they had had to rely on 'experience' (i.e. trial and error) but seemed to feel that this was not particularly a problem - *"education was lacking but it would not have been much use anyway"*. This was echoed by 23 other respondents who asserted that **only** experience can prepare one to care for the dying, indeed 5 respondents seemed to be 'anti-education', e.g. *"I feel experience is the only thing that counts and helps"* and, *"It is all instinct, learning from a book is seldom any good for a practical nurse. For those as managers, book learning is all they have!"* (sic), in a sense such responses perhaps had undercurrents of "horizontal violence" (Roberts 1983).

Others were less antagonistic, saying things like *"only experience helps you to care for these patients"*, and, *"I learned everything by experience"*. Smith (1992) also found that nurses in her study were "unwilling to believe that they could learn to react" in difficult situations. Instead they preferred to see learning about feelings and emotions associated with death and dying as only being achievable through 'experience' (ibid).

Others in the present study, asserted that much of what is needed is a *"caring personality"*, seemingly coming from the belief that 'good nurses are born not made', therefore calling into question the necessity of covering subjects like the psycho-social aspects of care, in nurse education programmes at all. Whether this is the case or not, many did not seem to be aware of what education in this area might entail other than aspects of physical care, symptom control and pharmacology, in turn perhaps a reflection of the input they had received.

It was therefore apparent that for a significant number, this was an area of

nursing practice that they perceived one can only develop as one 'goes along' - from 'experience', by having 'common sense', and "just picking things up" Smith (1992). Of course for some, this may merely reflect reality - "that may be all they have" (Kiger 1994). It may also indicate the level of understanding of the subject (novice or expert practitioners [Benner 1984]), and perhaps in turn an indication of levels of education and the content thereof. Furthermore one does wonder, if the same attitude would have been seen to prevail if the question had alluded to more practical issues in surgical or medical nursing.

It would have been interesting to ascertain the respondents' "concept of death" (Schuster 1980) so as to identify just how effective, unguided experience in the face of regular exposure to the death of others is, in the development of cognitive and affective acceptance of death - particularly one's own. The identification of the level of "cognitive awareness/affective rebellion" (where the inevitability of death is accepted as real, yet viewed as external to self [Nagy 1948]), amongst respondents' would also have been useful. Both of these could potentially illustrate just how closely the self-perceptions of nurses' regarding their concept of death approximates with actuality, i.e. exactly how comfortable are they with it.

What constituted the educational process for many, also became apparent, in that invariably respondents who referred to it, alluded to things like "*getting things out of books*" and "*sitting in a classroom*" being told about things. Indeed for some, learning from books appeared to be construed negatively in that it was somewhat sardonically referred to as "*book-learning*", the alternative in this case being "*instinct*".

It is also interesting to note that those most opposed to education in this area tended to be those who claimed to have had very little of it. Over 30 respondents actually asserted their preference of experience over education, while 15 claimed no education or theoretical preparation at all. It is a possibility therefore that this could be as much a case of psychological rationalisation than

as a true self-belief in individual nurses' knowledge and expertise derived from experience. Given the data from earlier items, it may also have reflected a relatively low level of self-awareness in this area, as well as a poor quality input.

Independent study was mentioned by only a handful of respondents, but all of these claimed to have found it very useful - perhaps because it was very meaningful to them, at the time. For example *"I read 'On Death and Dying' [Kubler-Ross] when my mother was dying. I used many things to make a model of care from this book. It worked! We all grew through the grieving process"*.

Experience was referred to in another way also, this time in terms of personal experience of bereavement. Many respondents who had been bereaved put forward the view that it was this experience that had been educative and had prepared them to care for the dying and their relatives 'better'.

In spite of the presence of people who had received education on caring for the dying and their relatives, and indeed a number who had been bereaved themselves, almost two thirds of those who responded to this item (70 out of 108) felt that they were not adequately prepared to deal with the psychological and emotional needs of dying patients and their relatives. Included in this 70 were:- twelve who again claimed *"experience is the only preparation"* often going on to say that such experience was essentially through personal loss; a further 12 'requested' further education on the subject, often referring to the lack of coverage in terms of time spent and content in basic programmes. One very insightful response was *"I suppose a lot of being prepared is coming to terms with your own mortality, which I don't think I have"*. Another said *"experience in a hospice would be more beneficial than any form of education"*. Such people seemed to be saying that one has to truly experience grief to fully understand and appreciate what it is like.

Also within the 70, were 13 who said that one can never be prepared, saying things like *"everyone is different"* (6) and *"with experience you learn to cope"*

better and become more confident...but I do not feel it is something you get used to", also "you can only be prepared so much. I find it very hard to be so unemotional as to not to really feel, when the relatives are about to lose someone they love deeply, you can't be so unemotional that it looks as if you couldn't care less".

Thus there were a whole array of reasons for respondents feeling unprepared in this regard, ranging from lack of experience, to almost philosophical standpoints on the notion of 'preparedness'. Perhaps this reflects the reality that this is an area essentially left to individual nurses to sort out for themselves (Lavandero 1981; Smith 1992). As Leonard points out, there is an imperative for professional workers committed to helping others during such crises as dying and bereavement, to remove their own fears and develop an understanding of the meaning of death, yet little or no provision is made to meet such need (1976). The data also highlights the fact that personal experience of bereavement *per se* does not automatically lead to meaningful insight into the grief of others.

What did seem to come out of such responses, was the suggestion that for many, being adequately prepared to deal with the psychological and emotional problems of patients and relatives equated to being able to retain personal 'control' and being confident (or appearing so) at all times. Also to high levels of self-expectation referred to by Smythe as "rescuer fantasy" (1984) or the 'super nurse' syndrome, which were also found in the data from the 'Ideal v Actual' section of questionnaire 1.

Such high self-expectation were considered by Norris to be examples of irrational ideas concerning the goals to be achieved in their work such as an imperative to succeed in taking care of all patients' needs, which nurses tend to develop as a result of their training and socialisation (1973). In other words, as many nurses may feel inadequate because their expectation of self is so high, than who do so because of an actual low level of knowledge and expertise.

This again suggests serious perceptual flaws in their knowledge base in terms of what active help one can realistically give to alleviate the psychological and emotional suffering of dying people and their grieving relatives.

Those who did feel prepared (38:35%) invariably said that they had come to be so by "*experience*" - usually as a nurse (34), and typically by trial and error. Only 5 mentioned being able to refer to a role model or skilled colleague(s). Age was also seen as a factor by some, these respondents giving the impression that their age made them more empathic to peoples' needs and that they were somehow more sure of themselves and what they believed in. In this vein, one person was moved to write:- *"My nurse training many years ago, dealt with live patients only - you put the dead ones in a shroud and send them off to the hospital mortuary. I have since unlearnt (sic) many things taught to me in my training and now deal with things on a more honest and human level"*.

Interestingly this perception goes against the findings of Murphy et al (1992) who found that empathy amongst ICU nurses at least, tended to be inversely proportional to years of experience, i.e the more experienced they are professionally, the less empathic they become.

Overall however, respondents who appeared to have truly worked through their feelings and approaches towards the dying and their relatives, tended to be the ones who had reflected upon and combined education with personal and professional experience. These reflections were often apparently triggered by personal loss. These 'well-balanced' individuals also seemed to be people who held realistic views of what they could do to help bereaved people, presumably they would also be people who recognised their own needs as well as those of others, following the death of a family member or a close friend.

There is also the probability that there will be few nurses capable of empathy and thus able to offer meaningful support to the dying and their relatives. This is because empathy requires identifying with another persons feelings and experiences, thus it would be extremely difficult (indeed impossible), for

someone who relies on distancing (physical and intellectual) to do so, as axiomatically empathy is precluded where a party **presumes** the feelings of another, rather than **eliciting them** 'in fact'.

The responses to the items on 'professional distancing' cast general doubts over the educational preparation of respondents. They were asked to discuss the issue of the optimum level of involvement of nurses with patients and relatives, and whether nurses can become over-involved with them. A further, more hidden agenda, was to elicit information about purposive efforts made to establish meaningful nurse-patient/relatives relationships, and whether the psychological well-being of staff as per writers such as Worden (1983), Egan (1984) and Parsons(1964) were considered whilst doing so.

In the event, the responses to these items allowed two conclusions to be postulated:- firstly, that there was little awareness on a conceptual level, about what constitutes an optimum level of involvement between patients/relatives and nurses. This suggests that they (the respondents) possessed little or no insight into concepts such as 'affective neutrality' (Parsons 1964), the 'counsellors distance' (Kennedy 1977), or indeed any other yard-stick by which to approximate a level of personal involvement with patients and relatives; and, secondly, that respondents had little or no awareness of the intentional and planned "therapeutic use of self" (Orlando 1961), either in theory or practice.

In turn there are two major implications of these in terms of the therapeutic relationships (Altschul 1972) such respondents would presumably have with their clients.

The first is the apparent lack of theoretical underpinning (either literature or experientially based) to their communications with their clients (including relatives). This means that there can be little planned intervention in this area (when one has no idea of what one would **like** to achieve, how can one possibly plan to do so?). This returns us to the earlier point of nurses being willing to

"answer questions [and] involve relatives in care if and when they ask", this time illustrating that in the case of relatives, much of the onus would be put upon them (relatives) to open and maintain channels of communication with staff, and to seek information rather than it be proffered to them.

The second implication moves on from this in that as a result of the lack of planned contact, relationships with relatives could be as variable as the number of staff involved. The possible extremes being cold 'professional' aloofness and avoidance (Webster 1981) at one end, and self-sacrificing, self-destructive over-identification and perhaps burnout of the nurse (Llewelyn 1984; Freudenburger 1974) at the other. Both are undesirable and potentially damaging for those involved (Kennedy 1977; Maslach 1976). Smith explains the first of these (professional aloofness), saying there is an expectation that the more senior a nurse becomes, the more they are expected to cope with upsetting situations. Also that as their feelings are rarely acknowledged, they are likely to develop distancing strategies which keep them from personal involvement with patients and relatives, even though they recognise that they may be becoming hard (1992).

This apparent difficulty in establishing therapeutic nursing relationships was termed "nursing's Achilles heel" by McSweeney and Nyatanga (1989) who went on to assert that while "nurses' clinical skills and procedures may well be satisfactory, it is clear that the ability to form helping relationships...leaves much to be desired". Perhaps a major step forward in this regard would be a move from nurses being in a situation of doing **to** and **for** clients, to one of doing **with**, which would require that they release (or at least share) 'ownership' of patients. In this way they would then be in more of a position to acknowledge and internalise the lesson that real involvement paradoxically, requires the ability to remain outside another person's problems (Burnard 1985). The fact that at least some respondents did not have this awareness is made evident by comments to Q8, which bemoaned the fact that many nurses-relatives become *"obsessional...and lose objectivity"* about the care of their

relative. To many lay people this would be seen to be understandable, to some nurses however it is apparently a sign of weakness and of not 'coping'. To the student of communications, it highlights the stressful nature of nurse/patient and nurse/relative relationships and goes some way towards explaining professional nurse 'burnout'.

The ad hoc nature of developing relationships was also reflected in the responses regarding how one would know that optimum involvement had been achieved. Few respondents were able to expand meaningfully on this issue. This again reflects Smith's (1992) study, in that she found that following their psychiatric nursing placement, general nursing students could identify advanced communication skills and had indeed developed some. However, once they returned to their general nursing education and placements such skills and knowledge disappeared again. This reiterates the adage that one must 'use a skill or lose it'. Exceptions of note in the present study however, were the nurse who said *"I think it would be an optimal level if nurses became involved enough to befriend both patient and relatives. To be able to relate with them easily and to appear approachable. However, not involved to the extent of giving preferential treatment to a patient or [the nurse] becoming emotionally unstable"*. Also the respondent who said that the optimum level has been passed if *"the involvement becomes destructive...if it begins to affect the nurses health, or relationships with her loved ones due to stress and worry"*.

In the main however, when considering the responses to these items one is drawn to reflect upon the concrete nature of much of it, and also the fact that so much was made of ad hoc, often nebulous, and therefore unreliable modes of assessment of the therapeutic environment and consumer satisfaction. For example, the numbers of letters of thanks or complaint, and *"general feelings of satisfaction all round"*, which can all be seen to be the professionals' interpretation of their own performance and not the actively canvassed views of patients and relatives. This again reflects the unplanned approach to a key area of care - developing therapeutic relationships, in this case with relatives, in turn

increasing the chances of such relationships being found wanting.

For many respondents, over-involvement seemed to connote and manifest as "*showing favouritism*" towards the patients and relatives involved, often with an ensuing 'over dependence' on their part on a particular staff member. However, negative connotations for staff were also identified both in terms of their psychological well-being, and the loss of 'professional objectivity' that may ensue. An interesting paradox appears here therefore, in that much of what respondents referred to as 'over-involvement' and how one gets to be over-involved, is actually emotional involvement, which is said to characterise the 'new nursing' (Salvage 1990). This is because of its basis in humanistic philosophy and an accent on assessing and meeting the holistic needs of patients and clients via nursing models, the nursing process and the 'therapeutic use of self'.

What seems to have been the case therefore is that the majority of the nurses did perceive that one can become 'over-involved' and that this may have negative sequelae for both staff and clients. However, almost without exception these respondents could not realistically identify any purposive mechanism for facilitating meaningful relationships or communications. Nor did they seem to be able to identify any way of approximating 'professional' distance other than "*knowing by instinct*" or "*general feelings of satisfaction all round*".

There was little explicit mention of any cultural expectation regarding 'distancing' oneself as a nurse from clients. However, the fact that 89 of the 105 who responded to the question "can nurses become over-involved?" (ie 85%) in the affirmative, while only 4 (4%) said "*no*", would seem to support the suggestion that in nursing, one is seen to be 'guilty' of over-involvement, and not praised for it. That is, it is not positively viewed because it can lead to "*lack of objectivity*" and "*unfair levels of attention*" being paid to or expected by, certain clients, and therefore it should be avoided. Unfortunately no

guidelines appear to be available to facilitate the 'correct' distance, and hence ego-defensive mechanisms such as intellectualisation, avoidance and evasion can be presumed to be utilised.

This view was further supported by the 15 or so respondents who said that over-involvement occurs more quickly and more often when caring for children and in long term care areas. Problems seemingly unique to such environments were enumerated by some, along with the impression that 'traditional' ego-defensive techniques (Menzies 1961; Jourard 1971; Wallis 1987; Wilkinson 1991; Lyall 1990) do not work in such areas.

It should also perhaps be pointed out here that in the absence of a 'helping' position based on the tenets of counselling relationships, it would be very easy for nurses who do become involved on a personal or 'emotional' level to find themselves deeply involved in the problems of their patients and their families, potentially to the detriment of their own mental health. This was what Fielding et al were alluding to when they said that communication skills training can be hazardous to nurses' health and can promote 'burnout' (1987). Respondents should not therefore be viewed negatively out of hand in this respect, as they may merely be protecting themselves from morbidity in the absence of more constructive mechanisms (within the self and the organisation) for doing so. Indeed the ability to be meaningfully involved in the emotional work of nursing, may have been socialised out of them (Smith 1992).

Given this apparent absence of planned intervention with relatives, and the reality that the 'distance' between the nurses and patients/relatives is basically a function of the individual nurse's own approach and personality, it would seem reasonable to say that these data provide further explanation of the problematic relationship between nurses and relatives, which the latter complain of so often. Not least because there are no guidelines to follow to facilitate 'competence', but unwritten and therefore nebulous rules which nurses know they should obey and not pass beyond. Furthermore, the lack of any form of

planning regarding the development of rapport and trust with relatives would seem to suggest that this will not change in the foreseeable future.

It was also apparent from data analysis, that conceptions and practices in other areas of dealing with the dying and their families, were to a large degree based upon colloquial or 'popular' belief. There were a considerable number (35:30%) for example, who asserted that **they** would have to assess what patients want to know. Unfortunately there was a dearth of comment on how they would go about this assessment apart from relying upon ad-hoc, almost fable-like beliefs such as *"staff will know because the patient who wants to know will ask, and/or will shy away if they don't"*. Thus the willingness of patients who 'really want to know' to ask for information was identified, and seemingly accepted as the indicator that people want information. Other beliefs expounded were along the lines of 'patients know anyway', in certain cases by some sort of extra-sensory perception (ESP).

Another important point raised was the apparent lack of knowledge and insight into the needs of the dying and their relatives, and the issue of giving and receiving bad news in particular. Only 2 respondents actually mentioned a person's (patient or relative) 'normal' reaction to receiving bad news, suggesting little meaningful insight amongst respondents into the psychological and emotional realities of grieving. However several did point out that such openness would possibly engender nurse-patient trust and relationships i.e. *"shocked at first but maybe grateful afterwards - some doctors don't know what to tell them"*. Many said or gave the impression that a reason one should not give information is because one might 'upset' people too much and lead them to *"give up"* or *"even take their own life"*, i.e. they seemed not to have considered that emotional outbursts and losing control are normal, natural and perhaps even necessary tasks to be undertaken by a person who is confronted with bad news (Buckman 1993; Raphael 1983).

It was also obvious from a number of replies that this situation could be

complicated by input from relatives, particularly if they (relatives) also perceived that the patient could not cope with such news, as this could lead to a situation of both professionals and the public sharing the same 'popular' conceptions and beliefs and leaving the patient at the centre of a "cycle of evasion" (Lyll 1990).

It may also be of course that this reticence to give such information was a rationalisation for avoidance of the situation by staff who were afraid of "being blamed for the news...of unleashing a reaction...of not knowing all the answers, and of expressing emotion oneself" (Buckman 1984). That is, those involved may be engaging in "projection" - transferring their anxieties and fears onto others so as to avoid difficult situations whilst saving face themselves (Burnard 1990).

The data also brought into question the interpretation that many respondents had for the term 'coping', i.e. some seeing it to be the apparent absence of reaction and associated with terms such as "mastery and defence" (White 1974) rather than "responses to external life strains which serve to prevent, avoid or control emotional distress" (Pearlin et al 1978) where the stressful situation is not (necessarily) overcome, but where there is a balance between management of the problem and regulation of the distress (Hirth et al 1994).

The first two seem to pertain more to the 'stiff upper lip', cognitive distancing and ego-defensive mentality, while the third offers the view that anything which mitigates against or alleviates emotional distress is 'coping'. Thus it would appear that for a number of these nurses at least, coping connotes control, confidence and calmness, and not necessarily meaningfully dealing with a situation or an emotion.

This was also found to be the case with regards the specific issue of 'coping' with a diagnosis of terminal illness, in that the person who 'copes' would apparently be expected to accept philosophically and with stoicism, their impending death. There seemed to be little or no insight that for some this may

be some way away; that it requires psychological work (Worden 1983); that support is needed; and that some people, for a variety of reasons, may never come to terms with their own fallibility, but that is not to say that they are not 'coping' with their diagnosis and the implications thereof.

Thus it would seem fair to say, that few respondents utilised conceptual or theoretically based reasons within their replies, and as a result gave the impression that at best, custom and practice and 'common sense' would underpin such issues and activities for these nurses. At worst, unqualified hunches, assumptions and uninformed opinion would form much of their bases for action. If one accepts this point, then it is not unreasonable to assume that for many, dissonance will be minimal and that the determination to positively act as a source of information to clients will be low. This will be so because there is little or no stimulus or direction to dictate otherwise - either internally or externally (eg from other professionals [Stein et al 1990]) or from the bureaucratic organisation [Corwin et al 1961; Green 1988]) to change the situation. As a result of this, the status quo of staff rather than patient-centred provision, will continue both as a result of cognitively having no theoretically driven compulsion to alter it, and subconsciously (perhaps) because it is part of a psychological defence mechanism to prevent over-identification with patients and so mitigate against anxiety.

It would appear therefore that in the main, the staff in this sample had not been formally and realistically prepared, to undertake the role of holistically caring for, and supporting, dying patients and their relatives. This was the case in terms of both the ethos and the practicalities of such care, and the issue of developing the ability to holistically care for the terminally ill whilst retaining a personal sense of emotional well-being. As a result of this, respondents had either:- come to be meaningfully prepared by personal grievous loss followed by reflection on the experience; come to **perceive** themselves to be prepared but gave the impression that this may not necessarily be the case in reality; or, did not feel prepared at all.

The latter two groups constituted the majority of respondents and therefore provide cause for concern for clients and staff alike, as most nurses are expected to fulfil such a role. Furthermore, this apparent lack of meaningful knowledge into the emotional and practical realities of dealing with loss is of obvious concern, as professionals such as nurses are often seen by the wider community as experts in such areas, as indeed do many nurses themselves.

Nurses as recipients of the health care system, both as patients and relatives.

Perhaps the major point raised by these data was the identification of the fact that when a patient or relative is also a nurse, things are 'difficult'. Also that the problems identified by Crawley (1984) for nurse-patients, were indeed found to have parallels with those of nurse-relatives, as postulated in the literature review (Olivet et al 1991).

In terms of nurse-relatives as helpers, the first issue to raise is the fact that only 30 respondents (26%) in this study claimed to have had any experience of involving nurse-relatives in care, and only half of these gave any details of this. Four spoke of experience as a relative taking part in care; 6 of experience as a nurse who had seen relatives participate in care; and, 5 who gave general opinions on the issue.

Interestingly, those who had provided care as a relative, tended to accentuate the benefits they derived from being 'allowed' to be involved by the staff, while the others in the main identified negative issues. These were mostly about feelings of unease about being watched. One respondent also said that "*they [nurse-relatives] tend to be so involved they are obsessional*" (sic). These findings were reinforced by the rest of the respondents in that the problems identified fell into two main groups - problems for the 'working' staff, and problems and issues pertaining to the nurse-relative(s).

For the staff, issues like feeling inhibited and threatened by being 'critically' watched were again raised. As were the views that nurse-relatives can be "*over-involved*" and "*may try to take over*" - the presumption seeming to be for

many therefore, that a nurse-relative will wish to be directly involved in hands on nursing care, and that this was invariably a 'problem'. These constituted the majority of the replies.

For nurse-relatives, there were a much smaller number of replies. These referred to making sure that they (relatives) as a helper, did not hurt themselves or the patient (for reasons of accountability and legality x 4), and that such relatives may have extra needs because they are also a nurse with more insight and therefore concerns (13). That such people may also be afraid to ask questions was also raised.

Few (15 in all), were of the view that dealing with a relative who is also a nurse would somehow make things easier. Three felt that it would because such people *"would be easier to approach"*, would readily accept a *"caring role"* and *"be able to cope - even more than another person"*. Several mentioned nurse-relatives providing hands-on care. Interestingly, one respondent, a nurse from a burns unit, said that she had no problems being watched or assisted by nurse-relatives because *"being in a specialist area, I know more about the treatments than they do"*, thus providing insight into what may make nurses feel uncomfortable in such circumstances, and the expectations of staff of nurse-relatives.

In the main the rest of this group answered in this potential sense - suggesting no experience of the situation, or lack of reflection upon it, eg *"I don't see that there would be a problem"*.

It would seem therefore, that the unease generated by having relatives around for much of the time, is intensified for most nurses if the relative is also a nurse, and particularly if they wish to take an active part in caring for the patient. This has obvious parallels with earlier data regarding the preferred roles of visitors and indicates that many of these respondents perceived that difficulties **will** arise with nurse-relatives, essentially because they will not fit easily into such

roles. They will presumably never be "naively trusting" (Robinson and Thorne 1984) for example.

It is also noteworthy that this perception would appear to be there at the outset, that is, it would be **expected** to be problematic, perhaps potentiating a self fulfilling prophecy.

Interestingly, those who claimed to have no experience of dealing with nurse-relatives also made the same assertions, suggesting that the perception that nurse-relatives are typically 'trouble' is not necessarily developed through experience, but may also be an aspect of nursing 'lore' passed between group members from generation to generation.

It would seem reasonable to propose therefore, that many nurses would feel awkward with nurse-relatives around, and that nurses feel awkward when they are visiting people in hospital.

Data from respondents who had actually been recipients of the health care system (particularly hospitals), further confirmed the problematic nature of this for the majority of respondents.

On being a nurse-relative, only 11 (12%) people were in any way positive. These usually referred to staff "*using professional or technical language*" with them. The rest gave an overwhelming impression of uneasiness generated between nursing staff and them as nurse-relatives. This had typically had the effect of encouraging, or perhaps even expecting them [as relatives] to 'fit in' and assume a passive role eg "*I helped in any way I could...but did not interfere with treatment*". Some (24:26%) identified that this passivity had been to the point of not revealing to the staff that they were in fact a nurse, preferring instead to appear to be 'just another relative', so as to avoid problems with the ward staff.

All in all, the majority tended to report feelings such as awkwardness, frustration, and a general unwillingness to ask questions for fear of being labelled interfering or critical. This illustrates a difficulty in playing the role of 'visitor' or 'worker', and obeying the 'normative control' which goes with them. Eight (8) complained that a corollary of this was a lack of information and meaningful communication, further complicated by the fact that a number of respondents described staff "*backing off*", avoiding nurse relatives, and being generally evasive when approached by them for information. This reflects Knight's observation that "having nurse relatives in attendance...causes a deterioration in the communication skills of nurse-carers" (1985). It also illustrates ego-defensive coping strategies in action.

The respondents' observations of nurses dealing with nurse-relatives and their own dealings with the same were sought. Replies included terms like "*wariness...hostility... ..suspicion, and over-expectation*" of their insight and knowledge. One respondent said "*I got the feeling that we must do everything by the book or they might catch us out!*". This and similar responses seem to connote low levels of self-confidence in their own nursing ability and knowledge. Again Melia's work offers some insight into this when she highlights that much of what nurses do is essentially to "work from the routines of training and not from first principles" (1987), and furthermore that such routines are often picked up from nursing auxiliaries. This 'learning from Nellie' is obviously not the best basis on which to build self-worth and confidence in one's skills and knowledge base, and one can understand such people feeling intimidated by the presence of a person considered to have 'inside' or even superior knowledge.

