Nursing Diagnosis:
Characterization of Coping Problems by Clinical Nurses

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Chapter 1

Introduction

Nursing diagnosis requires careful examination to increase the precision, clarity, and relevance of this emerging language to the practice of nursing. In 1985, twelve years after the first National Conference on the Classification of Nursing Diagnosis, Gordon suggested the refinement of current concepts, rather than generation of new concepts, should be the first priority of research in this area. The purposes of this study were to (1) examine the validity of the diagnostic category ineffective individual coping, (2) extend our understanding of coping phenomena nurses identify within their treatment domain, and (3) compare terms and concepts used by clinical nurses in describing coping phenomena of individuals they treat with those proposed by Nursing Diagnosis Conference participants.

Nursing diagnosis is in an embryonic state. More research is needed, particularly in the domain of coping. Coping, a concept that emerged in the third conference (Kim & Moritz, 1982), is a diagnostic category of major importance. Our understanding of this human response has far reaching implications in health care. Nursing studies of coping have examined characteristics of patients that influence coping, stressors and coping methods, and interventions to improve coping outcomes, but few studies have looked at nursing diagnosis of coping.

Research Questions

The specific research questions of this study were the following:

1. What patient situations are diagnosed as coping problems requiring independent nursing intervention?
2. What patient characteristics are considered as critical in the decision to intervene in these situations?
3. What contextual features in the health care setting do nurses identify which influenced their diagnosis of patient coping situations?
4. What is the range, diversity, and consistency of terminology used to label coping problems?
5. How do the identified patient situations and characteristics compare with coping diagnoses accepted for testing by NANDA as defined at the Eighth Conference on the Classification of Nursing Diagnoses?

Literature Review

Selected literature on coping theory will be discussed first to clarify the concept of coping and issues related to diagnosing coping phenomena. This will be followed by a review of the nursing diagnosis literature to describe the evolution of diagnostic concepts in general, and specifically the coping diagnoses, and to critique methods used for concept development and verification.

Conceptualization of Coping

The concept of coping has a rich history in the psychological literature, and is a term widely used in nursing and health care. Diagnoses of coping phenomena may vary in meaning to nurses when based on different conceptualizations of coping. Mengel (1982) defined coping in two ways: as a set of behaviors for managing stress, a dynamic process to mobilize resources; and as "a product of the way people define their relationships with their environment" (p. 2), i.e., adaptation to life stresses. The ambiguity suggested by a paradoxical understanding of coping, as process and product simultaneously, may be confusing for the clinician or researcher, and obscure diagnosis or study findings. More importantly, diagnosis based on coping as a process suggests different intervention than might be selected for coping as a product or state.

Many studies of patients with acute health conditions illustrate the problem of this paradoxical understanding. For example, Sherman, Ernst, Barja, and Bruno (1988) found through their own research and extensive literature review that patients with persistent phantom pain following amputation tend to be tagged as psychologically different. However, these patients are largely those "with whom the referring clinician does not get along and who persist in complaining about their pain through numerous interventions" (p. ix). These patients may appear on the surface, perhaps, to be coping ineffectively. However, the options available may be very limited, and have no association with their innate capacity or usual repertoire of coping strategies. Hence, when coping is viewed as a product or trait, these individuals will be diagnosed as having ineffective coping. Pearlin and Schooler (1978) commented on the importance of context in relation to coping efficacy: "Coping failures...do not necessarily reflect the shortcomings of individuals; in a real sense they may represent the failure of social systems in which the individuals are enmeshed." (p. 18).

The following study illustrates research on coping in which stress was conceived out of context. Ziemer (1982) noted that many studies reported in the literature on coping have included coping measures based on behaviors of people self-selected because of exposure to particular stressors. Ziemer sought to identify what coping behaviors are consciously employed by normal individuals in a study of students at an urban eastern college. Despite this researcher's acknowledgement that coping depends on the contingent situational demands, subjects were asked to identify behaviors in response to a stressful situation free of any particular context. On finding that few reported seeking new information, in contrast to other studies, Ziemer suggested that this may have been due to the featureless frame of reference. The approach used suggests a stimulus-response model of stress and coping in which features of the stressor are uniform to all "normal" people serving only to stimulate behaviors which may be counted as typical or atypical depending upon their distribution within the population studied.

Panzarine (1985) discussed the understatement of coping in research advocating designs reflecting the multidimensionality of this construct. Important features not accounted for often included stressor characteristics, personal and contextual characteristics, changes in coping and adaptational outcomes over time, and the reciprocal nature of coping and its outcomes. A transactional theory of stress and coping encompasses these features, whereas stimulus-response models limit our examination to one or two aspects which may lead to a false conception of the "normal" or "successful" ways of coping.

An abstract conception of coping apart from the context in which it occurs is not useful for an understanding of individual responses to stress. Lyon & Werner (1987) conducted a comprehensive review of the nursing literature from 1974 to 1984 to evaluate the theoretical underpinnings and empirical generalizations in stress research. The 82 studies examined were categorized by four theoretical orientations: (1) stress as a stimulus; (2) stress as a response; (3) stess as a transaction; and (4) atheoretical. In their analysis, the authors took the position that the transactional view of stress was the only theory compatible with the discipline of nursing. In this theory, coping with stress is viewed as a dynamic process in which person-environment interactions are reciprocal and form new meanings that subsume each of the interacting variables. Contrary to the stimulus and response models, transactional theory accounts for individual differences important to an individualized approach to health care espoused by nurses.

The transactional approach to stress and coping is well represented in the work of pyschologists Lazarus and Folkman (1984). Their conception of coping provides a multidimensional perspective with clear meanings for diagnosis and application in clinical practice and concepts of appraisal important to an understanding of individual variations in coping responses to stress. In this theoretical framework appraisal includes (1) an evaluation of an event in terms of its meaning to the self, i.e, as a loss, threat or challenge; what effect will it have, and (2) an evaluation of coping options; what can be done about it. In discussing the multiple functions of coping, they identify two major ways of coping: (1) emotion-focused coping; and (2) problem-focused coping. Coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). As they point out, this definition is process oriented, distinguishes coping from habitual adaptive behaviors and the outcomes of coping, and emphasizes management rather than mastery.

This transactional definition of coping fits with a phenomenological view of stress and coping (Benner & Wrubel, 1989) used as a framework for examining coping problems in this study.

> In the phenomenological view of stress and coping, the person is not seen as a rational calculator of external events whose meanings are limited only to the pointing out and designation of objects, facts, and events. Rather, the person is understood both to constitute and be constituted by meanings. This constitutive role of meaning is the ontological basis of perception. That is, the concerns,

> background meanings, skills, and practices of the person set up what counts as stressful and what the coping possibilities are. In the phenomenological view, coping can never be an unlimited choice from a list of effective and ineffective options. Instead, coping is bounded by the meanings and issues inherent in what counts as stressful. Some choices will always be untenable or unrelated to the person's concerns and most often not easily translated to the person's situation. (Benner & Wrubel, 1989, p. 63)

The relevance of context in coping diagnosis is suggested in the exemplars of nursing practice used by Benner and Wrubel (1989) to illustrate a phenomenological view of stress and coping. In a paradigm case titled "A Quiet and Peaceful End" (p. 90), a nurse describes her transactions with a patient and the attending physician in helping the patient participate in the management of her terminal illness during her few remaining days of life. Choosing was clearly the central issue in this story in which the patient's acceptance of her impending death and decision to forego "medical heroics" were at odds with that of her spouse and not supported by her physician. The nurse was an enabling force in the patient's exercise of choice "to die peacefully and as comfortably as possible" within an adverse social context.

The concerns of the patient and the role of the nurse in this situation were significant. It was a unique experience, yet commonalities with other situations might be expected. Nursing's ability to communicate this is a critical issue in our discourse with others, in our justification for time or reimbursements for the helping role of nursing, and in our educational programs.

In summary, simple models like those in stimulus and response theories do not adequately explain the experiences of stress and coping in humans. Contemporary theories have shifted from a unidimensional approach toward a multidimensional view of stress and coping with an emphasis on the person-environment interaction. In transactional theory, coping is more clearly defined and the importance of context recognized. Coping is seen as a process, in this theory, and is differentiated from adaptation, an outcome of personal stressor-coping interactions within specific contexts at specific times. Transactional theory is consistent with the philosophical underpinnings in nursing, "interaction, phenomenology, and existentialism," Meleis (1985, p. 182) identified in an examination of the areas of agreement between nursing theorists. It is not clear in the nursing diagnosis literature what the underlying conceptualization is. The use of a label such as "ineffective coping" implies the conception of coping as product.

Nursing Diagnosis Taxonomy Development

The literature on nursing diagnosis, particularly on nursing diagnosis research, was reviewed to delineate how diagnoses have evolved, to evaluate the current taxonomy in general, and to explore the possibility that a gap exists between the labels and applicability to clinical practice.

The North American Nursing Diagnosis Association (NANDA) has approved diagnostic categories for clinical use and testing. In an overview of conceptualizations of nursing diagnosis, Gordon (1985) acknowledged a lack of consensus among theorists in the literature reflecting the diversity of nursing models. Researchers investigating nursing diagnosis have "bypassed the conceptual diversity and defined nursing diagnoses as problems, states, or responses that were treated by nursing intervention" (Gordon, 1985, p. 128). She offers little guidance for constructing diagnostic concepts. She implies that concepts be grounded in the everyday practices of clinical nurses.

Shoemaker (1984) conducted a Delphi study to achieve consensus on the essential features of a nursing diagnosis. Participants were 111 nurses with at least a master's degree in nursing from throughout the United States and Canada. All had knowledge of nursing diagnosis as evidenced by publications, research activity, and workshop leadership. Variables related to nursing diagnosis identified from the literature were categorized using an analytic method, the Soltis technique, into generic, differentiation, and conditions features of a concept. Following three rounds in which participants ranked variables as essential, important but not essential, useful for explaining the term, or rejected as not appropriate, essential features were identified with the caveat that none could stand alone.

A summary of Shoemaker's findings defining nursing diagnosis included the following essential features: nursing diagnosis is a conclusion about the patient's actual or potential health state or problem, i.e., physical, psychological, sociocultural, and spiritual conditions, and etiology (for actual states) or risk factors (for potential states) based on a pattern or cluster of signs and symptoms, i.e., verifiable subjective and objective data, validated by the patient whenever possible, which are concisely stated and which may be independently treated by a nurse.

The formal classification of nursing diagnosis began in 1973 with the inception of the National Conference Group for Classification of Nursing Diagnosis. Conference participants represented most of the United States and a few provinces in Canada and included staff nurses, clinical specialists, directors of nursing, deans, faculty, theorists, and researchers with a wide range of education and experience (Gebbie, 1982). Working groups of nurses with a mix of clinical practice areas, level of education, work setting and geographical region generated nursing diagnoses related to a specific human functional system and worked on refining a group of related diagnoses at later national conferences. Participants used an inductive approach, basing their work on recollections of patients from their own experiences, a method termed as "group empiricism" (p. 10). Work groups communicated at plenary sessions to achieve consensus of all participants on the developing classification system. In subsequent conferences, participants selected diagnostic areas to review and these work groups then made recommendations to a committee for final decisions which were based on formal guidelines.

From the beginning, research was encouraged to test and refine diagnoses. Research or clinical data had to be submitted with proposed diagnoses or changes in diagnoses at the fifth conference. It was after the fifth conference that the small work groups were discontinued as a method for generating and refining diagnoses (Hurley, 1986). Currently a formal review cycle is used with the submission of new diagnoses and for the continuous development and refinement of the taxonomy. New diagnoses or changes in diagnoses are reviewed sequentially by five different groups within NANDA: (1) a Clinical/Technical Task Force composed of experts drawn from the NANDA membership and other groups such as the American and Canadian Nurses' Associations; (2) the NANDA Diagnosis Review Committee, (3) the NANDA Board, (4) the General Assembly during the National Conferences, and (5) the NANDA membership through mailed ballots. The Clinical/Technical Task Forces are guided by a set of criteria to be met by proposed diagnoses which include substantiating materials, i.e., a list of references "demonstrating a reasonable review of relevant literature" (Carroll-Johnson, 1989, p. 560).

Gordon & Sweeney (1979) described three models for the identification and validation of nursing diagnoses. The first, a retrospective model, is based on the recall of nurses to describe health problems they treat. This inductive approach was used in early work by national conference groups as the major method to generate diagnoses. Methodological limitations identified include the biases of nurse participants, either as a result of their circumscribed practice or the difficulties inherent in retrospective recall (Tanner & Hughes, 1984).

Tanner (1984) has pointed out several biases in assigning probabilities to relationships in diagnostic reasoning based on recall. These biases are also germane to the generation of diagnostic categories and defining characteristics by conference participants. These biases include (1) frequency of occurrence in our own experience, (2) recency of experience, and (3) the profoundness of memory. In other words, those experiences that were most frequent, recent, and most dramatic likely influenced the group empiricism method. Gebbie (1982) acknowledged that this approach does not capture diagnoses that are rare or those requiring highly specialized skills to identify and treat. For generating coping diagnoses, this model is limited by the biases of recall and the varied theoretical (or atheoretical) perspectives on coping of participants.

The second, a nurse validation model, was described as useful in testing identified nursing diagnoses. In this model, nurses are asked to validate defining characteristics of existing diagnostic categories. Two areas of weakness are inherent in this model. First, validation is limited to the defining characteristics of a diagnosis; the definition of the category is given, and not subject to testing in this model. A limitation of this model for validation of a coping diagnosis is the assumption that the definition adequately describes the diagnostic concept and clearly differentiates this condition from similar or related conditions. Secondly, nurses are often asked to rate separately the frequency with which each proposed characteristic occurs with a diagnosis. In this design, the problem statement of the diagnosis is disconnected from its related factors, i.e., etiology, while presenting characteristics for validity judgments. What may result, then, are agreements with characteristics that define broad, general categories, but not those characteristics that define more specific, clinically relevant phenomena. Also, this method may not capture the clustering or pattern of characteristics for a particular diagnosis. As with the retrospective model, nurse-validation requires a judgement based on recall.

Third, the clinical model is designed to collect data from direct observation of patient behaviors to identify and validate nursing diagnoses and has not been used as frequently as the other two described above. The data may be collected retrospectively from patient records or literature review, or using concurrent observations in practice. This model overcomes the problem of retrospective recall. It is subject to the same problems of reliability and validity as that of any observational study, e.g., intra/interobserver reliability.

A critical feature of all three of these models is the selection of nurse participants with relevant diagnostic expertise. The reliability and validity of data from which diagnoses are generated and validated will depend to a great extent on the experience, clinical specialty knowledge, and diagnostic ability of nurses sampled. Fehring (1986) commented on a validity gap between the NANDA list of diagnoses and those used in clinical practice. One of the reasons he cited for this gap was the lack of documented expertise of many participants in regional and national work groups who derived the diagnostic categories. He presented methods to validate and standardize accepted diagnoses. Quantitative methods to establish reliability and validity of measurement tools were incorporated with the nurse validation and clinical models. The need to sufficiently develop diagnostic concepts prior to quantitative validation studies was recognized.

Nearly two decades ago, nurses began to identify and classify health conditions they may diagnose and treat. Issues in the development and standardization of nursing diagnoses have been identified. The initial process of taxonomy development was undertaken with the group empiricism method. Classification of diagnoses predicated on this method is subject to the biases of recall and the varying levels of expertise suggested by descriptions of nurse participants. The nurse-validation and clinical models used to identify and validate diagnoses are also subject to the biases of nurse participants. The proposed diagnoses require further testing and refinement with methods that result in operational concepts and valid labels that may be reliably applied in clinical practice.

Coping Diagnostic Category Development

The coping diagnoses were introduced and accepted at the third national conference, apparently using the group empiricism method. They have undergone a few changes since that time. In 1986 when the theoretical framework was applied to taxonomy development, the coping diagnoses were grouped under the human response pattern of "Choosing" (Figure 1). Diagnoses included one label on individual coping and three on family coping responses. The original label, Coping, patterns: individual, maladaptive, was changed to Coping, ineffective individual (Kim & Moritz, 1982). Proceedings of the Eighth Conference (Carroll-Johnson, 1989) do not show any further changes for this diagnosis. Ineffective individual coping is defined as the "impairment of adaptive behaviors and problem solving abilities of a person in meeting life's demands and roles" (p. 538). Critical defining characteristics are (1) verbalization of inability to cope, and (2) inability to meet basic needs.

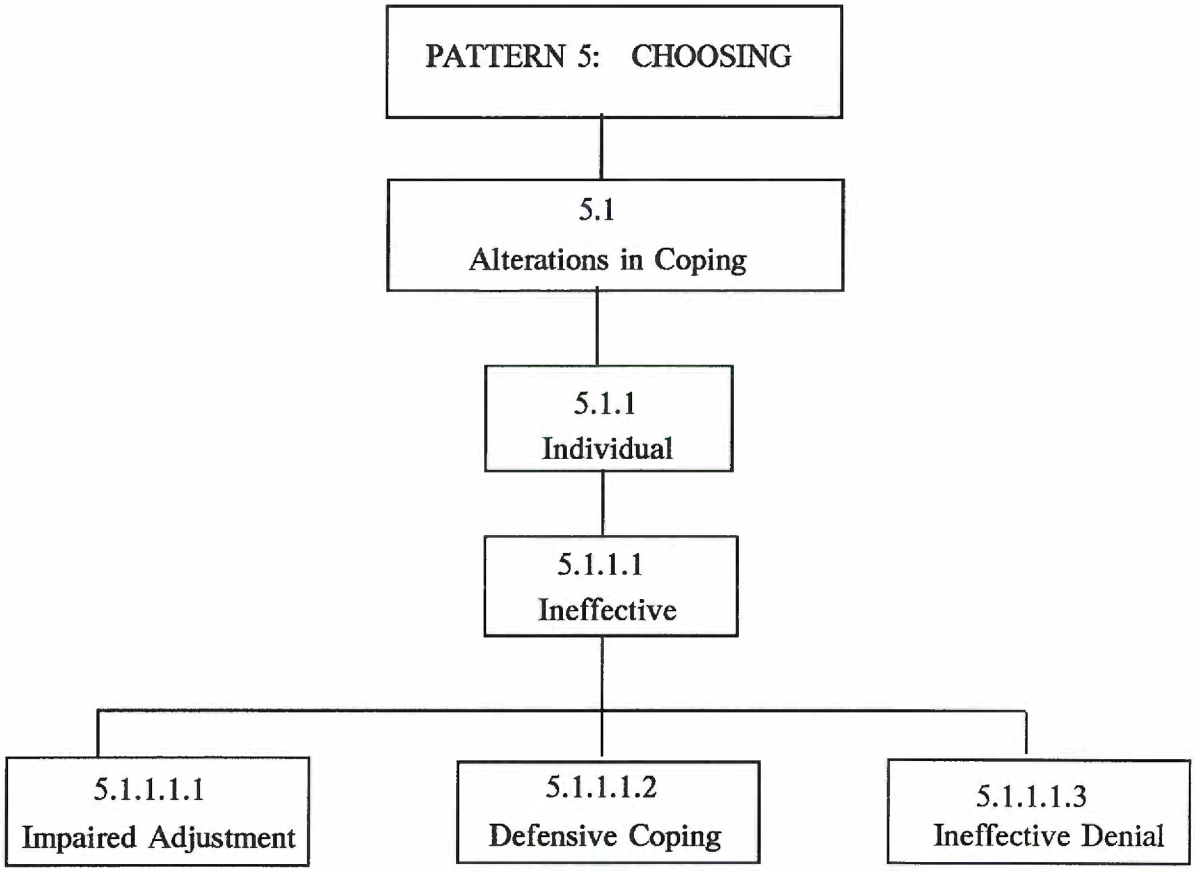

Figure 1. Branch of Individual Coping Labels of Choosing in NANDA Nursing Diagnosis Taxonomy.

Impairment, a critical term in the definition of ineffective coping, is described in Webster's dictionary (1985) as damaged or made worse by diminishing in some material respect. This implies that adaptive behaviors preceded ineffective coping, and thus restricts the use of this diagnosis to situations (requiring coping) in which adaptive behaviors have changed, i.e., diminished or worsened. What about situations in which the coping behaviors, though useful in a past crisis, are inadequate to meet current demands or do so at great cost? What about those situations in which the coping behaviors needed to meet the crisis have never been a part of a person's coping repertoire? The label ineffective coping may describe an outcome rather than a response, and therefore limits what can be done as an intervention ex post facto.

