

THE IDENTIFICATION OF STRESSORS
AND COPING MECHANISMS
IN NURSE SUPERVISORS

by

Margaret Foley Daniel, R.N., B.S.N.

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APPROVED:

[REDACTED]

Associate Professor, Thesis Advisor

[REDACTED]

Sandra Stone, RN, MSN, PhD, First Reader

[REDACTED]

Second Reader

[REDACTED]

College of Nursing

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m.f.d.

DEDICATION

To my parents who had the foresight to provide the best of nursing education and to Dick, Lisa, Mary Ann, Laura, Jay, Tim and David who supported, encouraged and endured their wife and mother returning to graduate school.

TABLE OF CONTENTS

CHAPTER		PAGE
I.	INTRODUCTION.	1
	Review of the Literature.	2
	Historical Perspectives and Conceptualiza- tion of Stress	2
	Role of the Supervisor	5
	Nursing Studies Related to Stress.	6
	Coping	12
	Conceptual Framework.	15
	Statement of the Purpose.	16
II.	METHODS	17
	Design and Purpose.	17
	Subjects and Setting.	17
	Instruments	19
	1. Demographic Data	19
	2. Identification of Stressors.	20
	3. Coping Scale	21
	Data Collection	27
III.	RESULTS AND DISCUSSION.	30
	Introduction	30
	Description of the Sample and Response Rate	31

TABLE OF CONTENTS (Continued)

CHAPTER	PAGE
Qualifications and Characteristics of the Supervisors.	32
Situational Stressors Identified by Supervisors.	37
Coping Mechanisms Utilized by Nursing Supervisors.	47
Summary of Findings.	52
 IV. SUMMARY, LIMITATIONS, AND RECOMMENDATIONS	 54
Summary.	54
Limitation and Recommendations for Further Study.	57
Conclusions.	59
 REFERENCES.	 61
APPENDICES	
A. Institutional Release.	64
B. Demographic Data and Situational Stressors	65
C. Coping Mechanisms.	67
ABSTRACT.	69

LIST OF TABLES

TABLE	PAGE
1. Educational Preparation of the Supervisors.	32
2. Children of Supervisors	36
A. Numbers of Children Per Supervisor	
B. Numbers of Dependent Children Per Supervisor	
3. Frequency of Situational Stressors Within Categories. .	38
4. Sub-categories of Interpersonal Relationships Between Administration and Supervisors.	40
5. Sub-categories of Interpersonal Relationships Between Supervisor and Staff.	41
6. Sub-categories of Interpersonal Relationships Between Supervisors and Physicians.	43
7. Sub-categories of Stressors Related to Physical Environment	44
8. Sub-categories in Respect to Lack of Time as a Stressor.	45
9. Sub-categories in Respect to Staffing Issues.	46
10. Frequency with Which Coping Mechanisms were Used. . . .	49
11. Coping Mechanisms Used Frequently	48
12. Coping Mechanisms Used Occasionally	50
13. Coping Mechanisms Used Rarely	51

LIST OF FIGURES

FIGURE	PAGE
1. Organizational Structure of Patient Care Services....	18 a

CHAPTER I

INTRODUCTION

Stress as a scientific phenomenon has been studied extensively and continues to offer an intriguing field of investigation. Stress crosses all boundaries of socio-economic strata and seems to occur at every level of human endeavor. An individual's perception of wellness, his physical health and even his behavioral responses are conditioned by his reaction to stressors in his environment. Health care professionals are placed in a unique situation with respect to stress. They not only deal with their own personal and professional stressors, but must support clients, patients, and their families as they undergo varying degrees of physical and emotional stress.

The nurse supervisor encounters a myriad of stressful situations. As a member of middle management, the supervisor often is held accountable for matters over which she has little control. For instance, the nursing supervisor has little control over the fluctuation in the number of patients admitted to her nursing care unit, yet the income generated from the unit is directly related to the daily census. The supervisor must maintain adequate staff to care for the patients, but not so large a staff that the salary expenditures exceed a fixed percentage of the revenue generated. She must supervise her staff in an efficient manner, serving not only as supervisor, but counselor. Her allegiance to the hospital management system should be unquestionable and at the same time support of her staff should be unequivocal. This dichotomy predisposes her to stressful situations.