It should also be acknowledged that the feeling that working nurses may have - that they are sometimes being critically observed by such people, would appear to be warranted, as several respondents referred to checking charts and "*making sure my relatives [got] the right care*". It may therefore be the case that some nurse-relatives are checking up on staff and the care that they give,

perhaps because they see this as being part of the role of the 'family nurse', identified and expanded upon within the first part of the study and alluded to by several respondents in this questionnaire. Indeed it may be **expected** that they do so - by the patient and/or their family, that is, it is perceived as their family role or duty.

Most of the respondents who claimed to be acting in this way from the beginning, seemed to identify that they adopted a 'professional' demeanour with the staff, often enhanced by their working in the same hospital and in two cases this involved them wearing their uniform during visits. Interestingly these were the people who claimed to be happiest with their or their relative's treatment. This was reinforced by the nurse who said that she had been a visitor twice, once when known to staff and once when not. The point being made that *"when known to staff, I was made to feel I was welcome anytime and given all information"* whereas when *"not known to staff, they made me feel that I was being too nosy and pushy and had no right to ask questions"*.

This 'professional' alignment as a means of decreasing role conflict was further illustrated by the respondent who identified that she was often *"critical towards some things, however I never voiced these criticisms. But if any other of my relatives criticised I tended to stick up for my profession"*. Melia (1987) adds to this discussion by her contention that "fitting in" and not being deviant is an 'attribute' developed very quickly in a nurses career, and is one which is very difficult to overcome or 'unlearn'. She also asserts that it can become a need so deep-seated that they may not even realise they are doing it, to the point that they may continue behaving in certain ways even when it is okay not to do so. In this part of her work, this amounted to nurses being reluctant to talk to patients for fear of being seen as 'skiving', even though the ward sister encouraged them to do so (Melia *ibid*).

The role of the nurse-relative was also seen by some to be complicated by an expectation by staff and their relatives, that they would understand what was

going on, even when they did not work in the clinical speciality concerned. For some this manifested either as a complaint that the staff gave too much information or at too high a level. Others however, found that it was presumed that as they were a nurse, they would know all about tests and treatments - even though they worked in a different speciality, and so were given little information at all. Therefore it was apparent that the 'family nurse' role existed for a number of these respondents, and that it can be problematic as the family may also expect them to know things, irrespective of their educational and clinical background.

In itself, this could also be seen to be an example of a lack of meaningful assessment of relatives' needs, with a resulting mis-match between what relatives want and what they actually get. This was a fact recognised by the respondents who said that their experience as a nurse-relative had made them appreciate that this over expectation of knowledge was common and that there is a need to "*assess and explain*" properly.

This again reflects Crawley's (1983) beliefs about nurses when she talks of them "having one system of communication for relating to other nurses, and a different one in their relationships with patients and relatives". If a patient or visitor is also a nurse (or perhaps even a colleague), then confusion arises as to how they should be treated - in the manner of a colleague who in return for 'favours' will be rational and understanding of any shortcomings of care or provision, or in the 'professional manner' described earlier as 'benevolent paternalism'. Consequently the nurse-relative has the dilemma of which role to play whilst also fulfilling their remit of the family spokesperson for health, which often includes actively seeking information from staff, and so precludes them from acting out the seemingly preferred 'passive' role of 'visitor'.

It has to be said that in some areas, there were obviously 'perks' for nurse-relatives. Some (a few) respondents referred to their being "*given more information; permission to use the staff canteen; and, the increased presence of*

senior staff". In the main however, respondents seemed to be of the view that working nurses tend to feel awkward, uneasy and even threatened, when they have to deal with relatives who they consider to have knowledge and insight, in this case another nurse. One even said "*tread very carefully!*" They also reiterated that evasion and avoidance of 'nurse-relatives' by working nurses, does go on. At the same time they offered some reasons for why this may be so - such as the fear of being 'found out', concern about the over-critical eye of such people, and perhaps even the fact that they may be aware of 'short cuts' taken in care - as per Melia (1987).

There is also the possibility that such mechanisms are utilised, so as to diminish personal identification with the nurse-relative and hence reduce anxiety for attending nurses.

Overall, the impression from these respondents, considered in the light of Crawley's and Melia's work particularly, was that a situation did indeed exist in which there was confusion and a tension regarding the expected norms of behaviour and roles to be played by nurse-relatives, i.e. whether to play the role of 'relative' or 'nurse', as it would appear that they cannot satisfactorily play both.

Furthermore, this 'reality' seemed to mean that both playing and not playing those roles can put nurse-relatives into conflict, either internally and/or with others (their family and/or with staff), placing them in a no-win situation - one said to demonstrate "role uncertainty" on the part of the nurse-relative (Olivet et al 1991). This is perhaps the reason one person encouraged her relative to "ask her G.P. for hospice treatment" so that she [the nurse] felt more "*able to help without being thought interfering*". The suggestion being that attitudes towards relatives would be different in a hospice (a view espoused by several respondents) and so she would be able to feel more able to fulfil her family nurse role. These differences would presumably (given the data) be things like increased involvement in their relatives care and generally feeling that their

relative was being dealt with in a more empathic/sympathetic manner than is the norm in general hospitals. All this allowed them to be in some ways, a nurse and a relative rather than either/or.

It may also refer to access to information, which because of the more open ethos of hospices and perhaps the 'type' of person who work in them (Fisher 1988) would mean that such conflicts would be ameliorated for nurse-relatives. Such data about preferring hospice to hospital care may also suggest that some respondents at least, are unhappy with the "deeper structure" and provision of hospital care (Handy 1986), and perhaps would try to mitigate against it when they or their family come to access it.

A few respondents did speak of *"the care being done properly when they [nurse-relatives] are around"*, suggesting that at other times this may not be the case. The fact that so many respondents in this study (i.e. almost all who gave a response to the question of whether their experience as a nurse-relative had affected their subsequent treatment of relatives) stated their determination to *"treat relatives better in the future"* would seem to point to this.

It also reiterates the possibility that the experience of being the recipient of the service one usually provides can often be a salutary one, perhaps because one is confronted for the first time, by the 'deeper' organisational realities and the professional training and socialisation factors, which can mitigate against humanistic, patient-centred hospital care.

Melia says "because nursing is construed as work to be done, a tension is produced between the ideal form of nursing and its operationalised form which is practiced on the wards...the essential nature of nursing can be sacrificed to the organisation of care" (1987). Perhaps some nurse-relatives react against this for **their** relatives, even to the point of expecting care to match the perfect yet typically unattainable ideals drilled into nurses during training (Smythe 1984; Norris 1973).

Notwithstanding all this, it is apparent that as stated earlier, being a nurse typically complicates the situation of being a hospital visitor, which in itself is often already problematic.

Furthermore, those respondents who said that they had not been nurse-relatives tended to reflect the responses of those who had, again reinforcing the view that these results reflect norms of behaviour encountered and displayed, by nurses (staff and nurse-relatives) involved in such a situation; and that they are not just the views of dissatisfied customers, but relatively common aspects of hospital life.

For the issue of being a nurse and a patient, respondents tended to answer in much the same way as for nurse-relatives, in that for some, 'perks' - such as "*side-rooms*"; "*extended visiting hours*"; "*more information*"; and, "*speedy attention*" were seen to be available. One respondent was moved to reflect that she was "*made to feel part of the ward and the staff*" (*sic*), while another spoke of the positive reactions she received for "*being a nurse and wanting to a part of the team*" - again suggesting continued professional affiliation and wanting to 'fit in' for these people.

The majority however referred to the negative connotations of the situation. These could be sub-divided into those who had 'problems' with the role of 'patient', and those (a greater number) who had problems which echoed those of nurse-relatives.

The patient's role problems were things like feeling "*insecure...awkward [and]...out of control*" thus highlighting the powerless nature of the patient role. While the others were wariness by staff; a tendency on their [respondents] part to withdraw and attempt to be passive and unquestioning; an over-expectation by staff of their insight and knowledge into what was 'going on'; and an expectation by staff of an enhanced ability on the part of the nurse-patient, to deal with their illness and hospitalisation. For some, this went as far as their

being denied adequate analgesia post-operatively; discharge information being inadequate; and a general expectation that they would be capable of self-care earlier than other comparable non-nurse patients. In the main the experience was seemingly a disturbing and salutary one, as they perceived having been a patient as having had a positive effect on how they subsequently treated patients in their care, just as nurse-relatives had said of their intentions towards relatives in the future.

It is apparent from these data therefore, that a degree of 'cognitive awareness but behavioural denial' goes on, in that there seems to be a paradox whereby the majority of respondents asserted that they recognise the needs of patients and relatives, and having been in the position themselves were more diligent in meeting them. However the statements about their experiences as recipients of the system show that at the time of the study at least, the problems were still current.

Overall therefore, from the items regarding nurses being recipients of the system they work in, there was an overwhelming feeling of concern and awkwardness both for nurses with 'nurse-relatives' and vice versa.

For 'working' nurses this was said typically to lead to evasiveness, wariness and defensiveness - perhaps as a result of uncertainty about how to treat and react to relatives who are also nurses, or because of the potential for projection and identification with them (Crawley 1984; Olivet 1991), and an ensuing challenge to their existential denial of their own death and those closest to them.

For nurse-relatives, it would seem that feelings of concern and awkwardness 'encouraged' many to attempt to adopt a passive and non threatening persona, even to the point of denying the fact of their being a nurse. For others, the role of 'family nurse' dominated, and so a more active role was assumed, including checking up on care and generally making sure their relative was properly cared

for.

Both, in their own way, may elicit stress within the nurse-relative. For 'passive' individuals this will be from the fact that they are not truly fulfilling the family role, while for the 'active' there will be a concern that their behaviour will be seen as 'interfering' and may adversely affect the care of their relative, particularly as they will be aware of how powerful staff are in determining rewards and punishments for patients and relatives (Tagliacozzo and Mauksch 1972; Anderson 1973; Taylor 1979).

To explore and explain this further, a nurse-relative may attempt to accommodate and reconcile her behaviour not only to herself, whilst at the same time be cognisant of the needs and expectations of her family (to ask questions and to speak for them authoritatively). In turn this could be complicated by the fact that as a nurse she will have insight into how such behaviour may make her appear to staff (a 'non-nurse', interfering, not fitting-in); have an understanding and perhaps subconscious affinity of reasons for difficulties in communications (functional uncertainty; a fear of saying the wrong thing, contravening 'rules'- being 'un-professional'); have an awareness of how she may be making the nursing staff feel and behave (awkward, dissonant, evasive); and also perceive that such feelings may translate into sanctions against her and/or the patient. The nurse in this position is thus highly pressured and in a true dilemma in that each 'solution' (i.e. playing or not playing particular roles) may have unsatisfactory and/or unpleasant ramifications for self or others. This goes a long way towards 'unpicking' the feelings of awkwardness in the relationships between nurse-relatives and staff re-visited later.

Interestingly, Hardy (1978) goes on to say that the resolution of role-overload involves role bargaining - including ingratiation and self-deprecation or denial, tactics borne out in this study when respondents said that they often try to keep quiet, the fact that they are a nurse.

Whilst on the subject of 'keeping quiet' it is pertinent to reflect upon the role of the 'knowledgeable intermediary' discussed in the literature review. It was identified there that nurse-relatives may also be reticent to add to the stress levels of their family by sharing insights into the patient's tests and treatments, and instead prefer to reflect on the ominous possibilities alone. One interviewee (a staff nurse) for example took this to the extent of being the **only** person who knew of her mother's diagnosis of multiple sclerosis.

All this really ties up this section to illustrate that being a nurse-relative is potentially a very stressful and difficult role to play. Furthermore if the person involved is being pushed to be the 'family nurse', then they may often feel even more awkward as they attempt to strike a balance between their role as the active seeker of information for the family, and the expectations about the behaviour of a relative held by staff, whilst being aware of the possible sequelae of failing in either of these functions. This is truly a situation of "role uncertainty" (Olivet 1991) .

Data regarding coping strategies of nurses.

At the risk of repeating points made already, it would seem useful to summarise these data at this point. The issue of 'coping' was raised in several guises in the questionnaire, including the need for nurses to be 'strong' and in control emotionally, and to be seen as such by others for fear of being considered weak; the issue of coping being seen to connote control. Also an apparent perception by some, that a patient coping with terminal illness is characterised by their unconditionally and immediately 'accepting' their fate.

The questionnaire also elicited significant data regarding coping strategies used by nurses. Perhaps the most important aspect of coping alluded to, was the possibility of nurses using various distancing techniques, to protect themselves from identifying too closely with their clients.

Included among these were the avoidance of personal involvement with

patients/relatives, intellectualisation, and the existential denial of their own mortality, and/or a conviction that death is always something that happens to 'other people'. As discussed in the literature review, such mechanisms may afford professionals' a 'distance' between themselves and patients and relatives, and so provide a degree of protection from identifying with the suffering of clients. Unfortunately it will also inevitably lead to shortcomings in the care of the dying and their relatives.

The chances of nurses from this study using such coping strategies would seem to be fairly high, as there was a tendency to claim a self concept as a 'coper' for a number; very few seemed able to identify what a 'realistic' professional distance was; and there was apparently little idea of how to go about developing a nurse/patient relationship that could allow them to deal meaningfully with patients/relatives whilst remaining cognisant of their own psychological well-being. This conclusion is reinforced by the views of the nurse from spinal injuries quoted earlier, and by other studies which suggest that ego-defensive mechanisms continue to be used by nurses (Smith 1992; Ehrenfield et al 1990; Bond 1986) Furthermore it is a conclusion which can be reached in spite of the increased input of interpersonal and communications skills, and material on death and dying into curricula which had preceded this study by several years.

Questionnaire 2 - Summary of findings and implications for nurse-relatives.

It would appear that in the main, this questionnaire succeeded in eliciting the sort of information being sought for the purposes of this study.

Lack of preparation for caring for the dying and their relatives.

It was noteworthy that the respondents' had an apparent lack of preparation with regards to such things as knowledge and skills in areas of modern nursing care such as the therapeutic use of self; professional distancing; realistic and detailed insight into dying, bereavement and grieving; and breaking bad news to people. In the context of this study, such data provide further insight into the

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unease and awkwardness of nurses working with dying patients and their relatives on an emotional level, as to all intents and purposes, they appear often to be left to develop such expertise unguided.

Furthermore one would question if individuals would seek to develop such expertise, as it would appear to be neither encouraged nor facilitated within the medical hegemony described earlier, i.e. why would nurses develop such skills when they often lack the autonomy to use them meaningfully and are not encouraged to do so?

As a result of this, it was apparent that many of these nurses at least, acknowledge and utilise 'popular' belief to guide their dealings with the dying and their relatives, particularly regarding insight into the realities and processes of grief and bereavement, and 'coping' with bad news. Many seemed happy to do this whilst also eschewing "*book learning*" (sic) and asserting experience as all the preparation one needs. This is all the more worrying if one acknowledges that the public and indeed many nurses themselves, believe that nurses have specialist knowledge in such areas.

The results of this lack of preparation for individuals appeared to vary, in that some respondents said they felt prepared to deal with the psychological and emotional problems of dying patients and their relatives. Such people were typically nurses who had had some education in this area; or, had come to feel prepared through experience - usually as a nurse (i.e. in the course of their work) rather than 'personally'. These 'camps' encompassed the majority of the respondents and it could be seen therefore, that such data may impinge on the family nurse role, either because the nurse is **expected** to have knowledge and expertise, yet does not actually have it; or because they (the nurse) may **perceive** that they have such insight, yet it is based upon purely theoretical knowledge (e.g. 'knowing' about Kubler-Ross's stages of dying), or by perceiving that they know what grievous loss is like because they have experienced it vicariously via being involved with grieving people. Furthermore,

that by 'knowing' about it theoretically, they are somehow immune from, or more able to cope with their grief, than 'ordinary' people, a perception reinforced by the 'popular view', and the expectations of the public.

This lack of knowledge may also in part, go some way to further explain the apparent passivity on the part of many respondents, in the area of patients, relatives and information. That is, a lack of such knowledge may manifest as inaction because they are not aware or convinced of the need for a change, or because they do not feel confident enough in themselves to be assertive and call for change (Aroskar 1980; Bond 1986; Greenleaf 1973). It may also be that for some, inaction and therefore tacit acceptance of the status quo mitigates against dissonance, in time leading the individual to perceive previously unsatisfactory or problematic situations, to be the acceptable norm, via the processes of "accommodation" (Feldman 1977).

Another result of the apparent lack of adequate educational preparation in the area of grief and bereavement, is that a family nurse may also experience conflict when at some stage they are confronted by the reality that one cannot truly experience grief vicariously and so 'know' what it is like. Also that grief is a painful, exhausting process which has to be worked through on an emotional - not an intellectual - level (Worden 1983). This process is at best merely hindered by simple knowledge of the grieving process, and at worst may be complicated by such insight because the person perceives for example, that their ability to identify they are going through a particular 'stage' somehow gives them control over it, and the ability to conquer it using intellectual, rather than emotional processes. In turn this may be affected by the fact that nurses are often perceived as experts in grief and bereavement (by self and by others), yet data from this study suggests that the chances are that many are in fact informed by 'popular opinion' regarding issues like meaningful and effective 'coping' with bereavement. As a result, nurses may attempt to demonstrate their ability to 'cope', for example by remaining stoic and/or intellectualising the situation by concentrating on the 'facts' of the matter, indeed it might almost

be said to be expected of them.

Of course, the 'family nurse' may be an individual who acknowledges the realities of grieving, and so gives herself time to grieve. An example of this was the respondent who said her local vicar had given her *"a very good informed talk about death and the understanding of it, thus helping myself and my relatives have a time to grieve"*. Unfortunately it would appear to be the sort of insight only developed by personal experience of loss and reflection upon it, rather than as a result of any educational or preparatory programme aimed at facilitating self-awareness and insight into the 'realities' of loss and grieving. Such being the case would also obviate the shortcomings of many respondents when expected or attempting to fulfil the role of 'community educator' in this area.

Nurse-relatives and the 'family nurse.'

It was identified that respondents, and those nurses they had observed, often felt awkward and even threatened by the presence of nurse-relatives, because of fears of them 'trying to take over'; their having the knowledge and insight to identify shortcomings and/or mistakes in care; and the issue of whether to treat them as a professional/colleague or as a 'relative', as both seemingly have specific and often conflicting roles to play.

The results of this awkwardness were then identified as being a wariness on the part of such nurses towards nurse-relatives, manifesting as aloofness, avoidance and sometimes even aggression.

This leads on to the question of autonomous practice in nursing, and allows the suggestion that in this area at least (information giving and caring for the dying), most of these nurses did not perceive themselves to be autonomous. Neither did the majority seem to wish for it (hence their apparent satisfaction with the status quo). Furthermore, it would appear that in many cases much development, in terms of knowledge, skills and attitudes, would be necessary

before autonomous practice could be deemed practical, desirable and perhaps even safe, in this area of care.

It was apparent that the role of 'family nurse' had been played by many respondents and that awkwardness and even antagonism on the part of staff had been encountered, this along with personal feelings of awkwardness, even to the point of attempting to conceal the fact that they were a nurse. What seemed to be the case for such people, was that a state of "role uncertainty" (Olivet 1991) or "role conflict" (Crawley 1984) existed, whereby they were being expected by various others and indeed self, to fulfil roles that are apparently incongruent with each other - that of 'active' family- nurse (encouraged/expected by family) and 'passive' relative/visitor (encouraged by staff to reduce threat).

In turn this may lead to a dilemma as they consider which role to play whilst cognisant of the possible implications of their 'choice', for both self and for the patient. At the same time, they will be attempting to deal with the emotional distress of having a sick relative in hospital. The amalgamation of these can then be seen to lead to stress to the point of role overload (Hardy et al 1978) for some nurse-relatives.

There is also an additional problem for such people, that being that if their relative is seriously ill or dying, they as a nurse may have insight to that effect but feel unable to share that burden with her family at that time, thus adding to their distress. This secrecy and its possible negative effects, are clearly identified in the 'interviews with bereaved nurses' later in this study.

Possible reasons why nurse-relatives are treated in such ways became apparent - both from the data itself and in comparisons drawn from other studies in this area. The main focus of enquiry in this study was the area of access to information, especially who controls it, and the nurses' perceptions regarding what it is okay to say, and the possible sanctions for going beyond this 'party

line'.

This was chosen not only because it is a major area of discontent amongst patients and relatives (as discussed at length elsewhere), but also because it allowed for exploration of the power and politics that the nurses perceive themselves to be governed by. It therefore provided confirmation of 'rules' that nurse-relatives will be cognisant of when enacting the role of information seeker for their family. This is very important as many other writers on the subject tend to connote the apparent control of information by nurses, with personal protection against anxiety (Menzies 1961; Jourard 1971) or shortcomings in terms of personal communication skills, and thus put forward solutions at the level of the individual, typically through education in communication skills.

The findings of this study however, also highlight the organisational constraints (some imagined, others very real) which respondents perceived themselves to be working within - the "deeper structures" of the hospital bureaucracy described by Handy (1986), and of the medical establishment. Such constraints are said to have led to the maintenance of a passive and malleable workforce (Coxon 1990; Richman 1987). The upshot of this is that dealings with relatives seem to be problematic, and particularly so with nurse-relatives, **but** that the answers do not always lie within the sphere of influence of individual nurses.

Within a wider context of the prevailing 'humanistic' environment, the data provide further insight into the potentially problematic nature of hospital visiting for nurse-relatives, in that there appeared to be evidence of staff assuming control and even 'ownership' of patients once admitted. This would presumably be viewed negatively by many lay-visitors and even more so by a family-nurse, who on top of attempting to meet the expectations of the role, may also be experiencing self-recrimination and feelings of guilt about the fact that the patient has had to be admitted to hospital for care that they potentially could give. It was apparent from the data that this would not be ameliorated by nurse-relatives (indeed any relatives) being actively encouraged to participate in

the care of their relative.

The data also suggested the presence (in potential at least) of a conflict between the humanistic approach to care (lay/ideal - Kitson 1987) and the reality of hospital care. The 'reality' being accepted relatively passively by staff whilst working, but perhaps not found so palatable when they and their relatives come to be the recipients of the system.

Finally, the data as a whole would seem to suggest that there is widespread acknowledgment of cultural and organisational norms and rules, which govern and direct nurses' activities - the particular case in point for this study being the perception for many, that nurse-relatives equals trouble and hence are to be avoided where possible. The fact that a nurse-relative will be aware of this would presumably therefore only add to her role conflict/overload, and thus potentially provide fuel for further self-recrimination should anything untoward happen to their relative whilst they are psyching themselves up to 'play' the 'family nurse' role to the full.

Aspects of coping.

Perhaps the most important aspect of coping raised by this questionnaire, was the possibility of nurses using various distancing techniques to protect themselves from identifying too closely with clients and their relatives. Also the possibility of their using existential denial of their own mortality, or a conviction that it will always be something that happens to 'other' people, as a means of reducing any death anxiety. The successful use of an existential denial of death requires a stubborn belief (albeit sub-conscious) in one's own immortality, and/or the ability to blame victims, so as to reassure oneself that one can avoid similar circumstances (Walster 1966). Axiomatically such perceptions are not possible when a relative or a person him/herself becomes ill, and thus a coping strategy typically seen to be used by nurses is deemed unusable when a relative or someone close to them is hospitalised. The same can be said of other ego-defensive strategies such as intellectualisation, emotional distancing and

evasion.

This is important, as it has been argued elsewhere in the present study (literature review and the discussion of the 'coping questionnaire' for example), that nurses may tend to develop and utilise such techniques to the exclusion of other more positive coping strategies, in both their professional and private lives. As a result, they may attempt to use such mechanisms when they experience personal bereavement, with potentially devastating results for their self-concept as a 'coper', given that such techniques are by-passed and/or irrelevant when grieving.

Thus the data from this questionnaire would seem to support the contentions of the wider study, enumerated in the literature review and conceptual framework chapters.

They suggest for example, that many nurses find themselves almost daily, in the position of facing patients (including those who are dying) with emotional needs, with little or no guidance as to how to handle this, other than to be 'hard' or distant, and by trial and error develop a distance that they find works for them - if not the patient. This has obvious negative connotations for patients/relatives and also for nurses.

Also that they may feel that they are more able to deal with their own grief if their knowledge into grief and bereavement is at the level of 'knowing about' relevant theories, rather than truly comprehending the emotional realities. Professional peer pressure and expectations of family and friends may further reinforce this.

There is also the potential that ego-defensive coping strategies will come to be used excessively in dealing with such situations, including within the individuals private life. This will potentially lead them to the position of being the family's 'tower of strength' in any personal bereavement, armed with a coping strategy

which requires them to have the deceased and their relatives at a metaphorical arms length, while family and friends expect stoic 'coping'.

This is potentially problematic, as the development of and over-reliance on, coping strategies that are of little use when personally bereaved, may complicate the 'normal' grieving process. As will any extensive delay in the onset of grieving due to enacting the role of the family tower of strength.

Problematic relationships between attending nurses and nurse-relatives when visiting, were also identified. These were said to be characterised by aloofness and even aggression towards nurse-relatives by working nurses, and feelings of intimidation for nurse-relatives. Reasons were put forward for these problems, and the potential for role-overload identified, the implication being that nurse-relatives may be required to walk a tightrope between acceptable 'professional behaviour' and fulfilling the role of the family nurse. In turn this may lead to self-recrimination should anything happen to the patient while they decide how to proceed.

Guilt may also be elicited by the reality that as a nurse, they could potentially look after the patient themselves - a situation complicated by a tendency for staff to 'take-over' once a patient has been admitted to hospital.

The issues of the level of insight into the realities of grieving, reliance on ego-defensive mechanisms of coping, and the difficulties of fulfilling the role of 'family-nurse' are therefore important to this study, and will be re-visited later when discussing the study overall and its implications for nurses and nursing.

Chapter 7.

**Findings, interpretation
and discussion of data
from interviews with
bereaved nurses and
midwives**

The intention of this part of the study, was to allow the exploration of factors thought to predispose to complicated grief, alongside aspects of the culture of nursing and midwifery, **within** the context of actual cases where nurses and midwives had been bereaved. This can be seen to be the part of the study intended to provide data regarding relationships between concepts. As will be seen from the ensuing exploration of the data, all of the above aims were achieved, along with the identification of certain 'variations on themes', provided by the investigation of actual examples of nurses and midwives who had been bereaved.