Ineffective individual coping has been used as a higher level category for more specific diagnoses added at subsequent conferences. The label, Impaired Adjustment, was added to the category of Choosing at NANDA's seventh conference (McLane, 1987). Impaired adjustment was defined as "the state in which the individual is unable to modify his/her lifestyle/behavior in a manner consistent with a change in health status" (p. 494). The numerical indexing system used by NANDA places impaired adjustment as a subcategory of ineffective individual coping.

Other labels introduced at the latest conference (Carroll-Johnson, 1989) are also numerically indexed as subcategories of ineffective individual coping: Defensive

Coping and Ineffective Denial. Defensive coping was defined as "the state in which an individual repeatedly projects falsely positive self evaluation based on a self protective pattern which defends against underlying perceived threats to positive self regard" (p. 438). Ineffective denial was defined as "the state of a conscious or unconscious attempt to disavow the knowledge or meaning of an event to reduce anxiety/fear to the detriment of health" (p. 443).

As a higher order category, ineffective individual coping should be at a higher level of abstraction than those coping labels described above and contain the general characteristics of its subcategories in the taxonomy, i.e., impaired adjustment, defensive coping and ineffective denial. There are inconsistencies in the definitions and defining characteristics of ineffective individual coping and its subclasses. The former describes an impairment, i.e., change for the worse in coping behaviors, while the latter seem to describe longstanding patterns of behavior. Some defining characteristics of the subclasses do not fit within any of those listed for the class within which they are categorized. The defining characteristics for each of the coping labels are summarized in Table 1.

Table 1. Defining Characteristics of Coping Labels.

Ineffective Coping	Impaired Adjustment	Defensive Coping	Ineffective Denial
States unable to cope/unable to ask help	States non-acceptance of health change	Denies obvious problem/weakness.	Relevance of symptoms not perceived. Can't admit impact of diagnosis on life patttern
Inability to problem-solve	Non-existent/ unsuccessful ability to be involved in problem solving or goal setting	Reality testing difficulties	
Inability to meet role expectations/ basic needs	Lacks movement toward independence	Lacks follow through in treatment	Delays seeking or refuses health care to detriment of health
Inappropriate use of defense mechanisms	Extended shock disbelief or anger about health	Rationalizes failures	Minimizes symptoms. Doesn't admit fears.
Alteration in societal participation		Difficulty establishing relationships	
Change in communication patterns			
Verbal manipulation		Projection of blame/responsibility	Dismissing gestures or comments when speaking of distress
High illness rate; high rate of accidents		Hypersensitive to slight/ criticism	
Destructive behavior toward self and others		Hostile laughter/ridicules others.	Self treatment with home remedies
		Superior attitude toward others	
		Grandiosity	
			Inappropriate affect
			Displaces source of symptoms to other organs

Only one study in nursing was found on the diagnosis of ineffective individual coping (Vincent 1986). This study sought to validate the defining characteristics of the diagnosis. Nurse participants were mailed questionnaires with graphic rating scales in which each defining characteristic of the diagnosis was listed. Two additional characteristics added to the scales by the researcher, anxiety and life stress events, were the most frequently observed defining characteristics identified by nurse participants. These two characteristics were not among those listed in the NANDA literature. In this study, 82% of respondents wrote in a total of 90 additional behaviors occurring nearly always to frequently, which were used as criteria for this diagnosis. Vincent concluded that the list of defining characteristics was incomplete and should be expanded.

The selection of nurses as representative of experts in diagnosing ineffective coping was a particular strength of this study. A random sample of 1000 participants was selected from a list of 1183 clinical specialists obtained from the American Nurses Association. The 51.3% return rate of questionnaires resulted in 513 participants. All participants had masters or doctoral preparation with the majority in psychiatric/mental health nursing. The sample represented all 50 states.

The questionnaire constructed for the study asked participants to consider "a hypothetical sample of 100 clients with ineffective coping" (p. 208). They were instructed to rate how frequently, on a scale of 1 (rarely present) to 5 (nearly always present), this population exhibited the specific signs and symptoms of the diagnosis. Reliability was reported (Cronbach's alpha= .74) and met Nunally's criteria (1978) for purposes of research. It was unclear in the report of this study whether contextual features in which clients were exhibiting ineffective coping were described. However, given the above description of a hypothetical sample, this is unlikely. This suggests that concepts were based on a stimulus-response model of stress and coping and poses a major weakness in this research project.

The defining characteristics were the only features of the diagnostic construct tested. The definition of the diagnosis was not challenged when the researcher found that five of 11 defining characteristics listed for this diagnosis were rated as present "always to frequently" by less than half the respondents. For example, one characteristic, "verbalization of inablity to ask for help" was rated as seldom to never present by 35% of respondents. The diagnostic category of ineffective coping is lacking in conceptual development and hence requires a different research approach.

In summary, issues in the development and standardization of coping diagnoses were raised which parallel those for the taxonomy in general. (1) Coping diagnoses have been generated by the group empiricism method and are subject to the biases of recall and the varied expertise of participants. (2) The concept has not been refined or validated through research. (3) A validity gap between the proposed diagnostic labels and clinical practice has been suggested. Only one study on the diagnosis of ineffective individual coping was found. In this study, the method used did not allow nurses to verify the definition of this concept and the findings suggested the list of defining characteristics was incomplete. In addition to these issues is the differing and incompatible theoretical frameworks implied in the coping diagnostic labels. Coping is viewed as a process by some, and a product or trait by others, so it is not clear what nurses mean when applying this term for diagnoses.

Qualitative methods are appropriate for conceptual development. Poorly defined diagnostic concepts require exploratory and descriptive methods to adequately define terms which can be consistently applied by different nurses. Qualitative research has been referred to as the first level of inquiry (Norris, 1982). The retrospective and clinical models are essentially qualitative, that is, descriptive in nature; however taken alone these methods have limitations that threaten the validity of findings. The present study was an attempt to combine models to enhance the quality and richness of data collected.

Chapter 2

Method

Design

This study was a qualitative, descriptive analysis of diagnostic data on coping phenomena of the adult patient and his/her family. The data were collected through interviews of nurses in acute care settings about patients in their current and past caseload who were diagnosed with problems in coping with their illness experience. For purposes of this study, coping problems were defined as episodes in which patient's thoughts and behavioral responses for managing situational demands, generated internally or externally, were significantly strained or constrained due to the nature of demands or the lack of needed resources. Nurses were asked to describe patients to whom a coping diagnosis was applied.

Interviews followed a semi-structured format. General questions were open-ended with a broad focus to allow participants maximum opportunity to reveal specific information which they found to be relevant. As interviews progressed, more specific questions were formulated based on data already provided by participants to clarify or verify information.

Patient records were also reviewed when they were accessible. Data obtained from interviews were analysed for themes describing the nature of situations nurses related in which patients or their family were having problems coping. Cases were examined for recurrent patterns in five areas: (1) nurses' interpretation of the meaning of situational features to patients and their family, (2) patient and family coping responses, (3) defining characteristics of coping problems, (4) the influence of contextual features of the care setting on the diagnostic process identified by the nurses, and (5) terminology used by nurses to describe coping problems. Additionally, nurses' terminology and implied definition of concepts related to coping were compared with terminology and definitions approved by NANDA.

Participants and Setting

Setting. Study participants were selected from those nurses who worked with patients on three medical-surgical wards in two large metropolitan hospitals. Nursing diagnosis was introduced in these settings about the same time: 1980 and 1982. In each setting, content on nursing diagnosis has been included during a period of orientation for new nurse employees since its introduction. Performance expectations and standards of documentation mandate the use of nursing diagnosis in practice for hospital nurses in these settings. Nurses are expected to conduct a comprehensive nursing assessment when admitting patients and to diagnose conditions they are accountable to treat. The nursing diagnoses and a plan of treatment are documented in the medical record, and referred to by all nurses providing patient care.

Participants. Nurse participants were recommended by their supervisors based on the following criteria: (1) minimal education of a baccalaureate degree in nursing, (2) at least five years of experience with their current patient population, (3) skilled in working with patients who have coping problems, and (4) recognized for their expertise by peers. In one setting, nurses listed were rank ordered for their expertise in treating patients with coping problems by their supervisor. The highest ranked nurse was selected from this listing for interview. In the other setting in which supervisors did not rank nurses' expertise, those who worked full-time were selected over those who worked part-time. Five nurses were asked to participate; all agreed to be interviewed.

Data Collection Procedures

Institutional review and approval were obtained through the appropriate research review bodies and nursing administration. Informed consent (see Appendix A) was obtained from nurse participants. Participant anonymity was protected by coding data without reference to nurse or patient names or other personally identifying data in tapes, field notes or written reports. Interview tapes and field notes were maintained in a locked cupboard with access restricted to the investigator.

Semi-structured interviews lasting 45-60 minutes were conducted and tape recorded in the privacy of a closed room on-site where nurses worked. A separate interview session was conducted for each case described. The initial interview schedule consisted of an open-ended question asking the nurses to describe their assessment of the patient with a significant coping problem. During the interview, questions were generated to clarify information and to probe for data on the meaning of events to the patient or family members as understood by the nurse, patient and family behaviors, feelings, decisions, consequences of patient and family behaviors and decisions, and the nurse's intentions, feelings, actions and conclusions regarding coping phenomena. At the end of the interview nurses were asked what additional information would have been useful for a clearer understanding of the coping phenomena. Data were abstracted from patient records containing the nurses' admission assessment, nursing care plan, and progress notes in the two current cases in which nurses reported recording coping diagnoses.

During the course of study, two major changes in the interview schedule were made. Beginning with the third and subsequent interviews, nurses were asked to summarize the problem and to identify characteristics that were critical in diagnosing the coping phenomena at the end of the interview. Beginning with the fifth and subsequent interviews, nurses were asked to describe past cases, if possible, in which patients exhibited behaviors other than anger (a recurring theme) in responding to coping phenomena. When anger was identified, questions were generated to probe for the nurse's perception and interpretation of the relationship between anger and coping in patient situations described.

The first two participant nurses were selected from those caring for a patient group homogeneous with respect to a disease process as a major life factor affecting coping. Subsequent sampling decisions were based on data from interviews. Redundant themes in the two cases from nurses working in the same hospital unit led to the decision to select nurses from another unit with a potentially different patient population for variety in patient situations eliciting nursing diagnosis of coping. The decision to stop sampling was based on the richness and variety of data collected. Nurses described a wide range of coping problems in patients they cared for, and it was clear after eight cases that it would take many more to reach saturation. The magnitude of sampling needed as suggested by the small number of cases obtained was beyond the scope of this study and the investigator's resources.

Data Analysis Procedures

Each interview consisted of from 9 to 17 single spaced pages of transcription. The raw data were systematically analysed using techniques from grounded theory (Glaser & Strauss, 1967) and analytic induction (Lincoln & Guba, 1985) to uncover generalities about nursing diagnosis of coping problems. The data were coded concurrently with interviews to reveal major themes occurring in situations as a guide for subsequent interview questions and selection of nurse participants.

The amount of text used as the unit of analysis varied according to the research questions. For the first question, directed toward describing the nature of the patient situation, large sections of text were used to identify categories. Codes were identified for categories which had relevance to the question; each category was labeled, whenever possible with the respondents' own words.

Definitions or decision rules for categories were written for reference as inclusion criteria for data and revised when needed. The data were coded, coding categories revised, then data were recoded. This iterative process was used until all of the coping situations were adequately described by the categories and the coding categories could be reliably applied to the data. The same process was iterated for questions two, three and four. For question two on the defining characteristics of the coping diagnosis, the size of text varied from one sentence, usually quotes of patient or family, to a paragraph describing an entire nurse-patient interaction. Text in which nurses identified contextual features in the care setting that had an influence on the diagnostic process, question three, tended to be only a few sentences. The size of text coded for question four, terminology nurses used to label coping problems, included only a few sentences. Coded data were placed on 5x8 cards and labeled with category and subcategory headings. These categories will be defined in the next chapter in conjuction with the results of data analysis.

Lastly, situations were summarized from each data set by abstracting relevant content to reduce redundant information and order events in the narrative as a way of maintaining the integrity of the whole situation in an easily read text. They were examined for the fit and representativeness of NANDA nursing diagnostic labels and definitions to answer the fifth research question. Text containing nurses' terminology in labeling coping problems and defining characterisitcs were compared with NANDA diagnostic terminology and defining characteristics.

Chapter 3

Results and Discussion

In this chapter a description of the patient cases in the sample is presented followed by a discussion of analytic procedures and findings. Interview data are presented and discussed in relation to each research question.

Sample

Eight patient situations were described. Three were current patient situations and five were past situations that were considered to be outstanding examples of coping phenomena by the nurses involved. Coping problems of individuals were described in five cases and family coping problems in three cases. Male and female patients were included in the sample described ranging from 35 to 70 years of age. Acute and chronic health conditions were represented, including a psychiatric diagnosis, which were being treated by medical and surgical modalities. Patient characteristics are summarized in Table 2. A brief summary of each case follows including the major coping concerns and issues defined by the nurse.

Table 2. Description of Patients Coping with Health Conditions

Case	Age	Sex	Significant Others	Health Condition/ Duration
1 Current	64	F	Husband Daughter	Metastatic Breast Cancer/ >3 years
2 Past	50	F	Husband Children Boyfriend	Metastatic Gall Bladder Cancer/ >2 years
3 Past	70	M	Children Son-in-law	Hepatoma/Recent-about 1-2 weeks
4 Past	45	F	Husband Daughters	Sepsis/ >3 weeks Acute Renal Failure Diabetes/ adult onset
5 Past	35	M	Fiance Mother	Renal Failure/ >1 year Diabetes/juvenile onset
6 Past	40	M	Wife	Asthma/ ? Schizophrenia/ ? R/O Cardiac Disease
7 Current	50	M	Sons Ex-wife	Malignant melanoma/ Recent diagnosis-n days
8 Current	37	M	Mother Lover	AIDS/ ? Perianal Herpes/ ? CMV Retinitis/ ?

Case 1. The patient was a 64 year old housewife married to a retired air force colonel. Numerous treatments for the patient's metastatic breast cancer over the past three plus years had included double mastectomies, adrenelectomy, colon resection with a resultant colostomy and chemotherapy. The nurse had cared for the patient since her initial diagnosis and described her as a very quiet person, independent and always looking nice. She had become very debilitated and was now totally dependent requiring highly skilled nursing care. The current treatment included antibiotics for a urinary tract infection, tube feedings, and patient controlled analgesia.

When the family asked about hospice care, the doctor told them she wasn't going to die soon and hospice wouldn't give her the kind of treatment she needed. Usually passive and quiet, the patient finally expressed her desire to go to an extended care facility, because "she would feel safer," but the patient's husband feared his wife would die if she went to a nursing home.

Case 2. The patient was about 50, married with children and grandchildren. She had cared for her husband, who had a cardiac disorder, for the past 10 years. They had separated after she was diagnosed with cancer of the gall bladder, because "she couldn't deal with him not understanding that she was sick and that she needed some help." A year later, following initial treatment with chemotherapy, she was readmitted with uncontrolled pain. This time her husband and an attentive daughter were with her.

The patient was very frightened and didn't want to be left alone. Her daughter described her as always having been kind of nervous. She had her light on a lot. "It was just 'help me, help me' and if you asked what is it I can do to help you, she couldn't tell you." Several days elapsed before it was discovered that she had an infarcted bowel. Meanwhile a lot of people began to believe that she was making it all up, "as if she was completely unable to cope with the fact that she had the disease and it had advanced." Referral to psychiatry resulted in treating her with thorazine. Her affect changed then and for the first time she was calm.

Case 3. The patient was a 70 year old Korean man who was diagnosed as having a hepatoma. This was a shock to the patient's family as he had been well and living alone independently. Also, they had recently lost their mother in a car accident. Family members wanted to stay overnight with the patient, but were unable to as he was in a two bed ward. They were very upset when his condition declined significantly overnight. The son-in-law, a practicing pharmacist, attributed the decline to the use of Benedryl for sleep. Despite assurances by physicians that his condition was due to the liver cancer, family members continued to question that aspect of his treatment.

After the patient was moved to a private room, family members were vigilant, staying with him in shifts and directing the nurse to do trivial things; "every little thing had to be perfect." The nurse sensed feelings of guilt in the family: "It's just kind of an instinct, because I've seen families in the past that have maybe felt like, well, I should have been more involved in his life while he was healthy. And maybe I would have picked up on some of these things."

<u>Case 4</u>. The patient was a female, in her forties, married with four grown daughters. She had adult onset diabetes and had undergone surgery at another hospital after which she developed sepsis and acute renal failure. She had been in the intensive care unit for three weeks and was still in a coma at the time of her transfer to the general care ward. The ICU nurses had reported family members opposed the transfer; they thought the patient too ill. The nurse described the family as anxious. "I remember that they hovered very close to the bed. They didn't want to leave the room. They would direct me to do things." In a conference with the family, family members were able to talk about feelings of anger with the patient, because she hadn't taken very good care of herself; she had a lot of minor infections and didn't manage her diet "the way that she knew that she should have." When the family discovered that agency nurses rather than the regular hospital staff were assigned to care for the patient, they angrily protested.

<u>Case 5</u>. The patient was in his mid-thirties. His fiance and mother, who lived out of town, were with him daily. He had juvenile onset diabetes and had been on continuous peritoneal dialysis and then hemodialysis for about the past year. The nurse had cared for him since the

onset of his renal failure, and was now caring for him after renal and pancreas transplants. He had warned the nurse that he wouldn't cope well with rejection should that occur. The nurse described a change in his behavior following signs of transplant rejection from that of an outgoing guy who smiled and joked a lot to a withdrawn frightened man venting his anger on his family.

Case 6. The patient was a male caucasian, about 40 years old, married to a Filipino and estranged from his family of origin. He had a history of asthma and shizophrenia and was undergoing cardiac and respiratory testing. He would angrily demand to see his doctor when nurses attempted to assess him for complaints of difficult breathing and chest pain. He told them "you don't know what you're doing and I should go back to the Philippines." The nurses became frustrated and began avoiding the patient. Assessments and testing didn't reveal any cardiac pathology. After the patient "blew up" at his roommate and began yelling, the nurses requested consultation from the psych nurse. It was discovered the patient was frightened and anxious about his symptoms and what they might mean for his lifestyle. Also he had been unable to contact his wife, who had no phone, and felt overwhelmed outside his adopted culture without social support.

Case 7. The patient was a male truckdriver in his 50s who had traveled away from his home to a tertiary care center to rule out malignant melanoma. He was divorced and supported two teenage sons who lived with their mother. He had undergone surgery and was placed on an extended care ward where minimal time was spent with patients. The nurse was told the patient was demanding before she met him. The patient was described as angry and his roommate said he got real negative.

The patient shared a litany of complaints with the nurse that included a medication error on another unit, dissatisfaction with his medical workup prior to surgery, and discomfort from drains in the surgical site. The patient learned after his surgery when a CAT scan was done that his cancer had spread and he had six months to live. He told the nurse "I can't feel anything about it. That's just the way it is." He refused chemotherapy and wanted a second opinion.

Case 8. The patient was a 37 year old single male with AIDS and painful perianal herpes lesions that were refractory to treatment. His mother visited him daily; and except for about a month while he was gone on vacation to Greece, his lover was also a constant visitor. His condition was very poor; he was unable to eat, taking only oral fluids. He was totally dependent and would get "jittery, twitchy motions when he attempted to move."

After being told that his condition wasn't responding to treatment and he probably wouldn't get better, a decision was made to stop aggressive treatment and concentrate on the patient's comfort. The nurse reported the patient withdrew at that time and was uncommunicative for about a week. He later agreed to see someone from a local AIDS volunteer group and resumed interactions with staff and family.

Research Question Number One: What patient situations are diagnosed as coping problems requiring independent nursing intervention?

The data were analyzed in two ways. First they were coded for medical diagnosis and other major, obvious, shared features of illness that emerged, i.e., time from diagnosis, prognosis, physical condition, treatment and the health care context; coping resources were also identified as significant features of coping situations. Secondly, qualitative analysis was employed to examine the data for recurring themes across illness and resource categories.