Frequently, in the process of selecting a supervisor, little consideration is given to whether her resume documents any management course work. Often, the "best nurse" is chosen for this responsible position and later the lack of knowledge and preparation for the position surface as stressful situations arise. Interpersonal and professional relationships with doctors, peers and subordinates are potential problem areas.

The magnitude of the stress level within the individual supervisor is directly related to the personal resources each individual brings to that position. If the major stressors of nurse supervisors were identified as well as the behavioral responses most frequently used in those situations, programs might be devised in which the supervisors learn how to deal more constructively with those energy consuming encounters.

Review of the Literature

The review of the literature includes a description of the historical perspectives and conceptualization of stress. The role of the supervisor is documented. Nursing studies related to stress are reviewed as well as a nationally recognized study of stress conducted by two social psychologists. Lastly, studies related to coping are presented.

Historical Perspectives and Conceptualization of Stress

Although Hans Selye is generally credited with the conceptualization of stress and the major research in the area, other earlier scientists identified stress and recognized its importance. Walter

Cannon as early as 1935 conceptualized stress from a broad perspective. He perceived stress as including "physical as well as emotional stimuli." Among physical stressors he included cold, lack of oxygen, low blood sugar, and loss of blood. In addition to physical and emotional stress, he used the term in relation to social and industrial organizations.

Mason (1975), an endocrine physiologist currently with the Division of Neuropsychiatry at Walter Reed Institute, has been involved in stress research since 1955. He points out the fact that Selye's definitions of stress have changed over the years, yet the rationale for these changes have not been published. Mason has been reluctant to define stress and has refuted several of Selye's statements of non-specificity as they pertain to physiological manifestations. Mason has added an important dimension to research related to stress in that he has identified a psychological component to what has been predominately a physiological approach.

Selye, the major contributor to the stress literature, has been called the "great pioneer in psychosomatic medicine" (Pelletier, 1977). He defined stress as "the non-specific response of the body to any demand made upon it." Although Selye began his study of stress in 1935 he actually became interested in the subject much earlier. As a medical student he noted a commonality of symptoms which were present in all ill individuals irrespective of their diagnosis. He referred to these symptoms as "the syndrome of just being sick." This observation stimulated his thinking and culminated in the vast body of research related to stress. In 1956 Selye published his first book, "The Stress of Life."

In this treatise he discussed the processes by which he came to define stress and also the local and general adaptation syndrome (LAS and GAS). Both the LAS and the GAS are considered in a physiological context. However, in "Stress Without Distress" (1974) he acknowledges the psychological component and states that in his early research he was too preoccupied with the "biochemical mechanisms" to attach any importance to the psychological. Selye's life work was dedicated to the research of stress, predominantly from a physiological perspective.

Lazarus (1966) approached the study of stress from the perspective of a psychologist. He acknowledges the fact that the definitions in use promote misunderstanding but readily agrees that a workable definition is extremely difficult because what one person perceives as stress may not be stressful to another individual. Lazarus studied the stimulus-response mechanisms and has identified differences between psychological and physiological stress and coping behaviors.

Two major types of stress have been identified in the literature: systemic or physiological, and psychosocial. The concept of systemic stress is concerned primarily with disturbances of tissue systems and the identification of these phenomena. This study has been directed by the work of physiologists such as Cannon and Selye. The concept of psychological stress has been introduced by researchers such as Lazarus and McGrath. They have studied the humans' response to stressors, and their coping mechanisms.

Stress, for the purpose of this study, will be considered to be both physiological and psychosocial in nature. Stress can be both

positive and negative, thereby producing favorable results if the individual perceives the stimuli or stressors as positive, or harmful if the stressor(s) is/are perceived as threatening or distressful. Thus, a stressor which one individual may perceive as distressing may be perceived as positive stress by another person. To illustrate, one nurse may anticipate with enthusiasm her assignment of being responsible for a very complicated new post-operative patient while another nurse freezes and becomes faint over the prospect. For this study then, the stressor is the stimulus which produces the stress response within the individual.