The interviews were very much guided by the nurses and midwives themselves and often ran to well over an hour. This had major implications not only for data analysis, but also its presentation because content analysis led to fragmentation of the data in the sense that the aforementioned relationships were no longer necessarily identifiable. After much deliberation, it was decided to present the data according to themes identified in the data, supported by *verbatim* quotes. An interview which stood out as an exemplar for the study's content and intentions is presented in edited form as appendix 5 This is because it demonstrated the inter-relationship(s) between several factors thought to predispose towards complications in grieving (after Murray-Parkes 1972, 1975), identified from the actual 'concrete' experiences of a nurse, i.e. from 'reality'. Throughout 'I' is used to signify the interviewer talking, while 'S' signifies the research subject as talking.

Key areas of data could be encapsulated within the following six headings:-
The effect that assimilation into nursing/midwifery, had had on interviewees - particularly regarding the 'need' to be a copier, and their views on independence; the issue of social support, from personal and work sources, both prior to and after the death of a family member; the role of the family nurse, in particular its implications for caring for family members both in and out of the hospital setting, and in bereavement; the level of selflessness shown by interviewees; and the issue of insight and/or actual knowledge of their relatives condition and

prognosis, before anyone else in their family, which in many cases led to intricate webs of deceit and secrecy; the incidence of guilt feelings regarding both the hospitalisation of their relative and the fact that they subsequently died; the treatment of nurse-relatives by staff - both in general terms, and during the period around the time of their relatives death, along with interviewees feelings when visiting in hospitals; and, apparent examples of complicated grief reactions experienced by interviewees.

The 'need' to be a coper.

Almost without fail, the interviewees alluded to or mentioned overtly, the importance of nurses and midwives being seen to be able to 'cope' and to be in control, by professional colleagues and by people in wider society. This can be seen to concur strongly with the data from the two questionnaires.

Several identified that they had always been a 'coper', and explored reasons for why this was so. Staff Nurse A said that it was unclear to her *"whether any of the things that happen and the reason why I cope the way I do is because I am a nurse or because I am an only child and things fall to me anyway"*.

Sister B related the cathartic experience of attending a course on self-awareness, when she felt unable to hide her true feelings any more:-

S. "I mean the time before that when I cried, I must have been a child, because I never allowed myself to cry because it weren't acceptable, either as the older sister with a disabled sister at home, and then the nurse, it was never acceptable to cry, it weren't all right, my mother used to say if you cry I'll give you something to cry for. I grew up with a mother who was a very austere woman, who had had a pretty hard life, and that picked up in her coping with people".

What is also interesting is the fact that family and friends found this 'new' person who suddenly asserted her right to break-down from time to time very hard to accept.

She then went on to discuss how she felt that being able to unburden herself 'safely' had helped her...

S. *"Because I was the eldest I was always the one looked to - and so there was lots of stuff in there and lots of other things besides that you know, my childhood, absolutely everything came up; and I - as I say now I just think I'm one of the luckiest people alive that that has happened to me, to have had that opportunity, to empty myself of all this emotional rubbish that I carried around for years"*.

These then were people who saw themselves as copers before they even entered nursing. How working in nursing and/or midwifery might influence this sense of 'needing to cope' was also touched upon by several people. Several believed that it had changed their personality...

Health Visitor C... *"I can say that when I started nursing I was very much an introvert, but I have gone extrovert - particularly as a health visitor, you know, you have to be....My whole personality has changed - sort of evolved over the years"*.

I. "I think that's one of the points that I'm looking at with this study. We are perhaps socialised into seeing that nurses should be copers in the hospital situation, that there's no room for weakness..."

S. *"It's not so much that there's no room for weakness, it's just that the situation doesn't allow it"*.

This view was echoed by Staff Nurse D who said *"you don't have time, you just have to get on and do things don't you?"*.

Another (Staff Nurse E) commented on the strains of the job - *"the workload and having no-one to turn to for help"* [combined with having to] *keep your exterior calm, and trying not to talk sharply to a patient. I mean we are human aren't we and yet we are forced to repress these feelings while we are working, no wonder nurses are alcoholic! - the problem is - I think that is the nature of the job, you can't get away from that, you can't express those feelings etc to*

patients, but I think that it has got to be seen that when you are not at work, there's got to be some space and time out and it should be okay to say to other people I can't deal with this, or I can't - or I'm not coping well with this, or whatever. But I think if nurses do say that other people see them as being weak, you know. If a staff nurse said it you bet your bottom dollar she wouldn't get a sister's post off that nursing officer".

The need to be seen as a copier.

The need to be **seen** as always coping for fear of later professional repercussions, was reiterated by several of those nurses and midwives interviewed.

Health Visitor C quoted earlier was of the opinion that there were great differences between nurses and nursing in hospitals, and in the community. She believed that individualised care was provided in the community and that initially she had found this difficult. She put this down to the fact that her training had been a lesson in "*hands off*", in the form of encouragement to maintain a distance from patients.

S. "I was a hard nurse. I was. But your experiences change your outlook. I've changed tremendously ... Yes, when I first started nursing, you were definitely not encouraged to integrate with patients. By the end of my qualifying and being a staff nurse, and then a sister, it was starting to change a bit - you were sometimes encouraged, especially at visiting time if someone didn't have a visitor, to go round and talk to those people. But before then, you were definitely not allowed".

Sister F was of the view that time *per se* in the 'job' can mitigate against 'hardness' even in hospital settings and that staff can begin to "*move in and love people without feeling un-professional or threatened as a person. Whether you're male or female, you actually can do that. I think you learn to do that as time goes by, and that its not so easy to have it when you're young...*".

I. "Do you think the time to develop that, could be shortened by insight,

perhaps provided by education and guided experience?"

S. *"I don't know. Do you think so?"*

I. "Well I think that what many people do is what you're saying - that as they get a little bit older they feel they can move in and love people. Unfortunately, I think that nurse education and training and the socialisation that goes on, might actually mitigate against it."

S. *"Why?"*

I. "Well if you read the literature and if you talked to the staff nurses who filled in the questionnaires I'm getting back, where I've asked questions like - 'do you think it's okay for you to talk with relatives and discuss their prognosis and diagnosis', it all comes back to "it all depends on what the doctor said".

There's an awful lot of "I would, but...I'd get into trouble" and "I think it's the doctor's job to tell patients bad news". It would seem to me that the conspiracy of silence identified in the 1950's is still alive and kicking".

S. *"Unfortunately Yes. I see what you mean. And yet, you see it is fairly essential to be able to do those things, because the quicker you learn how to do them the more likely it is for somebody who is dying, to die better, from whatever they are being treated for. The more likely your grieving person is going to identify themselves, because they won't identify themselves if you are a stranger, if you're insincere, because people who are grieving can very quickly tell whether or not the people who are listening to them are sincere. The quicker you can prove to them in some respect that you really want to listen to what they've got to say and whatever they want to say is confidential, the better".*

It is pertinent to point out here that Sister F. had been the coordinator for a Terminal Care Support Team for 10 years, prior to her resignation to allow her to go and work in the community 4 months before this interview took place. Her interview is returned to several times as her insights are invaluable to the study.

In summary then, there was a consensus amongst those who referred to

'coping', that it was expected of them. For some professional socialisation had merely reinforced existing traits, while others claimed to have undergone apparent personality changes after entering nurse training. Furthermore, it seemed that the more extreme views on the importance of coping, were held by those whose entry behaviour was reinforced by socialisation.

Views on 'independence'.

All of those interviewed stated that they were independent and did not like to feel dependent on others to some degree. This highlighted the benefit of these interviews for the study overall, as it afforded further insight into the range of willingness to depend on others, by a group of nurses and midwives. This can be seen as an adjunct to the data collated from the semi-structured interviews previously discussed.

For example:-

I. "You sound very sort of level headed, and you said that you were independent. Do you like to be seen as independent?"

Health Visitor C. *"Yes. I like doing my own thing, always have done. That's why I enjoyed industrial nursing, I loved the challenge, and I worked on my own most of the time, so I didn't have anyone to tell me what to do, I always had to do my own thing - and I liked the work".*

I. "Is the opposite true, that you are not that keen on being dependent on other people?"

S. *"Possibly, well yes I suppose I don't".*

There were some who were of the view that it is sometimes beneficial to be able to let someone else make decisions, or to take over in difficult times. However, it was more common amongst these interviewees, to be towards the other end of the spectrum. Stages along the continuum therefore were:

I. "Do you feel that you are an independent type of person?"

Staff Nurse G. *"I suppose it depends on what you mean by independent. I mean I am independent but I am supported by my husband and my mother, and we work together, if I'm upset I go to my mum or to my husband and vice*

versa, and we all get together and we sort of close ranks".

I. "What I am trying to get at is that sometimes there are people who are the very independent types, for instance they always like to be in control, and they don't like to be beholden to anyone else for anything, you know these types?"

S. *"Yes I do. But no, I'm not. I mean I don't like to be too dependent on anybody or anything, but you know, if I felt I needed help I would go to somebody".*

I. "Do you think that's common in nurses, do you think that most nurses are like that?"

S. *"I don't know really, it depends how old they are".*

I. "That's interesting, what do you mean?"

S. *"I feel and it might sound like boasting or whatever, I don't know, but I feel I've always been older than - people have always said even to my mum, you know, isn't your daughter mature, isn't she sensible? And I've always been like that - I don't know if I have always lived up to what was expected of me I don't know, but I have always been that sort of person. You know people have always thought I am a lot older than I look".*

Towards the middle of the continuum were comments like: *"I am usually a very independent person, a bit of a tom-boy really, and I don't like to depend on people. But after my dad died I was dependent to some extent on my husband I suppose"* (Staff Nurse H.).

At the other end of the spectrum were people like:-

Charge Nurse I. who said *"I am very independent. I prefer my own company a lot of the time. I spend most of my time with my wife but I like solitude. I can function without my wife - I don't want to, but I know that I could";*

Staff Nurse A. who said *"I hate feeling dependent on anyone";*

Retired Ward Sister J. who still worked voluntarily for the night sitter service because *"I like being a giver",* and the feeling of dependability that comes *"when other people are depending on me";*

Also Sister K. who said *"The problem is, I wouldn't even know how to go about*

saying thankyou to someone who helped me, and I wouldn't want to anyway" (sic). It was also interesting to note that later she said that it made her *"angry when other people don't tell me that they need help, because that's what I'm there for"*.

Another telling point, is that Staff Nurse A. and Ward Sister K. had found this independence/dependence issue problematic when they had been bereaved. The latter because it was only after his death, that she realised how much she did depend on her husband, while the former had suffered mood swings and depression after the death of her father, to the extent that her work suffered and her managers were approaching the first stages of disciplinary action, if she did not seek help. The researcher was so concerned about this individual that he terminated the interview early and subtly recommended a professional bereavement counsellor. The interviewee was dubious about this as she *"didn't like the idea of talking to anybody about it"*, but said that she would think about it. It was also apparent that most of those interviewed, were depended upon by both relatives and wider social groups:

I. "Have you always been the sort of dependable one in your family?"

Staff Nurse A. *"Always. I've always been the most dependable to everybody. I've been a bit of a Claire Rayner. Even as a child I would say, really I was always the dependable one...Somebody once said if you go to a woman's house and have a look at the state of the her cutlery drawer, and if it's 'a mess, you can guarantee she will sit and listen to your problems all day. Well my cutlery drawer is a mess. It wouldn't worry me if somebody knocked at my door at two o'clock in the morning, I'd be quite happy to listen to them, quite happy. But I don't know if I would go and knock on somebody else's door at two o'clock in the morning"*.

I. "You don't sound as if you would".

S. *"No...I think nurses get as much out of it as patients do, I think we do. I think there is a bit in us all...you know that rather likes the fact that what we do with Mrs Jones in the second bed, for her to say 'Oh I do feel better', and for her relatives to say 'thank you, she looks better, she feels better'. There is*

a bit of well, what do you call it - ego, I don't know".

I. "I don't know. I think perhaps it comes down to this dependency thing again, and dependability, do you think?"

S. "Yes".

I. "We like the job that we do because we like people to be dependent on us".

S. *"Exactly. If I had my way, I would prefer it if all these patients were in bed. I much prefer bed patients. If it's a nice day and we've got long term patients, the girls have said 'Right. we'll take them round the grounds', 'we'll take George for pint', or 'it's a pity we can't get a trip up for them'. They could leave me all day with a ward full of bed patients. I would hate going out and playing bingo. I shouldn't like that at all. That's probably because my role would be different you see."*

I. "It's nice to feel needed, isn't it".

S. *"Absolutely. I would sooner do that than go and have a game of bingo in a pub with them. Much sooner, yes. So there you go. You see I'm finding out a lot about myself"*.

Perhaps this section and the implications of the data therein, can be best summed up by Sister F. who said *"I suspect that life is made up of all sorts of people and things. But basically there are givers and takers if you know what I mean, and it seems to be that the givers find it very hard to take from others, but in the long term they are going to be the sufferers"*.

It would appear therefore, that these nurses at least, were definitely 'givers'. This was reflected by the fact that at least twelve of them had physically cared for their dying relative to some degree - a point returned to later. Furthermore, many found it difficult to accept help, advice and support from others - some to the degree that it had apparently elicited problems in grieving.

There was also an acknowledgment by some, that the concept of dependable people relishing others being dependent on them, was true for them. These points will also be returned to later when considering the interviewees'

willingness to accept support when offered. Also the roles they played during and after the final illness of their relative.

Social Support.

A general point to be made from the data regarding social support, was the positive effect that social support (in its various forms) had apparently had on the grief experiences of respondents. That is, there appeared to be a connection between those who related their experiences as being very difficult for them, with the low degree of social support that they perceived had been available to them, or the degree that they were willing to accept it when offered.

The relationship between social support, independence and expectations of nurses to 'cope'.

One interview in particular was unique amongst the 22, in that the interviewee (Sister F.) had over 10 years experience as coordinator of a Terminal Care Support Team, in a District General Hospital.

S. "Nurses are givers, aren't they? They have a personality of giving and difficulty in accepting help. And accepting that perhaps they are - they can't - that they've got permission to ask for that help, you know somehow they can't latch on to the fact that they have every right to be normal and every right to react in exactly the same way that other people would react".

I. "I have had several people in the interviews and in the questionnaires that I've got back who have actually - nurses I'm talking about - who it's actually been said to them - 'well, you know about this sort of thing. You should be able to deal with it, because you're a nurse', that sort of thing".

S. "I am sure you are right. I'm sure you are right because many times in the job I did, I had people say to me 'Well, you do it all the time,' or 'you're a nurse'. I remember when my mother died, and I was sort of knelt at the side of the bed and I was hanging on to her hand, and I just really wanted to be with her. I mean I knew she was dead, and I know I was crying, and all I could think

of was that she had been disabled all her life and I kept thinking your 'poor old feet won't ache any more' sort of thing, you know. And I can remember a nurse coming up behind me and putting her hand on my shoulders and I had known her a long time, and saying 'come on S...., you've dealt with all this before'. But I knew what she was trying to do, so it didn't disturb me, because I knew exactly what she was trying to do. She was trying to bolster me and give me courage and give me comfort, but it was the way in which she did it, that was her way, that was her personality. And she wasn't capable of doing it any other way... "

A point to be made from this, is that several times the interviewee asserted the benefits of having insight into the processes of grieving, and that having such knowledge had helped her to cope with the death of her mother almost alone. However she revealed later, that at the time she needed help she went to see her nurse manager and was asked to reflect upon the fact that she was letting people down. Furthermore she was basically made to feel that the problem lay with her, as opposed to her loss, the stresses that were brought on by the job and the lack of support from managers. As a result of this lack of help when she cried out for it, she left her job as the coordinator of the terminal care support team and went to work in the community. A reasonable observation to make would seem to be that she was beginning to show the signs of burnout and needed time out to recharge her batteries. Also that the insight she possessed into grieving had not necessarily been as useful as she perceived - in fact it may have complicated matters somewhat.

The perceived lack of appreciation by managers.

Sister L. from midwifery referred to the issue of social support by bemoaning the lack of appreciation by managers. She was also of the view that there was one rule for staff and another for 'the rest' (eg patients, relatives...)

S. "If you think about it, nobody really gives us any regard. There seems to be an awful attitude of 'Well you must get on with it.' For example, take our

pregnant girls here. I've just got two girls gone off on maternity leave. I've got two others who are pregnant on this ward at the moment, and when we have a lady who is say twenty weeks pregnant we are saying to her, as midwives do, you must have a rest at lunch time. You must go to bed for at least an hour and get your head down and sleep. We have got these girls wandering around with great big bumps out here and it's tough, they are just expected to get on with it, and they don't want any moaning. I try to be sympathetic because I've got kids of my own and I know what it feels like, but you do get it from the other corner saying "Well, they decided to have this baby so let them get on with it." So what we're actually doing is working a double standard. We have got all this sympathy and concern for our ladies, but our midwives can get on with it. Its the same with midwives who aren't coping for some reason, perhaps they can't cope with an abnormal baby. You still get this thing 'well you knew this was going to happen before you came into this job. You know all babies aren't always born the way they should be. You should have rationalised this before you came on the ward and should be able to cope with it'. They don't give them any sort of support. On the questionnaire that I filled in for you, I'm afraid that in the column 'What sort of support would you expect to get from your immediate manager?', I've gone none, none, none, none, none. I'm not saying that I don't get like my immediate manager as a person, but I don't feel any warmth coming across".

The relationship between perceived support and its apparently positive effect on the grief experiences of those interviewed.

This was identified at the beginning of this section. It would seem to reflect the theories of both Murray-Parkes (1972, 1975) and House (1981;1988) in that the perception of social support being available appeared to be associated with smoother resolution of the loss, the support being seen to be 'buffering' the effects of stress. As will be seen in subsequent sections however, such support was often not available because the family-nurse could not access it due to not sharing all the facts with their family; because their family expected them to be their 'tower of strength'; and/or because they expected this of

themselves.

As was identified in the above passage, work sources of support if they existed, were typically people who had been friends for several years - perhaps from training days. Also notable was the fact that at least six people said that they had been supported at work by colleagues who were in a similar situation, i.e. who had also been relatively recently bereaved. Both of these perhaps reflect the rather ad hoc nature of support networks in professional nursing and midwifery.

The views of support from managers tended to reflect those of Midwifery Sister L. earlier in that it was neither expected nor offered in most cases, even to the extent of some people feeling that they had not even received their basic entitlement to compassionate leave, as they had had to use their holiday entitlement for this purpose. Two people however did say that their manager had been very supportive. Of these, one felt very grateful at the time, while the other recalled reacting with *"as far as I am concerned life goes on"*, it was only over time that he came to realise that this had not been the case. Fortunately for this person, the manager concerned had not been 'fooled' by this statement and had orchestrated a system of covert support enlisting the help of the hospital chaplain, for this colleague 'in trouble'. This situation leaves one to wonder if the fact that this manager's mother died six months earlier had anything to do with this.

The apparent lack of meaningful knowledge of bereavement amongst work colleagues and managers.

In at least half of the interviews, it was apparent that work colleagues and managers tended to act towards bereaved colleagues rather like the general public are considered to act towards the bereaved - with embarrassment and often silence. Several referred to the fact that on returning to work no-one mentioned their loss. Also it was often expected (by both self and others) that they return to work as if nothing had happened. This would seem to affirm the

cultural norm that nurses should not bring their own problems to work with them. It also reflects an apparent lack of expert knowledge regarding grief and bereavement amongst the population from which the sample was drawn - a finding which triangulated with those from questionnaire 2 and one which is of obvious concern given the societal expectation of nurses and midwives to be experts in this area.

Perhaps it also pertinent here, to return to the point made in the 'Social Support' section of questionnaire 1, that managers in other 'industries' might also be viewed, rightly or wrongly, in the same way (i.e. un-supportive), by their subordinates. Once again the answer to this is unclear, and the same conclusion again reached - that of all 'managers' in all 'industries', surely nurse managers should be the most caring and the most supportive of their staff.

In summary then, social support when offered and accepted, did appear to buffer stress and enhance resolution of grief. As will be seen later, family circumstances may mitigate against this happening 'at home', while from this section, social support would not typically be expected from work sources - except 'friends'. Given the fact that much of the support required in times of loss is emotional in nature, it would seem reasonable to assert that 'family-nurses' may often find themselves relatively unsupported when bereaved. In part this may be due to its usual source (family) being blocked, and work sources being unavailable due to an apparent cultural norm of hospital nursing - that personal issues and problems are to be left 'at home'. As one person put it *"nurses are expected to hang their personal lives on a hook by the door when they arrive for work"*. As was seen in the questionnaires however, the intrusion of professional into private life was common and indeed expected.

The Role of the Family Nurse.

'Selflessness' demonstrated by 'family nurses'.

A major point to raise in this regard, was the fact that over half of the

interviewees physically cared for their relative during their final illness, two to the point of death and the carrying out of 'last offices'. This level of 'selflessness' amongst the group was all the more notable when one considers that the deceased were not always parents or spouses, but also uncles, aunts and 'in-laws'. It is also a fact that with the notable exception of one person, those involved in care-giving did so whilst also working full-time as nurses or midwives. Furthermore, during such times, there was often minimal support from other members of their family and little concern or consideration shown by work colleagues (particularly managers) other than from 'friends'. It should be acknowledged however that at times this could have been as much a function of the nurse not telling work colleagues and managers of their situation, than of these people not being supportive when asked. This was a significant finding in its own right.

There were several reasons put forward as to why these people became involved in direct care-giving. Some did it because they wanted to; some because it was expected of them - either by their family or the sick relative him/herself; and some because their conscience said that they ought to do so. Examples of these included Staff Nurse M. who cared for her father by essentially working double shifts...

"...I was going home to help get him out of bed, and then going back on a night time to get him into bed, or get him to a bath, or helping to wash him. We tried a district nurse but it wasn't satisfactory, my mum was managing during the day and I was going from early in the morning".

Between herself and her mother, her father was cared for at home with no help from the rest of her family. She put this down as partly because her sister for example, was pregnant at the time and every else was rather busy. However it became apparent that a major factor was that they would have been embarrassed about seeing their father naked - to quote Nurse M *"I suppose I could be more discrete about it than them"*.

Her father also got very angry at times. This was something else she perceived she could handle because she was a nurse. *"...He used to curse and swear at my mother, and she'd get all upset, and she'd come down crying, and so it was easier I suppose I was just - I was able to understand why he was like that".*

I. "You had the skills to deal with it".

S. *"Yes. But mum hurt her back, so we tried the district nurse and I think they came in for about two days, but he didn't like that my dad, he didn't want anybody else to touch him, so I it fell to me. We never got any support from anybody else, I was the support for my dad".*

I. "So you took on a role which meant everyone else could get on with their lives really".

S. *"Yes I suppose I did".*

Another Staff Nurse (N.) looked after her Uncle who deteriorated very quickly from stomach cancer. Significantly she arranged her days off so she could accompany her uncle to see the consultant...

S. *"...Afterwards I went outside with the consultant, and he said 'I'm sorry there's not much we can do, he's far too ill and the cancer is far too advanced'. The family started asking the question 'How long?'. So I asked the consultant and he said weeks rather than months. I didn't tell the family this. I didn't think they could cope with it".*

This 'family nurse' involvement continued, the importance and centrality of her role being illustrated by the reaction of her aunt when she answered a call to say that her uncle was very sick...

S. *"...when I got to the flat, he was virtually dying, he was practically unconscious. They really were frightened, and M... said she was glad I was here, because she felt safe when I was there".*

After he had died she then carried out last offices on the body. What is interesting is that having done all this for P..... and his family, the interviewee was upset that *"at no point did anybody come to the door and say are you all*

right? Do you want anything? And it distressed me terribly". This illustrates a problem for anyone trying to support such a person, as one has to question how anyone would know that she wanted support at that time and not at any other?

Staff Nurse O. referred to looking after her mother and their family after her mother's death. She took time off (annual leave) to care for her, rather than have her go into hospital. When asked why she said...

S. *"Because I felt why should she go into hospital when I am a nurse, what can they do for her that I can't do? My conscience wouldn't let me".*

I. *"So you felt it was your role then, to..."*

S. *"No, I didn't feel it were my role, I felt the need to do it, I felt that I needed - I knew she was dying, and I'm a nurse and I know how to look after her, and I'm sure I can do it better than they can because everybody wouldn't - I don't mean to say I didn't trust them, but it's the one to one basis and the fact that I can care for her".*

I. *"Yes, I understand that. And afterwards, did you take on responsibilities?"*

S. *"After my mother had died. While she was still - because all the family were there, we were all together when she died - I couldn't cry in front of them. I still can't".*

I. *"Yes".*

S. *"Not because I were ashamed to or anything like that, but I felt that I needed to be strong, because me younger brothers and sisters were absolutely devastated. I meant I felt as though I had to cope because they couldn't - to put it in a nutshell, and with my experience, then I should be more able to cope, you know, I shouldn't break down".*

Another example was Sister B. who had undergone the cathartic experience on a self awareness course referred to earlier in this chapter. She described how she had come to care for her mother almost completely for the last few months of her life. Not least because on hearing that she had terminal cancer, her previously independent mother put herself to bed and insisted that she did so .

S. *"She wouldn't have a nurse in to look after her and she wouldn't have*

anybody to see to her, except me. I had to do everything. Towards the end I did find it quite easy to do these things for her, and it was like a blessing on me, a benediction from one person to another".

This carried on for several months, with the help of other members of the family who worked a rota system akin to a ward off-duty.

She finally related how at the end, she had sent everyone away and after her mother had died in the middle of the night, she washed and dressed her in her 'special' nightie, and felt at peace. She then spent a couple of hours alone with her mother and perceived that this was her grieving time. It only became apparent at the workshop, that this was not the case at all, and that she had repressed her feelings about a whole range of things about her mother - including her grief. Also that the workshop acted as a catalyst to let them out.

Complications of being 'knowledgeable', including keeping secrets to 'protect' the family.