Data elements clustered within two constructs, background meanings and coping responses. Within the construct of background meanings are three major categories: (1) meanings of illness, (2) meanings of care, and (3) meanings of resources. The nurses described patient situations in terms of their meaning to the patient and/or family, and this interpreted meaning constituted the nurses' assessments of the patients' coping. Background meanings were the underlying factors related to patient and family coping responses. Within the construct of coping responses are again three major categories derived originally by Karen Horney (cited in Billings, 1980) and nine subcategories of specific responses. Horney's categories were selected both for the fit with the data and because, as Billings proposed, they suggest directions for nursing intervention based on patients' needs. Additionally, these categories simplify complex concepts and are sufficiently neutral and broad enough for clinical application.: (1) moving toward, (2) moving away, and (3) moving against. Figure 1 gives an overall outline of constructs and major categories. Relationships are suggested only in a very broad sense, i.e., that coping responses are embedded in the meanings of situations to individuals and their family.

Categories are not intended to be hierarchical; neither are they exclusive nor exhaustive. Categories are not all on the same level and are of variable size. Further research would need to be done to develop descriptions by nurses.

A table was constructed to allow comparison of categories and subcategories across cases. The subcategories of meanings (illness, care, and resources) and coping responses (moving toward, moving away, and moving against) are listed by case in Table 3. Coping responses and the meanings of illness, care, and resources were synergistic; however for purposes of explication they will each be presented separately and discussed in detail although they can only be fully understood as a gestalt.

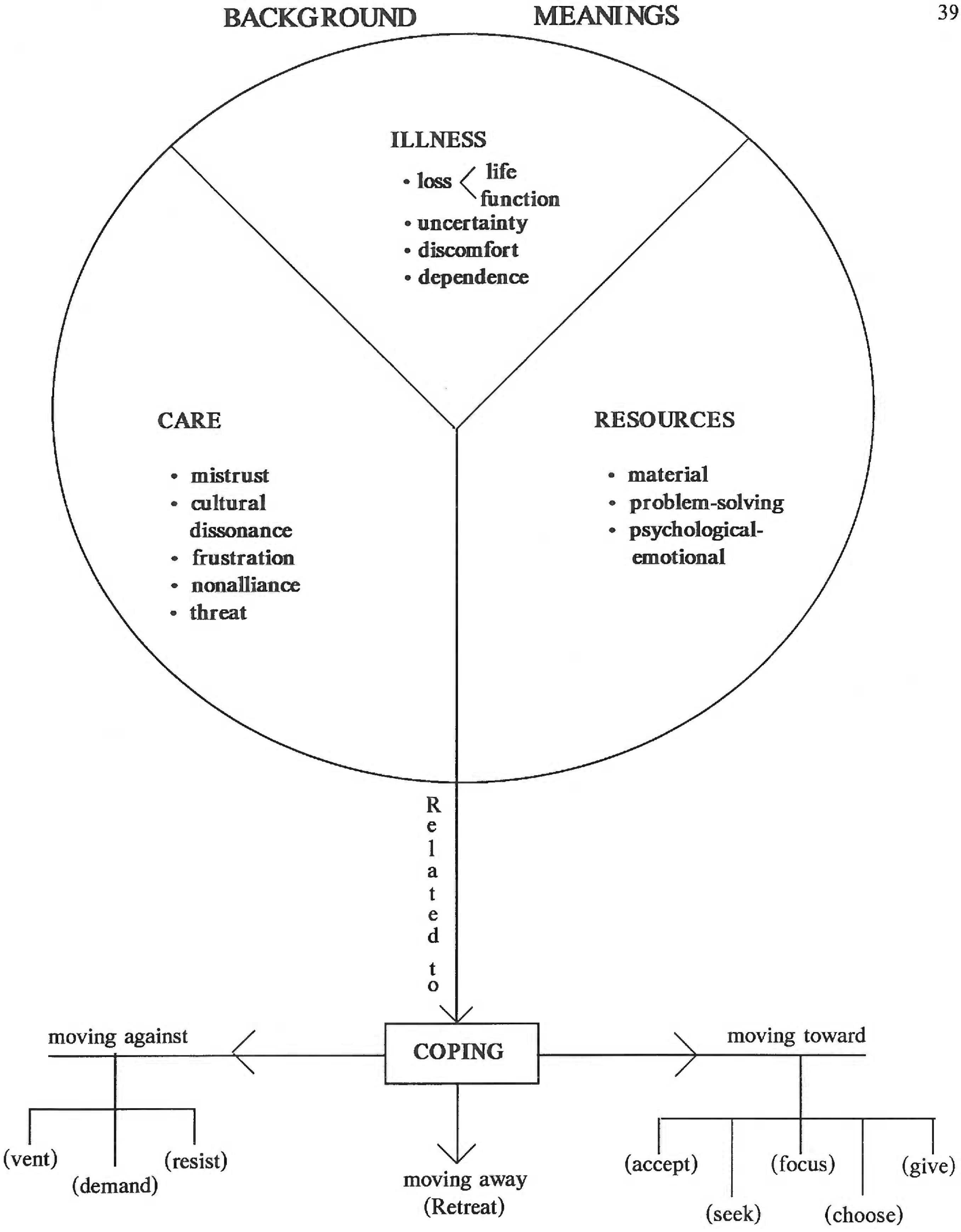

Figure 1. Categories emerging from nurse interviews on patient - family coping problems.

Table 3. Categories of Data Occurring in Patient (P)-Family (F) Cases Described by Nurses.

	BACKGROUND MEANINGS			
CASE	ILLNESS	CARE	RESOURCES	COPING RESPONSE
1	Loss Uncertainty Discomfort Dependence	Threat Cultural dissonance Frustration	Material Psychological	Moving toward (P-F) Moving against (F)
2	Loss Uncertainty Discomfort	Nonalliance	Material Psychological	Moving toward (P)
3	Loss	Mistrust Cultural dissonance	Problem-solving	Moving against (F) Moving toward (F)
4	Loss Uncertainty Dependence	Threat Mistrust Frustration	Material Psychological	Moving against (F) Moving toward (F)
5	Loss Uncertainty		Psychological	Moving against (P) Moving away (P)
6	Loss Uncertainty Discomfort	Threat Cultural dissonance Mistrust Frustration Nonalliance	Problem-solving Psychological	Moving against (P) Moving away (P)
7	Loss Discomfort Dependence	Mistrust Frustration Nonalliance	Material Psychological	Moving against (P) Moving away (P)
8	Loss Discomfort Dependence		Psychological	Moving away (P) Moving toward (P)

Meanings of Illness

The category of meanings of illness was defined as the patient's or family's evaluation of the meaning and significance of illness related experiences they found stressful in the day to day course of living with illness as understood and described by the nurse. These were derived from data which included elements on physical condition, pathology, symptoms, treatment and prognosis. Four major themes on the meanings of illness were found: (1) loss, (2) uncertainty or ambiguity, (3) discomfort, and (4) dependence. Each theme and subcategories, when they exist, will be presented and discussed in turn.

Loss. In all situations, the critical nature of the illness presented significant anticipated losses, (1) death, of self or significant other, and (2) vital functional losses. Patient and family emotional responses were described, with a mix of responses in each case, and are listed in order of their frequency of occurrence: (1) anger- 5 cases, (2) fear and anxiety- 5 cases, (3) shock in the form of disbelief or difficulty "accepting" information about diagnosis and prognosis- 3 cases (4) guilt- 2 cases, and (5) sadness- 3 cases.

The prognosis for patients was very poor in six cases; five had diagnoses (cancer, AIDS) associated with terminal illness, however uncertain the remaining time. In the other two cases patients anticipated losses due to kidney transplant rejection or cardiac dysfunction which were associated with a dreaded dependence on others and major lifestyle changes. Nurses reported the threats to life and functional abilities were extremely stressful to patients and their families as the following excerpt illustrates.

> He obviously was real fearful. I could see a frightened look in his eyes. He asked a lot of questions. Questions that wouldn't have a good answer. It was like he was searching for me to tell him that everything's going to be OK. But of course I couldn't tell him that...He said to me one day, "I just can't lose this kidney, because I can't go back on dialysis. Dialysis is terrible....His fiance came back (after his discharge from the hospital)...and she was in tears. Apparently he wasn't doing real well at home. Her words were to me, "he told me to just get out of his life." Her interpretation of that was that he wanted just to die. (Case 5)

Benoliel (1985) has discussed the multiple facets of loss related to terminal illness. Loss was acknowledged as "a central experience in human development" (p. 439) and major losses defined as those that place a heavy demand on personal and social resources and an "established pattern of coping with adversity and change" (p. 440). The significance of loss was associated with the importance of attachment, potential replaceability, time in the life cycle, amount of disruption incurred, and environmental supportive features.

Time in the illness cycle also has significance in coping with loss. In three cases, diagnosis was recent and patients or their family were just beginning to cope with the meaning of illness and imminent death. This was compounded sometimes by an additional burden, a pressing urgency to make decisions about medical treatment.

Patients experiencing chronic illness and advancing disease were also struggling with an uncertain future in the wake of past discomforts and treatments that failed to provide a cure. Changes in condition were seen as new or renewed threats.

One patient with cancer was hospitalized for the second time because her pain had become uncontrollable. Although it was acknowledged that her cancer "had advanced," her abdominal pain, which was inconsistently relieved by morphine, was felt to be exaggerated until several days later when it was discovered she had an infarcted bowel. As her nurse described it, her fear of dying was translated into an obsession with a dreaded future and a terror of being alone.

> She was terribly afraid about the eventual outcome and I think so absorbed with that, that she couldn't live. She used a lot of energy being painful, screaming all the time and shouting. She had her light on a lot. She didn't want you to leave once you got there. She would say, "don't leave me. I'm too afraid. It's too scary by myself." (Case 2)

<u>Uncertainty or ambiguity</u>. In five cases, the meanings of illness were uncertain or ambiguous. Uncertainty about events, i.e., not knowing when or if losses were going to

occur, was significant in determining patient and family responses. Lazarus and Folkman (1984) discuss the stressful chararacter of event uncertainty in illness as it sets up opposing pathways for coping and often results in mental confusion. If loss is anticipated, coping may focus on mourning and preparations (when appropriate) for compensatory functions, whereas hope and coping strategies that enhance recovery follow if loss is unlikely. Being unsure may lead to continued worrying and indecision with concomitant increased arousal in the form of fear and anxiety. In cases involving uncertainty about diagnosis or prognosis in this study, patients and family members experienced fear and high levels of anxiety.

In the case of one patient with a cancer diagnosis, uncertainty regarding what was causing the increased and difficult-to-manage pain also posed problems for caregivers and may have contributed to the painful sensations.

> She was probably hospitalized that first time for a week...and then she came again and her disease had advanced a whole lot....Had lots of pain and the unfortunate thing, I think, is that a lot of people began to believe that she didn't really, she was making all of this up. And it was just as if she was completely unable to cope with the fact that she had the disease and it had advanced. They did some studies and couldn't find a reason for her pain. So she had lots of, uh, don't-leave-me kinds of times and, so much that she impressed physicians

> to have the psychiatric people come see her because she seemed clear out of control. (Case 2)

Discomfort and Dependence. In five cases, disease and its treatments brought significant discomfort in the form of pain, nausea and difficulty breathing. These discomforts arose from painful herpes lesions, tumor metastases, asthma-like attacks, chemotherapy and post-surgical drainage. Three patients were totally dependent in activities of daily living, two due to extreme weakness and additionally one had neurological involvement from AIDS further affecting his ability to care for self. The third patient, who was septic, was comatose. One other patient was dependent on nurses for care of his drain following surgery. This dependence was a significant factor in his inability to cope with the discomfort experienced with the drain. Discomfort and dependence were vividly illustrated in the first case.

> She got chemotherapy through an arterial line for over five days and was flat on her back for those days. And then when she got up she was just so weak, and then with the chemo, it's debilitated her and now she can't eat. She's kind of got like a [sic] inferior vena cava syndrome from the blockage from the pelvic tumor. She's just kind of swollen, from the nipple line on down, and we've been giving her lots of diuretics and stuff to try to get rid of that. And she got the UTI and we had to take her foley and now she's incontinent. On and on and on. So there's a lot of, she is a very sick

person. (Case 1)

Meanings of Care

The category of meanings of care was defined as the patient's or family's evaluation of the meaning and significance of health caregiving processes they identified as stressful. These were derived from data on the level and type of care needed, cultural aspects of the hospital setting, and patient/family perceptions of care given or planned. Conflicted caring emerged as a major theme of the meaning of care to patients and their family members. Conflicted caring encompassed situations in which conflicts arose between patient or family and caregivers in the hospital. Five subcategories were found: (1) mistrust, (2) nonalliance, (3) threat, (4) cultural dissonance, and (5) frustration.

In all but two cases, there were conflicts, whether real or perceived, between patients or families and health care providers regarding treatment planned or received. Perceptions that patients' care or future plans for care were less than adequate were threatening, and mistrust was associated with prior and current experiences perceived as poor care. Nurses felt mistrust of providers and perceptions of threats were often justifiable and were rooted in patients' or families' anxiety and fears. Frustrations were evident in situations in which the needs of patients were not met.

Communications between patients and care providers were important in forming and changing these perceptions. One patient who was reported to be very demanding "listed a whole litany of complaints" when the nurse first met him.

> Most of the interaction with the staff was regarding his drains. He wanted them emptied on an hourly basis and the staff thought he was crazy basically. (In) Extended Care, we're alloted X number of hours, so what you do for them is real minimal...and he was on the light about every hour. The nurses were all getting tense, because he was way down the hall.... I talked to him and he said, "You know, if you had a drain attached to your body that was hanging there, after it gets a little full, it's heavy and it hurts." Perfect sense, made perfect sense. But he never communicated that to anybody. Nurses always care for drains and we don't teach our patients to do that. What we did with that was train him to drain it himself. This was unusual. Which worked out beautifully and really did serve to de-escalate his demanding behavior. (Case 7)

Conflicts precipitated diagnosis of coping problems, in some cases after patient's coping behaviors disturbed the smooth functioning of the hospital ward. One nurse described how she felt as well.

> Usually his demands were needing to see a doctor because (he thought) the nurses didn't know what they were doing and once the doctor got there he usually either didn't have a problem at that time

> or he did the same thing to them...The man had a problem, I think, dealing with his lack of control over his situation in the hospital. He didn't have a support group. He came from the Philippines and his wife was overseas and he just didn't seem to be coping with his situation real well. Here was this man who vented a lot on the staff or other patients over that two to three weeks. Inside I felt very angry and frustrated. I felt, here I am trying to help this person and he is yelling at me. And won't let me help him...Realizing this was becoming a ward problem, because the nurses then were not wanting to take care of this patient, we decided to call in our psych nurse to speak with him, with his permission. (Case 6)

Conflicts related to differences between customs of the patient or family and policies and common practices in the hospital stood out in three cases. These conflicts or differences were labeled "cultural dissonance." In one case, hospital rules which forbade families to stay overnight with a patient in a double room placed strain on the family of second and third generation Asian immigrants who would normally stay with the patient at all times. Unfortunately, the patient suffered a significant decline in his condition in their absence. This, coupled with the fact that he received a medication for sleep which may have contributed initially to his decline, was considered a major factor in some temporary mistrust of hospital staff. The event made it more difficult for the family to arrive at a clear understanding of the patient's fatal liver cancer and need for immediate decisions about care.

Another instance of cultural dissonance occurred with a patient's husband who was accustomed to exercising control during a military career and now was faced with accepting a decision he didn't make and didn't agree with. To him, transferring his very ill wife to a nursing home for continuing care once aggressive treatment was completed was tantamount to letting her die. "I'm afraid that if you send her home or if you send her to a nursing home she's gonna die." His nurse was careful in her talks with him about the proposed transfer plan, referring to a nursing home as a skilled nursing facility.

> Back when I worked in a nursing home, they didn't have skilled care. They didn't do IVs and stuff like that, so. And I explained that to them too. That nursing homes can, within a nursing home, have skilled beds....We don't use the word nursing home, because that has a very negative connotation. His father just this winter, beginning of the year I think, died and they transferred him to a nursing home and he made it for about one day and died in the nursing home...He said it was just really depressing and he made it there one day and then he died. And you know, that's common. We've sent a lot of patients out and they're there for like two days and they just give up, I think. I think he's afraid too that (his wife) will give up. (Case 1)

Nonalliance between individual patients and their health care providers surfaced in three cases. Nonalliance was defined as a state in which staff did not connect with the patient or family to establish a trusting relationship in the caregiving situation. In these situations, staff did not understand the emotional motivation for behaviors and distanced themselves rather than entering into an empathic relationship. Interpretation of behavior was based on inadequate information and biased judgments which were recognized by the nurses in their diagnostic process as seen in the excerpts below.

> I think a lot of the nurses did- "Oh, he's a psych problem and there's nothing we can do about this kind of behavior" (Case 6)
>
> I think sometimes what happens is you'll have a patient and the staff sometimes will have a preconceived notion about them already. And it kind of colors how you sort out what the true situation is. When the staff looked at this man's current case, they saw a demanding person who was a real pain-in-the-neck. (Case 7)

Care provider decisions and actions that patients or families found threatening did not necessarily accord with nonalliance even when extreme dissatisfaction with care was expressed. It was difficult for the nurses to endure protestations which either maligned or strongly questioned their judgement and skills or others of the health care team and yet they did. Having an understanding of the patient's or family's underlying feelings explained a perspective that allowed them to engage in caring for patients and families with respect for their concerns. The most extreme case of that in this sample highlights the nurse's capacity for understanding the meaning of the situation to the family and the importance of a cohesive health care team.

> I got the feeling from them that they believed that somebody had screwed up somewhere (at another hospital). And I think that they tended to blame. And then I think they decided that this was a target. They couldn't pick on the ICU, because they knew how dependent this women was in the ICU. And they couldn't pick on the physicians because the physicians were responsible for their mother's care, but here was something that they could pick on. We can pick on the nursing staff and we can pick on this one specifically because she's letting agency nurses take care of this person that we love so much. So I got a lot of these currents of anger from them and I was real real lucky in that (the nephrologist) was such a strong advocate for me. It was amazing to me how much I could take from them. I mean, they just kept at me, at me, at me, at me...So I had (the health care team) all being somewhat protective, you know, but still letting the family vent as much as they could without letting me break down. Which I didn't do until the end. You know after they had left. (Case 4)

There were two cases in which no conflicts with providers were reported. Both patients, who had chronic illnesses, were from the same nurse's practice, and so factors related to the nurse may explain the absence of conflict in these situations. One had AIDS and was at the end stage of his disease and another with juvenile onset diabetes had just been transplanted with kidney and pancreas.

It may be these patients had experienced conflicted caring at sometime in the course of their illness and had developed what Thorne and Robinson (1989) describe as guarded alliance. In their qualitative study of 77 patients with chronic illness, the researchers concluded that relationships between patients and providers evolve through stages of naive trust and disenchantment to guarded alliance. Patients' and families' reconstrusted trust in providers was described by perspectives labeled hero worship, resignation, team playing and consumerism. Variations in their perspectives were explained by dimensions of trust, in a health care professional and in their own competance.

Meanings of Resources

The category of meanings of resources was defined as the patient's and family's evaluation of the meaning and significance of resources for coping options to manage stressors. These were derived from data elements on social supports and intrapersonal aspects. Social networks of patients were described and were important resources within each situation. Families were in the foreground for all patients in this sample, whether or not they were present physically, and were sometimes the focus of nurses' concerns about coping phenomena they described. In the case of a family whose loved one had terminal cancer, the husband dominated the nurse's assessment and intervention for coping. In the case of two patients who were comatose, diagnosis of coping was oriented to families. When the family's coping needs were the focus of nursing diagnosis, resources identified came from within the family.

The meanings of resources for patient and family fell into three categories of functional typology and were labeled (1) material support which included money, home, and services, (2) problem solving, and (3) psychological and emotional support.

Material Support. Tangible support was significant for coping in three cases and varied in qualities of availability, usefulness and cohesiveness. In some cases, material support was available, but could not be used. Availability was defined simply as the presence of potentially supportive resources; usefulness referred to support that was applied in the situation; and cohesiveness meant that supportive resources worked together toward a common goal. For example, financial support was available as perceived by a family member in one case in the form of income and medical insurance, even though this could not be used to provide continued care in the hospital setting as desired due to economic constraints in health care financing. Family had to search for a skilled nursing facility despite divided agreement among members that this was an acceptable option. The lack of cohesiveness, i.e., disagreement and attendant resistance in this effort, was a source of distress for both family and patient.