The role of the family nurse was also affected for all respondents, by the knowledge they possessed regarding their relative's condition. This had usually come about initially due to professional insight, but was often confirmed by direct contact with medical staff - typically without the knowledge of the rest of the family, including the patient. This was usually rationalised as acceptable because they could then 'protect' their family, such protection amounting to keeping it from them in most cases. This led to a variety of scenarios covering a range of situations and outcomes. For example, the Staff Nurse referred to earlier who kept the truth of her uncle's cancer from the rest of her family (including the patient and his wife). She believed that her aunt was grateful to her for this, but could not be sure as they had never discussed it. There was also the case of a Sister who kept the secret of her father's cancer for a year *"because I didn't think it was relevant to anyone else"*.

Secrecy backfired badly on Staff Nurse O. She did not tell her family about her

father's lung cancer, having become privy to the knowledge via discussions with the consultant several months before.

S. *"A couple of days before my dad died, I knew he wasn't going to get better, and my mum and dad - my mum and family just didn't have any idea, so I made the GP come and tell them. You know, I said - I want you to - you must go and tell them, I want them telling straight. And he went in and told them, and I'd been sat up with my dad, and my dad said 'This is it, isn't it? and it was so hard to say yes. After he had told them, my mum said she'd had no idea, and my sister said she should have been told, and my other sister said 'Why didn't you tell me?'*

I. "To you?"

S *"Yes, and my brother got very annoyed, and I said I was trying to protect him because he were so young. But we shouldn't have done".*

I. "It's very easy in hindsight, isn't it? There were lots of reasons for keeping it to yourself, but you ended up taking flak for it. The other thing is that by keeping it from your family and because your husband was saying he couldn't believe it, you kept all that bottled up. When it comes down to it with the benefit of hindsight the subterfuge was in a lot of ways, a recipe for disaster".

S. *"It was because after my dad died, he lingered on sort of that day and died fairly peaceful just after midnight, we were all there, all sat round his bed, because nobody wanted to leave, but my mum couldn't settle. And then he die, and they come and took him away and everything. And then afterwards, we all argued. They were all saying 'I should have known before', and I suppose nobody could understand why I didn't tell them. I said, well I was only trying to my best".*

In at least two cases therefore, secrecy led to problems with grieving. For the nurse just discussed for example, family dynamics were damaged for over two years, with individuals unable to talk to each other about anything, let alone their shared loss.

Such data as this allows the point to be made that the insight nurses had, often

complicated things for their family, and particularly themselves, in the long run. Typically, such knowledge had not even allowed them the opportunity to begin the process of anticipatory grieving because invariably they had kept the information to themselves. It also highlights the fact that many of the nurses and midwives interviewed, equated protection of their family in such circumstances with keeping their relative's condition a secret. In effect, such views triangulated with findings from the open-ended questionnaire where there was also an apparent sense of 'self as a nurse' being somewhat more able to 'cope' than non-nurses. It would also seem to confirm that the views of these nurses and midwives regarding dealing with 'death and dying', reflected its taboo nature in wider contemporary society, rather than from any theoretical perspective. This is also indicated by data from the open-ended questionnaire.

Finally, it is worthy of note that for several of these nurses and midwives, this interview was the first time they had ever had the opportunity to discuss their loss with someone else. Furthermore some actually thanked the researcher for allowing them to take part - both verbally and by letter. This again reinforces the isolated situation family-nurses may find themselves in.

The issue of guilt felt by 'family nurses'.

Several interviewees expressed feelings of guilt as a result of the death of their relative and/or the circumstances surrounding it. One of the saddest cases was Staff Nurse O. mentioned earlier, whose secrecy led to family schism. She found that she had to grieve for her father at the same time as feeling guilty about the ramifications of her decision to 'keep quiet' to the rest of her family.

In the main however, guilty feelings were elicited because the nurse/midwife involved felt that they should have been more proactive or involved in their relative's treatment and care. There were also two who said that they regretted the fact that their relative was hospitalised when potentially (though not realistically in the researcher's opinion) they could have cared for them at home.

Charge Nurse I. felt guilty about the circumstances in which his Grandmother had died. She had undergone surgery for a hiatus hernia, in spite of being a very poor operative risk due to chronic chest problems. Such guilt was present irrespective of the fact that he and his parents (also nurses) had *"foreseen the risks before"* but couldn't persuade her not to go through with it. Not least because she was *"a very single minded person, a very dominant woman"*. They also apparently felt guilty that they somehow *"didn't try hard enough"* to dissuade her. This anecdote also therefore illustrates the fact that rationality can be thrown out of the window by the emotional turmoil of grief.

Later in the same interview the conversation shifted tack back towards the issue of nurses in families. Guilty feelings were again mentioned.

I. "You said both your parents were nurses. Presumably you weren't identified as what I'd call the family nurse?"

S. *"No. That's right. My father and my mother are both nurses, and my sister is now a nurse"*.

I. "So when your grandmother died who was the organiser, the central figure?"

S. *"My father. Yes it was my father definitely. I mean he was an only child and my grandfather had died when I was quite young really so I mean he was a next of kin if you like sole heir. He was also the person that would be identified as the person to be in touch with not just because he was the next of kin which is reasonable, but because he was part of their hierarchy"*. (N.B. he was the Chief Nursing Officer for the hospital concerned).

I. "How did he react to that?"

S. *"In hindsight it all seemed to be quite natural really. It did occur to me later on that maybe they'd done her a bit of disservice, and I talked to dad about it quite a lot later and it had obviously crossed his mind a lot sooner than me, that maybe if he regretted anything it was that they might really have tried to save her because of his position, and that they carried on for a long time, whereas if they'd just take a step back and looked then maybe they'd have seen that they weren't doing any good"*.

I. "So he felt guilty about the fact that by virtue of his being a nurse he had

perhaps prolonged his mother's life?"

S. *"Yes. I'm sure he did".*

Staff Nurse P. felt guilty for another reason.

S. *"You know as a 'medical person' that with heart disease, on some days they don't feel so well, and that's the days when they should rest. But sometimes when I used to talk to Dad he would say "I'm not well" and all this, and I'd say to him "Oh Dad you know you have good days you have bad days." And I suppose I never really took any notice. I accepted that he would have good days and bad days. And I think looking back over the last few months before he died he were having a lot of bad days..."*

I. "Did you feel bad about that afterwards. Do you think you should have noticed or been more sympathetic?"

S. *"Yes. I think, I feel that I should have been more sympathetic to him rather than poo-pooing it, a bit like the psychiatrist - pull yourself together. Yes, I feel like I should have taken more notice of it. But to some extent it happened very quickly. It did happen very suddenly, and there was an element of relief when it happened, and then I had guilty feelings about that. I think my mother experienced this as well, relief and then guilt".*

I. "That guilt aspect - I mean there are lots of reasons why people can feel guilty, and it really does mess things up for quite a while, doesn't it?"

S. *"Yes. You have to try and recognise that you're not feeling glad that he's dead, but that you are glad that he's no longer suffering, you know? They are two different things".*

The fact that feelings of guilt are typically unreasonable and also that they may not disappear even some years after a death, are highlighted by the final quote in this section. It is from Nurse Teacher Q. referred to later who *"decided she wasn't going to have an extended grief"*. She felt guilty about several things associated with having moved to England from Scotland only a few months before. In particular the fact that she (a coronary care nurse) was not there when her father began having chest pains. She also felt resentment to her

husband's firm and to an extent her husband, for moving jobs just at the time her father needed her most.

The situation was further complicated by her belief that doctors had missed the simple diagnosis of a myocardial infarction (simple given her father's apparently cardinal symptoms). Here again is someone who attempted to protect her family from such knowledge. She did so because...

S. *"I also didn't want my family to start, you know, blaming somebody for something that they couldn't reverse... my dad had gone, and I felt that it would only extend their grief if they latched on to the fact that he had been misdiagnosed.*

I. "While you kept all that to yourself?"

S. *"I've had to bear all that on my own, that that doctor hadn't done his job right and he really did need reprimanding. Especially in that sort of area, where a lot of young people do have infarctions, it's a high risk area. But at the same time, I didn't want them to suffer any more than they were suffering. The thing that cut me up the most was the fact that the night before the funeral, there was Algipan lying in the kitchen and my mother said my father had sent my brother to the chemist for it because the pain was so bad in his chest over the weekend, he had been using it to try to relieve the pain and you know that just really broke my heart. I can't smell Algipan now without thinking about my dad. That he'd actually been rubbing that into his chest to try and get rid of what was probably for that amount of pain and he needed diamorphine or something. That makes me feel really bad".*

The problems of the 'family nurse' keeping secrets are again therefore highlighted by this example.

As a group these data highlight that feelings of guilt were relatively common within this population. Also that while not necessarily 'causing' complicated grief, it certainly did not help in its successful resolution. The data also shows that the causes for such feelings are many-fold and often either unfounded or

outside the individuals' control. Sadly however there is sometimes a grain of truth in the recriminations. For example, if the CCU nurse had remained in Scotland, things might have turned out differently - a difficult cross to bear.

The treatment of nurse-relatives by staff, and the feelings engendered in nurses/midwives when visiting in hospital.

There were several pertinent areas in this regard in the data. Of particular note was the way that several nurses were told of their relative's diagnosis/prognosis and for others how they were told of their death.

Discovering their relatives diagnosis/prognosis.

As indicated earlier, all those interviewed had prior knowledge of their relative's condition, either by professional insight or actual information. Typically this information came from meetings with medical staff. The experiences of this varied from the doctor being seen as supportive - Staff Nurse N. to the point of telling her as the family-nurse, what to say to her relatives ("*a growth not a tumour*"), to situations like that of Staff Nurse R. whose mother had undergone exploratory abdominal surgery...

S. "They called me into the office, and there was this little fat doctor, all smug, and he sat me down and he said , 'Your mother's got cancer, she's got six months to live'. I don't think they told me anything else, or asked me if I wanted a drink, nothing".

I. "Why you?"

S. "I don't know, they knew I was nursing but..."

I. "Perhaps you were the first visitor who came?"

S. "Maybe. I don't know, because my sister was married and working, maybe I was, I don't know, but I think it was 'cos I were a nurse. Anyway they just expected me to go back to the ward and sit with my mum. And she said 'What did they want you for?' You know so I said they wanted my signature on something. I think I must have asked them what do I say to her? And they said

tell her it was a gangrenous appendix. Then she came home, and I did the dressings. I was at home then. Then she kept asking things, and I kept making excuses and it were a farce. Looking back now, I wish somebody had been there to let me mum know".

I. "You weren't willing to tell her or everybody else?"

S. *"No, because I suppose I didn't know whether I ought to do, you know. But now I think I would have been better off saying something, because then she would have been able to sort of learn faster. And also I just felt really guilty about that. It's like an 'if I knew then what I know now', sort of thing".*

The most striking point to be made from another interview, (retired Sister S.) was the way she came to know that her husband was dying...

S. *"I was at work and the doctor just came into the office and said 'your husbands got four weeks to live'".*

I. "Do you think being told in that way had anything to do with the fact you were a nurse?"

S. *"Oh yes. We are supposed to get on with life and not have any feelings".*

She then went on to say that this expectation extended to the fact that she would look after her husband, and that in the event this meant she had to care for him virtually unaided...

S. *"When I asked about a night sitting service, I was told 'we don't do that sort of thing round here! and besides you'll be able to cope won't you?'. In fact in the nine months she cared for him, she had one night sitter, and that was on the night that he died. She now works for the night sitting service in that area.*

Nearer the end Sister S. found people saying things to her like *"well you'll be all right won't you? You are used to it"*, which she took to mean 'You don't have any feelings', and that it wouldn't effect her because she was a nurse. At times her husband was hospitalised, and at these times she felt very awkward, and tried to 'blend in' when she visited him, as she didn't want to be seen as

interfering. She was aware that the staff were very wary around her. She only complained once - because her husband had mouth ulcers from poor oral care (i.e. none). A nurse told her that she shouldn't have complained 'because sister doesn't like it'.

Finally, Sister S. was another nurse who kept her relative's condition a 'secret'. Even though he had cancer of the bowel and multiple metastases, her husband was never told. Even the GP was sworn to secrecy. She did this because she believed that her husband would 'give up' if he knew. The day before he died he asked the doctor outright what was wrong with him, the doctor answered truthfully. Perhaps she was right.

Both these people therefore felt that they had been told in this way because they were nurses, although they also felt that non-nurses wouldn't necessarily have been told with any real degree of tact and consideration. Also those who consulted with doctors 'behind their family's back' gave the impression that their discussions were very factual, medically orientated and matter-of-fact - rather like being given an impartial medical opinion. This in a sense reflects the views of Crawley (1984), in that those involved remained in the role of 'professional' so as to allow the interaction to take place. It is tempting to suggest that if the nurse had acted like a 'relative'- becoming upset, losing control etc. then the consultation would have been ended, or perhaps not even have taken place.

Nurse-relatives finding out that their relative had died.

Several examples were given of people being asked to come to the hospital with the often used euphemism 'your relative has deteriorated'. Two were actual examples of how people were 'told' of their relative's death. One of these is articulated in the exemplar interview provided in appendix 5; the other concerned Nurse Teacher T. who on reaching the ward where her father was being cared for, was approached by the Sister...

S. *"She took us out of the ward through the doors and on the corridor, she actually told us on the corridor, that my dad had died. I thought then that she might take us into a room and sit us down and say did we want a drink, but there were nothing like that, and I didn't cry, me mother cried, then she [Sister] said did you want to see me dad...I have a feeling I said something to me mum like 'It will be all right', and then we went in. The first thing were the sheet were over his face and there were no counterpane on his bed, he had no pillow under his chin, and all I could see was me dad hadn't got his teeth in and his mouth was wide open, and he looked absolutely awful. It were awful, I can't describe what it were like..."*

I. *"It sounds like your worst nightmare to me".*

S. *"It was. Although I suppose it's faded a bit but I think I were just too - I don't think - I couldn't believe that I was seeing me dad, and I don't know what sort of feelings I had I think it was just disbelief. I don't think the Sister had actually been in beforehand and I think - I picked up that she was slightly taken aback".*

I. *"What do you mean - that somebody else had prepared your dad and she hadn't checked."*

S. *"She hadn't checked, and that she didn't realise - I mean it were awful It were like looking at somebody out of Belsen, because his cheeks were sunk in and his face just looked like a skeleton I mean it just wasn't me dad. It were awful - but - then me mum in fact I didn't even go near bed. I stood - we both stood, we didn't go near the bed - we couldn't have gone near the bed. And then sister took us back out and she gave us me dad's things...and that were it, we didn't go in anywhere private, no tea, nothing. No matter whether it was a quiet office on the ward, I can't remember ever telling anybody things in a corridor, and not offering them a drink and giving them opportunity to talk. Anyway, I thought I won't say anything because if it didn't affect my mum very much I don't want to make my mum worse by telling her how I felt about it".*

I. *"So what about afterwards - I mean you said you kept yourself in. How long did you do that for?"*

S. *"I don't know. I didn't - I did cry, but not - what you really call cry. I mean*

that didn't happen until the dog got killed". (N.B. Six months after her father's death).

General feelings of unease when nurse-relatives visit.

More general data referring to the attitudes of staff towards nurse-relatives, and the feelings engendered when visiting, reflected very much, the findings of the open-ended questionnaire. That is:- staff tended to be wary of both nurse-relatives and the patient; nurse-relatives felt awkward and went to great pains to avoid confronting or criticising staff (one to the point of defending staff when her relatives complained about care); and, nurse-relatives tended to adopt a passive 'relative' role, a helper role, or retained a 'professional' demeanour with staff. It was also a fact that some felt that their relative received better care because they were a nurse/midwife, while others felt the opposite. Charge Nurse I. identified that being related to nurses may have led to his grandmother being kept alive unnecessarily, so as to ensure that 'everything had been done'. This interview was also interesting in that it could almost be seen as a case-study on the difficulties some nurses have when dealing with patients or relatives who are also nurses, as getting information was obviously a problem. Views were also elicited as to why such difficulties might arise for nurse-relatives - essentially a belief that working nurses often perceive that nurse patients/relatives are seeking to be critical and to somehow catch them out.

He also went on to describe how his wife had helped him to understand this reaction:

"I got a really useful insight into this from my wife who was an intensive care nurse and had been there for about six years. I would talk to her and she was able to identify some of these things - like, 'I wouldn't like you asking questions about the ventilator, or why has it been on sixty per cent oxygen for so long, because I often wouldn't have those answers. I wouldn't be able to answer them, and I don't like having to say to people 'Well, I really don't know'. I feel the same when a relative comes up to me and says can you tell me how so and so is getting on, and I have to say well you know, I've been on

holidays for a week and I've only just had the report, and I'll find out for you in a minute. You can go back five minutes later and give them the information and everything's okay but you still have that negative feeling inside you when you should know. You know, you're expected - you're there, you should know what's going on, you can't rationalise it".

This section of the data was perhaps most meaningful when considered in relation to findings elsewhere in the study - most notably, feelings of awkwardness in relatives and staff, when one of the relatives is also a nurse.

The lack of planned intervention to meet the needs of bereaved relatives.

The data suggested that this was an issue in general terms, i.e. not just for nurse-relatives. However in all probability this is further complicated by the fact that nurse-relatives were involved. One doubts for example, that a non-nurse would find out that her father was dead by being shown the body (see later); or that they would be informed of a relative's diagnosis or prognosis in such an unfeeling manner.

The fact that it was actually said that they were fortunate and somehow immune from the pain of grief, because they 'knew' about death and dying explains this to some degree, as 'popular belief' seems to prevail in both nurses and non-nurses, including the perception that knowing about death and dying, or working with dying or dead people makes things easier when one is personally bereaved. It is also possible that such an attitude shown by professionals to other professionals, is an example of working nurses having difficulty in seeing nurse-relatives as anything but a nurse or a relative - not both (Crawley 1984). The experience of the Charge Nurse in seeking information reinforces this view.

Apparent examples of complicated grief reactions.

The researcher has been careful to write 'apparent' examples of problematic grieving. This was because he is not a psychiatrist or psychologist and so not

qualified to make such diagnoses. However, there were several obvious examples of delay in the onset of grieving (i.e. > 2 weeks - Stedeford 1984) within this group of 22 bereaved nurses and midwives. There were also at least three people interviewed who in spite of their loss happening several years before, became extremely upset during the interview, giving the impression that their grief was 'chronic' (Stedeford *ibid*). For one of these nurses, this problem was seen as the underlying cause of ongoing disciplinary problems.

Being the family 'tower of strength' and its effects on grieving.

There appeared to be a strong relationship between being the 'family copier' or tower of strength and a delay in the onset of grief, for example:-

Charge Nurse I. *"It was a while after really that dad [a nurse] started to grieve. If you like our grieving started as soon as we got the news that she died, but dad sort of put it on hold for a while really. He had to get all the things sorted out. He had to - you've got to understand that Gran's family were quite sort of fragmented. We weren't a particularly close lot although she had a lot of - she had a lot of good relatives, so he had a lot of people to get in touch with, and rigmarole, he had a funeral to organise which was quite difficult in terms of co-ordination so that people could be there, and it was - he got on with all of that and then - and then once that was sorted out - secure would be a better word, her estate was safe in the hands of solicitors, that was his time, I think. I wouldn't honestly be able to tell you how long it went on, but quite a few months I think".*

Another example of circumstances leading to a delay in the (overt) onset of grieving was Nurse Teacher Q., whose situation was complicated further by the 'need' of the interviewee to protect her brother who was being criticised by aunts and uncles for not doing more after his father's death. In actual fact he had been badly affected by it. In this sense this example relates back to the issue of 'selflessness' discussed earlier:-

S. *"my brother was totally distraught, and we got the relatives saying things like 'S... 's not pulling his weight...and with all that, I felt I had to cope - I had*

to try and protect them".

I. "Not pulling his weight?"

S. *"That's right, with him being a boy I think a lot of the relatives expected him to be coping better, and that he ought to have taken over and taken charge of things. So you see, I took charge because of the fact that I knew what to do. Also my father was a right copper and I knew he would expect me to you know cope".*

I. "Did you say anything to anyone about that?"

S. *"No because I felt it was really silly. It was worrying me at the time, but I didn't really speak to anybody about it because I was too busy, because we had all these people coming in and out the house, and you are making them cups of tea and they were upset"*

I. "You were still the tower of strength at that time".

S. *"At the funeral my husband came with me, but he really didn't have much of a clue what to do, he's a bit useless when it comes to things like that. He is good in other ways though, but when it comes to things like that he turns to me so really I was left to that myself and arrange everything, and then when people were coming to the house, I had to see to them, because my mum - I wasn't really wanting my mum doing that, and my brother was really quite upset, but then I heard my auntie say to me things like 'What is S... doing?' in a really scathing tone and I thought well I am managing fine I don't really need him to help me and he really was too distraught and that really upset me as well, I knew they were thinking bad thoughts about him but he was - they weren't really concerned with the fact that he had just lost his dad and he was really distressed about it".*

I. "How long after was that, I mean you are sounding as if you didn't really take time out to actually grieve".

S. *"I came down here - back here and I had decided that I wasn't going to have any extended grief because it was my dad it wasn't a strain and that really wasn't the worst thing that had ever happened in my life. But when I came back down here I was crying right away basically, I started crying in the car on the way down on the motorway, but there was nobody down here that knew*

him that I could talk to anyone. I'd only been down here a month but I had actually made a couple of friends in that time, but I couldn't actually talk to them about it. In fact this is the first time I have really talked about it to anybody. I couldn't really talk to them because they didn't know who I was talking about so I just had to cry on my own and get really really upset in the house you know. I was grieving for a long long time after it. It must have been sort of two years at least that I was like that... I think what extended it even more was the fact that I was here and there was no connection with my father here, because he hadn't even had time to come down and visit. So there was no connection at all here".

What is particularly interesting here therefore, is the fact that apparently perceived that she would be able to cognitively control her grief.

A third example of apparent complicated grief comes from the interview with Nurse Teacher T. who earlier described how she was shown her father's body in a poor state...

I. "You said you kept yourself in. How long did you do that for?"

S. *"I don't know. I didn't - I did cry, but not - what you really call cry. I mean that didn't happen until the dog got killed [six months later]"*.

I. "So something sort of snapped when your dog died?"

S. *"Yes, I just could not stop crying, all the way home I were crying, I didn't stop crying all night. And it wasn't just crying it were heart breaking crying, and it were just all night. I mean I'd just set off and I'd be absolutely in tears"*.

I. "But in terms of managing grief, isn't that the best thing? I think you've got to work through your own feelings because otherwise - repressing strong feelings is actually something that can lead to complications if it's for any length of time. I mean in some ways perhaps, you were fortunate that your dog got knocked down. I mean I know that sounds an awful thing to say but it gave you a catalyst to actually get rid of that emotion".

S. *"I know, I mean I spoke to D.... [husband] and I said 'It's daft', I said, 'I'm doing more crying than I ever did for me dad'. He said 'You're crying for your*

dad now'."

The relationship between being strong and being seen to be so, and problematic grieving.

This was illustrated by the case of Charge Nurse U. who had great difficulty coming to terms with the tragic and sudden death, of the Junior Sister of his ward. He articulated that he had subconsciously attempted to carry on as 'normal'.

S. The day after she died, I were back at work and people were still dazed - they were grief stricken. But you still had to deal with visitors, you still had to deal with ward rounds, and you know, I just carried on, and I didn't think anything were amiss. I just carried on my normal job and so I put P..'s death in a compartment so that when for example visitors talked to me about a patient I spoke about that, and when we talked about what we'd seen on TV, I sort of spoke about that compartment, and I tried to express my self in a very small compartment, and I didn't realise how big the effect it had on me, until like, until a few months after".

I. "Because you internalised it all?"

S. "Yes, I think instead of it coming out, as it should have done, it went internally and became destructive, and I was coming out strange ".

I. "In what way?"

S. "Well I didn't know. You see I didn't know anything about it, that's the thing you see. I just came back from my holidays at Christmas, not realising what negative thoughts I'd been having. I was feeling very isolated and small and I couldn't relate very well to people, and eventually J... and J... who know me as well as anybody sat me down to see if there was a problem, and they said we think that you've got problems coming to terms with P...'s death. And it was just like when you've been wearing dark glasses and somebody takes them off for you. I suddenly realised what they were saying, and I admitted that I felt differently, and they asked if I had thought about professional help because it might be useful. What frightened me most, was that it were a very

gradual thing, where my thoughts emotions changed, and the voice in you realises that you are having really black thoughts. Really black horrible thoughts about being worthless and useless, and inefficient and that you weren't a very nice person".

This led on to the issue of support, and his willingness to access it...

I. "Did you have anybody you could talk to about this?"

S. *"Not really. I didn't want to bother my wife about it, so I tried to keep working. I thought I was coping with it you see, so I didn't feel the need.*

I. "So you were putting on a front. Why do we put on that front do you think? and in what ways - how do we develop that front in the first place?"

S. *"I think it's just that nursing teaches you to cope with stress, various stresses, whether its acute, emergencies, or dealing with relatives of patients who are ill or in pain, explaining operations and things to them. And I think that as a nurse, you think you should be able to do it for yourself, because you are doing it for others, so you should be able to cope, but the difference is that when it happens to yourself, or it happens to a friend of yours, you suddenly realise that you've got something going on inside you and you need help, and I think as nurses, it's very difficult for us to admit we need help, or that we are out of their depth. Anyway, what sort of struck me was after they approached me about what they saw as my altered behaviour, I realised what had happened. They said I should go to occupational health, but I didn't want to go, because I thought it was attention seeking. I just wanted to absorb whatever had happened and carry on as normal, but I suddenly realised that I had no choice".*

I. "So you suddenly realised that you weren't actually dealing with it, you thought you were, but in reality you weren't?"

S. *"I think probably that's what nurses do. They think I should cope with this, and if I just carry on as normal then it will go away, so they bury their grief, or whatever they call it, or their resentment or their anger. Bury it deep inside themselves, and they can talk to people and can deal with people who are*

grieving - which happens you know just about every day. But they know what they should do and what they think is right, but afterwards there is like an emptiness inside the shell. It was like a numbness. I felt numb, like I suppose nursing by numbers. You did what you had to do, but I think the difference was also when I was working on the ward, as a figure head of the ward, I was expected to perform certain duties like counselling relatives and generally being the person that communicated with various departments and people that came to the ward. Sometimes I just wanted to - sometimes I have been busy doing something, and then I'd have a few minutes free, and I'd go into a sluice if there was somebody in there who knew P.. well, and I would just say to them 'You know, I really miss P.., of these mornings'. And that were my way of getting it out because I - I couldn't just - well, I never - I couldn't sort of collapse into - into grief".

I. "Why not?"

S. *"I think it's because I'd feel that I'd lost control. When I were a lot younger, I used to be very emotional up and down, and when I came into nursing, it had a great sort of balancing effect on me because obviously you can't be like that. It would be a bit confusing for staff and patients alike, if I were acting on my emotions, and I suppose you discipline yourself, by disciplining your emotions...Anyway, I went to occupational health and they just let me talk, and basically I said what I've said to you, but I suppose the thing was the actual time of the death was a lot nearer and I did sort of - I never broke down into floods of tears but it were gradually working itself out, you know, at that point".*

I. "Yes, being a copper is very important isn't it?"

S. *"I think what it is, is that nurses tend to put the nurse in them first and the human being second. I think the problem is with the best of nurses, is that they see themselves as nurses twenty four hours a day and its very hard to remember that despite the fact that you wear a uniform all day, you are part of the human race and that the same things that afflict what they call lesser mortals or whatever, afflict them too. They are still part of the human race. But I say when P.. died, for me the lesson was simply that I realised that for all*

I'd filled my head with my training, that at such times, what you need is simply someone to sort of hold your hand or at least be able to talk to, and you know, be a friend".

I. "But the interesting thing is although like you were saying M.L. came along and gave you the opportunity to do that, you weren't capable of picking it up at the time, you know she came and said "How are you?"

S. *"Yes. I remember her saying "How are you?" She emphasised it. But I was just thinking - I wasn't thinking about myself I was thinking about getting back to the ward and getting things done. Because I'd just buried it, you see, and I didn't want to think about it. Because I didn't really think that anything could be done, because I thought well, you know it will resolve itself".*

I. "What I'm trying to say is that there needs to be something more than just the presence of that 'friend', because if you're not ready to take advantage of that situation, it's wasted, it's got to be provided, but you've got to be ready to accept the help".

S. *"Yes, you are right, I didn't feel like that at the time".*

This interview therefore tied together several issues, including social support, self-concept as copier and the influence of professional acculturation (Dingwall 1977), all with apparent influences on this nurses ability to resolve the grievous loss of a valued friend and colleague. It also suggests a lack of knowledge of the 'active' nature of grief work (Worden 1983), a lack apparently shared by the majority of those interviewed.

The complications of over-independence.

These were referred to in an earlier section with regards to the two nurses who had found difficulty in resolving their grief, due to the realisation that they had been dependent on their deceased relative to some degree. Murray-Parkes (1972) identified this as a pre-determinant to complicated grief as it leads the person to be confronted not only with the death itself, but also with the fact that their self-concept of not needing anyone else, is flawed. Both of these require time and emotional energy to resolve.

Another situation of pertinence, was that of Staff Nurse O. who said that *"even now, five years after my mum died"* she still resented the elderly patients in her care because they were old and infirm, while her mother had died at the age of sixty. Not only that, but she felt guilty about feeling that way but saw no way of resolving it. This was the first time she had been able to talk about such feelings to someone else.

The point to be made from this section therefore, is that delaying grief was quite common amongst these nurses and midwives, typically because they were the 'tower of strength' for their family and (often) wider social circle. Furthermore, for some this went far beyond the two week rule of Stedeford (1984), some for months and others, years.

Brief summary of the chapter.

It was stated at the outset of this chapter that the intention of this part of the study, was to allow the exploration of factors thought to predispose to complicated grief, alongside aspects of the culture of nursing and midwifery, **within** the context of actual cases where nurses and midwives had been bereaved. The data reviewed and discussed here demonstrate potential, yet nonetheless real-life, complications of being a professional nurse or midwife **and** a family nurse when personally bereaved. The interviews therefore certainly served their purpose to the full. As stated earlier the exemplar interview with Sister V. provides a narrative account of how one person may have a combination of factors said to predispose to complicated grief. It is presented in appendix 5.

Chapter 8.

**Overall discussion of
results from the study.**

The most obvious remit of a discussion such as this, is to relate data from all sections of the study so as to allow consideration of the relationships between the various key issues. As planned however, the interviews with bereaved nurses and midwives went much of the way to achieving such an end by providing actual data not only about the pertinent concepts identified in the conceptual framework (chapter 3), but also relationships between them. That said, the intention now is to reaffirm such concepts and relationships, utilising all the data from throughout the study, along with the identification of serendipitous data where relevant, and pertinent information from the literature regarding issues not examined directly in the study. The end-product of this discussion, will be a modified and more detailed version of the original 'conceptual framework', which could then be seen as a 'theoretical framework'. A narrative will be offered to facilitate understanding of the relationships between concepts and how they may combine to predispose nurses towards complicated grieving, when personally bereaved.

The structure for this chapter, is based around the matrix of concepts and the relationships of particular interest, identified in the conceptual framework chapter. It would seem reasonable to do this, as data from the questionnaires appear to validate the existence of the concepts envisaged at the outset, while the interviews with bereaved nurses and midwives suggest that relationships do exist between them.

The impact of professional acculturation on individuals.

The fact that the majority of respondents had entered nursing directly on leaving school, was derived from the biographical details section of questionnaire 1 (Ch.5 Section A). It was pointed out in the conceptual framework chapter, that directly measuring personality and self-concept on entry to nursing was not an intention of the study. However, data from both sets of interviews suggested that it was indeed the case that nursing had attracted people who were dependable, resilient and level-headed - 'copers'. This point is further reinforced

by the references to such attributes in the 'I am' component of the TST and OCT section of questionnaire 1 (Ch.5 section G). Furthermore, interview data suggested that the more extreme views on coping and independence were held by those whose entry behaviour was reinforced by professional socialisation.

The literature can also be seen to support this view, not least the 'Nurse Selection Project' undertaken for the UKCC by Child (1993). This identified that not only do prospective nursing students utilise work experience to "ascertain their suitability and ability to cope with the role of the nurse", but also that having "responsibility...and stress" were perceived to be "positive features" by those who were interested in pursuing nursing as a career, and negative features by those who were not.

Other findings of pertinence in Child's study (ibid), were the attraction of "caring for people" (a view shared by Hodges 1988); the perception that nurses possess caring qualities; and that both of these views were irrespective of age or degree of interest in pursuing nursing as a career. Smith (1992) suggests that both the nursing profession and the public, perceive 'caring' qualities to be present in nurses before entry to the profession. The parallels of such findings with the data from interviews in the present study are clear.

Components of the acculturation process (Dingwall 1977) or professional socialisation, of particular interest to the study, were also quantified by the data:

Role-models were identified as ideally being clinically based, being 'experienced' and being capable (> 55%) in section B. of questionnaire 1.

The issues of coping in nursing, and being seen to cope, were highlighted in various ways throughout the study, providing triangulation of findings and enhancing the validity of conclusions and implications derived thereof.

The data from the 'preferred coping strategies' tool (Ch.5 Section C) for example, appeared to support Dewe's (1987) view that nurses rely heavily on 'direct' or cognitive strategies to deal with stress. Furthermore, the data would seem to suggest that they value such mechanisms to the extent that it may be at the expense of developing other methods of coping to any meaningful degree (potentially to their detriment should they be personally bereaved). Also that the issue of control was apparently important, at least to these respondents.

In point of fact therefore, the view that the coping strategies encouraged in nursing are archetypally masculine (Farmer 1993; Muff 1980; Glick et al 1974; Bem 1974), was supported by the data.

The possibility that the nurses and midwives valued such mechanisms because they reflect a persona of the 'ideal nurse' as a calm, collected, dependable 'professional' which many in nursing aspire to was also suggested by the data. Other studies have identified that such mechanisms may offer some protection against burnout. There are several reasons therefore, why nurses may perceive this to be expected of them.

Data from sections E and F in questionnaire 1, regarding 'professional coping', expanded upon this suggestion in several ways. It was affirmed for example that it was a perceived expectation of the profession(s), that its members be able to 'govern and manage disturbing emotions in themselves and others' and 'display stability and endurance under pressure', to the point of being unable to admit fallibility. It was also confirmed, that failure in this regard was perceived as potentially disadvantaging an individual nurse in the future, in terms of promotion and their standing with supervisors and colleagues.

It was also apparent that most respondents perceived that there were high expectations of them, regarding being a copier and **being seen to be so** by the public. The level of this expectation was illustrated by the interviews. Indeed the impression was given by some, that expectations of the public were higher

and more unreasonable than those of the professions. Furthermore, self expectations to be a copier (perhaps engendered in part by societal forces) were also very high. That is, almost 96% of respondents asserted that it was 'important for nurses to be seen as dependable and able to cope by the public', whilst over 40% felt that even 'ideally', they as a nurse should not lose control.

The ramification of all these, is that all influences would seem to:- contribute towards nurses developing a self-concept of a 'professional copier', perhaps reinforcing personality traits that were present at the outset. They may also encourage rescuer fantasies and perfectionism, with an attendant over-concern for the avoidance of errors and achievement of unrealistically high standards (Smythe 1984; Brooking 1986; O'Brien et al 1994). Also that nurses may not tend to admit to having difficulties or seek support from peers and/or supervisors (discussed further later), for fear of being seen as a non-copier, which might be held against them at a later date.

All of these are pertinent to the study as any of them could serve to complicate the grieving processes of a nurse:

- a) by virtue of them having or developing a self-concept of a 'copier', and/or
- b) because they may not feel able to approach work colleagues or supervisors for fear of being labelled a non-copier, and therefore unprofessional.

Both these possibilities would also presumably deter them from accessing counselling services - whether they be independent, confidential or both, a point reinforced by the fact that while 95% said that 'Ideally' they would access counselling services if they were available, only 51% said that they would 'Actually' do so.

The relationship between the personal and professional persona of nurses.

It should be pointed out at this juncture, that it is not a contention of the researcher that it is unreasonable for society to expect professionals such as

nurses, midwives, doctors and fire-fighters to be calm and collected in a crisis - 'when all around are losing their heads' to paraphrase Kipling, indeed it can be seen to be a necessity in times of emergency. This was reflected in the responses to sections E and F (Questionnaire 1) in this study. However it is not inconceivable, given this level of expectation from all quarters (professional, societal and self), that many nurses may perceive that the 'ideal' professional should be calm, collected and display minimal affect at all times, including when they are not on duty - hence the marked overlap of responses in the TST and OCT. That is, this may be a "metaperspective" (Skevington 1984) held by nurses, of how they are seen by peers and the public with regards to coping and being in control. Potentially it underpins their professional and personal self-concepts.

Over-reliance on intellectual and ego-defensive mechanisms for coping.

Data from this study (particularly that from the preferred coping strategies tool and questionnaire 2); from other studies (Birch 1983; Game and Pringle 1983; Field 1986; Boyle et al 1991; Robinson et al 1992), and from informed opinion (Jourard 1971; Bond and Bond 1992), concur to identify that nurses may come to rely heavily, and indeed over-use, intellectual and ego-defensive mechanisms (eg distancing, evasion, and intellectualisation) for coping with stress (including dealing with the dying and their relatives) at the expense of developing other forms of 'coping'.

This study also identifies that for these nurses and midwives at least, the overt expression of emotions was not common. This may be attributable at least in part to expectations held of them by self and by others; deficits in the official curriculum regarding such areas as interpersonal skills and dealing with the dying and their relatives; as well as the shortcomings of the hidden curriculum already enumerated. It is also possible, that the use of such mechanisms may not only be confined to the professional aspect of their life, but become a primary focus of their coping skills repertoire at all times, as discussed earlier.

If this is the case (and the interviews with bereaved nurses suggest that this may often be so), then the chances are that when nurses encounter personal problems - in this case bereavement, they may attempt to deal with it cognitively or 'intellectually', rather than on an emotional level, ego-defensive mechanisms having been immediately circumvented by circumstances. Unfortunately as was discussed in the literature review, this could lead to problematic grief given the truly emotional basis of the processes of grieving (Worden 1983). This issue will be returned to later, when considering the role of the 'family nurse'.

The possible effects of professional socialisation on feelings of 'independence' were also explored in the study. It was observed in both sets of interviews for example, that reliance on others was consistently viewed negatively by the nurses and midwives. This was while there was also a general consensus that having people depend on them (perhaps needing them) was a positive aspect of the role of nurse. Again, the potential of this for complicated grief are evident, this time the factor being that self-perceptions of being 'independent' and not needing anyone else, can lead to problems in grieving (Murray-Parkes 1972, 1975). This in turn is due to the nature of grief being such that it confronts the bereaved with the reality that they **did** need and perhaps relied on the deceased, perhaps more than they realised; and that therefore, their self-perception was in that sense flawed, is now lost, and must also be 'mourned'.

The final point to make regarding the processes and products of professional socialisation, is that as a result of the prevalence of distancing, evasion and a lack of planned intervention on an interpersonal level (see data from questionnaire 2), the environment which professional neophytes will be confronted with will not be the humanistic, patient-centred, care-focussed one they probably expected to find. Furthermore, while they will assimilate into this environment (or leave) so as to resolve any dissonance, the chances are that should they or a loved one, become a 'customer' of the health services, such dissonance could re-surface, with all its attendant anxieties.

The role of the 'family nurse'.

It was indicated earlier, that entry to nursing and the ensuing professional socialisation and acculturation, may lead to the development or enhancement of a 'coper' self-concept, and extreme feelings of independence. Data throughout the study affirmed that entry to nursing also invariably leads to an individual becoming the 'family nurse'.

Interestingly, only two interviewees said that they were not the 'family nurse' as this was a role occupied by their mothers - who were both nurses! Typically this role was characterised as being the focus for illness-related problems within the family and often wider social circle (eg friends and neighbours), and the family spokesperson and representative for health and illness related matters. This was in terms of providing information, advice and often physical care. The questionnaires quantified the boundaries of this role, as well as identifying that for some, the responsibility was not always welcome or indeed reasonable, and at times led to feelings of inadequacy and guilt because they felt that they were not always up to the job.

Data from questionnaire 2 for example, raised questions about the knowledge base of the nurses and midwives regarding death and dying, communications and interpersonal skills, and many respondents claimed that they did not feel adequately prepared to deal with the dying and their relatives - presumably including their own.

In turn, the interviews took these insights into another dimension. That is, reality. For many, the 'general' expectations of self and by family/society discussed earlier (i.e. a coper) became intertwined with the role of 'family nurse'. This was to the point that they assumed almost total responsibility for their dying relative - from knowledge of their condition, which they often kept to themselves; to physically caring for them and carrying out last offices in some cases. Invariably they did this because it "*seemed the right thing to do*" - i.e. they expected it of themselves, and it was not necessarily imposed on them

by others.

It was also common for them to feel isolated to some degree from their family in the time leading up to and following a family death. This was by virtue of unshared insights and 'secrets' kept to 'protect' them (the family), perhaps fuelled by a perception that as a 'professional copier' they are able to 'take' such information, while others typically cannot; and the need/expectation for them (the family nurse) to act as a 'tower of strength' while the family get on with the job of grieving. This isolation at times was reinforced by the stated views of others, that as a nurse *'you will be alright, you know all about people dying. You deal with it all the time'*. In the event, this isolation meant that anticipatory grieving was impossible, and that they had to delay their grief work - for some, indefinitely.

In part this may again also have been complicated by the intellectualisation of their loss, by the individual nurse. That is, they may actually have believed that because they 'know' about theories of death and dying, then that somehow provides exemption from the emotional realities of grieving.

It may also be that they identify with the popular conception, that coping connotes lack of affect, and a rational approach to dealing with difficulties or stress. Not least because professional role-models, acculturation and 'popular belief', encourage them to believe this, and the official curriculum apparently does little or nothing to disavow them of it (see data from questionnaire 2).

Implications of hospitalisation of relatives, for the 'family nurse'.

It was alluded to earlier that the time leading up to their relative's death was problematic for many family nurses, particularly if the relative was hospitalised. Unease and anxiety on the part of both working and visiting nurses, (identified in questionnaire 2 and the interviews with bereaved nurse) was one such problem in 'reality'. That is, 'family nurses' invariably felt awkward and

embarrassed, and where possible they attempted to occupy a 'back seat', rather than risk irritating the staff. For some this resulted in their keeping the fact of their being a nurse, from the staff, while staff utilised avoidance, evasion and even antagonism at times, towards nurse-relatives.

Some nurse-relatives attempted to retain a somewhat professional demeanour (as per Crawley 1983), and even identified professional loyalties, such as defending the actions of staff to their relatives. Interestingly no-one in the entire study, claimed to have challenged staff regarding the care and treatment of their relative, though few were totally happy. An unwillingness to 'rock the boat' was usually the rationale for this, i.e. they were cognisant of possible negative ramifications for self and for the patient, of being seen as 'interfering' by staff.

Difficulties in obtaining information were also identified by a range of data, and constituted a common problem for the 'family nurse'. The most compelling data was from the interview with a charge nurse when he discussed the difficulties he had in getting information regarding his grandmother. In turn this was reinforced by data from questionnaire 2, which explored the issue of the control of information in hospitals and provided a range of impediments, real and imagined, to nurses providing meaningful information to patients and their relatives - particularly in the case of terminal illness. Also that the nurses and midwives felt that they could do little about this.

Several of the bereaved nurses and midwives mentioned the way in which they came to be shown the body of their dead relative by ward staff. Typically this was recalled as a traumatic experience, not because of seeing their loved one dead *per se*, but due to the callous way they were told of the death, introduced to the body, or both.

Some said they felt that they were dealt with in this way because they were a nurse, perhaps because they would be expected to have seen dead bodies

before. This therefore either says something about the lack of recognition on the part of working nurses that the death of a nurse's relative is somewhat different to the death of 'just any patient', or suggests that the way that bereaved people are treated on wards in general, reflects the lack of knowledge and skills referred to throughout this study.

In closing this section, it should be acknowledged that invariably in both the questionnaires and interviews, participants did say that if a problem had been big enough, they would have interceded on behalf of their relative and family. In any event, they tended to have felt extremely dissonant and uncertain whilst visiting, which usually led them to try to be a 'visitor' or a 'helper' where possible, so as to minimise their threat to the 'professional self-concept' of staff, and so maximise the chances of 'good' care being given to their relative.

Guilty feelings in 'family nurses'.

For those bereaved nurses and midwives interviewed, there were few examples of guilty feelings being elicited due to the avoidance of overtly playing the role of 'family nurse'. This was presumably much to do with the fact that no-one had encountered a major problem and had therefore not been confronted by the dilemma of having to choose between enacting an active role of family advocate, and keeping quiet to avoid conflict with staff. Further studies of nurses and midwives who **did** have complaints regarding the care of their relatives would therefore be useful.

Several did feel guilty because they had not foreseen (i.e. diagnosed) an illness; been more understanding to their sick relative; or because their relative was admitted to hospital and so they had not cared for them personally. These feelings had served to complicate their grief, though not (apparently) in a "pathological" sense (Stedeford 1984). That is, it made things just that bit more difficult for them.

Social Support and nurses.

The issue of social support becomes pertinent here. It was identified earlier that a ramification of being the 'family nurse' was to be cast in the role of 'tower of strength', in the event of family illness/bereavement. Furthermore, that this could lead to feelings of isolation and thus predispose to problems in grieving. In this sense, the isolation was seen as a result of support (particularly emotional support) being lacking from personal sources (eg family), because :- a) they (the family) are grieving and wish/need themselves to receive such support; and b) the source of that support to the family will in all probability be the 'tower of strength' - usually the 'family nurse'.

It is useful to identify here, that **all** bereavements require a 'tower of strength', **but** not all families have a nurse amongst their number. It is a contention of this study however, that this is a role which typically and readily falls to the 'family nurse' if they exist. If they do not exist then many of the problems attendant to that role will be encountered by the person who it does fall to - perhaps the eldest/unmarried daughter if the deceased is a parent. The point being made here, is that such problems are not peculiar to nurses *per se* **but** that being a nurse will tend to lead to the assumption of responsibilities associated with being the 'tower of strength', in the case of a family bereavement.

It could of course be postulated, that the effects of this potential (yet probable) lack of support from personal sources for nurses, could reasonably be expected to be mitigated against by the provision of support from work sources, who after all are from **the** caring profession and are widely considered to have insight and skills in the area of supporting the bereaved.

This was another focus of the study, in that a perceived lack of social support (from all sources) may be a pre-determinant of complicated grief (Murray-Parkes 1972, 1975). Furthermore, examination of this area would shed more light on the issue of the overlap of nurses' and midwives' personal and professional lives and personae.

In the event, the possibility that work sources would unequivocally provide social support (in all its forms) to nurses, particularly when experiencing family bereavement, was firmly refuted. Recurrent throughout the data was the assertion that potential work-based sources of support (colleagues and supervisors/managers) would be unsupportive at such a time (indeed apparently at any time). The exception to this was support from colleagues well known to the individual, who in many ways could be considered friends, and therefore a personal source, rather than merely a work colleague. It should be pointed out however, that this would be undermined by the practice of moving staff on a regular basis, which is a common practice in hospital nursing and midwifery (Coxon 1990 and Ch.5 section A).

In point of fact, the typical views held of managers were negative in the extreme - both in the social support questionnaire, and from the interviews with bereaved nurses and midwives. Indeed in some instances, it could be said that the reported attitudes of supervisors and managers were such that they would actually intensify the stress of their staff, rather than ameliorate it.

Theories of "Oppressed Group Behaviour" shed light on why this may be so. Feire (1971) notes that "it is the rare peasant who, if promoted to landowner, does not become the tyrant of the peasant". It may be that as individuals make the transition from nurse to manager, they pass through a socialisation process just as compelling as that from student to trained nurse (Basset 1993; Melia 1987; Kramer 1974), with the distinct possibility that their "allegiance will be to the maintenance of the status quo" (Roberts 1983) rather than to colleagues left behind and a commitment to change. This issue is discussed at some length here, in an attempt to highlight the insidious and almost inescapable certainty that this will happen to the majority of nurses who 'progress'. Furthermore, that it is not a situation that comes about **necessarily** because such people wish to align themselves to management and/or medicine, but that this is a change brought about by "social conditioning" (Le Roux 1978) and as such, individuals may not be consciously aware of it happening to them. That

being the case, it not really surprising that many nurses find their supervisors unsupportive as they may be following a different (e.g. corporate) agenda to the nurse's own; and, they (managers) may consider their subordinates with disdain and aloofness, and therefore not worthy of their support, advice and concern (Roberts 1983).

That this was often perceived to be the case, was made evident by the data which showed that nurse managers were rated extremely poorly for all forms of social support, including the most basic functions of management such as providing constructive feedback on job performance.

All this aside, it would appear to be that there is a great potential for a 'family nurse' at a time of family bereavement, to find (or at least perceive) that social support is not available either from personal or work-based sources. Given the discussion in the literature review, the potential impact of such a scenario for the grieving processes of nurses so affected is obvious.

It is also confirmed that for these nurses and midwives at least, the reality is that any overlap of personal and professional lives, is invariably one-way, 'professional into private', and that in fact this would appear to be common - perhaps even 'the norm'.

Personal and professional implications of the study overall.

Possible personal implications of nurses and midwives being commonly found to be prey to one or more of the pre-determinants of complicated grief (Murray-Parkes 1972, 1975) were enumerated and discussed at some length in the literature review.

It was apparent from the interviews with bereaved nurses, that the most common 'complication' was one of delaying the onset of their grief, and that this was typically associated with their role of 'family nurse' and being a 'tower

of strength'. Such a delay in the onset of grieving appeared to be the case for at least ten of those interviewed. Furthermore, there were three nurses in the sample of 22, who gave the impression that their grief was 'chronic' (Stedeford 1984; Worden 1983). Thus at least half of the bereaved nurses and midwives interviewed, had suffered (or continued to suffer), some form of complicated grief. Furthermore, this was invariably associated with their being a nurse or midwife.

The importance of such findings would seem to be self-evident, not least in terms of the potential personal ramifications of ill-health in bereaved nurses and midwives. In the literature review, these were categorised under the headings of psychosomatic, psychoneurotic and affective disorders. In practicality these refer to issues such as an increase in mortality of bereaved spouses (Parkes and Weiss 1983), and hypochondria and phobias - often about death and dirt, and depression and mania (Stedeford 1984; Worden 1983). Alcoholism may also appear for the first time in an attempt to gain some relief from grief, or due to exacerbation of a previously 'social' alcohol intake.

There is also a rapidly expanding body of literature on nurses and their possible predisposition to "chemical dependency" (La Godna et al 1989) i.e. drugs and alcohol, emanating particularly, but not exclusively from the USA. This will be returned to shortly, when implications for the 'profession' are discussed.

It was stated in the discussion of the interviews with bereaved nurses and midwives, that there were several apparent examples of complicated grief reactions, amongst the twenty-two interviewed. Most commonly these were examples of delay in its onset - some for months and even years. There were also apparent examples of chronic grief. Pathological sequelae of these were not examined in detail in this study. In part this was because those interviewed (not unreasonably nor unexpectedly) tended not to discuss such things as their alcohol consumption. Furthermore, the researcher did and does not, have clinical expertise in the diagnosis of psychopathology.

It may be the case, that any or all of those interviewed encountered somatic or psychological pathology associated with being bereaved and a nurse or midwife. It is part of the reality of the professional culture (and perhaps wider British/Western culture more generally) which was examined and quantified by the study however, that such data would not be freely offered in circumstances prevailing within this study. For example, being interviewed by another nurse, often within the environs of their workplace. That said, the candour which characterised the majority of the interviews was at times surprising, and said much for the degree of trust engendered by the researcher. In turn this illustrates that nurses and midwives can unburden their thoughts and feelings to others, if they sense the environment is right to do so - i.e. supportive and confidential. The fact that several stated that this had been the first time they had ever had the chance to talk of their loss meaningfully, may also have contributed to this willingness to participate so frankly in the study.