> You have to consciously remind yourself to include her in the conversation because she doesn't say anything. Her husband is more outspoken, but sometimes he doesn't ask what she wants. He's trying to do what he thinks would be right for her. We were talking about going home with 24 hour nursing care and she finally spoke up and said, "I don't want to go. I don't want to do that". She wanted to go to a skilled nursing facility as an interim step. I asked her, and it's cause [sic] she would feel safer. And I was really glad that she spoke up for herself. She is a very modest, a very private person. It's hard to read her. (Case 1)

In this case the daughter, who was a single working mother, was not available for caregiving as she lived in another city and the husband, although available, was not useful in this capacity in the nurse's assessment.

> He leaves the room even when we change her bed or change her colostomy bag or any of the care related to her. He's been uninvolved. He's very supportive and caring, but not in terms of the hands on care. And that's why when they say go take her home with nursing care it would have to be

> 24 hour skilled nursing care, because he would not be that involved I don't think. (Case 1)

Material support, as services in the quest for pain control, in one case was available, used and highly cohesive.

> He was very concerned that people attend to what (his wife) needed. I can remember him saying something like "Somebody has to do something" and insisting that they find out what was causing her problem....I think it depended on her level of how uncomfortable she was. Sometimes she did screaming sorts of things. And as it escalated for her, then his sense of urgency, he would need, in a more demanding way, need somebody to do something....Her daughter who would visit would try to do calming sorts of things, either with words or with rubbing her mother's shoulders and neck. (Case 2)

Problem Solving. Problem solving included dimensions of assessing, i.e., gathering and analyzing information about an identified problem, choosing or deciding upon a course of action or reframing appraisals to achieve new understandings. Resources for solving problems were important in two cases. In one case, family members were coping with decisions about care for their father. They were available and useful to each other, and although there was some discord among members about the best option, most members agreed in choosing comfort measures over aggresive but probably ineffective treatment. The other case in which problem solving was relevant, the patient's family was inaccessible and he was unable to "figure out what it was that was going on with him."

> He wouldn't do it on his own. No. He needed some assistance there. And I'm not sure his personality was really, it would be a major project, I think, to teach him how to do that. (Case 6)

Psychological and Emotional Support. In three cases, patients had been referred to tertiary care centers far removed from their home and families. These important resources could not be drawn on for psychological and emotional support in these cases. Nurses described this as a factor related to patient/family distress. The patient with schizophrenia had a history of conflicted support with his family of origin, but had developed supportive relationships with people in the Philippines where he had been living. His difficulty in communicating with his wife overseas who had no phone was seen as a critical underlying feature of this patient's anxiety.

The nurse's interpretation of this patient's behaviors incorporated her understanding of his adopted culture and went beyond simple recognition that he missed his family. Conway and Carmona (1989) discuss the importance of cultural assessment in determining the patient's perception of illness and hospitalization. In commenting on groups with active extended family systems, they point to the stress of hospitalization which tends to isolate patients from family. The Filipino, they note, "learns to pool his well-being with that of his family" (p. 70).

Patient's social networks displayed variations in their cohesiveness affecting provisions of psychological and emotional support to patients and each other. These ranged from a united front in communications with providers and shared vigilance with their loved one in the hospital to separation of the patient from the family at one point in time because she felt her need for care and love could not be met at home.

In the only case in which the nurse actually witnessed conflict between patient and family, the nurse revealed the complexity of the situation in which the patient learned from one of his doctors that his mother and fiance were squabbling.

> It was intensified (his angry behavior toward his family) after they had started squabbling. It was as if he perceived it was a legitimate reason to be angry. It was, well gosh, here's a good way to vent everything. I can get all my frustrations out under the excuse that they're fighting and causing trouble. When the real issue is, he was scared to death he was going to lose his transplant. (Case 5)

Coping Response

Coping responses included efforts, both behavioral and cognitive, to manage situations of disrupted health states. Three major categories emerged and were labeled as (1) moving-toward which included approach behaviors of resignation and acceptance of care, seeking (information, social support, or religion), giving social support, choosing care options, and temporal focusing, (2) moving-away which included behaviors of retreat (withdrawal, distancing and giving up), and (3) moving-against which included behaviors of resistance or opposition to care and venting (discharging feelings).

Moving-toward. Moving-toward was defined as thoughts, words, and actions which reach out to others and or health care, offered or given. In five cases, patients or family members responded by approaching each other or caregivers in coping with the meanings of illness and care. Behaviors included resignation and acceptance of prognosis and care options, seeking information, seeking and giving social support, seeking religion, choosing among care options, and temporal focusing.

In two cases, there was a considerable difference in the intensity of seeking resources. One patient's need for social support was so great that "she took a lot of energy, because she had her light on a lot. She didn't want you to leave once you got there...everyone who came into the room would get the same, help me, help me, help me". Whereas another patient, was very circumspect in seeking religion.

> Another thing we talked about as far as coping stuff was, did he, he was one day talking a lot about religion and stuff. And it was hard to understand quite what he was saying, so I jumped on that and said, "Do you want the hospital chaplain

> to come and talk to you? Has religion been an important thing in your life? Is that something you want to do?" And he adamantly said No...I remember him saying something about the bible, and something about God...now I see there is a Bible on his bedside table. (Case 8)

One patient's pattern of socialization changed during his illness. He was described as very independent and it was known that he hadn't told his mother how ill he was in a previous hospital stay. "He describes her as kind of doting, a doting mother, and he didn't want to be doted on. But now, I think he realized that it's OK for her to dote. He's really sick and he needs the support and she needs to be able to give it to him."

Temporal focusing was a concept which emerged to contain descriptions of patients who were "stuck" in time. For them, their anxiety over imminent death, whether personal or their family member's, narrowed their perceptions to a concern for some dreaded future. For one patient, being alone with her fear of death was an intolerable time. For the husband concerned about his wife's care, the anticipated time of transfer to the nursing home so captured his attention that he couldn't hear the nurse's reassurances.

> He'd be thinking of all these reasons why she couldn't go and you know, we try to explain to him. No we weren't going to send her out today, and that was not the plan. The plan was long term, to make plans down the road when she is to the point where

> she could get the same care in a skilled nursing facility. But he didn't hear any of that. It's, you know, she has to leave today. Well she's gonna [sic] leave Monday. Well how are we going to get her ready by Monday and that kind of stuff. (Case 1)

Benner and Wrubel (1989) speak of the concept, temporality, drawn from the philosopher, Martin Heidegger, who describes this phenomenon of time as having some qualitative significance. In this study, temporal focusing was seen as a way of confronting the event by moving to the future when some dreaded event would occur. Present time faded to the background while a certain future time became the focus of attention and attempts were made to draw caregivers with them. The husband who opposed plans for transferring his very ill wife to a nursing home attempted negotiations with the nurse in what for him was the significant time, i.e., the time of transfer.

Moving-away. Moving-away was defined as expressed thoughts, words, and actions that created distance, avoided, or minimized awareness of situational aspects or interactions with others, and health care given or offered. Withdrawal responses were reported in four of the individual coping diagnoses. Withdrawal responses were symbolized by the concept of retreat, which included a sense of going to some safe place, rather than just going away from some threat. In one patient, retreat shut out the nurses who had avoided his calls for help while he preserved his integrity, in some safe place, in what may have been an humiliating situation for him.

Thoughts and feelings of patients who retreated were not explicated; however, denial often associated with withdrawal may not have been operating in these cases. For example, the patient who refused chemotherapy expressed mistrust in care providers and wanted a second opinion before any further care. He acknowledged difficulty in accepting his diagnosis indirectly in a casual conversation with the nurse prompted by a television show and later talked about his poor prognosis directly. The nurse saw that he needed to go to some place where he felt more in control or secure, if only for a time.

> That gives him a little more control over the situation. And maybe doesn't physically buy him time, but emotionally buys him time to deal with his prognosis. And those are ways of coping. (Case 7)

The two patients in this study who did not have reports of conflicted caring both responded to their anticipated loss by withdrawing. Although reasons for their behaviors were inferred rather than validated directly at the time they occurred, they may have been instances of resignation; they may have reflected a common coping pattern for these patients; or both. Resignation was characterized by Thorne and Robinson (1989) as a feeling of powerlessness in which patient's showed little trust in their provider's ability to help them. In one case treatment failure was clear to both the patient and providers.

> The doctors flat out said to the family during the care conference, his prognosis is very poor. He's probably not going to recover this time. Jo (pseudonym) wasn't in attendence at the care conference, but he did come around then. His confusion went away and they told him too. They told Jo that nothing we're doing is working on these herpes lesions and you're not doing well and probably won't. I wasn't in attendence when they told him that, but I heard through hospital communcation channels. When he realized that nothing was working he started withdrawing. (Case 8)

Although the above situation seems straightforward, the patient's relationship with his lover may have played a part in his withdrawal. In what must have been an unfortunate timing of circumstances, his lover left for a long planned vacation to Greece within a day or two of the above disclosure to the patient. The patient cried the day he left and though withdrawal behaviors were seen before the lover left, the loss of his presence may have profoundly affected the patient's coping responses at this crucial time. Attempts to engage the patient succeeded only with topics unrelated to feelings at this time. In this case, the nurse did not feel the patient's coping was ineffective. Rather, he interpreted this as part of the normal grieving process, even though it was very disturbing to watch, and made himself ever ready for communication when the patient chose to talk.

Another patient who attempted to distance himself from his fiance, asked her to move out and leave him alone. He told her he wanted to die. He preferred giving up over returning to dialysis.

> That really let me know that, gosh, this was more than just having a little trouble dealing with how things are going. This is kind of major stuff when we heard that he was just wanting to be left alone to die. Also his fiance had stuck with him through all this transition of going through end stage renal disease and was always there for him and did whatever she could. (Case 5)

Moving-against. The category of moving-against was defined as thoughts, words, or actions which were in opposition to others or resisted health care offered or given. Venting feelings of anger, fear, or anxiety was most common occurring in four cases. One nurse remarked, "I think that people get angry as a way of denying their own feelings." This nurse shared insights on the phenomenon of patients discharging feelings on nurses, especially nurses with whom they feel safe, e.g., don't expect reprisals for their behavior.

In a large scale survey on verbal abuse in nursing (Cox, 1987), 82% of staff nurses and 81% of directors of nursing reported multiple experiences of verbal abuse in their practice. Comments in the survey revealed that nurses expect this and see it as "part of the territory...providing an outlet for temper tantrums" (p. 49).

An understanding of the patient's anger and its relationship to coping was explained by one participant, when reflecting on a current case description.

> What I didn't really see in him is the need, the anger, if there could be something stimulating the anger. I didn't get that far with him and now looking back, I think maybe he was afraid. Maybe that fear was coming from the fact that he was kind of stuck. Maybe everything was done for him and there was nothing else that he could do and maybe he was really afraid that he was going to hear that and maybe too he really knew that he was going to hear that. And that can kind of stick you in that helpless feeling. Seems to me you kind of flounder around trying to hang your feelings on something. And for him it was, hey the care here has been really cruddy. And you know, I'm going to let everybody know it. So that might have been going for him. (Case 7)

Resistance to health care offered or given was described in three cases. Patient or family members sometimes disagreed with provider actions or plans and actively resisted or aggressively demanded changes by the health team. Resistance was associated with mistrust in provider's decisions in one case based on previous experience. In all three cases, resistance was explained by nurses as a way of gaining control.

Summary. In summary, the diagnosis of coping problems was elicited in situations of threatened loss, uncertainty, discomfort, and dependence resulting from illness, often associated with conflicted caring, whether real or perceived, arising from the health care context. Patients and families experienced mistrust or nonalliance with caregivers, threats or frustration from caregivers' actions or plans, and in a few cases, cultural dissonance. Coping was influenced negatively and positively with variations in the availability, usefulness and cohesiveness of social resources in these situations for material support, problem-solving, and psychological or emotional needs.

Patients and families responded in varying ways through emotional currents, often angry, attempting to resolve or manage disrupted health states. Coping manifested in moving toward others, including caregivers, with varying intensity for information, social support, or religion; accepting or choosing care options; sometimes attempting to move others with them into the future to confront some dreaded moment, of death or abandonment. At other times coping involved moving away, retreating to some safe place, or moving against caregivers or family members by venting strong emotions of anger, fear and anxiety; by resisting caregivers and aggressive demands to meet their needs.

Research Question Number Two: What patient characteristics are considered as critical in the decision to intervene in these situations?

Cue patterns form the defining characteristics which may be interpreted to explain and distinguish nursing diagnoses (Carpenito, 1983). Cues are the data which are used to arrive at nursing diagnoses. They may signify change, deviations from a norm, or pattern development indicating the presence or risk of problems. Critical cues are those which are highly reliable and highly valid (Gordon, 1982). The data were coded for cues of coping problems. The data were coded in two ways: (1) by data source, i.e., the methodological nature of the data, and (2) by the substantive nature of the data, i.e., as cues indicating coping problems. In the first coding, cues were clustered into broad categories of (1) behavior, (2) direct reports of patient, family or staff, (3) extrapolation from personal history, and (4) nurses' intuitions. In the second coding, subcategories of data were coded within each data type: behavior included arousal, selective attending, aggressive negotiation/demands and for families only, vigilance; subcategories of reports included feelings and concerns; the data on personal history and intuitions varied considerably so coding was not refined further. Cues were examined within cases for patterns as defining characteristics and were compared across cases for commonalities.

Behavior. Observed behaviors included facial expressions and actions, which included bodily movements that were both purposeful and nonspecific, i.e., had no apparent purpose. Arousal in the form of anger, i.e., angry affects and bodily gestures, stood out as the most common critical cue signalling coping problems for nurses in this sample.

Anger is a basic emotion common to humans and other species. It is viewed as a protective instinct (Lorenz, 1963; Gaylin, 1984) with autonomic responses to threats which may be expressed in hostile actions or turned inward. The inward expression of anger may take the form of self blame with guilt and negative thoughts or withdrawal, which is often associated with denial and somatization and illness (Thomas, 1988). For humans, threats may be real or perceived, present or potential.

Anger varies with the nature of threats and appraised coping resources to deal with those threats. In one view, anger is seen as a source of power for the threatened individual to combat feelings of powerlessness (Roberts, 1986). Anger may be a converted form of anxiety and is often associated with fear and guilt (Gaylin, 1984; Roberts, 1986).

Benner and Wrubel (1989) discuss the "language of embodied intelligence" (p. 76) in which emotions are viewed as a nonreflective bodily response to a situational gestalt offering important guidance for coping. Anger in this frame of reference gives a clear warning to the individual and others in the situation that something is amiss. The anger expressed by patients in the paradigm cases presented by nurses in this study were most often seen as stemming from real threats which were not always amenable to problem-solving skills.

In only two instances was anger acted upon in a destructive manner. Rather, anger propelled patients and families more often to engage care providers in the resolution or management of threats. The anger associated with protective behaviors of families was judged as appropriate, although distressing to care providers. This was also true in judging individual patient's behaviors; some of whom were able to obtain assistance in solving some problems through their expressions of anger.

In the situations described, the sources of anger were multidimensional. These were presented above in the meanings of illness and care. Frustration with providers' actions was evident in several cases: in the resistance of a husband to plans for transferring his wife to a nursing home; in a family's displeasure with the transfer of the patient from ICU before they thought she was ready; in a patient's demands to have his drain emptied every hour; and in a patient's angry response to the nurse's attempts at assessment rather than calling his doctor for episodes of chest pain and difficulty breathing.

Betrayal of trust in cases where the patient or family felt providers were at fault engendered anger: when a patient was given medication associated with a decline in his condition; when a patient felt the approach to care was not well thought out prior to intervention and compared unfavorably with outcomes for his sister's disease seen as similar to his. Anxiety, fear, and sometimes guilt were feelings displayed or reported by patients and families in conjunction with angry words and behaviors.

Specific signs of anger were described with some prompting of nurse participants. Our common understanding of this emotion usually needs no description other than this single word, angry. When nurses were able to provide some description of patient or family behaviors, these were terse and sometimes as abstract as the concept of anger, such as "hostile, threatening, intimidating, short with the family, blew up." One nurse was particularly descriptive.

> He just seemed, wasn't really explosive, but seemed like he had that potential. Just angry...his face would get really red. And he'd, you could just hear the tension in his voice. And his voice would start to get louder and louder and everything he said was negative...Seemed like nothing was going right for him and everything reminded him of all those things that didn't go right. And it was just kind of like fireworks. (Case 7)

Arousal of strong emotions other than anger was observed less often. The husband who was concerned about plans to transfer his very ill wife to a nursing home was not characterized directly as angry. However, desriptions of him as threatening and intimidating along with his "obsessed" behaviors in trying to convince staff to keep his wife in the hospital suggested anger mixed with his anxiety. As discussed above, fear and anxiety were common. Sadness was observed in three situations in which patients' confronted their imminent death. Two patients cried, one very briefly who then grimaced in what was a characteristic facial expression for him when talking about distressful content.

Behaviors of selective attending were seen clearly in two cases. These included lack of eye contact and lack of response to reassurances or information given when talking about stressful subjects. When focusing on a future event, the patient or family member were inattentive to present events and interactions, behaving as though they were not fully present. Nurses were sometimes unsure if a patient or family member heard what was said because they did not acknowledge remarks or respond as expected.

Aggressive negotiations included behaviors in which patient or family members argued heatedly with caregivers attempting to shape caregiver responses to meet their own needs. Vigilance was expressed by behaviors families exhibited in attempting to protect the patient. This included testing, directing, and watchfulness. Family members tested nurses, asking if they knew what they were doing, and directed them to be careful or to do something. Watchfulness was acutely felt by nurses in two situations, both at times of transition for the patient and family when they seemed alert to any danger. Vigilance is well captured in the following excerpt describing the family's behavior after transfer of the patient from intensive care to the hospital ward.

> I remember mostly that they hovered. They hovered very close to the bed. And they didn't want to leave the room. They would direct me to do things. "That's her line for this. That's that line that does this. And make sure that doesn't come out,

> and, do you know what you're doing with that bottle?" (Case 4)

Reported Feelings. Patients and family members reported feelings of distress including fear, anxiety, and in one case denial of feelings about prognostications of death within six months. Family also reported concerns about patient welfare and sometimes questioned the appropriateness of caregiver decisions and actions. Other nurses' reports or patient roommates were sources of important information. In the former, ICU nurses were instrumental in alerting the nurse to family concerns about a patient's transfer to the ward that were critical in assessments of family coping.

Personal History. Patients and family shared information about personal experiences and sociocultural aspects in their histories that were relevant to coping problems. These included data on past losses, lifestyle, coping responses to previous stressors, a psychiatric diagnosis of schizophrenia, prior use of antianxiety medications, substance abuse, and cultural preferences and history. One patient told his nurse that he didn't cope well with "little crises" and that he wouldn't be able to cope with transplant rejection should that occur.

Intuition. Intuition included a spontaneous understanding of behavior based on "feelings" about situations. These judgements were not necessarily based on verifiable data, but were instances in which the similarity of situational features to past experiences was strongly sensed. In a pilot study done to identify the nature and role of intuition in expert clinical judgment, Benner and Tanner (1987) found that nurse experts perceived patient situations as a whole and were able to diagnose complex unstructured situations in which verifiable evidence was lacking. Benner and Tanner defined intuition as "understanding without a rationale" (p. 23).

Intuitions of fear and anxiety underlying angry behaviors were described by nurses. One family's mistrust of the health care team, the nurse felt, was attributed to perceived malpractice at another institution. Intuitions also included recognition of guilt feelings of family members in reaction to loss in two cases.

> I got the feeling somehow that there was a lot of guilt involved...I don't have enough knowledge and background to know how to get at that...but I got the feeling that there were some fairly odd dynamics there. A lot of guilt on the part of the husband. Maybe that he didn't take care of her, that he didn't pay attention to her. And here she was on her deathbed. And what was he going to do? And I got that from the kids too..."Maybe we didn't appreciate her." I think everybody did, is threatened like that, the loss of somebody in their life. Goes through that feeling of guilt. I thought this was a little bit more than what you'd expect. (Case 4)

Summary. Nurses' reports of critical characteristics of patients and families were derived from observations of behaviors indicating emotional arousal, the most frequent of which were signs of anger; and sometimes were intuitively inferred, as signs of fear, anxiety and guilt. Concerns and feelings were reported by patients and families concomitant with observed arousal. Behaviors were sometimes described as selective attending, aggressive negotiation/demands, and vigilance, prompting diagnosis and intervention by the nurse. Disclosure of personal history provided significant background information for nurses' interpretive assessments of what was seen and heard.

Research Question Number Three: What contextual features in the health care setting do nurses identify which influenced their diagnosis of patient coping situations?

Contextual features of the health care setting that were salient to the diagnostic process in these particular situations were related without deliberate prompting. Data elements fell into three categories labeled (1) resources, (2) nurse-patient relationships, and (3) workload.

Resources. Nurses described three different colleagial resources useful in diagnosing patient and family coping phenomena. These resources included a nurse specialist in mental health, a social worker, and collaborative nursing rounds in which peers discussed difficult cases and made recommendations on diagnosis and intervention.

> We were kind of stumbling around, not quite understanding what his problem was. He did have a psych history, and so the first thing, I think, a lot of the nurses did was, "Oh, he's a psych

> problem and there's nothing we can do about this kind of behavior". But as we delved deeper into and got some expert advice from our psych clinician, we began to understand this man a little bit better. (Case 6)

Nurse-Patient Relationships. Some aspects of the relationship between patient-family and nurses emerged as important contextual features of diagnosis. Two nurses had cared for patients in multiple hospital admissions as the primary nurse and were able to develop an indepth understanding of their behaviors and experiences.

> Sometimes when patients express their anger to me I don't deal with it very well myself. But with him, I've known him ever since he first came down with his renal failure and I have a good rapport with him. I get along real well with him. And so I knew why he was being so angry. (Case 5)

In other situations, shared cultural traits provided an understanding of behaviors and practices that were salient to diagnosis. Conversely, patient situations that were difficult to understand were related to cultural differences.

> I went in and he did a lot of avoidance, looking, he would not a lot of times look you in the face. He looked away and I wasn't sure if that was a cultural type thing. I know, in the Asian culture anyway, there's a lot of that. And that's usually more feminine than masculine. (Case 6)

Workload. The busy workload of nurses constrained data collection at times. Caseloads were affected by organizational factors on level of care and situational factors of day to day staffing. One patient was limited in the amount of nursing hours available when assigned to "Extended Care." One nurse related difficulty in doing a thorough nursing history or finding time to read the patient's chart because of her workload. In another situation, the nurse described constraints for caring when sick calls decreased staffing for a shift making it difficult to take time for ongoing assessments of patient and family coping.

> Well, like on Sunday we were down [short] three nurses. And how do you take the time to sit and talk to them? I've made the time, and I seem to be able to make the time to talk to him. But sometimes there are some days there's like, I don't want to hear this again. I don't have time to go over this whole thing again. So I talk, I brief her, you know, when I have five patients and I'm running around. I feel real bad, because I feel like I don't have the time to spend with them that I would like to....So there are times where it seems like you can get the basics, give her the meds, give her that stuff, but the psychosocial stuff comes when you have time. (Case 1)

Summary. Nursing diagnosis was influenced positively by colleagial resources and negatively by workload. Background aspects of the nurse-patient relationship that enhanced trust and mutual understanding were significant to the diagnostic process. Shared experiences through repeated contacts, knowledge of cultural practices and an awareness of patient or family vulnerability in the health care setting enabled nurses to interpret coping from a client-centered perspective. The data also suggest that nurses in this sample, acknowledged by peers as experts in treating patients with coping problems, were highly empathic.

Research Question Number Four: What is the range, diversity, and consistency of terminology used to label coping problems?

Except for one participant, nurses characterized each patient situation with summary statements that included the term coping (or cope with) with descriptors that qualified coping; all included related factors that identified the major stressors. In two of the current cases, coping diagnoses were written in the patient record and included the term coping, qualifiers, and stressors. Summary statements were conceptualized as the nursing diagnosis label (Table 4). One nurse also stated the coping problem as a "conflict". The nurse who did not include the term coping when summmarizing, expressed the problem in terms of feeling states (fear, anger, mistrust, and guilt).

Table 4. Summary Statements of Patient Coping Problems by Nurses

[Written] Alterations in coping related to metastatic breast cancer with progressive metastatic disease
[Stated] Coping with the fact that she's dying and feeling of abandonment if she has to go somewhere else

[Stated] Unable to cope with the fact that she had the disease and it had advanced; she was afraid to die/being by herself

[Stated] Conflict with the family in terms of the life threatening illness/Alterations in coping with life threatening illness and recent diagnosis and anger that they felt

[Stated] Fear and anger and mistrust in the system, and the medical care...mixed in with some guilt

[Stated] Alteration in coping, ineffective individual (related to) losing hope/potentially losing his kidney/grieving processes longer (than expected)

[Stated] Problem with coping, individual, related to his anxiety/too overwheming, fear and anxiety and lack of support

[Written] Ineffective Individual Coping Secondary to Diagnosis (changed to) Secondary To Grieving
[Stated] Alteration in individual coping related to his diagnosis/needed some control over his environment (changed to) alteration in coping secondary to the grieving process

[Stated] Potential ineffective coping related to terminal illness and failure to thrive

Qualifying terms for coping included the following: alteration in (4), unable to (1), problem with (1), potential ineffective (1) and ineffective (1). Three identified the individual in stated diagnoses and one in a written diagnosis. One nurse identified the family in a stated coping diagnosis. Major stressors related to coping that were included in diagnostic statements referred to losses, feeling states, variables of care and social support resources. Life threatening or terminal disease states (3), advanced or progressive disease (2), and hopelessness (1), suggesting critical losses associated with disease were cited. Feeling states were also referred to as stressors related to coping: fear (3), abandonment (1), anger (2), grief (2), anxiety (1), mistrust (1), and guilt (1). Variables of care included "the system, and the medical care" (1) and having "to go somewhere else". In one case, lack of support was identified as a stressor.

Summary. Nurses in this sample were consistent in the use of coping as a term for labeling situational problems, which they qualified with a range of adjectives to denote change or difficulty in coping. Although there were similarities in the concerns of patients and families, e.g., loss, diverse terms were used to describe these specifically.

Research Questions Number Five: How do the identified patient situations and characteristics compare with coping diagnoses accepted for testing by NANDA as defined at the Eighth Conference on the Classification of Nursing Diagnosis?

Although there was some similarity between diagnostic terms, i.e., alterations in coping, used by nurses in this sample and NANDA terminology, patient and family coping problems described did not fit the definition for the label ineffective coping- for individuals or family diagnoses, and more often included defining characteristics that were unique to the data.

In this sample, nursing diagnoses did not match NANDA constructs for individual and family coping phenomena from three perspectives: (1) discrepancy in concept definition: nurses' implied definition did not match NANDA's concept definition, (2) discrepancy in coping theory: nurses qualified coping in process terms versus an outcome, i.e., ineffective, and (3) discrepancy in problem orientation: nurses' viewed coping from the patients' perspective versus the caregivers in describing coping problems.

Discrepancy in Concept Definition

The NANDA (Carrol-Johnson, 1989) definition for ineffective coping hinges on the concept of impaired adaptive behaviors and problem solving abilities. In order to assess whether patients' adaptive behaviors are impaired, information on prior coping is needed. In four cases, current coping responses were described as similar to past responses to problems or crisis and did not meet this definition of impairment.

Nurses sometimes did not have information about prior coping patterns. In four cases, past coping responses were unknown to nurses. Some of the nurses identified lack of knowledge about patients' personal histories, wishing for more information to better understand their current responses.

> I never had a sense of what she was really like. And here we had her in this environment that was completely alien to her life. I don't know exactly what more, except maybe to have seen her function on the outside. (Case 2)

Nurses' implied definition of coping problems was that of an overwhelming situation for which the patient and family were unprepared, and in which they had little control over problem management or resolution. The situations presented novel stressors for which patients and families had no effective strategy for coping. Coping styles, i.e., cognitive and behavioral patterns of coping to situations across the life-span, have been the focus of much research, however our knowledge in this area is incomplete (Lazarus & Folkman, 1984).

Discrepancy in Coping Theory

The NANDA label of ineffective coping assumes an outcome without a specific context. Situational crises, maturational crises, and personal vulnerability are listed as related factors to ineffective individual coping. However, these non-specific abstract factors do not relate how individuals vary in their interpretation of crises and the background of meanings for those interpretations. This view is inconsistent with concepts central to nursing on person-environment interactions.

As discussed in the introduction, coping behaviors and coping outcomes are different, interacting concepts. It is important to evaluate coping outcomes, however to combine these concepts into a diagnostic construct may not be helpful in communicating patient problems as a guide for nursing intervention. Too often, avoidant coping is seen as an ineffective way to deal with situations. Yet, this may be highly effective when confronted with stressors which cannot be solved through instrumental or problem-solving means.

Nurses did not qualify coping as ineffective except in two cases. In case five, the term "ineffective" was not applied in initial decriptions of the coping problem when anger and withdrawal were viewed as a part of the normal grieving process. However, the same responses when prolonged were later interpreted as ineffective coping by the nurse. In this case, prior coping described by the nurse was consistent with the patient's current coping response. In light of the patient's chronic illness, diabetes, past coping responses may have been shaped by experiences in which he felt little control over outcomes, leading to feelings of helplessness.

In another case, the term ineffective was included in the written diagnosis, but not stated in the summary by the nurse when interviewed. In the nurse's interpretation, this patient's coping response was effective for him. It may be that the label used to record the diagnosis reflected terminology in use by the institution, but not the nurse's thinking about a specic patient situation.

In most cases, there were multiple coping responses suggesting that patients and families were attending to more than one aspect of the situation, i.e., responses were simultaneously focused on emotional control and problem resolution and were sometimes fluid, changing with the prominence of various situational demands. A variety of terms were used by the nurses to qualify coping, e.g., alterations, unable to, problem with, which are process oriented and do not imply an outcome. Multiple responses described gave a flavor of the complexity of coping, in which efforts may achieve some goals better than others, but all efforts are meaningfull within the context of specific situations. This finding is consistent with that of Lazarus and Folkman (1984) who comment from a theoretical and an empirical base that problem-focused and emotion-focused coping can both facilitate and impede each other.

Discrepancy in Orientation

Finally, since nursing diagnosis seeks to describe the patient's (or family's) response to health states, the onus is on the patient (or family) when using the term ineffective to qualify coping phenomena. Use of the term ineffective may set up a bias or mind-set which predisposes the nurse to focus on the patient's personal shortcomings in a coping situation with less attention given to situational demands.

In four of the five individual coping situations described, coping responses of patients were judged appropriate by nurses. Nurses described an empathic understanding of responses in these cases, "I just put myself in his shoes and thought, I know I wouldn't act in a normal manner. I might regress a little and be real fearful." In one case, the nurse acknowledged a partial understanding in retrospect.

In all cases descriptive of family coping, responses were also judged appropriate. Family coping constructs identified in NANDA writings (Carroll-Johnson, 1989) include the terms "ineffective" (disabling or compromised) and "potential for growth". "Coping, Ineffective Family: Compromised" compares to the family coping phenomena in this sample in much the same way as the individual coping label applies for individuals in this sample. According to the NANDA system, compromised family coping is:

> Insufficient, ineffective, or compromised support, comfort assistance, or encouragement, usually by a supportive primary person (family member or close friend); client may need this support to manage or master adaptive tasks related to his or her health challenge. (Carroll-Johnson, 1989, p. 540)

Family support in most instances was not insufficient or ineffective. Family members who "hovered" over their loved ones were said to be partially motivated by guilt as well as concern for their well-being. Even so, this was acknowledged as a normal response in the situation. Nurse's were able to care for patients and family based on an understanding of these behaviors.

In the case described under the section on Meanings of Resources, conflicts among family members did not clearly result in ineffective support for one patient. In this instance, the nurse's interpretation of the patient's response to the "squabbling" of his mother and fiance over how much he should be walking after surgery did not indicate support deficits needed for this patient's adaptation to the situation. Rather, the nurse indicated the patient used the family disagreement as a vehicle for discharging feelings of anger. The nurse implied this may have been helpful to the patient at that point in time, in coping with his underlying fear and anxiety over signs of transplant rejection.

Coping problems of patients and families may also present coping problems for caregivers. Emotion-focused coping by patient or family in the face of extreme unavoidable stress, not uncommon in illness, often proves to be a significant challenge for the caregiver. In one situation, the patient's coping response to news of treatment failure was not viewed as ineffective despite its stressful nature for the nurse.

> It was like taking care of a vegetable. He wouldn't talk to us. Everything was superficial and you know he had all these thoughts going on in his mind. He had to with all the issues he was dealing with, and yet he wasn't expressing them. That was hard. I would have liked to have seen him be the model of self-actualization or something. Spilling his guts and all that stuff, right from the start. But of course that doesn't happen. (Case 8)

Outcomes may vary for a coping response used for different demands and at different points in time when demands are continuous; and when immediate or long term effects are measured. Judgments may be biased if certain coping efforts are labeled as productive and others as destructive or nonproductive without taking into account the needs of the person who is coping or the nature of demands. Larazus and Folkman (1984) warn against labeling any coping strategy as inherently good or bad.

One of the defining characteristics considered to be critical in making the diagnosis of ineffective coping in the NANDA literature is the verbalization of inability to cope. This could also be viewed as an adaptive behavior, i.e., a way of seeking help when the individual's coping resources are exceeded.

Comparison of Defining Characteristics

Critical defining characteristics were compared with those listed by NANDA (Carroll-Johnson, 1989, p. 538). See Tables 5 and 6. The major similarity between characteristics of individual coping phenomena in this sample and those listed by NANDA were: (1) states unable to cope or unable to ask for help, and (2) inability to meet role expectations or basic needs. There were few cases in which other NANDA characteristics were present. This was even more pronounced in family coping phenomena in which two of the five characteristics for ineffective family coping were not present in any cases. Characteristics critical in defining coping problems were more often unique to the data in this sample for both patient and family.

Table 5. Frequency Defining Characteristics Matched NANDA Listing for Ineffective Individual Coping or Were Unique to Data on Individuals.

Characteristic	Frequency
NANDA Listing	
.States unable to cope or unable to ask help	3
.Inability to problem-solve	1
.Inability to meet role expectations or basic needs	5
.Inappropriate use of defense mechanisms	2
.Alteration in societal participation	2
.Change in communication patterns	2
.Verbal manipulation	1
.High rate of illness/accidents	0
.Destructive behavior toward self and others	2
Unique to Data	
.Arousal -anger most commonly (sometimes with reports of distressful feelings-e.g. fear; sometimes with reports of concerns)	5
.Personal History	4
.Intuitions of guilt, fear, anxiety	4
.Retreating	4
.Venting	3
.Seeking (information, religion, social support)	3
.Selective attending	2

Table 6. Frequency Defining Characteristics Matched NANDA Listing for Ineffective Family Coping: Compromised or Were Unique to Data on Families

Characteristic	Frequency
NANDA Listing	
.Client concern/complain re: SO* response with concommitant personal reaction, e.g., grief	1
.SO's expressed inadequate understanding or knowledge that interferes with effective assistance/supportive behaviors	0
.SO's asssitance/support attempts less than satisfactory	1
.SO withdrawal or limited/temporary communication with client at time of need	0
.Protective behavior of SO disproportionate to client's ability or need for autonomy	1
Unique to Data	
.Reported concerns of SO with concommitant arousal-i.e., anger fear, anxiety	3
.Vigilance	3
.Personal history	3
.Selective attending	3
.Intuitions of guilt, anxiety	3
.Resistance to care/plans by SO	2
.Seeking information	2
.Venting	2

*SO: Abbreviated for significant others which included family members, fiance and "lover" of patients.

Summary. Patient situations identified by nurses as coping problems within their domain were not well represented by NANDA labels. Three areas of discrepancies were evident: (1) in coping problem definitions; (2) in theory underlying coping concepts; and (3) in orientation of coping problems from the perspective of patients-families versus caregivers. Defining characteristics salient to nurses' interpretations of coping problems were more often unique to data on individuals and families than they were similar to those listed by NANDA.

Nurses' implied definition of patient coping did not suggest impaired behaviors as NANDA defines ineffective coping. Knowledge of patient-family past coping responses to stressors provided important information for nurses' interpretations of current coping responses. These responses were not viewed as impaired; instead they were explained as ways of coping with strong emotions aroused by novel stressors or insoluble problems, and as ways of gaining control over some aspect of situations in which there seemed little opportunity for control.

Coping phenomena described by nurses fit within a transactional theory of coping contrasted with a stimulus-response model suggested by the coping diagnoses accepted for testing by NANDA. Coping responses were described in process terms, and the use of ineffective to qualify coping was generally avoided. Ineffective coping, suggesting an outcome or product of coping, did not often apply to the nurses' understanding of coping responses they found appropriate at specific times in specific situations.

It may be that the range of diagnoses for coping problems is at this time too limited. Ineffective coping may reflect a persistent pattern over time and if so defined would suggest different intervention than would coping problems related to novel stressors for which past coping strategies may not be effective. Lazarus and Folkman (1984) give examples of different treatment strategies that have been effective for recurrent and novel coping problems. For instance, desensitization as a treatment for recurrent fearful response to specific stimuli differs from stress innoculation techniques used for treatment when anticipating coping problems.

Coping problems were viewed by nurses from the perspective of the patient-family although they may have elicited coping problems for caregivers. Patient-family personal history gave nurses a background for understanding ways of coping, and intuitions about emotional responses to coping problems. Patients were sometimes tagged as demanding or ineffective copers when their responses disrupted the smooth functioning of hospital staff. Yet, nurses were able to go beyond personal feelings to gain an empathic understanding of patient-family concerns in their diagnosis of coping phenemena.

Chapter 4

Summary

In this chapter a summary of the research study and conclusions will be presented. Limitations of the study are discussed and recommendations for future study suggested. Finally, this chapter ends with some thoughts on the implications of study findings for nursing practice.

Research Summary

The classification of nursing diagnoses is an important process for the discipline of nursing. The specification, clarification and definition of concepts which describe phenomena within the treatment domain of nurses provides a cornerstone for communication, practice and research. Diagnostic concepts and terminology need to be grounded in the everyday practices of clinical nurses. The current taxonomy of nursing diagnoses, mainly derived by the group empiricism method, is tentative and requires ongoing testing and refinement.

The NANDA diagnoses used to label coping phenomena have not been adequately tested. Ineffective individual coping is a major diagnostic category subsuming more specific diagnoses of impaired adjustment, ineffective denial, and defensive coping. There are inconsistencies in the definitions and defining characteristics between this major category and its subcategories. Only one research study of the diagnosis, ineffective individual coping, was found in the literature and its design did not test the construct's definition.

The study sought to examine the validity of the diagnosis, ineffective individual coping, to extend our understanding of coping phenomena nurses identify and treat, and to compare terms and concepts used by clinical nurses in describing coping phenomena of individuals they treat with those proposed by participants in national conferences for the classification of nursing diagnoses.

This was a qualitative, descriptive study of diagnostic data obtained and interpreted by nurses on coping phenomena of adult patients and their families. Five nurses were selected for interview based on their clinical expertise in identifying and treating coping problems in adults hospitalized for various health conditions. Nurse participants had a baccalaureate degree in nursing and at least five years of experience with their patient population. Information about assessment data and coping diagnoses for nurses' current cases and outstanding past cases was obtained. Taped interviews were transcribed and analysed using grounded theory and analytic induction techniques. The data were compared with diagnostic concepts in the taxonomy of diagnoses accepted for testing by the North American Nursing Diagnosis Association. The specific research questions were:

1. What patient situations are diagnosed as coping problems requiring independent nursing intervention?
2. What patient characteristics are considered as critical in the decision to intervene in these situations?
3. What contextual features in the health care

setting do nurses identify which influenced their diagnosis of patient coping situations?

4. What is the range, diversity, and consistency of terminology used to label coping problems?

5. How do the identified patient situations and characteristics compare with coping diagnoses accepted for testing by NANDA as defined at the Eighth Conference on the Classification of Nursing Diagnoses?

Cases were described by the nurse participants in which patients and/or families were given coping diagnoses. These cases were coded and analysed to answer the research questions. Common themes in these situations included loss, uncertainty, discomfort, and dependence resulting from illness. Conflicts with professional health care providers also emerged as a common theme. With the exception of two cases, patients and families experienced mistrust or nonalliance with caregivers, threats or frustration from caregivers' actions or plans. Conflicts were sometimes associated with dissonance between the personal background of the patient or family and the hospital culture. Intrapersonal and social resources influenced coping responses in positive and negative ways based on availability, usefulness and cohesiveness. The meaning of disruptions in health states and salient situational aspects varied creating different concerns and possibilities for coping.