Even as a lay-person, it was apparent that some nurses and midwives had experienced psychological difficulties as a part of their grieving - typically prolonged depression. This study was never intended to differentiate between the incidence of this amongst nurses and the wider population. This is an obvious area for useful future research.

One cannot be sure as to how the internalised emotions and anxieties of those who delayed their grief to the point of chronicity, would/will be dissipated, or the form this will take. The only apparent certainty is that they will be "manifested to the full in some way or other" (Deutsch 1937). It can only be hoped that it is in 'safe' circumstances akin to those of the bereaved Sister who confronted her grief at a self-awareness seminar. Or that they will seek the services of an independent counsellor, having not been deterred from this by the constraints of being a 'professional copier' within a professional culture where counselling is something for 'patients', and may be considered an admission of 'weakness' and inability to 'cope'.

Professional implications of the study.

It was the case that one of the nurses interviewed as part of the study, came to be so for two very different reasons - the concern of a close colleague, and the strong recommendation of a manager faced with a member of staff with a rapidly deteriorating work record. Indicators of this deterioration were remarkably similar to some of the common problems of bereaved nurses, who presented themselves to 'CHAT'- the counselling service of the RCN. Crawley (its chief counsellor) listed these as:- "difficulties at work; sudden or developing intolerance of certain patients; irritability and anxiety; prolonged distress over the death of patients; and being under threat of disciplinary action due to a marked drop in standards" (1984).

Examples of these are scattered throughout the interviews with bereaved nurses and midwives. It is acknowledged however that only one out of the twenty-two involved had **apparently** reached the level of professional problems. This may of course be a function of a culture which encourages the keeping of "helper secrets" (Larson 1987), i.e. there could have been more. It could also be that this was merely artefact, a one-off example of problems relating professional nurses with complicated grieving. Alternatively, it may be the case that this was indicative of the level of incidence of personal bereavement having ensuing **marked** professional implications for nurses and midwives. If so, then it suggests that there indeed could be cause for concern as this equates to approximately 5% of nurses and midwives - a significant proportion of both the professions and in turn, wider society. This of course can not be unequivocally proved or disproved in a study such as this, limited in terms of both size and random-ness of sample.

Further study would therefore of course be required to answer this question. However, given Crawley's experiences and much anecdotal evidence, the researcher doubts that this was merely artefact, and that there is indeed a significant (potential) problem for the profession(s) and those they seek to care for, i.e. the public.

These then are specific implications of problematic or complicated grieving, for nursing. In a more general sense there is also the issue of the myriad of factors identified throughout the study as being 'stressful' to nurses in general, particularly during family ill-health and/or bereavement, and especially if they are the 'family nurse'.

It is axiomatic that sickness and/or hospitalisation of a relative will be anxiety provoking. This study has gone some way towards quantifying the extra responsibilities and anxieties that a 'family nurse' will feel at such a time. This along with the fact that the majority felt themselves to be expected to fulfil this role (over 90%) - whether they were comfortable with it or not.

As well as possibly leading to complications in grieving as discussed earlier, there may also be more non-specific ramifications of 'professional coping'; an independent self-concept; and perceptions of being unsupported personally and professionally. That is, general reactions to stress such as somatic and psychological illnesses; absenteeism; frustration; and causing nurses to leave the profession or seriously consider doing so (Milne et al 1986; Moore 1984; Beck 1984; Rogers et al 1979; Fimian et al 1988). Furthermore, the possibility that by attrition over time, or kindled by a specific episode such as family ill-health or death, "burnout" may occur (Maslach 1976).

In point of fact, all of the presenting factors attributed earlier to Crawley (1984) are included in some form in Lavandero's "manifestations of burnout" (1981). If burnout implies and is characterised by "emotional exhaustion in which the professional no longer has any positive feelings, sympathy or respect for clients or patients" (Maslach 1977), then this too is possibly an important implication of this study, for the nursing profession and the people they serve.

The issue of nurses being 'impaired' by chemical dependency, was mentioned earlier, as was the fact that a number of authors have identified that a reaction to the pain of bereavement can be to turn to alcohol and/or drugs. Evidence

from America suggests that nurses are commonly affected with such problems. Estimates of the scale of the problem fluctuate around the 5-7% mark (Sullivan et al 1988; Kabb 1984), while Brennan (1991) asserts that dependence on drugs is 50% higher for nurses and physicians, than for the general population.

Few data are available on the scale of the problem in the U.K. Booth (1987) indicates that less than 25% of disciplinary actions taken against nurses in England and Scotland are related to alcohol or substance abuse - a significant proportion nonetheless. Furthermore as Sullivan et al (1990) conclude, reported cases to regulatory boards may only be the tip of the iceberg. This is not least because recognising and identifying the 'impaired nurse' may be very difficult because of the nature of the job - because of the level of trust placed in practitioners, and also due to the fact that such people may often move jobs regularly to avoid detection (Brennan *ibid*).

Therefore while the issue of alcohol and substance abuse were not examined directly in this study, it would seem reasonable to at least raise it here, as a possible ramification of complicated grief amongst nurses and midwives. Furthermore, as a meaningful area for further research associated with problems with grieving for 'professional copers' - not least because in their study, Kelly and Mynatt (1990) found that 34% of the chemically dependent nurses they surveyed (n = 77) perceived that loss by death had contributed to their dependence on drugs.

In summary then, data from this study considered alongside the literature, would seem to identify a potential for complications in grieving associated with an individual being a nurse, with a variety of possible manifestations.

The proposed theoretical framework.

The theoretical framework of 'potential causal routes of delayed grief reactions in nurses and midwives' indicated at the beginning of this discussion section is now presented, along with explanations of the perceived relationships between concepts, and how they may predispose bereaved nurses and midwives, to complicated grief.

The broad aim of the study was identified early in the research process, and expanded upon in the conceptual framework chapter. In essence the intention was 'to examine the idea that the processes of normal grieving can be impaired or complicated by virtue of an individual being a nurse or midwife'. This amounts to the relationships between factors in the personal and professional lives of nurses and midwives, which may predispose them to pathological grief when personally bereaved.

Given the complex and intricate nature of the 'matrix of concepts' envisaged, it is felt that a simple narrative will best facilitate the statement and thus sharing, of the relationships within this study, with the reader. The 'potential causal routes for complicated grief' amongst nurses and midwives is therefore postulated to be:-

The narrative.

A person, typically a female school-leaver, enters nurse training, having been selected partly on the grounds of their perceived suitability for the 'job', including being independent, dependable and level-headed. Professional socialisation (via the official and hidden curricula) further encourages the development of these traits. Experiential learning goes on, to 'acculturate' the neophyte into the norms of behaviour expected of them by the profession, including the importance of retaining self-control in difficult situations, and being a 'coper'. Role models display such 'attributes', often using cognitive and ego-defensive mechanisms to alleviate the stresses engendered, eg using verbal and non-verbal distancing techniques to prevent over-identification with patients and

relatives. Official curricula do little to encourage students to develop mechanisms other than these. They may also come to feel that the 'caring professions' are perhaps not as caring and supportive to each other as they profess to be towards patients and relatives.

Entry into nursing may also lead to the individual becoming the health care spokesperson for their social group, termed the 'family nurse' in this study. This may require them to be a first line of enquiry regarding all forms of pathology and illness, and that they take the lead in seeking information and the best care possible, for a hospitalised member of the family or social group. They may also be presumed to have expert knowledge regarding 'death and dying'.

Enacting the role of 'family nurse' when family or friends are hospitalised, can be seen as stressful. Not least because the individual has insight into what the staff may be thinking and feeling about them, and the realities of the control of information in hospitals. The decision to 'meddle' or not, therefore has to be taken. This may be further complicated by insight into the nature of the relative's illness, particularly if the prognosis is potentially poor. They may choose to keep this to themselves so as to avoid worrying others unnecessarily.

If the relative subsequently dies, the individual may then find him/herself cast in the role of 'tower of strength', holding stoic and firm whilst those around break down and grieve. Indeed **all** those concerned (including the nurse) may perceive this to be right and proper. The role of 'family nurse' therefore may preclude meaningful support from personal sources, at this time. This is unlikely to be alleviated by support from colleagues or supervisors at work, either because it is not offered, because it is not accepted, or perhaps a combination of the two. The internalisation of feelings is therefore necessary, and the expression of same may be delayed for such a time as to be considered a delayed grief reaction, i.e. > two weeks (Stedeford 1984), and possibly many years. This has been identified as having potential negative ramifications for somatic and

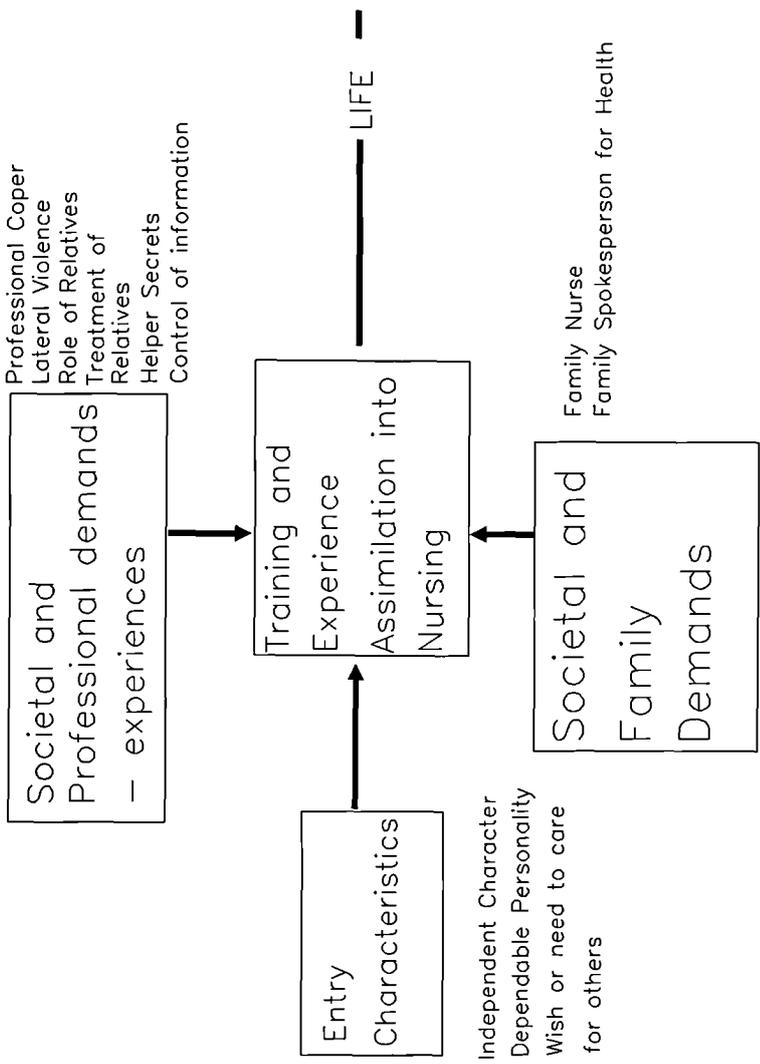
psychological pathology.

Feelings surrounding the death of their loved one may also be complicated by the presence of feelings of guilt that they did not do more, eg look after them personally, save their life, ease their pain etc - a further predisposing factor for pathological grief (i.e. ambivalence). They may also attempt to deal with their loss by a process of intellectualisation. However this will be an aberrant process as grievous loss requires emotional work for successful resolution to take place.

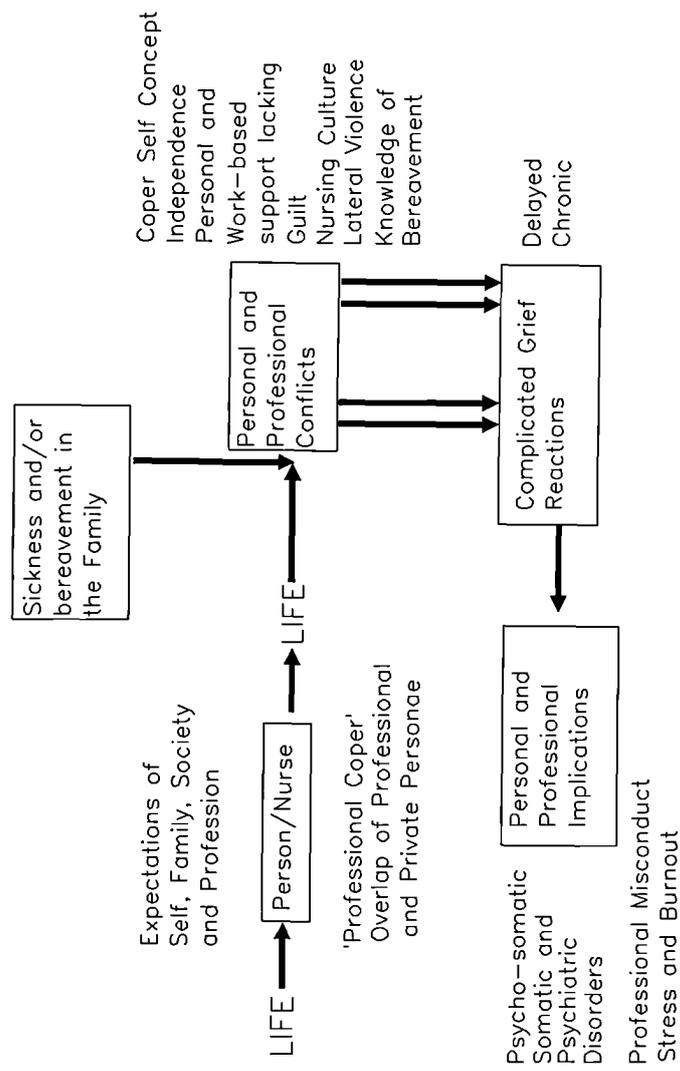
There are then, personal and professional implications of such problematic reactions. The personal has already been alluded to, in terms of somatic and psychological pathology, while professionally the implications are for the provision of humanistic care (including terminal care) by competent and knowledgeable practitioners, as well as the moral obligation to protect the rights and health of those very practitioners - not least because of the possible predisposition to 'burnout' and chemical dependency. The fact that internalised emotions may manifest as un-professional treatment of patients and relatives was referred to in the literature review.

A diagrammatic representation of the proposed theoretical framework is provided overleaf:-

Theoretical Framework.



Theoretical Framework - continued.



Limitations of the study.

There were a number of limitations to this study. Reasons for selecting the various tools and approaches were enumerated in the methodology chapter, as were their shortcomings, particularly the heavy reliance on self-reporting.

Several of the tools used were specifically developed in an attempt to measure certain concepts. This was felt necessary as existing tools often failed to examine relevant issues exactly enough. This has implications for the study as reliability and validity for such tools could not be established. There were attempts made to combat this however, for example interviewing respondents to questionnaire 1 to establish any influence of social desirability in their responses. Also the tools which were developed were based upon reliable and valid work of acknowledged experts in their various fields of study.

The fact that structured tools were developed and used at all, could also attract criticism to what was essentially an exploratory study. However, it was considered at the time that the personal experiences of the researcher, in addition to those of other bereaved nurses, and the literature on 'pathological grief', meant that the level of knowledge pertaining to the issues examined in this study, had in many ways advanced beyond the remit of such approaches. The data arising from the combination of structured approaches and unstructured interviews suggests that that was indeed the case. This is so because the concepts envisaged as relevant and important, presented in the conceptual framework, were corroborated through systematic study. Such study failed to elicit other pertinent issues. Furthermore, the possible effects of such issues as coping styles, social support and the role of the family nurse, on the grieving processes of nurses were also clearly examined, via the interviews with bereaved nurses and midwives.

The use of a convenience sample of nurses and midwives also imposed a limitation, as generalisation to the wider population of nurses and midwives is essentially precluded. However, tentative suggestions have been made based

upon the fact that the biographical details for both questionnaires appeared to reflect trends in this wider population.

A longer time-scale for collecting data could have increased the response rate for the questionnaires and allowed for more bereaved nurses and midwives to be interviewed. At the time this was impossible as the researcher only had 3 months for data collection before emigrating overseas. It was decided that cultural differences between the UK and Australia would complicate matters and so this was the time-scale available.

It is interesting however, to report that nurses in Australia identified greatly with the issues covered in the study, suggesting that many of the problems which nurses in this country perceive themselves to have, are actually global, perhaps in turn related to the issue of sex-equality.

This realisation, and the fact that the researcher has delivered papers at conferences and led discussion groups, both in the UK and overseas, based on findings from this study which have been very well received, would seem to suggest that while generalisations cannot be made due to the nature of the sample, one would be surprised to find data markedly different from that in this study, if the same or similar work was carried out elsewhere. Furthermore, the feedback received from other 'professional copers' at such conferences (Police Officers, Clergy and Doctors), suggests that this can be a problem for such people too.

On reflection therefore, the researcher considers that given the research climate which prevailed, and the level of knowledge available on the topic of bereavement in nurses and midwives (both at the time and now), the methods used, seemed most appropriate at the time, and in many ways continue to be so today.

Many changes have taken place in nursing since the data were collected, not

least the introduction of 'project 2000' style training programmes, with greater emphasis on academic preparation of nurses. It is also a fact that the respondents in this study had been prepared before such changes came to be employed nationally. Suggestions made may therefore relate more to 'traditionally' educated nurses, than those graduating from current day diploma courses. Systematic evaluation of the content, process and product of such courses, particularly with regards to interpersonal skills and caring for the dying and their relatives, would need to be carried out for this question to be resolved.

The 'system' within which most nurses work (the NHS) has also radically changed since data were collected, the most notable change being the introduction of 'Trusts'. Further work would also need to be done to see effects such changes have had on the issues examined in this study.

Finally, this was an exploratory study, with little being known about several of the issues under scrutiny. Further work must build upon this work, perhaps along the lines of the theoretical framework developed from this study.

The above section identifies another limitation of the study, in that only nurses and midwives were consulted. This means that direct comparisons with other caring professionals were not made, neither were they compared with the general population. The study retains its importance however, as the role of 'family nurse' and its potential for problems in personal bereavement as identified in the study, sets nurses apart from the rest of the population.

Recommendations from this study.

Having identified possible causal routes for complicated grief in nurses, and examined potential ramifications (both personal and professional) for same, it would now seem pertinent to make recommendations for action which could offset such a risk for nurses, whilst cognisant of the limitations of the study.

General/organisational recommendations will be offered first, followed by those aimed at individual nurses.

Recommendations regarding professional socialisation/acculturation via both the official and hidden curricula, can be made. Whilst the usefulness and attractiveness of cognitive strategies for coping with stress are acknowledged, there is an imperative to appreciate that they should not be developed and utilised, to the exclusion of other coping mechanisms. There is a recommendation therefore that nurses should be encouraged to develop a range of coping strategies, including recognising the need for reliance on others and seeking/accepting support at times, in both their private and professional lives.

One hesitates before suggesting that 'coping with stress' - for example by encouraging the expression of personal fears and feelings to peers, should be a taught component of pre-registration nursing and midwifery programmes. Not least because this in isolation from the 'real world' of clinical practice identified throughout this study, could leave individuals open to the 'reality shock' of ridicule, and potentially professional disadvantage in terms of career advancement. The recommendation is made therefore, that educational programmes for nurses, addressing the issues of professional carers coping with stress and emotions, within self and others, be devised. Such programmes should then be provided for all members of staff, i.e. not just those undergoing basic preparation or post-basic courses. This is vital as these people represent the mass who will socialise neophytes to the profession(s), as well as being in a majority within the health service, due the fact that post-basic education reaches relatively few people at present.

In turn, this should be **accompanied by** an attendant acknowledgment by the organisation (i.e. managers, including nurse managers) of the stressful nature of the work. This would be characterised by for example:-
an acceptance that problems (including personal problems) **may** impinge upon and influence, the working lives of nurses - whether they wish it to or not.

Furthermore, that such people should be offered the necessary support, rather than be considered a non-coper and be potentially disadvantaged in the future; an acknowledgment that the 'organisation' has a role to play in recognising and alleviating stress for its people, rather than seeking to make people 'fit' environments and encouraging individuals to find personal solutions (e.g. meditation or relaxation techniques), to what are often organisational problems such as poor communications and lack of role clarity; the provision of comprehensive, independent counselling and support services for all staff would be a start. This would of course still be affected by the reticence of 'professional copers' to access such services.

Universal encouragement to utilise them, particularly during times of personal and professional stress could overcome such reticence, as could a system of routinely offering support to staff at such times as family bereavement. It is a truism that it would take time and word-of-mouth testimonies of efficacy and confidentiality, to break down the barriers for many. This perhaps is the only way that such programmes will become effective.

It was stated earlier, that the public could be said to have a right to expect its 'professional copers' to be calm and collected in a crisis. Indeed it can be vital that they be so in emergency situations. Perhaps the important thing therefore, is for such professionals to recognise that this cannot always be the case (even at work).

Alongside this, is the need to acknowledge that cognitive coping strategies such as distancing and evasion, which are un-arguably effective as defences against personal involvement with clients and ensuing anxiety, tend not to be effective when used to deal with personal emotional problems such as bereavement.

At the same time, 'organisations' (peers and managers) need to demonstrate an acknowledgment and acceptance of this, by providing opportunities for nurses to deal with their problems and emotions effectively, whilst retaining public

confidence in them and the services they provide. In other words, there should be opportunity and encouragement for nurses to unload the emotional burden of their work (at least), within a safe, structured and supportive environment - akin to the idea of counsellors themselves being counselled, to protect their own mental health.

The enactment of such recommendations would also mean that individual nurses, could reasonably assert rights which they would obviously like to have, given the data from the ideal v actual questionnaire. For instance, the right to admit to fallibility, from time to time.

Besides the issue of coping with stress, other recommendations regarding the content of official nursing curricula can also be made. Again the issue of educating the **whole** work-force and not just student nurses applies here, given the realities of professional acculturation.

Most obvious, is the need for more meaningful coverage of issues related to death and dying, and dealing with emotions in both the self and others. Here, **meaningful** refers to issues such as overtly seeking to develop inter-personal skills, rather than merely talking of their importance; encouraging the development of a personal concept of therapeutic nurse-patient relationships; internalising and using the work which has been done on 'breaking bad news'; and, crystallising the emotional realities of grief and bereavement for nurses, rather than having them 'knowing about' for example, Kubler-Ross's stages of dying in an intellectual vacuum. Only in this way will we begin to see such attributes of 'expert practice' being regularly role-modelled to neophyte nurses in clinical practice.

This of course will also require that such skills become more valued by both the organisation and the profession(s), than they apparently were for respondents in this study (see chapter 5, section E).

Particular emphasis could also be placed on the difficulties encountered by nurses when they or a relative, receive care. This would not only sensitise staff to the stress that 'family nurses' may be experiencing, but also perhaps ameliorate the anxiety and awkwardness they have been identified to feel, in this study. It might also improve the care of bereaved relatives both in general, and in particular with regards such issues as the way in which they are informed of their relatives death, and how they are shown the body of the deceased. In practice, this could be attended to, merely by encouraging discussion of these issues amongst nurses and the agreement of common approaches, policies and procedures.

In turn, consideration of such issues, could act as a catalyst for nurses to truly come to articulate and value their unique contribution to health care. A corollary of such positive self-belief, could then be, not only the demise of oppressed group behaviour within the profession(s), but also less of a sense of insecurity when being observed in practice by others, leading potentially to improved communications between nurses and patients/relatives - including those who are also nurses.

It could also mean that as nurses become more adept at being meaningfully involved with their clients on an individual, perhaps emotional level, the environment of hospital care will evolve to be more one characterised by humanistic, patient-centred principles, than by a commitment to 'getting the work done'.

Any or all of these recommendations would, one feels, bring about a meaningful change in the professional culture of nursing and ameliorate at least some of the stresses of being a nurse or midwife in contemporary society, which have been articulated throughout this study. One can also recognise however, that such changes would require an alteration in mind-set on behalf of organisations and managers and the nursing profession, of epic proportions.

It is with this pragmatic perception, that the researcher makes a further recommendation, which would at least minimise the professional implications of nurses being predisposed to complicated grieving. Namely that staff at all levels of the organisation, should be aware of the potential for stress and subsequently burn-out and chemical dependency, which may be associated with a situation such as family ill-health and/or bereavement amongst professional nurses.

Furthermore, that they should recognise their professional, moral and legal responsibilities to identify persons in such a situation to the relevant authorities, for the protection of patients/clients in their care.

These then have been general recommendations, typically directed at the organisational level. More specific recommendations for individual nurses - particularly on how to best mitigate against their own risk of complicated grief when personally bereaved, can also be made.

It was identified in the conceptual framework chapter, that nurses may be unaware of the nature of the professional culture within which they work, and which shapes and guides their thoughts, attitudes and actions. It is recommended therefore, that individual nurses should reflect upon and identify, the degree to which their professional socialisation may have reinforced entry characteristics (particularly their sense of independence, their self-concept as a 'coper', and their unwillingness to accept help when offered), which may predispose them to complicated grief.

This will of course be easier for some professionals than others, given the implicit need for a significant level of self awareness alongside insight into the culture. It is hoped that a study such as this will offer not only the cultural insights, but also material on which individuals might reflect, and subsequently lead to a recognition of aspects of self previously 'hidden' to them.

A similar recommendation can also be made regarding a recognition of the problematic nature of the role of the 'family nurse', during family ill-health and/or bereavement. Having considered this, individuals may still choose, and/or be expected to, retain the role of 'family nurse' and all this has been shown to entail. It has in fact, been argued elsewhere in the study that this may be necessary within a family bereavement. It is important however, that such professionals appreciate that they too have a need to work through their grief, and that they must either assert this right within their family group at a time deemed reasonable, or that they give themselves 'permission' to meaningfully work through their feelings in some other forum - perhaps a counsellor in some form.

It is also a possibility, that individuals could still enact the role of 'family nurse', yet not assume **all** responsibilities during times of family ill-health and/or bereavement. It was seen in the interviews with bereaved nurses and midwives for example, that information regarding diagnosis and prognosis, was often kept from the family (and even the patient) by the family nurse. Surely this is not a necessary aspect of the 'tower of strength' role, and could be shared with others.