Coping included three major categories of responses. Moving toward others included approach behaviors of resignation and acceptance of care, seeking information, social support or religion, giving social support, choosing care options, and temporal focusing in which attention was selectively directed toward some dreaded future event. Moving away included behaviors of retreat, i.e., withdrawal, distancing and giving up. Moving against others included behaviors of resistance or opposition to care and venting in which patients or family discharged feelings of anger, fear, anxiety and guilt.

Nurses reported critical defining characteristics of patient and family coping problems that were derived from observations of behaviors, reports of concerns and feelings and disclosure of personal histories by patients and their families, and intuition. Coping problems were most often signalled by anger in patients and families. Other behavioral cues were signs of fear, anxiety, and guilt. Less frequent were characterizations of selective attending, aggressive negotiation or demands, and vigilance.

Nurses identified contextual features in health care settings that influenced the diagnostic process. Colleagues, both peers and specialists, helped nurses to explore and clarify the meaning of patient and family behaviors. Background aspects of the nurse-patient relationship that enhanced trust and mutual understanding emerged as salient in diagnosing coping problems. Shared experiences through repeated contacts, knowledge of cultural practices and an awareness of patient or family vulnerability in the health care setting enabled nurses to interpret coping from a client-centered perspective. Workload sometimes had a negative impact constraining data collection with initial diagnostic hypotheses and ongoing assessments.

Nursing diagnosis of coping problems did not match NANDA constructs for individual and family coping phenomena in this sample. Nurses were consistent in the use of coping as a term for labeling these situational problems; however descriptors used, most commonly "alterations in," contrasted with the term ineffective, and nurses' implied conceptual definitions contrasted with the concept of impaired behaviors in the NANDA definition. Nurses' diagnoses suggested ways of coping with strong emotions aroused by novel stressors or situations not amenable to problem solving, and as ways of gaining control over some aspect of situations in which there seemed little opportunity for control.

Coping phenomena described by nurses fit within a transactional theory of coping contrasted with a stimulus-response model suggested by the coping diagnoses accepted for testing by NANDA. Coping responses were described in process terms, and the use of ineffective to qualify coping was generally avoided. Ineffective coping, suggesting an outcome or product of coping, did not often apply to the nurses' understanding of coping responses they found appropriate at specific times in specific situations.

Conclusions

Several conclusions were drawn from the findings. These are outlined as follows:

1) The variability of situations diagnosed as coping

problems was not well represented by diagnostic labels approved for testing by NANDA.

2) Defining characteristics of coping problems were identified which differ from those listed by NANDA. This may be related to the variability of situations.

3) Organizational factors may constrain or advance the diagnostic process as they affect the hours of nursing care, the mode of care delivery, and access to colleagial resources. Most of the nurses also identified a need to increase their knowledge and skills for assessing coping.

4) Nurses were consistent in the use of some form of the term coping in labeling problems. However, a wide diversity of descriptors characterized summary statements of coping problems that were meaningful to each clinical situation.

Limitations of The Study

Two major limitations in this study are noted. The first may affect theory development and the second may pose a threat to the validity of results.

The small sample in this study was not sufficient for data saturation. The theoretical sampling strategy provided the desired variation; however, resource constraints prevented continued sampling needed to more fully explore properties of categories and relationships among categories. The coping problems identified in this study only serve to illustrate some of the situations that may be encountered in medical-surgical nursing. Many other cases need to be analyzed to develop and clarify diagnostic concepts of coping problems encountered with acutely ill adult patients and terminology used by clinical nurses before results may be generalized. Because of the small sample size, patients or families whose coping responses better fit the NANDA definition for ineffective coping may have been missed. Perhaps the phenomenon of ineffective coping occurs more frequently in other settings, e.g., in mental health clinics.

Of greater concern is the question of validity. The use of past cases may have introduced a systematic bias, and thus threaten the validity of findings. Past cases used were outstanding for the nurses in this sample, one of the criticisms cited of the retrospective model. However, identifying and exploring outstanding cases is not in itself a threat to validity as long as that is acknowledged. Rather, those contribute to the variation seen in coping problems as dramatic situations and may suggest areas of priority for nurses that bear more investigation. The strength of inductive group processes, in which recall was used, lies in the representation and consensus achieved for generating diagnoses. The method of interview and analysis used in the present study, in contrast to the group empiricism method, provided an indepth examination of each case recalled by nurses, and builds on the work of the national conferences.

Nurse participants and the investigator both contributed to the validity of the findings. It may be argued that nurses in this sample mislabeled problems, confusing coping diagnoses with other more appropriate diagnoses, such as anticipatory grieving or anxiety. However, it may also be argued that these problems are appropriately framed by the concept of coping, and that anticipatory grieving and anxiety are factors related to coping. Nursing intervention may be most helpful in assisting patients-families in their coping efforts to manage anxiety and anticipatory grief. Nurse participants were chosen, not for their expertise in using the approved diagnostic language, but rather for their acknowledged expertise in recognizing and working with patients who have coping problems. Expertise was substantive rather than semantic with respect to diagnosing coping problems.

In qualitative research, the validity of findings includes an awareness of the investigator's effect on the field of study and theoretical interpretations of data as concepts and their properties are identified as important. In this study, results are based on a single investigator's coding of the data. Even though systematic techniques were used in coding data, it is possible that a second coder may have derived other categories or applied the text differently to identified categories. Participant nurses were given the opportunity to review case summaries and descriptive analysis as these applied to cases they described. Confirmation of interpretations of the data gave some credence to the validity of results. Readers of the research report need also to examine the fit of results to their practice experiences as a test of validity.

Implications for Research and Practice

Research Implications. This study suggests areas needing further study. First, research is needed to expand the repertoire of coping diagnoses to better represent variations seen in clinical situations. Secondly, the findings raised questions about nurses' skills in diagnosing coping problems and organizational factors affecting this phase of the nursing process. The third area of study suggested by findings is related to the construct of conflicted caring.

First, categories of coping diagnosis need to be expanded and current concepts more clearly defined. Other diagnostic labels need to be constructed and tested which have greater relevance to the coping responses and issues encountered during illness as suggested by this study. The findings of this study may be extended and refined by continued research using similar qualitative methods to describe and define coping problems of acutely ill adults and their families. Further study using this method should include validation of conceptual categories and the reliability of coding by at least one other investigator skilled in this method. A longitudinal design could shed light on the consistency or change in coping responses in context over time. Additionally, ineffective coping as defined presently may apply for some patients; however, the definition and theoretical underpinnings need to be explored further.

Secondly, the study raised questions on the clinical assessment of coping. It may be that nurses need further education and/or skill development in this area. In focusing on the present needs and activities of care, nurses sometimes did not explore the past with patients as a source for understanding their current concerns. In some instances, nurses reported gaps in their knowledge or skill in eliciting this information. In other cases, lack of time due to busy caseloads was cited as a barrier to the data gathering process suggesting that efficient strategies need to be developed for assessing patient and family coping. Also, nurses sometimes expressed new insights which led to new understandings or raised questions for them about patient-family coping phenomena during interviews. This may have been related to a process of reflection prompted by the interviews.

Third, further study is needed on the construct of conflicted caring. This phenomenon has important implications for caregivers as well as patients and families. Research questions addressing these three areas are suggested below:

(1) Is the basic educational preparation of nurses

sufficient for assessment and intervention in the psycho-social domain?

(2) Are there differences in the basic levels of nursing education and nurses' ability to diagnose and treat coping problems?

(3) What effect may collaborative research with clinical nurses on patient-family coping have on their skills in diagnosing coping problems?

(4) What are the precursors to and characteristics of conflicts between patient-family and caregivers?

(5) What are various caregivers' common interpretations and responses to patient-family anger?

(6) How may the environment in hospitals be manipulated to enhance coping of the patient-family with illness and its attendant stressors related to care?

There are also methodological implications for research on nursing diagnosis suggested by this study. The variety and richness of data obtained through this method recommend its usefulness to explore other nursing diagnoses for concept clarification. This could be especially fruitful when differential diagnosis is difficult due to the similarity of diagnostic categories, like hopelessness and powerlessness; and for diagnoses that are as yet undefined, such as anticipatory grieving. Expert clinicians have a wealth of information on patients that may be tapped to describe patient problems they treat which may be difficult to obtain in other ways. Direct observation is very time consuming, and patient records as yet provide inadequate accounts of nursing care in much of the independent domains of nursing. Interviews on patient problems concurrent with care provided offer a rich data source for grounding diagnoses in the everyday practices of clinical nurses. It may be that clinicians and researchers may collaborate in this endeavor to construct diagnoses with language that reflects specific clinical phenomena within the treatment domain of nurses.

Practice Implications. Implications for nursing practice are suggested for assessment and intervention. The findings suggest that expert nurses use a multidimensional approach for assessing patient-family coping. The triangulation of data derived from observation of behaviors, patient-family report of concerns and needs, patient-family history with special attention to cultural factors, and the nurses' intuitions provide a pattern of cues for an interpretation of the meanings of illness and related care as well as coping resources of individuals and their families. It is also evident from this study that knowledge of past coping problems and responses may be important to an understanding of the current situation. Nurses may need further education to enhance their assessment skills in this area.

It is also evident that nurses need to validate their impressions with patients and family. Discussing coping concerns requires communication skills that convey respect for the personal identity and views of the patient-family and that enhance mutual trust in the patient-nurse relationship. The neutrality of diagnostic statements may be an important factor in gaining and maintaining trust. To suggest to an anxious patient that he is ineffectively coping may only succeed in creating distance between the nurse and patient, and cut-off opportunities for the patient to disclose inner feelings or to be open to new possibilities for coping. The data further suggest that family relationships and the effects of illness and hospitalization on the patient-family unit are salient to adult patients' coping, and assessments should include family data in this regard. Again, nurses may need further education and development of skills in this area.

Finally, factors in the hospital environment that constrain patient coping and nursing assessment and intervention need to be addressed. With national attention on the shortage of nurses, recognition has been given to the need for greater involvement of nurses in policy and governance in health care agencies for nursing recruitment and retention. The political and financial environment are timely to forward nursing's agenda in health care which gives greater emphasis to the psycho-social issues of illness and the importance of preventive care. Patient-family coping with illness has entered a new dimension with changes in health care delivery that demand their greater participation. Nurses may provide the leadership needed to develop an environment that is patient-family centered and allows some flexibility in addressing their concerns related to the individual meanings of illness and care.

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Abstract

Title: Characterization of Coping Problems by Clinical Nurses

Author: N[redacted]

Approved:

Christine Tanner, RN. Ph.D., Thesis Advisor

This was a qualitative, descriptive study of diagnostic data obtained and interpreted by nurses on coping phenomena of adult patients and their families. Five nurses were selected for interview based on their clinical expertise in identifying and treating coping problems in adults hospitalized for various health conditions. Nurse participants had a baccalaureate degree in nursing and at least five years of experience with their patient population. Information about assessment data and coping diagnoses on three current cases and five outstanding past cases was obtained. Taped interviews were transcribed and analysed using grounded theory and analytic induction techniques. The data were compared with diagnostic concepts in the taxonomy of diagnoses accepted for testing by the North American Nursing Diagnosis Association (NANDA).

Nursing diagnosis of coping problems did not match NANDA constructs for individual and family coping phenomena in this study. Nurses were consistent in the use of coping as a term for labeling situational problems; however, nurses' implied conceptual definition contrasted with the concept of impaired behaviors from the NANDA definition. Coping phenomena described by nurses fit within a transactional theory of

coping. Coping responses were described in process terms, and the use of ineffective to qualify coping was generally avoided. Ineffective coping, suggesting an outcome or product of coping, did not often apply to the nurses' understanding of coping responses they found appropriate at specific times in specific situations. Nurses' diagnoses suggested ways of coping with strong emotions aroused by novel stressor or situations not amenable to problem solving, and as ways of gaining control over some aspect of situations in which there seemed little opportunity for control. Defining characteristics were more often unique to data on individuals and family rather than similar with those listed by NANDA. Implications for nursing research and practice are identified.

Appendix A

CONSENT FORM

Nola Becket, R.N., is conducting a descriptive study entitled "Nursing Diagnosis: Characterization of Coping Problems by Clinical Nurses" as part of the requirements for graduate studies with the advice and supervision of Dr. Christine A. Tanner, Professor of Nursing at Oregon Health Sciences University. The purpose of this study is to explore the characteristics of nursing diagnosis related to phenomena of coping problems in individual adults hospitalized for various health conditions.

If I agree to participate in this study, my participation will include one or two two-hour interviews by the investigator. The interviews will focus on examples from my current and past clinical practice.

All interviews will be tape recorded and transcribed. The only risk of the study to me is the potential loss of some privacy. My confidentiality will be maintained as much as possible. The researcher will keep my name separate from the recorded interview and transcripts. My name will be coded by number and kept in a locked file so that my confidentiality will be protected. Any information that could be traced to individual patients will be deleted from the transcripts.

The study has been explained to me. Nola Becket has offered to answer any questions that I might have. She can be reached at 279-7456. I understand that I may refuse to participate or withdraw from this study at any time without affecting my relationship with the Oregon Health Sciences University or the Portland Veteran's Administration Medical Center.

I have read the foregoing and agree to participate in this study. In addition, I agree to one of the conditions listed below regarding use of excerpts from interviews with me. My agreement is indicated by my initials by ONE of the following conditions which applies:

______ Transcripts of interviews may be reviewed only by members of the investigator's research committee of OHSU nursing faculty.

______ Transcripts of interviews may be reviewed by members of the investigator's research committee. In addition, excerpts may be used in publications or presentations on the condition that my anonymity be maintained.

______ Transcripts of interviews may be reviewed by members of the investigator's research committee. In addition, excerpts may be used in publications or presentations on the condition that they be attributed to me. I will have the opportunity to review the manuscript and reconsider my decision to have the excerpt attributed to me.

______________________________ . ______________________________
Participant Signature Date Investigator Signature Date

Appendix B

Case 1

The patient, (Mrs. Brown), is (a) 64 (year old housewife married to) a retired airforce colonel. They live in a real nice condominium in (a large Northwest city). She's steriod dependent and when she can't take them, she has steriod crisis which is what brought her in (to the hospital). It's been (over) three years (since) she was first diagnosed with metastatic breast cancer. (She) has undergone numerous treatments, including double mastectomies, adrenelectomy (and) colon resection (with a) colostomy. Has had pleural effusions, numerous yeast infections, and fungal sepsis. It's been really hard for her. She doesn't have any hair now. She's always looked nice- always had her makeup perfect, her wig on, tried to keep everything up.

Right now she has a UTI again. We had to take her foley (out) and now she's incontinent. She (has an) inferior vena cava syndrome from blockage from the pelvic metastases (and is) swollen from the nipple line on down. We've been giving her diuretics (for) that. She (just completed) chemotherapy through an arterial line for over five days and was flat on her back.

She used to be very independent, but is very dependent on us now. (After her) chemo, she was so weak. It's debilitated her; and now she can't eat. She has no appetite (and is on) tube feeding. It makes her nauseated and the pelvic mets make her nauseated. She's got back pain so she's on a PCA (with) continous morphine. She feels lousy all the time and she might not make it out.

She's not receiving aggressive treatment right now. Once (the) antibiotics (are) finished we can't leave her here, so the doctors have talked to the family about skilled nursing home placement. The problem arises with her husband. He said to me, "if you send her home or if you send her to a nursing home she's gonna die". He's afraid she's going to die sooner than she normally would because they aren't going (to) be able to take care of her properly. His father just died this winter after transfer to a nursing home. Mr Brown said it was really depressing. Back when I worked in a nursing home they didn't have skilled care. We've sent a lot of patients out and they just give up, I think. That's common. We don't use the word nursing home, because that has a very negative connotation. He knows that she's terminal, but that we're doing everything for her and making her as comfortable as possible...the doctors are here.

He's an A type personality, a little over 65; still very active and is used to things going his way. He can be frustrating and threatening, intimidating to people. He does have good insurance and makes good money. No matter what we say, his response is narrow focused. He doesn't have a lot of direct eye contact. Almost every day he'll take me aside ranting and raving. His tone of voice gets real excited. He talks faster, emphasizing (with) a lot of hand motions, getting more emotion into it. He's real concerned. He's very supportive and caring but uninvolved in the hands on care. He leaves the room when we change her colostomy bag; even when we change her bed or (with) any of her cares.

(Their only) daughter is a single mother (with) a seven year old and an older child, so she's not free to come down whenever she feels like it. She seemed real close (to her mother). The social worker thought the daughter was more realistic, but when I talked to them she was saying the same things that the father was, that "they don't care, they just want us to get out of here and get the bed".

I think she (patient) gets really tired of hearing it, cause she knows that it's causing her husband a lot of stress. And I think she would like to stay here too, but she is more realistic. I get the feeling from nonverbals and the questions she asks, that she understands what's going on, realizes the bad prognosis. We had this family conference and the family brought up hospice. The doctor told her there wasn't anything right now that was going to kill her; downplayed the hospice and said they wouldn't give (her) the treatments (she) need(ed). She didn't really respond. She's always been a real quiet person. You have to consciously remind yourwelf to include her in the conversation because she doesn't say anything. Her husband is more outspoken but sometimes he doesn't ask what she wants; he's trying to do what he thinks would be right for her. We were talking about going home with 24 hour nursing care and she finally spoke up and said "I don't want to go. I don't want to do that". She wanted to go to a skilled nursing facility as an interim step. I asked her, and it's cause she would feel safer. And I was really glad that she spoke up for herself. She is a very modest, a very private person. It's hard to read her. She has a flat affect, almost a monotone voice.

I'm trying to be an advocate for Mrs Brown who never says anything. Also to be an advocate for Mr. Brown, because he feels like it's him against the system. I feel like I'm in the middle, trying to be on their side and work with social workers and discharge planners. It's been a real struggle. I went over the fact that it's not a decision we can make. Insurance laws and DRGs come into fact. There is some time factor to it. You know how fast (nursing home) beds go. I'd like her to stay here too, but we have to plan ahead. I think he's actually found one nursing home that might be acceptable to him, but now we're not ready (because) this urinary tract thing developed (and) she might need ureteral stents and IV antibiotics.

I was wishing that I had more information about what care people can receive at home and what's covered. And I didn't know what the plan of care, the goal was. To make her comfortable? To be aggressive with her treatments? The conference helped. I didn't have to beg (the doctor) to come and sit down and talk, but close to it. Cause they make these rocket rounds, we call them, in the morning (when) they all come around in a big ribbon. It's very intimidating. I told them that they just want you and me to sit down and talk and answer their questions. I think it's hard for them to deal with dying patients. They want to deal with lab values, but they're less likely to want to pay attention to psychosocial needs. They're more difficult. They want them to get better and go home. They have a harder time letting go, I think, than we do, cause we see them from day to day, and see what they're going through to be alive. They are approachable and in this case (it) helped having them come in and sit down.

Sometimes there are days I don't want to hear this again. I don't have time. I had another patient who was very ill, dying, and I felt torn between the two. You can give the basics, give the meds, but the psychosocial stuff comes when you have time. With her, it seems like that's the most important thing right now, so sometimes that takes precedence. And he's here everyday. I think he's not ready to let go. I think the underlying problem is coping with the fact that she's dying. And the feeling of abandonment if she has to go somewhere else.

Case 2

I took care of this lady a couple of years ago. I saw her over the course of a year's time. She had been diagnosed earlier (and) had come to the university as a referral from Eastern Oregon. She had gall bladder cancer. The first time she was admitted she had chemotherapy, an arterial infusion. Her husband had been sick with a cardiac history and (was) not able to do a lot for the last 10 or so years, so she was the caregiver. Then she was diagnosed with cancer and they separated because, as she described it, she couldn't deal with him not understanding that she was sick and that she needed some help.

She was a middle aged women, about 50 I think. She had four children and grandchildren. When I first met her, I thought this person with her was her son (but he) was her boyfriend. He had come with her from Eastern Oregon and was, I think, the son of some other family who were friends with them at one time. She was very nervous and (would) ask questions and need reasurrance about what was going to happen- a test or a catheter check. She'd been taking antianxiety medicine.

She was probably hospitalized that first time for a week (to) two weeks. The plan was (for her) to go with her boyfriend's family for awhile. There was a real struggle cause her children weren't sure that was what she should do. And her husband, from whom she was separated, certainly didn't think that was a good idea. But, I remember Mrs. Moore saying that she knew this was where she wanted to go, because these people loved her and cared about her and would look after her. Evidently she didn't have that sense to go to her own home.

Then she came again. She was admitted for uncontrolled pain and her disease had advanced. This time she didn't have a boyfriend anymore. She had a husband with her. It seemed important for him to be there assuring her everything was OK. He was so concerned and maybe somehow he'd come to understand that she needed support. So he was her advocate and we went through a period of time trying to manage her pain.

She was painful a lot of the time, frightened to be by herself, and seemed to do better when there was a family member there. She had a daughter who lived here in town and would come. Actually was very attentive, would try to do calming sorts of things, either with words or with rubbing her mother's shoulders and neck. We were initially trying to sort out what the patient was like before, what her nonhospital personality was. The daughter, I think, let us make some assumptions, because she described her mother as always having been kind of nervous. Things would throw her off at home, if they got out of line; if they were out of sync.

She was afraid to die. And she used to talk about that. I think that was maybe part of it, being by herself. She didn't have a lot of insight to what was happening right this minute. She was terribly afraid about the eventual outcome and I think so absorbed with that, that she couldn't live. She used a lot of energy being painful, screaming all the time and shouting. She had her light on a lot. She didn't want you to leave once you got there. She would say, "don't leave me, I'm too afraid. It's too scary by myself. Don't leave me, stay here with me." She would get focused and (was) not able to (hear) you explain (what was) going to happen. She was like a stuck record, repeat(ing), "don't leave me, don't leave me".

We identified that she didn't have a ready reserve of coping mechanisms, anything she could draw from. That sounds funny, because you think (if) people live to a certain point they will arrive at those skills. But she didn't have any reserve for figuring (things) out.

She was fairly independent. As I remember her pain, it was episodic and spasmodic. Sometimes it got worse than others. It would be really intense and then it would be different and so she could do her own bathing. They did some studies and couldn't find a reason for (her) abdominable pain. A lot of people began to believe that she was making all of this up, as if she was completely unable to cope with the fact that she had the disease and it had advanced. Everything we tried didn't seem to work. She was on morphine. Sometime it would (work), sometimes not. Sometimes she'd be painful and sometimes it was just, it was something else. She was nervous or scared. People thought she was a big time crock.

It was just "help me, help me", and if you asked what is it I can do to help you, she couldn't tell you. (The) physicians (decided) to have the psychiatric people come see her because she seemed clear out of control. The psychiatric people came to see her and made a recommendation for thorazine. And all the sudden Mrs. Moore's affect was different. The next day I came in and before I could say hello to her, she had greeted me. It was the first time of that admission that the first thing out of her mouth hadn't been, "Oh I hurt so much...or...help me... or I can't take this any more". She knew my name... and when she'd been in a panic she'd always say part of my name over and over and over. And I was astounded. (She) seemed calm and controlled. It really was magic for her.

That worked for awhile. And then it turned out that she had an infarcted bowel. She really did have pain. She had surgery for that and they were able to resect some. We kept up that regime of thorazine suppositories and eventually she had a vascular problem related to the thorazine. I think it was a clot in the leg. So she had to go again for surgery.

I (would have liked) to learn more about her, to have seen her function on the outside. I never had a sense of what she was really like. We had her in this environment that was completely alien to her life. I was trying to structure things for her so that... first of all, pain control was an issue, so medicating her routinely and seeing that she knew ahead of time that she was going to get medicine. My approach was (to) just try and relieve her of that anxiety, so she didn't have to worry. She could count on me or one of the nurses to bring her pain medicine around the clock. And provide time for her to say everything that wasn't right, how much either she hurt, or how much support she hadn't gotten from somebody at some point. Mostly it was her husband... though he was, on the second admission he was there. And then set a limit to that. Part of it was helping her, but (also) helping us to have enough energy to help her, because it could be very draining to spend time with her. She just... over this time had gotten increasingly debilitated though her affect was much better for awhile. (The cancer) had advanced so that her oral intake was really poor. And she had fairly wide spread metastases. As I remember, her disease has metastasized to her liver. So she eventually... she died in our intensive care unit.

Case 3

This patient (Mr. Kim) was older, 70's or so, Korean (and) spoke some English, but not fluently. He had fallen, hit his stomach and had a GI bleed. He had been in intensive care at (another hospital). In looking at the GI bleed, they found he had a liver tumor. They brought him over here to consider a liver transplant. He was a pretty healthy gentleman and then they find this hepatoma. It was a real shocker to (the family). He'd been at home (in) his own apartment taking care of himself, fairly independent. He was very affluent, educated, spoke a few languages. The first day I took care of him he was talking Japanese. I'm not fluent but I pick up a few words. The family, a couple of daughters and sons, wanted to stay that night, but he got put in a double room and we were packed full. The rule is that family cannot stay in double rooms so the nurses made the family go home.

That night he'd asked for something for sleep so the house officer on call gave an order for Benadryl. When I came on (the next day) he was confused (and) not real responsive. The family came in and were upset and angry. That was a real scary change for them. They're second or third generation (and) spoke English fluently. He was the only living relative of his generation. They'd just lost their mother, (Mr. Kim's wife), in a car accident a couple of months before. They all started jumpin on (us). They had some legitimate complaints. Probably since he didn't have much liver function, (the Benadryl) wasn't metabolizing out. And then we thought maybe his ammonia level was high cause he was (responding) like he had hepatic encephalopathy.

It was getting heated so I called a conference with the physicians and all the family and one of the social workers that knew them before. (The family) asked questions and were focusing on the Benadryl. (The physicians) were trying to tell them that probably that wouldn't have mattered. That his condition worsened and that's what would have happened (anyway); that's the disease process. But they weren't hearing any of that (and) were still asking about the liver transplant. That was ruled out. The other thing they were offered was chemotherapy. From our standpoint (chemo) would have been (adding) insult to injury. It would have made his quality of life poor (and) probably not much longer. That was presented to them in that respect. I gave my input about what I thought he would go through and that giving comfort measures at this point in time would probably be the best thing to do.

We didn't have the (specific) information on the chemotherapy. The (doctors) kept saying "we're going to have the heme-onc guys come and talk to you about chemotherapy and then you can make a decision". Even after they talked to them, they didn't make a decision at that time. They had to discuss it and come back and say this is what we want to do. There was one spokesperson, one daughter that was very outspoken, and the older son doing most of the speaking. (Her) husband was a pharmacist just starting out so he thought he knew everything about everything. He drove me crazy. He was looking up all these drugs and (asking) "why did you give him Benadryl if it's contraindicated in liver cases?". You know in practice there are drugs you give that may be contraindicated; it's not a total no-no to give Benadryl. But in this case it didn't help the situation any. The family, they were looking out for his best interests. I don't blame them, but it was real hard to take care of him.

I could sense a lot of guilt. Like maybe he'd been living on his own and maybe they were feeling guilty for not being around as much as they could have been. It's an instinct, a feeling that I have. Part of it was their overkill attitude. Every little thing they'd jump on. I'd come into the room and they'd (say), "this garbage needs to be emptied...this sheet..." every little thing had to be perfect. They would just hover around. I've seen families in the past that felt like (they) should have been more involved in (the patient's) life and picked up on some of these things. They kept saying, "this is our only living relative of this generation. We just lost our mother and we can't loose him too".

We were able to move him to a private room so they were able to stay with him so that helped. There were quite a few of them; they did shifts. That's common in the oriental cultures. I know whenever my relatives have been in hospitals there's been somebody with them. The family developed a lot of trust in me, especially the daughter that was one of the spokespersons. We had good rapport. I sat down and had a heart to heart talk with her and I was able to say "this is what I've seen, this is what I think", cause I knew it was going to come back again. I tryed to be real honest with her. I was able to feel more relaxed with her, a little more up front (when we) talked aside from the rest of the family. They were a very intimidating family. I think that's the air they were trying to give- we're in control.

They needed to explore all the options before they made a decision. They wanted to make sure that chemotherapy wouldn't offer him a cure or a longer life. The daughter was, I think, the more realistic and finally coming to the realization that he would be made sicker. The pharmacist still wanted him to get the chemotherapy down to the bitter end. I told them, whatever decision you make, you have to feel comfortable with it. That needs to be something that you feel (was) the best decision for your father. I didn't want them to carry that guilt around with them like a lot of people do. They were told there was no cure and that he was not a candidate for liver transplant. The staff physician knew the right things to say without sounding condescending.

The doctors were giving them the straight story, saying (it) in a nice way. After they started to absorb some of that, they realized the situation.

I was afraid he was going to code while we were waiting for those guys to make the decision. Mr. Kim was comatose (by then). He was third spacing fluid. His ammonia level was creeping (up). His respiratory status was crumby. When I know that the patient is terminal and that they're gonna die anyhow, to let them die in peace and in comfort with a little dignity is always nice. So we kind of harp on the doctors for no-code orders. That's our job as nurses. I think we sometimes see sooner than the doctors do that it's time to quit and make this patient as comfortable as possible. They have a harder time letting go. Not that we're ready to throw in the towel at any point in time, but we see them every hour of the day and see what they're going through.

(The family) came back with their final decision to make him a no-code. So we decided to do comfort measures and he died a couple of days later. I wasn't here when he died, unfortunately. I always feel bad when I'm not here when a patient passes away. The major problem we dealt with in this patient's case was a conflict with the family (who originally blamed staff for the sudden deterioration of father), the alteration in coping with a life threatening illness and recent diagnosis and the anger that they felt. Most of it was dealing with the family, in their anger and grief. (I was told) when he finally died, they seemed like they expected it and were prepared for his death. The word that we got was that they did feel that he got good care and were comfortable with the decision in the end.

Case 4

The patient was a 40 some year old who was an adult onset diabetic. I can't remember what kind of a surgery it was, but up in (another city) they did a couple of surgeries and ended up with a real horrible infection. They brought her down here to (our hospital). She was septic and in acute renal failure and was in the (intensive care) unit for probably three weeks in a coma. When she came down to us she had only been extubated a day or two, had a huge abdominal dressing and four pumps running hyperal, intralipids, insulin drip and was on Amphotericin, or some horrible major antibiotic like that.

The ICU nurses had called us and said that this family is very anxious. "They do not want her transferred. They don't think she's ready." When they transferred the patient, you could feel that tension in the air. Trying to get report from the ICU nurse in a coherent fashion and these people obviously anxious. I remember mostly that they hovered very close to the bed. They didn't want to leave the room. They would direct me to do things. "That's her line for this...and make sure that doesn't come out...do you know what you're doing with that bottle?"

The family of husband and four grown daughters were here every day; every night too. All were very angry that she was being discharged from the unit at this point in time. They did not feel that she was ready to come to a ward. The whole hospital was full. There was no other ward that she could go to and expect anything better. Part of the contributing problem was the fact that we were very busy. It was August which is our busy, busy time and we could not offer them (ward) nurses, so what we had to do was get agency nurses to take on the care on a one to one basis, with me directing that care, writing the care plans and supervising. I was trying to establish a relationship with them and they were aware that there was something different about me versus the other people. I explained to them that I was directing the care, and that this was the best that we could offer them under the circumstances. Despite our reassuring them she would have one on one type nursing care, they did not feel right about it. So at that point I made the nursing diagnosis of alterations in coping specifically for the family, because this women was still comatose. It was basically a process of having them learn to trust us. But it was hard. It was real, real hard. They did not want to do that at all.

The family was angry. They talked to our Department Director at that time and told her that they were angry about having agency nurses taking care of her. I think that there was a lot of repressed anger, because...I got the feeling from them that they believed that somebody had screwed up somewhere up in (another city). She had gone into the hospital for a relatively minor thing. I would think anytime you go into the hospital for a relatively minor thing and you end up at death's door literally, that you are going to tend to blame somebody. I think that they tended to blame and that's one of the reasons they had such a strong mistrust of me and the system.

Her husband was the most vitriolic. He was the angriest; the most hostile; the most verbal about that. There was one daughter who came a close second. She was the oldest. And then the other three just sort of hung out. It seemed that they were very close to their mother and still very dependent on her. The husband was about 50. (The) daughter's were grown, in their 20s. The girls definitely (had) a pecking order there where there was just the one who was running the show. I think three of them were married. A couple of them had families, younger children. They were all obese. I wouldn't say that they were in the upper echelons of the IQ status; average, to even less than average. I don't think most of the women worked. Their husband's did blue collar jobs, and he (the husband) had a real blue collar job.

Brenda (the patient) hadn't taken very good care of herself and they were able to verbalize that they were angry at her for not taking better care of herself. She had a lot minor infections and didn't take care of her diet the way that she knew that she should have, and "look at where she ended up, because she didn't take care of herself". I got the feeling somehow that there was a lot of guilt involved, a lot of guilt on the part of the husband. Maybe that he didn't take care of her, that he didn't pay attention to her. And here she was on her deathbed and what was he going to do? And I got that from the kids too... "maybe we didn't appreciate her". I think everybody is threatened like that (with) the loss of somebody in their life, goes through that feeling of guilt. I thought this was a little bit more than what you'd expect. I think that people get angry as a way of denying their own feelings.

You'd like to know what the family dynamics were. I don't have enough knowledge and background to know how to get at that, but I got the feeling that there were some fairly odd dynamics there. I think there was a brother that was a black sheep and not involved in the (family) relations before (this admission). (He) never came to the hospital once. I remember them talking about him; he wasn't an acceptable part of the family. So that gave me some idea that there might be some .....dynamics in the family.

A couple of days after the transfer I called a care conference, in which we had the attending nephrologist, the general medicine team, me, (a family counselor); and the ICU nurse who had been taking care of her came. We all sat together and basically let them vent their anger and their anxiety about having their mother transferred down to us.

I can remember (the attending nephrologist) telling them in the care conference that her chances weren't good. (He) can be very blunt, and he was. There was a very strong possibility that she was not going to survive no matter where she was; even if they kept her in the (intensive care) unit for the next six months. Most of that meeting that we had was spent with them venting their anger, specifically with me because I was the (ward) personnel involved. I was real, real lucky in that (the nephrologist) was such a strong advocate for me. It was amazing to me how much I could take from them. I mean, they just kept at me, at me, at me, at me. "How can you let agency nurses take care of us? Why can't you just provide a (ward) nurse to take care of her? This women is very sick. She needs the best that you can possibly muster." So it was that recurrent theme over and over again. I had the ICU nurse; I had (the counselor) and I had (the nephrologist) all being somewhat protective, but still letting the family vent.

After the initial conference, they saw that I was going into the room (and) seeing what the agency nurses were doing; talking to them about what was going on. It didn't take very long at all before they started to trust that things were going OK. Once she was no longer on one to one nursing care, it was basically the (ward) nurses, mostly me (that cared for her). By that time, Brenda was awake and alert. (She) knew me and it worked real well for both of us.

I think there was a combination of fear and anger and mistrust in the system, and the medical care that the family and patient had received thus far, mixed in with some guilt about their own shortcomings, manifested in their anger and hostility.

Case 5

The patient came in for a transplant, pancreas and kidney simultaneously. He had juvenile onset diabetes. The only complications he'd had from his diabetes was his renal failure. Immediately prior to the surgery he was doing hemodialysis. Six months or a year before that he had been on CAPD, but had had some problems with recurrent peritonitis and wasn't able to continue with that. So he had to go back to hemo. He was pretty healthy. Looked well nourished. Was pretty physically active.

He was in his mid-thirties. He had been (working), but just prior to the transplant wasn't. His work was not hard physical labor, but some kind of blue collar work. He was not college educated but you could tell in talking to him he was an intelligent guy. He's the kind of guy that when he's feeling well physically, and not feeling all the fatigue of dialysis and all that stuff, he's really an outgoing guy. He's got all smiles and jokin. And he's just a great guy. When he feels crumby he's not.

He was right up front with saying if I have some rejection I'm not going to handle it well. He told me himself, "I don't cope with little crisis well at all." He says "I get angry, I yell, and I withdraw, and all that stuff". I can remember going into his room one day when his lab work had come back, and the results weren't good for him. I explained that to him. I said, "Your lab work is up. There's a possibility of rejection. You need to be thinking about it, preparing for that possibility. Because a lot of people do reject. I tryed to emphasize that there are drugs we can give to reverse the rejection, so that it's not a lost cause if you start having some rejection. I also explained that were some other things that it could be.

He obviously was real fearful. I could see a frightened look in his eyes. He asked a lot of questions. Questions that wouldn't really have a good answer. It was like he was searching for me to tell him that everything's going to be OK. But of course, I couldn't tell him that.

He was more afraid of losing the kidney than he was the pancreas, because, the diabetes he'd lived with for years. The kidney failure he hadn't lived with for that long. And he hated dialysis. He hated it with a passion. He said to me one day, "I just can't lose this kidney, because I can't just go back on dialysis. Dialysis is terrible".

He did withdraw. He became more noncommunicative. I mean, he's really an outgoing guy. He was not outgoing at all after he got the word that there was some rejection going on. He would sleep till noon; stay in bed, the covers up to his neck. When you'd go in the room sometimes you could see that his eyes were open when you walked in the room, but the second you got in the there he would immediately close his eyes. He didn't want to deal with anything. Then when he was awake, he would become real angry. Not really so much angry at me, as he seemed to focus his anger at his family members. Being real short with them. Telling them to get out of the room, go away, leave me alone.

His mother hasn't had a whole lot to do with him in the past five, ten years. Not because she didn't want to; because they live apart. He had a fiance. They were living together. I think his father is dead. (Also an) Aunt and Uncle would come to visit.

The mother and fiance would squabble back and forth about were we walking him too much, were we not walking him enough. So that was real difficult. The fiance made it clear that she didn't want him to know that they were fighting. He was off at a test at the time they were fighting. She came to me in tears saying, "mom thinks that I'm pushing him too hard, making him walk. That it's gonna cause problems. I hope that's not true is it?" She didn't want him to know that they were arguing about this. So I told her, fine I won't tell him. Unfortunately there was a physician that walked in when she was in tears. The patient said, "Dr So and So tells me my family is fighting". His fiance was sitting there when he said this to me and she immediately looked at me, like -oh my god, you've just crushed me; my confidence is totally gone. So that was kind of hairy there for a minute.

We did all know that he wasn't coping well. The doctors would frequently ask me in the morning, "how's he doing today?" Beyond that we didn't really sit down and come up with any formal plan of action to deal with it, an interdisciplinary one. Mostly I was a sounding board for him.

It was intensified after they had started squabbling. It was as if he perceived it was a legitimate reason to be angry. It was, well gosh, here's a good way to vent everything. I can get all my frustrations out under the excuse that they're fighting and causing trouble. When the real issue is, he was scared to death he was going to lose his transplant.

Sometimes when patients express their anger to me I don't deal with it very well myself. But with him, I've known him ever since he first came down with his renal failure and I have a good rapport with him. I get along real well with him. So I knew why he was being so angry. He didn't really yell at me too much. It was mostly his family stuff. My reaction when the mother and the fiance were fighting-Oh boy, I just kind of looked at them both. They weren't acknowledging me and just kept on fighting, so I left the room.

(As far as the rejection), he was doing all he could. Our only treatment is to give immunosuppresive drugs. There's nothing more he can do to actually change the outcome of the rejection episodes. With kidney transplants, we have a pretty good success rate. Pancreas are still considered kind of experimental. Last I knew he was not dialysing. That may have changed by now, but I doubt it. It (the rejection) was stopped and then he, well, the story's not over yet. He went home and then again had a relapse of rejection. They were wondering if maybe there was some chronic rejection going on in his pancreas. So he came back into the hospital and he was real sick that time. I was more concerned about his physical needs at that time.

I do remember after his last discharge, I was working a weekend. His fiance came back onto the floor and she was in tears. Apparently he wasn't doing real well at home. Her words were to me, "he told me to just get out of his life". Her interpretation of that was that he wanted just to die. That he was tired of trying dialysis and he was afraid he was going to have to go back on dialysis. He just didn't want to do that- "just everybody leave me alone, I'm gonna die".

He was coping ineffectively. That weekend when his fiance came in really let me know that, gosh, this was more than just having a little trouble dealing with how things are going. This is major stuff when we heard that he was just wanting to be left alone to die. His fiance had stuck with him through all this transition of going through end renal disease and was always there for him and did what ever she could. I mean, she loved him dearly. And she was basically his whole source of support. For him to be willing to just say, get out of my life now, that's, I don't think that's something people do. I mean, I think if they're coping effectively, I think they might yell at their loved ones and spouses, but I don't think they would say, "move out, I don't want you here anymore". I think that's become ineffective.