This of course would require that those involved would not be governed by custom and practice and 'lay' attitudes towards such issues. In other words, they would have to believe that such knowledge is best out in the open, allowing as it does, that those involved can at least begin to acknowledge and resolve their grief. Given the data in this study, this is not commonly the case.

On the face of it, all this may seem to be easy advice to give. However it is acknowledged by the researcher that in practice it will be difficult to enact, given the myriad of factors which culminate in an individual becoming the 'family nurse', present day attitudes towards death, and the expectations of self, families and wider society.

It is also a truism that no-one other than nurses themselves will assert their right to do these things. The need for self-empowerment and personal acknowledgment of their own human rights unavoidably underpins these recommendations. Nonetheless, for the future mental-health of nurses it is important, even vital, that they do so.

These are perhaps the most important recommendations, as recognising that they may be so predisposed, means that individuals will *ipso facto*, have acknowledged that they are not infallible and independent of others. This will allow them to consider ways of mitigating against isolation and internalising negative emotions when bereaved. As a result they can begin to assert their rights and needs as an individual as well as a 'professional copier', both at work and at home.

Earlier, recommendations were made regarding the need for health organisations to be more supportive of their staff. There is also scope of course, for individual professionals to be more caring and concerned towards fellow workers - a move away from the 'horizontal violence' said to characterise relationships between nurses. It was apparent from the interviews with bereaved nurses and midwives, that when this had been available to them it had helped them to deal with their grief.

Unfortunately it was also identified that this was not common, and that the chances of it happening was diminished by the common practice of rotating staff around units and hospitals. The fostering of supportive relationships with like-minded professionals, as a form of co-counselling, is therefore also recommended. This may of course, be organised by individuals and/or organisations, and as such can be seen as an insurance policy against the negative sequelae of being one of society's 'professional copier' groups.

Implicit in this also, is a recognition that an extreme personal sense of independence can be problematic and should be avoided. Seeking and fostering

such supportive relationships and the possession of an extreme personal sense of independence, can be seen to totally incompatible. Accepting the support of others can therefore mitigate towards successful grief resolution.

Finally, as with the more general recommendations made earlier, there are two final suggestions which should be enacted upon, even if all else remains the *status quo*:- that individual nurses should recognise their possible predisposition to problematic grieving, and be prepared to admit it, at least to themselves, if or when it should happen to them. In this way, they will at least be able to seek the help and support they need, to give voice to their grief and in turn help resolve it; and that nurses should empower themselves, and assert their rights within their personal social groups (at least) to both offer **and** receive, social support - particularly during grieving. In a nutshell, to allow themselves to feel that it is okay to expect to be treated like any other human being, and not always as a 'professional coper'.

Summary of key findings from the study.

It was intended that the impact of professional socialisation, on the reinforcement of certain personality traits and patterns of behaviour within individual nurses would be examined in this study. This included both overt and indirect consideration of aspects of nursing culture, particularly with regards to its effects on the coping mechanisms commonly used by nurses; the reinforcement of a perception that professionals such as nurses are 'on duty' 24 hours a day if 'society' needs them; and the reality of social support available to nurses. Also to examine the role of the 'family nurse', and its implications when a family member is ill or dies.

Multiple examples of triangulation of findings between the questionnaires and the interviews were found to exist - as planned. This triangulation was found to both corroborate findings from a variety of perspectives, and provide coverage of all seemingly important issues - that is, if one tool didn't pick up on a

particular point, then another invariably did. Thus the stated intentions of identifying and describing predisposing factors to complicated grief amongst nurses, along with an exploration of relationships between them and potentially negative outcomes which were outlined in the methods chapter, were successfully achieved. As was the feeling of gestalt intended from the combination of structured and semi-structured questionnaires and interviews.

Discussion of the success of individual tools in achieving their individual intentions, were covered in their respective discussion sections and will not therefore be replicated here.

The impact of professional socialisation on individuals:

Nurses and 'coping'.

It was identified by a combination of the coping strategies tool, 'coping' items from sections E and F (questionnaire 1), and both sets of interviews for example, that there was a probability that the nurses would tend to value and hence develop, intellectual and ego-defensive coping strategies. It was then asserted that given the literature on 'coping', they would tend to 'over-learn' such strategies to the degree that they relied on them at all times, as most people tend to rely on certain approaches they find useful and effective. As a corollary of this, nurses would tend not to possess coping strategies which are of much use when personally bereaved. Indeed they may actually complicate the grieving processes for the individual, based as they are on avoidance, denial and emotional distance from the deceased.

Furthermore, it is probable they would tend to stifle their expression of grief to others, as they are not used to doing this. Neither would it be expected, or perhaps even tolerated of them, by others.

Data from questionnaire 2 suggested that reliance on such mechanisms, was as much a result of poor educational preparation in such areas as interpersonal skills and the care of the dying (the official curriculum), as it was related to a

'cope' and 'stay in control at all costs' ethos of nursing culture (the hidden curriculum), which was found to exist. There was also a tacit assertion that many respondents subscribed to the 'popular view' of 'good' coping as connoting control and/or suppression of affect.

Data from sections E and F of questionnaire 1 particularly, identified that the expectation of nurses to retain self control at all times, was not only held by self but also perceived to be held by other professionals, and perhaps even more so by the public.

Furthermore, these nurse and midwives at least, seemed committed to fulfilling such expectations 'at all times', even though this is patently unachievable, thus sentencing them to almost certain failure and ensuing negative feelings about self as both a nurse and a person (TST/OCT).

The role of nurses as 'professional copers' was thus identified, and found to be predominant amongst respondents. That is, most felt themselves to be such creatures.

Nurses and independence.

Both the follow-up interviews, and those with bereaved nurses and midwives, produced data which suggested that it was quite common for such professionals to assert their dislike of dependence on others, and to be of the opinion that it was others who depended on them. The majority of those interviewed (both interviews), and the literature, suggested that it was not uncommon that 'independent' people were drawn and even encouraged into the nursing profession.

Furthermore, they seemed to prefer and even encourage this, for example within their family and in patients. Unfortunately this 'pre-determinant to complicated grief' was only successfully examined in these interviews. It did seem to be important for the majority of those interviewed however, and had invariably

impacted on their feelings and behaviours when bereaved.

The relationship between the personal and professional personae of nurses and midwives.

It is apparent from certain of the above, that the relationship between the personal and professional personae of nurses was relatively successfully quantified by the study. For example responses in sections E and F of questionnaire 1 suggested that respondents felt that they were expected by self, by other nurses, and by the 'public', to be cool, calm and collected 'professional copers', at all times. This while data from the TST/OCT, reinforced the overlap of the personal and professional traits of nurses, not least the view of good woman/good nurse.

It would seem reasonable to suggest therefore, that many of the respondents to this study, would find themselves expected to be a nurse 24 hours a day. Furthermore, for some this was already a strain (sections E and F), while for others it was a natural corollary of their being a nurse but for whom it may become problematic when personally bereaved.

The role of the 'family nurse'.

This leads to the realities of being the 'family nurse', a role which was also successfully examined in this study. Data from questionnaire 2 particularly, highlighted the very real potential for role conflict, for a person attempting to play the role of 'family nurse' whilst visiting in hospital.

The overwhelming impression was one of unease and anxiety on the part of both attending staff, and the nurse visitor. Only two of those interviewed perceived that the care of their relative had warranted need for their intervention (though few felt that it had been ideal), neither did complain and this made them feel guilty. This meant that few, if any, had experienced the conflict of breaking the rules of relatives' behaviour, which were clearly identified by data from questionnaire 2. It is unclear as to whether this was because it had been

unnecessary (i.e. care was good), or because they had felt impelled or intimidated not to do so.

Other than the two people above, if guilt was felt then it was with regards the fact that interviewees had not cared for their relative personally, rather than them be admitted to hospital. The fact that this was patently impractical for most, did not seem to have made much difference. Impracticality had not deterred several nurses from caring for dying relatives however, as data from the interviews with bereaved nurses and midwives showed the degree of commitment to the family nurse role extended to carrying out last offices, for some.

The main ramification of being a 'family nurse' is perhaps more akin to the issue of social support, which in turn was explored in various ways throughout the study with regards both its perceived availability and nurses willingness to accept help even when it is offered.

Social support and nurses.

The social support questionnaire clearly identified that the respondents perceived social support, to be available only from 'personal' sources, and even then this was only emotional support to any meaningful degree. It was however apparent from data in sections E and F from questionnaire 1, and both sets of interviews, that in the circumstances of family ill-health or death, the family of nurses tend to expect them as the 'family nurse' to stand firm and provide such support to them. That is, to act as the tower of strength for the family. Thus in such circumstances, even emotional support would be lacking for the family nurse.

Furthermore, this would not be ameliorated by support from work sources, as they were poorly rated as a source of positive support by respondents in the social support tool, and the cultural expectations of being cool, calm and collected at all times - but particularly at work, would preclude this. This also

led to the conclusion that the overlap of the personal and professional personae of nurses, is typically only one of the professional into the private.

The respondents' willingness, or otherwise, to accept support when offered, was overtly considered by questions referring to accessing confidential counselling services, in the social support tool and sections E and F of questionnaire 1, and also within both sets of interviews.

Interestingly, many respondents said that in an ideal world they would do so, however far fewer said that they would do so in reality. This was seen in the interviews, to be a reflection of possible fears of a lack of confidentiality of such services, as well as a reluctance to seek help due to being an independent person. Also the possibility that counselling and the like, was for 'other people' who were perhaps unable to cope.

Such data, along with that from the interviews, gave the strong impression that a culture does exist, which discourages nurses from discussing personal or even emotional issues with work colleagues or superiors, this for fear of being considered weak or un-professional, which could be held against them in the future.

It was also apparent however that bonds of trust can be developed, particularly between peers, and that these can be very supportive and thus beneficial in times of personal or professional stress. The passage of time together was seen as the crucial in this regard however, and the practice of regularly moving staff around units and hospitals was seen as mitigating against this for many people.

All in all therefore, it would seem that the issues related to social support and nurses which were intended to be examined at the outset, were indeed examined. This whilst serendipitous data such as that associated with moving staff was also elicited. This highlights once again the benefits of the use of a

mixture of data collection methods, and the triangulation of findings.

The main conclusion regarding social support therefore, is that it would seem quite likely that a nurse could very well find herself lacking meaningful social support, when personally bereaved.

Therefore the aim of the study - *'To examine the idea that the processes of normal grieving can be impaired or complicated by virtue of an individual being a nurse or midwife'*, was achieved. This by successfully examining the concepts identified in the conceptual framework chapter, and the relationships between them.

It would seem therefore, that there are distinct possibilities that nurses could have difficulty in successfully grieving for a dead loved one, due to the fact that they are such a professional, and the expectations held of them by self, their family, their profession, and by wider society. Typically this would manifest as a delay in the onset of the grief.

The study can also be seen to have been successful, in light of the fact that no other major areas of concern related to the experiences of respondents as *'family nurses'*, and in particular at times of personal bereavement, were identified. This being in spite of opportunities for doing so being spread liberally throughout the study via open-ended questionnaires and relatively un-structured interviews. This would seem to demonstrate the strength of the conceptual underpinnings of the study.

Perhaps it also indicates that it may be an example of empirical research examining the "swampy lowland" (Schon 1983) of peoples' real lives, and particularly in this case, quantifying aspects of nursing culture which previously may have been hidden, even to those within it. Exploring the "high hard ground" (ibid), perhaps by abandoning the wide range of methods used, or even concentrating on one particular aspect of the conceptual framework would have

been much easier to undertake. This would certainly have been the case in terms of time and effort, however it would have produced an outcome of far less meaning and use, to nurses and nursing, and those who come into contact with them.

Summary of recommendations.

That nurses be encouraged to develop a range of coping strategies, to be used appropriately in both personal and professional settings.

That educational programmes for nurses be devised, to address the issues of professional carers coping with stress and emotions, within self and others. Such programmes should then be provided for all members of staff, i.e. not just those undergoing basic preparation or post-basic courses.

That there should be opportunity and encouragement for nurses to unload the emotional burden of their work, within a safe, structured and supportive environment - 'counselling for the counsellors'.

That issues such as dealing with the dying and their relatives, interpersonal skills training, breaking bad news and the emotional realities of grief and bereavement, be more meaningfully covered in preparation and in-service training programmes. Furthermore, that such related skills be more highly valued by organisations and the professions.

That hospitals and their staff consider the way in which they deal with relatives - particularly those who are bereaved, and identify ways in which this could be improved. This would obviously include the procedures and practices for breaking bad news, and also for viewing the body on wards or units.

That working nurses should recognise the unique difficulties of being a 'family nurse' (and indeed a patient), and consider ways of alleviating them. For

example, by meaningfully exploring the visitor's knowledge in the area, rather than presuming that they know and understand everything. Also by appreciating that their asking questions, is not necessarily a criticism of staff and treatment, but may be their attempt to meet the perceived needs of their family and the role of the 'family nurse'.

That staff at all levels of the organisation, should be aware of the potential for stress and subsequent predisposition towards burn-out and chemical dependency, which may be associated with a situation such as family ill-health and/or bereavement amongst professional nurses. Furthermore, that they should recognise their professional, moral and legal responsibilities to identify persons in such a situation to the relevant authorities, for the protection of patients/clients in their care.

That individual nurses should reflect upon and identify, the degree to which their professional socialisation may have reinforced entry characteristics (particularly their sense of independence, their self-concept as a 'coper', and their unwillingness to accept help when offered), which may predispose them to complicated grief.

That individual nurses should recognise the potentially problematic nature of the role of the 'family nurse', during family ill-health and/or bereavement, and appreciate and meet their own mental health needs as a person as well as a nurse.

That individual nurses empower themselves when enacting the role of 'family nurse and/or patient, and allow themselves to admit to staff and relatives, when they do not understand aspects of care and treatment. Also to expect that staff explain **fully** what is going on to them or their family, without being intimidated by fears of being considered or labelled, incompetent or unprofessional. In other words, to expect at least, the same care and consideration which is (claimed) to be given to other (non-nurse) patients and

relatives.

That nurses foster supportive relationships with like-minded professionals, both by offering and accepting support to and from, such people.

Suggestions for further research in light of this study of personal bereavement in professional carers.

Some suggestions have already been made, namely that entry characteristics of nurses should be examined further, perhaps along with longitudinal studies of how professional socialisation reinforces traits such as independence and the 'need' to be in control and a 'coper'. This would also allow quantification of the degree of overlap of the professional and personal personae of nurses, which was identified in this study.

It would also be enlightening to discover (perhaps by observation), if the relationship between over-valuing certain types of coping (in this case, cognitive mechanisms) and their over-usage, is confirmed as fact, rather than educated opinion. Examination of what meaningful alternative coping strategies might be, and how they might best be developed, is also required.

Studies comparing the incidence of factors predisposing to complicated grief amongst the general population with the nursing population, would also be very useful. However it should be acknowledged that the role of the 'family nurse' and societal expectations of 'professional copers', would still make this an issue of importance and concern for professionals, even if predisposition in all other areas were the same. Further research on the particular problems of nurses and midwives, when they are consumers of health services, is also recommended.

Comparative research examining perceived self, professional and societal expectations of other 'professional copers', e.g. emergency service staff and doctors, would also be useful.

An extension of the work undertaken in the interviews with bereaved nurses and midwives, would also be useful and informative. A larger sample would obviously be beneficial. As would be formal consideration and assessment, of the incidence of complicated grief present, and the form(s) it commonly takes. This would serve to confirm or refute the suggestions made in this regard, in this study.

Further work on support groups for nurses also needs to be undertaken, both with regards to the form they should take to be most effective, and also how such professionals could best be persuaded of their potential benefits.

Studies aimed at improving person/environment fit, so as to decrease the stresses incurred in this way, are also recommended. Unlike the majority which have already been undertaken however, it is suggested that more of a focus be placed upon the examination and modification of the environment, rather than concentrating on modifying individuals to fit the environment.

It seems almost obvious to suggest that evaluative research on maximising the impact of educational input (such as interpersonal skills training, and therapeutic use of self), being translated into practice. To this point, little has been done in this regard, as studies in the area have tended to reflect on content and students' stated intention to utilise such material, rather than actually evaluating its use in practice.

Related to this, is the work which needs to be done to examine and explain more fully, the feelings of discomfort many nurses apparently experience when being watched - particularly by people with professional insight, such as other nurses. This may in time, provide a means to resolve or alleviate such feelings, and so enhance professional-client relationships.

It was also identified earlier that research needs to be undertaken, which examines the effects of changes in the educational preparation of nurses

(specifically pre-registration), on skills particularly related to caring holistically for the dying and their relatives, and also conformity with norms of behaviour once qualified. This would allow the implications of data and recommendations from this study, to be considered for nurses prepared pre- and post-project 2000.

Further work on oppressed group behaviour amongst nurses would also be useful, as much of the literature in this area is anecdotal in nature. It would be interesting to examine for example, how widespread is horizontal violence. Also the incidence of negative orientations towards 'rank and file' nurses amongst nurses managers, to see if it can go at least some way towards explaining the high level of antagonism towards them, and the apparent disregard that many have for the well-being of their staff.

There is also a general need for research to be undertaken, on maximising the use of research findings in practice.

Concluding comments.

Becker (1975) makes the point that "in order to turn out a piece of work, the author has to exaggerate the emphasis of it...to oppose it in a competitive way to other versions of the truth [and in doing so] he gets carried away by his own exaggeration".

The researcher acknowledges the fact that not **all** nurses **will** have all, or indeed any, of the factors said to predispose to complicated grief, although the experience of the Sister detailed in the 'exemplar interview', highlighted the very real chance that they indeed may do so. Data from throughout the study highlighted for example, that the more extreme sense of independence and 'coper' self-concept appeared to exist amongst those who entered the profession with such traits, and that not **all** nurses necessarily developed them with professional socialisation. Why this is so remains unknown. Some

participants occupied the role of 'family nurse' but not to the degree that it delayed the onset of their grief 'pathologically'. Some nurses felt supported at work by colleagues and to a lesser degree, managers. For some, the personal experience of bereavement had apparently led to meaningful reflection and introspection, and an ensuing empathy for the feelings and needs of the dying and their relatives, but not in all.

All this points to the fact that complications in grieving are not **necessarily** a natural and unavoidable corollary of being a professional carer such as a nurse, but that there are apparently a number of ways in which this can be so.

Furthermore, there are already in existence, models of ways in which individual nurses, their families, and the organisations which employ nurses, can work to minimise the risk of complicated grief for them - again indicated via both sets of interviews.

It is to be hoped that this study will go some way towards persuading such people and organisations, to consider themselves in the light of the study findings, and act upon recommendations made, which are pertinent to them.

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Appendix One

Dear colleague.

The following bank of questionnaires, are part of a larger study of the factors affecting grieving and mourning in nurses.

The various sections of the document examine different factors that have been identified as affecting the satisfactory resolution of loss.

Please complete all the sections as honestly as possible, safe in the knowledge that all replies will only be seen by myself, and therefore total confidentiality is assured.

In order to follow up some of the issues in more detail, I would also like to a limited number of respondents on an individual basis. If you are willing to participate in this part of the study, please give your name and an address or telephone number at the end of the booklet, so that I can contact you to make an appointment.

I will be present while you complete the forms, so do not hesitate to ask if there is something you do not understand.

THANKYOU FOR YOUR PARTICIPATION.

PATRICK. A. CROOKES.

1. Age	21-25 years	1	
	26-30 years	2	
	31-35 years	3	1
	36-40 years	4	
	41 and over	5	
2. Sex	Male	1	2
	Female	2	
3. Rank and grade	Staff nurse D	1	
	Staff nurse E	2	3
	Staff nurse F	3	
4. Length of time in present position	0-6 months	1	
	7-12 months	2	
	13-18 months	3	4
	19 months-2 years	4	
	2-4 years	5	
	over 4 years	6	
5. Length of time in Nursing (since qualification)	0-6 months	1	
	7-12 months	2	
	13-18 months	3	
	19 months-2 years	4	5

	2-4 years	5	
	over 4 years	6	
6. Professional qualifications: (circle more than one if relevant)	RGN/SRN	1	6
	Dip. Nursing	2	7
	Degree in Nursing	3	8
	Other (please specify)	4	9
Studying for further qualifications?	Dip. Nursing	1	10
	Degree in Nursing	2	11
	Other (please specify)	3	12
7. What is the primary type of patient with whom you work? (circle one only)	Medical	1	
	Surgical	2	
	Paediatric	3	
	Elderly	4	13
	Neuro	5	
	Trauma	6	
	I. C. U.	7	
	C. C. U.	8	
	Other (please specify)	9	

8. "Grief is the characteristic response to the loss of a valued object, be it a loved person, a cherished possession, a job, part of the body etc." (Engel 1961).

Whilst mourning is "The process through which grieving people must pass to re-establish a state of health and well-being" (IBID).

Given these definitions, would you say that you have ever grieved and been through a mourning process?

Yes	1	
No	2	14

If yes, who or what was your loss?

Role Models in Nursing.

The following questions(1-3)concern role models in nursing.
by role model we mean a person that a nurse wishes to pattern him/her-
-self upon,because the role model is capable of providing high quality
patient care.

1. Who would you identify as being your primary role model for providing
quality nursing care? (indicate one only)

<input type="checkbox"/> Staff nurses	<input type="checkbox"/> Nurse Tutors	
<input type="checkbox"/> Ward Sisters	<input type="checkbox"/> Clinical nurse specialists	15
<input type="checkbox"/> Nurse Managers	<input type="checkbox"/> Other (please specify)	

2. Under ideal conditions,who do you think should function as the
primary role model for student nurses? (indicate one only).

<input type="checkbox"/> Staff nurses	<input type="checkbox"/> Nurse Tutors	
<input type="checkbox"/> Ward Sisters	<input type="checkbox"/> Clinical nurse specialists	16
<input type="checkbox"/> Nurse Managers	<input type="checkbox"/> Other (please specify)	

3. Consider your answers to the above questions and describe the
factors you feel those people possess,that makes them an ideal
role model.Of all the factors,which do you feel is the most
important?

17

This questionnaire aims to examine the methods you commonly use to cope with difficult situations and stressors.

Please consider these statements, which cover a wide variety of the methods commonly used, and then indicate on the grading scale provided, the extent to which each one describes your attitudes and/or responses to the pressures of work.

	very true	quite true	some- what true	not very true	not at all true	
1) I stand back and try to rationalise situations.	5	4	3	2	1	18
2) I become more involved in non-nursing activities--hobbies, leisure etc.	5	4	3	2	1	19
3) I express my irritations and frustration to myself--swearing, slamming things down etc.	5	4	3	2	1	20
4) I sometimes get mad at myself because I could have avoided the situation.	5	4	3	2	1	21
5) I forget work when I have finished for the day.	5	4	3	2	1	22
6) I tend to smoke more when I am under stress.	5	4	3	2	1	23
7) I try not to become too close to patients and relatives.	5	4	3	2	1	24
8) I try to cheer myself up by thinking about my days off.	5	4	3	2	1	25
9) I try to anticipate problems before they arise.	5	4	3	2	1	26
10) I am often reassured by the fact that other nurses are feeling the same way as I am.	5	4	3	2	1	27
11) I find myself picking faults and blaming other people.	5	4	3	2	1	28
12) I find myself going over the same problem in my mind over and over again.	5	4	3	2	1	29
13) I say to myself "well that's the job" and get on with it.	5	4	3	2	1	30

14)I have a few drinks to help me unwind,from time to time.	5	4	3	2	1	31
15)I try to think objectively about situations and so act in a calm,rational manner.	5	4	3	2	1	32
16)I use relaxation techniques such as yoga and meditation.	5	4	3	2	1	33
17)I sometimes snap at colleagues when i'm under pressure.	5	4	3	2	1	34
18)I sometimes reassure myself that everything is going to be okay.	5	4	3	2	1	35
19)I have taken the day off,because i can't face the thought of work.	5	4	3	2	1	36
20)I try to be as organised as possible.	5	4	3	2	1	37
21)I find that a bit of peace and solitude helps me to unwind.	5	4	3	2	1	38
22)I sometimes become a little self-righteous about the amount amount of work i have done.	5	4	3	2	1	39
23)I try not to let things get to me by refusing to think about it too much.	5	4	3	2	1	40
24)I dont like it when people get concerned about the pressures i am under.	5	4	3	2	1	41

The following sixteen statements describe situations when support might be needed by an individual. Please examine them, and then on the matrix provided indicate the degree of support which you would expect from the sources identified, or the degree to which you agree with the statement.

The degree of support should be assessed using a scale of one to five (1=not at all/doesn't exist;5=a great deal).

Example:-

When i'm down i can rely on --- for encouragement.

- 1)How much does this person make you feel liked or loved?
- 2)How much does this person make you feel respected or admired?
- 3)This person keeps me informed about how well i am functioning in my job.
- 4)This person will always show me how to do things if i don't know,without making me look stupid.
- 5)If i was finding work particularly difficult for a time,i could expect this person to notice and agree that i should be reassigned temporarily to a less demanding area.
- 6)I could trust this person with my secrets.
- 7)This person lets me know exactly what is expected of me.
- 8)This person is willing and able to provide me with sound career advice.
- 9)If i didn't feel well,i could expect this person to be sympathetic and perhaps send me home.
- 10)Any advice given by this person is essentially helpful and constructive.
- 11)If a close friend died,this person would agree that i should be allowed time off to attend the funeral.

	Spouse/Partner	Relative	Friends	Work Supervisor	Co-Workers	Others (Specify)
	1	4	3	1	2	1
1)How much does this person make you feel liked or loved?						
2)How much does this person make you feel respected or admired?						
3)This person keeps me informed about how well i am functioning in my job.						
4)This person will always show me how to do things if i don't know,without making me look stupid.						
5)If i was finding work particularly difficult for a time,i could expect this person to notice and agree that i should be reassigned temporarily to a less demanding area.						
6)I could trust this person with my secrets.						
7)This person lets me know exactly what is expected of me.						
8)This person is willing and able to provide me with sound career advice.						
9)If i didn't feel well,i could expect this person to be sympathetic and perhaps send me home.						
10)Any advice given by this person is essentially helpful and constructive.						
11)If a close friend died,this person would agree that i should be allowed time off to attend the funeral.						