Ordinarily I wouldn't want to put that tag on it, because I know anger, depression, the whole nine yards he's sensing a loss. He's losing his hope and his kidney, potentially losing it. I understand that those are just normal grieving processes, but my gosh, grief should be a self limiting thing. I guess it's around six weeks or so, and it was longer than that when the fiance came in and was all in tears and stuff. He's not getting over it and he's withdrawing further and now expressing a desire to die. So yeah, it's ineffective. What would my diagnosis be? Alteration in coping/individual- and I could have also written a family coping problem. We referred them to our social worker. In fact, we called the social worker on call for the weekend.

Case 6

The case I had in mind was about a 40 year old man from the Philippines who had a history of schizophrenia, but was here for cardiac and respiratory workup. This man had a history of asthma and would become extremely anxious and his way of dealing with this anxiety would be to act out or to clam up and demand to see his doctor. Usually his demands were needing to see a doctor because the nurses didn't know what they were doing and once the doctor got there he usually either didn't have a problem at that time or he did the same thing to them or various different things.

Initially it would start out, "I can't breathe. I'm having chest pain." I would come into the room or a nurse would come into the room. Our first interaction is mostly physical- "Ok, I need to get your vital signs"- and ask him some questions about what was going on with him. His immediate response would either be "Get my doctor. I don't want to talk to you" or it would be "Why are you not dealing with me as a person? Your doing all these physical things. I'm having problems breathing and you don't know what your doing and I should go back to the Philippines. The doctors there are wonderful" and he would start yelling and occasionally the nurses would be kind of frightened because he had been real verbally abusive in the past and they didn't know how far he was gonna go. And the patients as well. Patients were all wanting to move out of that room.

If you chose not to interact with this person, in other words not talk to them or not meet their needs immediately or fairly soon, if you ignored the problem, then he withdrew. He wouldn't talk to you. He wouldn't look at you. He would storm off to be by himself. It wasn't a total just sucking in of emotion. He was still angry. (more like he was shutting you out instead of pulling away) Which is almost more problematic than someone acting out to me because then you can't get to them. That did not happen real often and seemed to be precipitated by the staff not interacting with him. If he put his call light on, some of the nurses, on occasion, completely ignored him. They would say, what do you need and I'm busy now or something like that. The cardiac problem was more or less ruled out and he continued having chest pain. Nobody knew why and the complaints seemed to be (invalid). He might say something like, "Get down here now. I need to see my doctor immediately. If you don't, then this", whatever. So then the nurse would have to do something with him after she had staved him off, because he would just keep putting his light on. And he'd attempt to contact and then when you finally got down there he'd decided you took an hour or however long you took, then he wasn't going to deal with you. And then it was, "I'm not going to talk to you, good bye" or whatever he did.

(One episode in which the nurse took the patient's vital signs they were) absolutely normal. He had reported to the roommate that he couldn't breathe and his chest hurt really bad. And his roommate actually came out and got me. I went in and he did a lot of avoidance; he would not a lot of times look you in the face. He looked away and I wasn't sure if that was a cultural type thing. I know, in the Asian culture anyway, there's a lot of that. That's usually more feminine than it is masculine. I don't know if that was a psych thing, but I remembered real clearly that he wouldn't look at me and his face was very flushed. And he was a little diaphoretic. I told him, I need to take your vitals and he got real angry. I tryed to tell him what I was doing. He was yelling at me and very demanding. Wanted to see his doctor and I didn't know what I was doing and if he was back in the Philippines, they would see to his needs and everything would be fine.

He started escalating and I had to tell him, "I need to leave the room. I can't interact with you when you're talking to me like this and I need to leave. I will call your doctor. And when you're calmed down, I'll come back." Which I did. One of the problems is after gathering information of course, we'd go and call the doctor and he felt very frightened to be left all alone. He didn't like that. And also, sometimes the nurses didn't tell him what they were doing. And that was kind of frightening for him too. I called the doctor and I came back. He was much calmer and I explained to him what was going on and told him at the time, "Gee, your blood pressure's fine, your heart rate's fine. I don't know exactly what's going on with you", but I listened to his lungs and I assured him there was no wheezing. He didn't know if he was having chest pain or if he was having an asthmatic attack, but there was no wheezing, no sign that he was maybe having anything pulmonary-wise.

It was really hard for me to tell him, "Let's have the doctor come and assess and see if he wants you to take the nitro". He didn't think much of that nitro; it wasn't doing anything. I tryed to explain to him that maybe it wasn't, could this be a symptom of fear or something else that's going on. It was really difficult to talk to him, but I did try to do a little bit of talking to him. Later on the very same day, he blew up to his roommate and there was a big yelling match. And that's when we decided, hey, we can't deal with this.

The nurses were getting frustrated. It was a big toss up, you know flip a coin, whose going to take care of the man this time. (His primary nurse worked night shift) I don't think she had a lot of interaction with him. I think there was a lot of avoidance on the nurses' part to deal with this very difficult patient. And it was a situation where we saw, hey, we can't avoid him. We have to deal with this. It's becoming a ward problem. It got so bad at one point before we had people helping us that we did have to tell him that we would call security. And we did on one occasion.

The man had a problem, I think, dealing with his lack of control over his situation in the hospital. He didn't have a support group. He came from the Philippines and his wife was overseas and he just didn't seem to be coping with his situation real well. Here was this man who vented a lot on the staff or other patients over that two to three weeks. Inside I felt very angry and frustrated. I felt, here I am trying to help this person and he is yelling at me. And won't let me help him. It's so difficult to talk to somebody and not react and try to just stay very cool and professional. And really try to think things out while they're yelling and screaming at you. It's.. I felt very frustrated. And typically for me anyway... I don't know how other staff feel... but when I feel angry at a patient it's a real problem and someone has to help. I have a real high tolerance. I rarely feel anger towards a patient and when I do, I know it's a problem.

Realizing that this was becoming a ward problem, because the nurses then were not wanting to take care of this patient, we decided to call in our psych nurse to speak with him, with his permission. We first invited her to come and talk to us. Then she talked to him and then shared with us what she had gotten from him and then we all worked together on a plan of care for him.

The idea that he was anxious really came from her. We were kind of stumbling around, not quite understanding what his problem was. He did have a psych history, and so the first thing, I think, a lot of the nurses did was, "Oh, he's a psych problem and there's nothing we can do about this kind of behavior". But as we delved deeper and got some expert advice from our psych clinician, we began to understand this man a little bit better.

The problem goes back a little farther, I guess. He had a history of asthma and there was a question of whether or not some of his problems were cardiac rather than pulmonary origin. And he was a little bit frightened and anxious about this. She was able to establish a rapport with him and it was that route where we got a lot more information and a better understanding of this man. This is where the fear and anxiety came out. He knew he didn't have a support system. He knew he wasn't dealing with his problem in a real direct and helpful way, but this was the only way he knew.

He was able to tell this women that he was very anxious and fearful that he was in the United States and had kind of a trust problem. In the Philippines, there are alternate medicine like things they do there that they don't do in the United States, herbal remedies. He also did not have contact with his wife. They had no telephone. So he had to work through the Red Cross to find her and communicate with her, which was maybe a two to three week process. Looking back now I see this is a culture that's very extended family-like. And they all help each other. And they really need that and I think that's what he was really missing if you get to the bottom of it.

On one occasion, he did say that he was angry about something. He was frustrated because of our diet, nutrition situation. He wasn't getting the kind of meals he wanted. And that did sort of send him off on one occasion. But usually he had nothing to report prior to that. Though he waited so long to get a hold of his wife, I can't help but think that it was a whole lot of emotion that he wasn't really dealing with. This is just my feeling that he was really frustrated, really afraid. And he did share with the psych nurse that he did experience a lot of fear and anxiety.

Part of it was the possibility of having a cardiac problem on top of this asthma. It was very frightening to him when he became short of breath. And the possibility that maybe his heart was going and that would sort of, well, it would change his whole lifestyle. There was a possibility-well, would he be able to work, would he have to have surgery? They were talking about having all kinds of cardiac tests. And this was all new to him. And just a complete lifestyle change were all these things that were looming back there.

What we did was based on the information the psych nurse got together from his report and establishing a rapport with him was to diagnosis him with a problem with coping, individual, related to his anxiety. It was just too overwhelming, fear and anxiety and lack of support.

Case 7

We had a man in his 50s who had surgery and (was) transferred to us, Extended Care, so that we could take care of his Jackson-Pratt drains. His medical diagnosis was rule out malignant melanoma. I was told a lot about him before I met him. The nursing staff saw him as a very demanding, picky patient- nothing seemed to be good enough, or done right for him. He wasn't really explosive, but seemed like he had that potential. Just angry. You just felt he was angry.

He told me a little bit about his diagnosis and family history, and just every upset he'd ever had. He must have listed a whole litany of complaints. He felt that they'd done the surgery without doing enough testing first. He felt as those they probably spread his disease by doing the surgery. He was sent up here being told that this is where the experts were. He felt that that was a snow job and wasn't really true. He wished that he could have gone to where his sister was because he thought maybe the technique was better. He felt that his sister had had a similar type of melanoma. He explained some procedures that they'd done for her. She'd had no spreading and had done just fine. And so I'm talking with this man and I'm thinking, wow, he seems really angry, and I think I would be too if I felt as he did that his care wasn't being pre-thought out before the medical team was acting on things.

Being on Extended Care, the physician doesn't come in and see you daily. The surgeons don't see the patients any more than once a week. Which were the people he wanted to keep in touch with because they were the ones that did the surgery. They were the ones he had a lot of feelings about. And he wanted to talk to them.

I did talk to the Extended Care physisian and it was his feeling that this man was venting and was trying to work out a way of accepting what was going on with him. I got the feeling that he had refused chemical treatment, which is what they wanted to do for him...well...I got the feeling that he (the patient) didn't really effectively communicate well with them. I don't think he really let them know that he didn't appreciate how they handled things. That what he really needed was more diagnostic procedures done before they did the surgery. And I think he just kind of went along with whatever they said except when it came to the therapy that they wanted and then he didn't want to have anything to do with it. I think he was fed up.

He was on a different ward before he transferred to us. He'd been given the wrong medications...the person next door to him... I think after awhile he was sort of feeling like everything's terrible here. Nothing's working out. The service is awful. Some of the other complaints he had had to do with his meals. Things that really didn't have a lot to do with his care per se, but seemed like just more stuff. You rarely heard anything positive. His roommate commented on the fact that it really was a drag to be around him because he got real negative. He started on one negative subject and all of a sudden that would remind him of a million different other things that he'd bring in that might have nothing to do with your conversation. Seemed like nothing was going right for him and everything reminded him of all those things that didn't go right.

It was just kind of like fireworks. His face would get really red. And he'd, you could just hear the tension in his voice. And his voice would start to get louder and louder and everything he said was negative. But he never was verbally abusive. Probably a real trust issue with what was going on, his caretakers.

Most of the interaction with the (nursing) staff was regarding his drains. He wanted them emptied on an hourly basis and the staff thought he was crazy, basically. (In) Extended Care, we're alloted X number of hours, so what you do for them is real minimal. Any care we do is usually every four hours at the max. Usually when we have an extended care patient, they are not calling the nurses to their attention more than maybe, I don't know, three times max a shift I'd say, and he was on the light about every hour. The nurses were all getting tense, because he was way down the hall. He needed to be away from the nurse's station. He needed quiet, cause everything bugged him. So he was in the fartherest room from the nurse's station.

For instance, the thing about his drain, you know, he's Extended Care and we're not going to be doing that every hour. I talked to him and he said, "You know, if you had a drain attached to your body that was hanging there, after it gets a little full, it's heavy and it hurts. Perfect sense, made perfect sense. But he never communicated that to anybody. Nurses always care for drains and we don't teach our patients to do that. What we did with that was train him to drain it himself. This was unusual. Which worked out beautifully and really did serve to de-escalate his demanding behavior.

In the meantime, the doctors were pretty sure that this stuff was going to spread. Apparently, chemotherapy he refused so the radiologist was working him up and they decided to do a CAT scan. The CAT scan showed that it had spread. After that I just assumed, uh oh, it's all up now because he wasn't a candidate for radiation. He wasn't a candidate for anything and I could see that he could be really upset. When I did talk to him, the thing he kept saying over and over is "Why are they doing a CAT scan now? Why didn't they do it before surgery?" I didn't have any answers for him. I wondered too. Well after that, for him it was let me out of here. I want to go home. You're not going to do anything for me. And I want a second opinion from somebody. You know, all valid.

He'd come from (another city) and had no support here. He was divorced, but I think they still live together. I didn't really understand their relationship real well. He never talked about his wife. He did keep in touch with his wife and a brother that lived somewhere in the area. And then a sister lived in (another state). He had two teenage sons. They lived with their mom, but seemed like he lived there too. He was a trucker so I don't think he was home a lot. He probably wasn't going to be able to work any more and he was the primary support for the family, so he really needed to get everything straightened out.

He didn't have a support system and he really needed to talk. We were watching a program on TV, some show was on and whoever the character was said "I have a real problem with forgiveness" and he said "I don't have with forgiveness. My problem is acceptance." And bingo, that just hit it. I thought, whatever was going on with him, he needed to channel it in a different way. In other words, rather than vent with the staff, talk to them about what's going on or let them know that his complaints were valid.

He was picked for nursing grand rounds, and this was great because I got some help with his care plan. They sorted out for me that maybe his coping then was ineffective, but right now after he had been given this prognosis, it probably was effective for him. Well, I decided this man is possibly grieving and the way he's coping, ventilating with anger, is probably appropriate, but what he may need help with is the grieving process; so I changed his care plan to reflect that. I kept the same coping, but I made it secondary to grieving. And then added a few more interventions, to arrange for a way for him to interact with the interdisciplinary team so he could get home, because that's what he needed to do.

I saw him venting a lot and being demanding and I interpreted his demanding behavior as stimulated from anger. That's where that was coming from based on things that he'd said, you know, that they didn't do this right and this right and all these horrible errors that had happened to him and I just interpreted that as anger. I thought at the time that his anger wasn't going to allow him to cope with his situation. In fact, he had identified that he really needed to accept his diagnosis. Which I didn't see he would be able to if he was so consumed with anger. He was just disgusted by the whole thing. I just felt he was, it was real clear that he needed to make a beeline for home base and get back to the familiar instead of being here. I think he kind of felt helpless here.

He got to go home. Social work and the surgeons decided he can go to the clinic and they can remove the drains when it's appropriate. He'd already been taught how to take care of them. I did have a little time to talk to him about what was going on with him. He told me what the prognosis was. Six months. He seemed sad. When I asked him how he felt about his prognosis, he said, "well, I can't feel anything about it. That's just the way it is". He wanted a second opinion still and he did really need to get home and get some things taken care of. That gives him a little more control over the situation. And maybe doesn't physically buy him time, but emotionally buys him time to deal with his prognosis. And those are ways of coping. I got to see him the day he left. That he got to go home. He was real pleased, real grateful.

Case 8

This patient (Jo) is 37 years old. He came in originally to R/O pneumocystis pneumonia, which was ruled out. He had CMV retinitis, which is stable. It's not getting worse; it's not getting better. He also has perianal herpes lesions, very painful, which are not getting better. In fact, they're getting much worse. His nutritional status is going way downhill. He received hyperal for awhile and we (were) trying to feed him as much as we could, but he just wasn't hungry, wouldn't eat. He's here dying from AIDS and his coping issues are many. He wants to know when he's gonna die. Probably it will be his herpes, a combination of that and his nutritional status (which) is so poor he may become anemic to the point of not oxygenating and dying that way.

I'm his Associate Nurse. His Primary Nurse is on evening shift and I'm the one who primarily works with him on day shift. A time or two I said "how ya' doing emotionally; how ya' doing dealing with all this stuff?" And he said, "Uh, OK", like that. It was like taking care of a vegetable. He wouldn't talk to us. Everything was superficial and you know he had all these thoughts going on in his mind. He had to with all the issues he was dealing with, and yet he wasn't expressing them. That was hard. As far as a (nursing) diagnosis goes, I wouldn't say he's got Ineffective Coping. It's more of a potential for (ineffective) coping. He's doing pretty well. He knows he's gonna die. He's not happy about it of course, but he's ready to. It's just issues of letting him say what's on his mind.

If I saw any signs of him starting to withdraw again (as in the past) or something, I might start searching for more things like past coping skills and that stuff. His past coping patterns were probably not real good, because I know he used to be involved in some drugs and heavy alcohol use. But he seems to be doing real well with them now. I know a lot of people with AIDS have their familys and everybody abandon them. But that's not the case with him. He has a mother who supports him; who's here every day religiously. And he has a lover who comes everyday also.

He had been a real independent guy and in fact didn't even want his Mom to know he was doing this poorly, until he got to the point where she had to know. He'd been hospitalized previously for some infection that responded to treatment and I don't believe he involved her at all in any of this stuff. He describes her as kind of doting, a doting mother, and he didn't want to be doted on. But now, I think he realized that it's OK for her to dote. He's really sick and he needs the support and she needs to be able to give it to him.

He's doing very poor. All he'll do is drink some things for us, juices or water. During the week when I wasn't taking care of him, when I was taking a break, a decision was made that it's time to stop being so aggressive. The mother concurs with this and so does Jo. So we've stopped just about everything. All we're doing now is hydration; so his nutritional status is going to continue to deteriorate. We're just basically to the point of comfort measures for him now.

He's weak and he has real jittery, twitchy motions when he attempts to move. They're thinking that's something to do with the herpes infection invading the central nervous system and that's not going to get better. He can't do anything for himself; he's basically total care. So he's physically draining in that respect. Emotionally it's also quite draining for two reasons. One, he's a young guy. He's only 37 and he's dying. And that's never fair, whether it's AIDS or cancer or anything. It's just real tragic. And the other way he's emotionally draining- the things we're doing to treat his herpes, which aren't working anyway, is to clean them off and apply some acyclavor cream to them. And this lesion, it's huge. It's like six inches in diameter circular and an eighth to a quarter of an inch deep; one massive lesion and it's extremely painful for him. He's getting morphine around the clock as a sustained release oral tablet and we're also premedicating him with some IV morphine. Even with that when you do it, it's so painful for him he just screams out. That's really hard to do that when he starts screaming and crying and you're the cause of it. So that's another reason I took a break from him.

It was after a period of a few weeks of trying everything we could to reverse the problems that are going on with him now physically. He had a period of time when he got real confused; wasn't talking and was deteriorating quite fast. So we had a care conference and got Power of Attorney for his mom and discussed what treatment plans would be. At that point they wanted to go all out. The doctors flat out said to the family during the care conference, his prognosis is very poor; he's probably not going to recover this time. Jo wasn't in attendence at the care conference, but he did come around then. His confusion went away and they told him too. They told Jo that nothing we're doing is working on these herpes lesions and you're not doing well and probably won't. I wasn't in attendence when they told him that, but I heard through hospital communication channels.

When he realized that nothing was working he started withdrawing. He withdrew, probably right before his lover went away. He's real supportive when he's here, but you know, he went on vacation. He'd been planning a vacation to Greece for over a year. And here he's in the hospital, not doing well, dying, but he went on vacation anyway. He wasn't happy about that, about his lover going. No, he didn't want him to. He cried the day he left.

Another thing, he was one day talking a lot about religion and stuff. It was hard to understand quite what he was saying, so I jumped on that and said, "Do you want the hospital chaplain to come and talk to you? Has religion been an important thing in your life? Is that something you want to do? He adamantly said no. It was a little bit garbled. I remember him saying something about the bible, and something about God. That's when I asked if he wanted us to explore that. He didn't. I need to talk to him about (it again), because now I see there is a Bible on his bedside table. He's decided to use that to help him cope, or that's his mother trying to push that on him.

He will talk about his feelings and I'm mostly just a sounding board for him. Answer questons. Offer support. Try and let him express these things so it doesn't become Ineffective Coping. I didn't want to step on the primary nurses's toes. I would have written a diagnosis of a potential for ineffective coping. Related to a realization that he's gonna die. Probably would have worded it a little differently. Make it sound more professional. Potential ineffective individual coping related to terminal illness and failure to thrive. Now that he seems to be coping OK, I think whatever we're doing and he's doing is working. He could go to a hospice. The problem is funding. Hospice costs money and he doesn't have any. So the issue is even finding some for him.