- 12) How much can you confide in this person?
- 13) I can talk confidentially and without fear to this person, about work-related problems
- 14) There would be no argument from this person if I needed a little extra personal time off work.
- 15) I am regularly made to feel that I am doing a good job by this person.
- 16) This person is someone, other than myself, whom I know shows interest in my future career prospects.

Spouse/Partner	Relative	Friends	Work Supervisor	Co-Workers	Others (Specify)

Instructions.

Please consider the following statements and situations about nursing.

You are asked to indicate the degree to which you agree or disagree with the statement

Try not to let your answer to one question influence your answer to other questions. Give your opinions; there are no wrong answers; there is guaranteed confidentiality.

Indicate the degree to which you agree or disagree with the statement by ticking one of the possible answers, these are:-

STRONGLY AGREE indicates that you agree with the statement with almost no reservations.

AGREE indicates that you agree with the statement with some reservations

UNDECIDED indicates that you could either agree or disagree with the statement with about an equal number of reservations in either case.

DISAGREE indicates that you disagree with the statement with some reservations.

STRONGLY DISAGREE indicates that you disagree with the statement with almost no reservations.

Example:-

Staff nurses believe that doctors are more professional than nurses.

N.B. For reasons of grammatical expediency, the female gender is used throughout this section.

- 1) A staff nurse tries to put her standards and ideals about good nursing into practise, even if hospital rules and procedures prohibit it.
- 2) A staff nurse does not do anything which she is told to do unless she is satisfied that it is best for the welfare of the patient/relatives.
- 3) If a staff nurse failed to cope with a difficult situation, it would not reflect on her badly at a later date.
- 4) Nurses are in an ideal position to act as the spokesperson on health matters for their own family.

STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

- 5) Staff nurses try to live up to what they think are the standards of their profession, even if other nurses or supervisors don't seem to like it.
- 6) Staff nurses spend more time at bedside nursing than any other nursing task.
- 7) Sisters and doctors allow staff nurses to tell patients (and relatives) as much about their physical and emotional condition as the nurse thinks is good for them.
- 8) Staff nurses would welcome the freedom to tell patients (and relatives) the above.
- 9) Doctors and senior nurses at the hospital, respect and reward nurses who spend time talking to patients meaningfully.
- 10) A staff nurse who believes that a patient ought to be referred to a psychologist would try to convince the consultant of this, even though he disagrees and makes this very obvious.
- 11) A nurse's ability to understand the psychological and social factors in the patients' background is regarded as more important than her knowledge of such nursing skills as giving drugs, dressing wounds etc.
- 12) It is important that a nurse is able to govern/ manage disturbing personal emotions in herself.
- 13) A doctor orders a patient to sit out in a chair twice a day, but a staff nurse believes he is not emotionally ready to do so, the doctor would respect her opinion and change the order.
- 14) Nurses' families expect them to explain what is going on when a family member is sick.
- 15) It is important that nurses display stability and endurance under pressure.
- 16) Nurses should not be affected by the death of a patient.
- 17) The staff nurses who are most admired are the ones who are realistic and practical about the job, rather than the ones who attempt to live according to idealistic principles about serving humanity.

STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

18) Nurses are professionals seen as dependable and able to cope by the public.

Now consider another set of statements and situations about you and nursing. This time you are asked to indicate both:-

A) The extent to which you agree or disagree with the statement from an ideal point of view.

and

B) The extent to which you agree or disagree with the statement from your personal point of view and/or experience.

Please use the same grading system as before.

1) It is always okay for me, as a staff nurse to say "i don't know".

A) Ideal.

B) Actual.

2) If i, as a staff nurse, failed to cope with a difficult situation, it would not reflect badly on me at a later date.

A) Ideal.

B) Actual.

3) It is not important for me as a nurse, to be always in control of my thoughts, feelings and actions.

A) Ideal.

B) Actual.

4) As a nurse i am in an ideal position to act as the spokesperson on health matters for my family.

A) Ideal.

B) Actual.

5) As a staff nurse, i would welcome the freedom to tell patients (and relatives) about their care and condition.

A) Ideal.

B) Actual.

6) As a nurse it is okay for me to say to superiors "i can't cope".

A) Ideal.

B) Actual.

7)As a nurse it is okay for me to say to peers "i can't cope".

A)Ideal.

B)Actual.

8)It is important for me as a nurse, to be able to govern/manage my own disturbing emotions.

A)Ideal.

B)Actual.

9)My family expects me to explain what is going on when a family member is sick.

A)Ideal.

B)Actual.

10)I think it is okay for nurses to show what they are feeling.

A)Ideal.

B)Actual.

11)It is important that as a nurse i display stability and endurance under pressure.

A)Ideal.

B)Actual.

12)As a nurse i should not be affected by the death of patients.

A)Ideal.

B)Actual.

13)As a nurse and professional, it is important that i am seen as dependable and able to cope by the public.

A)Ideal.

B)Actual.

14)If there was a confidential counselling service available to all employees, i would use it if i felt the need.

A)Ideal.

B)Actual.

STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

This is a very simple exercise. Below you will see two sets of numbers 1-20, column one is headed 'I AM', the other 'A NURSE/MIDWIFE IS'. Please complete the columns with anything that occurs to you as being relevant to the said statements.

I AM....

A NURSE/MIDWIFE IS....

1.

1.

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20.

Appendix Two

Please note: photocopies of the original questionnaire 2 for inclusion in this report, were of such a poor quality that new ones were typed. However the only difference between the original and the one presented is one of type-face - item content and spacings for replies were unaltered.

Dear colleague,

I am carrying out a research project examining various aspects of the care of the terminally ill and their relatives. Part of this is this questionnaire, which centres around the atmosphere that surrounds this group of people, in the hospital environment.

I would be grateful if you could spare some time to complete this questionnaire, which I will collect at your convenience, or you may if you wish, send it to me c/o the School of Nursing.

Most of the questions combine a YES/NO answer with an open ended reply, if the space provided is not adequate then please feel free to continue on the blank piece sheet provided.

For the sake of clarity, please note that a 'NURSE RELATIVE/VISITOR', is someone who is a relative or visitor WHO IS ALSO A NURSE.

Patrick A Crookes.

Part A.

Please circle your answer.

- | | |
|---|---|
| 1. Age. | 21-25 years
26-30 years
31-35 years
36-40 years
41 and over |
| 2. Sex. | Male
Female |
| 3. Rank and Grade. | Staff Nurse D
Staff Nurse E
Staff Nurse F
Ward Sister F
Ward Sister G |
| 4. Length of time in present position | 0-6 months
7-12 months
13-18 months
19 months-2 years
2-4 years
over 4 years |
| 5. Length of time in nursing (since qualification) | 0-6 months
7-12 months
13-18 months
19 months-2 years
2-4 years
over 4 years |
| 6. Professional qualifications (circle more than one if relevant) | RGN/SRN
Dip. Nursing
Degree in Nursing
SCM |

Studying for further qualifications?

Dip. Nursing
Degree in Nursing
Other

7. What is the primary type of patient with whom you work? (circle one only)

Medical
Surgical
Paediatric
Elderly
Neuro
Trauma
I.C.U.
C.C.U.
Obstetrics
Other (please specify)

8. Grief is the "characteristic response to the loss of a valued object, be it a loved one, a cherished possession, a job, a part of the body..." (Engel 1961), whilst Mourning is the "Process through which grieving people must pass to re-establish a state of health and well-being" (ibid).

Given these definitions, would you say that you have ever grieved and been through a mourning process?

YES
NO

If yes, who or what was your loss?

Part B.

1). Do you see caring for relatives as being part of your job?

How far would you/have you taken this?

2). Do you see relatives as being useful, in the way, neither or both? Please explain your answer.

3). What do you think are the needs of relatives?

Do we typically meet them? If not, why not?

4). Are you encouraged to speak openly and freely with relatives?

Is there anything that stops you from doing so?

5). What do you think about 'open' visiting times?

6). Do you mind being watched by relatives? How would you react and feel if a relative asked to stay during care delivery?

Any actual experience of this?

7). How do you feel about relatives helping to care for patients?

Have you any experience of this? If so, is it common practice?

8). What if the relative was a nurse? Any actual experience?

9). Have you ever been a nurse-relative/visitor?
If yes, how did you feel and act? Why? If no, how do you think you would feel and act? Why?

10). Have you observed others dealing with nurse-relatives?
Please describe your observations.

11). Have you dealt with nurse-relatives/patients?
How did you feel/react?

12). Have you had experience as a nurse-patient? If yes, please expand upon your experiences, positive and negative.

13). Is there an optimum level of involvement to be reached between nurses, patients and relatives? Is it ever reached?

How would one know if it had been reached?

14). Can nurses become over-involved with patients and relatives?
Please give examples.

15). Do you think patients are entitled to know their prognosis/diagnosis? Any reservations or exceptions?

16). Would you want to know your prognosis/diagnosis if you were a patient?

17). Who controls this type of information?

Should this be changed?

18). Would you prefer to nurse those who know they are dying, or those who don't? Why?

- 19). Is there a conflict between how you want to act and how you are allowed to act, in caring for the dying?
What is the conflict?
- 20). What do you think the reaction of patients, relatives and staff would be if YOU decided to tell a dying patient his diagnosis?
- 21). Has education helped, hindered or had no effect upon your care of the dying person and their relatives?
- Please expand upon your answer.
- 22). Do you feel adequately prepared to deal with the psychological and emotional problems of patients and relatives, especially in the case of terminal illness?
- Please expand upon your answer.
- 23). Have you answered any of these questions from personal experience? If so please feel free to give details to illustrate your point.

Thankyou for completing this questionnaire.

Appendix Three.

There were four areas of questioning in these interviews:-

Personality; Self-Concept; Social Support; and, the Humanistic Environment within nursing/midwifery practice.

During the interviews, which lasted anything between 30 minutes and an hour, not all the questions listed below were asked. This was either because the interviewee had already alluded to an issue, or because it did not seem appropriate to ask the question. It can be seen that the first three sections relate closely to questionnaire 1, while the fourth (Humanistic Environment) is more conceptually related to, questionnaire 2.

Personality.

- * Feelings about dependency - them on others, and others on them.
- * Feelings regarding personal self-disclosure.
- * Willingness to seek counselling advice, and why?
- * Discussion surrounding their feelings about death - do they ever discuss it at work or at home? Do they think about death eg. their own or their family? Why?
- * Feelings about self-control - do they admire it in others? Do they try to emulate it? What do they think about nurses who don't display it?

Self-Concept.

- * Discussion of how they view themselves as a copier, incl. Why? Any problems or benefits? and any examples.
- * Has nursing influenced their beliefs about personal coping?

- * What is expected of nurses regarding coping?
- * Do they see themselves as **having** to cope? What would happen if they didn't?
- * How do they feel about non-copers?
- * Discussion of the traits of an 'ideal' nurse.
- * Feelings about their need to be right?
- * Willing to say 'I don't know?'
- * Ever feel that they are the only one not coping?
- * Discussion of how their family views them with regards to the above issues.

Social Support.

- * Discussion of how feels about being supported under House's four areas of social support. That is, supported or not?
- * Do they feel have someone to go to if they have a problem?
- * Have they personally experienced times when they needed social support, such as bereavement? Was it provided? How?
Was it adequate?
- * What are your feelings when patients die? Are you able to discuss it with peers etc? Do you?
- * Any 'Helper Secrets?'
- * Do you ever feel that you have more responsibility than you are competent for?
- * Feelings about sickness and absence from work? Also views of how peers and supervisors react to people who are off sick.

The Humanistic Environment.

- * Discussion of the optimum level of involvement between nurses and clients. Also how this is reached, and whether over-involvement is possible.
- * Feelings about the patients right to know about their diagnosis and prognosis.
- * Views on the control of information in hospitals.
- * Exploration of their preference in dealing with dying patients who know their diagnosis and those who don't.
- * Exploration of any conflicts in the way they care for the dying.
- * Feelings about their education and preparation for caring for the dying and their relatives.

Appendix Four

Question 8 (S15 + S16 : Fig. F9):-

I = A (31 respondents)	5+5 = 4	Thus of the 31 who gave the same mark for I and A, 27 agreed it was important to be able to manage their emotions. Only 1 disagreed for both I and A - none 'strongly'.
	4+4 = 23	
	3+3 = 3	
	2+2 = 1	
I > A (44 respondents)	5+1 = 1	Of the 44 in this group, 13 were in disagreement for both I and A; 18 moved from 'agree' to 'disagree'; 10 went from agree to undecided; While 3 changed from undecided to disagree.
	5+2 = 5	
	5+3 = 3	
	5+4 = 13	
	4+3 = 7	
	4+2 = 12	
	3+2 = 3	
I < A (10 respondents)	1+2 = 1	Of these respondents, only one disagreed for both I and A; 7 changed from disagree to agree; the other 2 from undecided to agree.
	2+4 = 7	
	3+4 = 2	

Question 4 (S7+8 : Fig. F12):-

I = A (30 respondents)	2+2 = 7	Thus of these respondents, 17/30 were happy with the role of family spokesperson both for I and A; 6 were undecided and 7 were 'unhappy' with the role.
	3+3 = 6	
	4+4 = 12	
	5+5 = 5	
I < A (11 respondents)	1+3 = 1	All 11 respondents would therefore seem to feel uncomfortable with this family role, or at least less happy in actuality, than in the ideal.
	1+4 = 1	
	2+3 = 2	
	2+4 = 3	
	3+4 = 3	
	3+5 = 1	
I > A (44 respondents)	5+4 = 8	All these respondents rated themselves higher ideally than in actuality, 8 agreed for I and A while 18 changed from agree to disagree. 2 were in disagreement for both ideal and actual.
	5+3 = 2	
	5+2 = 7	
	5+1 = 4	
	4+3 = 7	
	4+2 = 11	
	3+2 = 2	
	3+1 = 1	
	2+1 = 2	

Appendix Five.

The following transcript, highlights the experiences of a Ward Sister in her bereavement. The reader will see that there were several factors which could have led her to have problems in resolving the loss of her father. Thus it serves not only to integrate the data for the reader, but also to demonstrate just how difficult bereavement can be for 'professional copers' like nurses and midwives.

I. "So you were saying you've been bereaved when you were a nurse?"

S. *"Yes. It's five years ago now when me dad died. He'd been poorly quite a long time and I really wanted to nurse him at home when he got to terminal stage".*

I. "Why is that - why did you want to nurse him at home?"

S. *"Because - I just - I think I preferred to be doing the things for him myself at home, and I felt that I wanted a time when he'd come to die, when I could to look after him myself and just care for him at home. The problem was that my mother was in such a state of panic that there were no way that I could do it. She wouldn't let him die in the house and she wouldn't let me take him to my house, so for that reason he was taken into hospital and I found visiting difficult in hospital - I still do. I'm not one of these people who can sit at the side of people's beds - even my own father's for hours and hours. Anyway, after he'd been taken in, his condition improved and I didn't really anticipate that he was going to die so soon, but he suddenly deteriorated in the night".*

She did not know this however because the staff thought she was going away. The news that her father had deteriorated was delivered by her brother who had been contacted by the staff, but who lived some two hours away...

S. *"I went straight to the hospital and I were the first person to get there, and I was quite upset when I got there - I must have driven at sixty or seventy mile an hour all the way there to get there to be with him but nobody told me he had died. Whether they assumed that I already knew because I was distressed and a little bit upset, or what I don't know. They took me behind the screens and when I got behind the screens and I saw the body that were me dad, and so naturally I started to cry. I was quite distressed, and it was said to me 'Oh come on. You've expected it, just calm down, be quiet'. I would like to have*

known before I went in so that I could have cried and got over me initial emotional upset when there weren't other patients around because I didn't particularly want to distress other patients by my reaction, and I wouldn't - if I'd have known before I went in I could have had time to compose myself and then gone in and see my dad, but I didn't know he were dead".

I. "They just took you behind the curtains and introduced you to this..."

S. *"There were a body and it was my dad. And it was something that I must admit lived with me for quite a long time, and took a lot of getting over, you know, just going behind the screens, and finding a body without knowing he was dead. That plus the fact that I felt awful that I hadn't been able to get relatives in".*

I. "Do you think they would have done that to anybody?"

S. *"No. I don't think they would have done it to anybody. I think it was because - and this person knew me and knew me as a sister - I think anybody else she would have taken to one side, and sat down and talked and said you know 'You do realise that your dad has died' and 'are you ready to go in?' But they just assumed I was ready to go in because I was a sister, and I wasn't ready because I didn't know".*

I. "Before this happened, how had the staff treated you?"

S. *"As a visitor I felt strange because some of the patients were patients I had known. I also felt that it was very difficult because when things weren't right, I were frightened to say in case they thought it were me picking or complaining, like on one occasion his pyjamas hadn't been changed and they smelt and I didn't know what was the best thing to do - did I draw the screens round and change them, or did I go to somebody and complain about it, and in the end I just changed them, and took the pyjamas home, but I didn't know which was the best way to deal with it, because I was a nurse. Had I just been a visitor and not a member of the staff, I would have said 'Is it possible for you to change my father's pyjamas?' But you've always got a fear if you're a nurse - a member of the nursing staff, that it's not quite right to go and complain about something. There's a fear that it might cause problems either for you or your relative".*

I. "So in your situation your awkwardness was because you didn't want to be

unpopular?"

S. *"I found it difficult because I didn't want them to think that I were being critical of them when they were just little things that weren't quite right. I felt, you know, I would have liked to have said something about it, but I didn't - I mean they were very good and I didn't particularly want to upset them".*

The conversation then moved on to the issue of family expectations...

I. "Do you find that your family and other people tended to expect you to be the family nurse?" (The term was explained)

S. *"Yes. I've always had this. Nobody will ring the doctor they ring me, this is what's always happened. I mean one time my dad was in really severe LVF, and they rang me. When I got there he obviously needed intravenous lasix as quick as possible. And yet nobody had thought to ring a doctor until I got there. Another time I got this phone call at home from my sister because my father was really ill in hospital. When I got there I went straight to the office to ask the staff what was wrong, and they said 'He's all right as far as we know'. It turned out he'd had an injection and he decided that it were making him really ill. The whole family were in a state of panic, and they couldn't be bothered to go to the office to tell the nurses. And the nurses on duty were really quite upset when a sister walked in and said 'What's wrong with my father, I've just been sent for?' And yet they didn't know there were anything wrong with him".*

I. "How did you feel about that?"

S. *"How did I feel about that? I knew it were my family and I knew it wasn't the nursing staff, and I had to reassure them - the nursing staff, that they weren't neglectful, that it was my family that were panicking".*

I. "Do you think it was fortunate that it was the hospital that you worked in? I mean do you think you would have been able to pour oil on troubled waters as easily as if it had been somewhere where you didn't work?"

S. *"No. I don't think I would. I don't think it would have been quite as easy".*

I. "Did you find that the - that the onus fell on to you for funeral arrangements and things like that when your father died?"

S. *"I found that everything fell on me. In a way I were a bit upset because I*

didn't have any family support when me dad died. I had to come through to hospital to collect the certificate and his clothes. Everything. Nobody came with me, they felt that I could cope".

I. "Was that just a feeling that you had or did anybody actually say it to you?"

S. *"I didn't offer to do it on my own, I did ask me husband if he'd come with me, and he said 'Oh no. You're all right. You don't need me to come with you'. And so he didn't. And nobody else did. I had to do it on my own and I found myself going and hiding in the ward kitchen while they sorted things out".*

I. "Did you find it easy being in a situation where you might have to be dependent on other people?"

S. *"I must say that I'm very much the one that does the coping and does all the arranging for everything anyway, but it was just at that particular stage that I would have liked that little bit of support. But at the funeral I got the same problem, because somebody had to go and ask to be with me because they felt upset - they just expected me to cope again without any support at all".*

I. "I think lots of nurses are pretty dependable people like that. Would you say that you were independent?"

S. *"I'm too independent. I suppose one of my problems marriage wise is that fact that I'm the independent woman, the one that copes and does all the organising and everything. Even with my in-laws, they ring me when anything goes wrong, they don't deal with it, they ring me because I am the copper, I am the one who does the organising, I'm the one who sorts it out".*

I. "You were saying about support, and you said you got support from peers on the ward that you were working on. Did you find that the case from managers?"

S. *"No, I got none at all. I mean I came back to work when my father died, to a situation where I'd got two people dying and their relatives needed coping with, and at that time I found it very difficult because I were still too raw. I mean my own emotions hadn't healed, it was less than a week from my father dying to coping with two patients dying on the ward and their relatives and I found that it was very difficult to keep my own emotions at bay because I felt like crying with them and for them, because it had just happened to me and I found that -*

you know - I didn't get any support from anyone".

I. "It might seem a silly question but why did you feel that you couldn't do that, and why do you think it's important that you didn't sort of show your emotions like with those relatives?"

S. *"I don't think that you should not totally show your emotions. I always think you should show that you care, but I think you've got to stay reasonably strong and calm to help them cope. And if you are there crying and wailing then you are obviously not helping them to deal with what the situation they've got to deal with".*

I. "Do you think that's how nurses feel that they've got to be, do you think they'd find it difficult to switch off like that?"

S. *"I find most of the time I can switch off from people dying. I always find it much worse if its somebody that I've had on a regular basis, you know somebody that I've really got to know well, when they die, I feel that bit more involvement but I still tend to be able to go home and switch off, and it's only on odd occasions that it's maybe a young death that it might affect me a little bit more".*

I. "What about switching off the persona of 'coper'? Do you switch off from that - are you a coper at home as well as at work?"

S. *"I am a coper at home as well. I tend to cope and be independent and do things you know - do all the organising for everything like - you know whatever there is weddings, you know anything, I mean usually everyone will say so and so's arisen, what are you going to do about it? And I'm the one that does the coping of it all, yes. That's just my personality".*

I. "Yes. But you would have liked - you would have liked on that one occasion - that people could have seen through that and recognised that you needed some help at that time".

S. *"Yes. I do think that I would have liked some support then".*

I. "We got - we were talking but we got off on a tangent with you mentioning a bit about the sort of help you had from management".

S. *"There wasn't any. As it so happens I was supposed to be going away so I was on holiday anyway, so that holiday turned out to be my compassionate leave, and I never got any - I never got offered any. They said I didn't ask for*

it, but I could have done with a couple of days more to get over".

I. "Was anything said to you about it? Did you ask for help or consideration?"

S. *"No. Nothing. Nothing at all. Nobody rung me up or asked me how I was managing or anything. I think that's common too*

- we can't see when our own people are having problems. I hope that as a ward sister I can see it when my staff are having problems, but I don't think any of our nursing hierarchy care about the problems. I also think you have got to be careful about letting your feelings and emotions show, because when you come to apply for jobs I think they remember it, so I think you don't let them see it".

I. "Actually one of the questions on my questionnaire asks that. If you failed to cope, do you think it would go against you in later on...?"

S. *"I think it would. I think you've got to be seen to be a copier and you've not got to let them see you've got feelings because then when you apply for anything that's when it does go against you. So you don't let them know, because if you do you are weak. Even if you get yourself really run down and you're shattered and you're not feeling well, you are not supposed to ever be weak, you are supposed to be strong all the time".*

I. "Superhuman really"?

S. *"Yes. Most of the time we are, just occasionally it gets to you and you get a weakness, don't you, you fray occasionally and you need a - well you have a burn-out just on odd occasions don't you?"*

I. "Yes. I think the overall sort of total burn out is not that common, but I think we have temporary burnouts..."

S. *"Just short burnouts, yes. When we moved wards after we had moved on Monday, I had that much hassle you know from various quarters I disliked it so much and I disliked the situation so much that I felt I just can't come back - I can't come back. I'm going to find a reason for going off sick, for the rest of the week, and then I'll come back and start coping. But I had two days off, and those two days revitalised me, I'm back and I'm coping".*

I. "I wonder if we shouldn't have sort of time outs, do you know what I mean where that's not frowned upon, perhaps so that it wouldn't reflect on people, and they could actually have time out in a less stressful setting".

S. *"Somebody asked me this morning if I would like to work with the terminal*

care team, and I said not on a regular basis because they wouldn't ever let you have time out to revitalise yourself, and you eventually burn yourself out, and you need that time out. I mean that's why sister has had to leave the job".

I. "Can I just go back to the issue of being a dependable person and being an independent person which you said you know you are. Sometimes, what goes with that is the feeling that independent people don't like to be dependent on other people. Do you feel that way?"

S. *"Yes I do. I don't like dependence at all. I like to be financially independent, I like friends, I like to have quite a lot of friends, but I can socialise without clinging to one particular person. I find that when I am having problems I will maybe talk to people about it, but I would rather stay away from people rather than them see me through that period. I want to work that out for myself, as a person and then I can pick up me social life again and start seeing everybody again and go out and be the person that I am. So I look to work it all out in my own mind independently.*

I. "And if you do see people it's just as a bit of time out from sorting that problem out?"

S. *"Yes. But not to sort that problem out. I want to do it all on my own, because I want it to be my total decision at the end of the day, not somebody else doing it for me".*

At no time during the taped conversation did the Sister refer to a time when she had taken time to grieve, a fact that is highly significant when one considers that it was over five years since her father's death. Later, off-tape (it had run out) she identified that she had never overtly grieved, though she did think of her father often, and became very upset at these times, a fact that she had kept to herself up to participating in this study.

This exemplar therefore highlighted the complex inter-relationships between factors predisposing to problematic grieving, the roles that many nurses and midwives play in their family, and the professional culture of nursing and midwifery. For example the interviewee felt guilty that her father was hospitalised and awkward whilst visiting him, for fear of upsetting the staff.

She found out that he was dead by being confronted with his body. She perceived that she had received little support from any source in her bereavement, though it is debateable whether she would have accepted it even if it had been offered. She definitely saw herself as the family nurse, a copier, and very independent - almost to the point of pathology. Finally it would appear that an amalgamation of such issues led to a continued inability to share the burden of grief with others - five years on.

This Sister's story therefore encapsulates much of the points in the data identified at the outset of this section of the study, along with the relationships between them. Given her experiences, it is not difficult to comprehend why she had problems in resolving her loss.