Role of Supervisor

The role of the supervisor is complex. She is in the pivotal position which links nursing administration with nursing care (Stevens, 1974). The supervisor is responsible to the assistant director of nursing and thereby to the director of nursing. She is the communicating link between nursing staff and administration and between administration and staff. She must implement on her unit the objectives and goals, policies and procedures established by the administrative officers. This is accomplished through her staff and demands clear perception and sound judgement, coupled with a generous supply of tact. The supervisor is regarded as a clinical expert in her field, therefore she must maintain her nursing care skills and expertise and be able to apply these in an emergency while at the same time her job description takes her away from patient care. She must be able to recognize and direct quality patient care and provide inservice

education to that end. She is responsible and accountable for budget, setting up schedules, evaluation and counseling of personnel, as well as recruitment and termination of unit employees. She must recognize that any significant change in practice on her unit could influence most of the other departments within the hospital, as a nursing unit acts as a pivotal point influencing other departments' interactions with the patients.

The nurse supervisor must also function as a manager and bring to that position all the management skills of decision-making, planning, motivating and disciplining, as well as time management. She must be able to establish a collegial working relationship with the physicians who care for the patients on her unit. And last, but not least, she must be able to function in the clinical area with equanimity in times of crises.

Nursing Studies Related to Stress

Only two studies were found in the nursing literature in which the investigators had attempted to identify stress producing stimuli in the clinical setting. Both of these studies along with a third unpublished study chose intensive care nurses as their subjects. Bailey and Claus (1980) reported a national study involving a large sample of intensive care nurses who responded to a "free-response" questionnaire. They requested the identification of stressful situations by their subjects, thereby eliminating the possibility of suggestion in determining stress for the individual. The data compiled

relative to stressful experiences were analyzed by "category formulation", a process used by Bailey (1956) in an earlier study. The responses fell into seven distinct areas: (1) interpersonal conflicts, (2) management of the unit, (3) nature of direct patient care, (4) inadequate knowledge and skill, (5) intensive care unit (ICU) environment, (6) life events, and (7) lack of administrative rewards. Bailey and Claus found that in rank order, 1794 ICU nurses identified interpersonal conflicts as their greatest source of stress, followed by management of the unit, nature of direct patient care, inadequate knowledge and skills, physical work environment, life events and lack of administrative rewards.

Leatt and Schneck (1980) identified "differences in stress perceived by head nurses across nursing specialties in hospitals." They used a Likert-type scale for collecting the data. The 21 item scale was pretested by 20 nurses. Ten of the items measured stress related to tasks while the remaining 11 items were intended to measure role related stress. The sample of head nurses were from 25 hospitals in Canada and included nine specialty units and 153 sub-units. The specialty units were described as medical, surgical, ICU, and pediatrics. Sub-units were identified as a geographic inpatient area of a hospital having a technological domain, an assigned number of beds, its own regular complement of nursing staff with shared goals, and a formal hierarchial structure.

Results were analyzed in two parts: first, the sources of stress common to all head nurses were analyzed to determine the content

validity of the items. No significant difference in stress perception was found among the head nurses except for an item categorized as "family upset." For this particular item, the study showed a difference between "auxiliary" and/or pediatric head nurses, and head nurses in rural and psychiatric hospitals. The investigators proposed that this difference resulted from the fact that "auxiliary" and pediatric units had a greater number of upset patient families than did the rural or psychiatric units. However the investigators did not define "auxiliary." On further analysis of the data they found that there were differences in perception of stress by head nurses that were related to age, experience and education. The investigators claim high content validity for the tool. The highest agreement among head nurses related to the category identified as "crises." A second category of high stress, related to "unavailability of physicians." The least stressful category was identified as "relieving on the same specialty."

The data were analyzed in terms of the perceived frequency of occurrence of stressful situations. This was done in order to test the hypothesis that there were differences in perceived frequency across sub-units. There was less agreement between frequency responses than for the perceived level of stress. For example, very few head nurses responded that the stress situations always or never occurred but they were not able to identify the frequency. The investigators made no attempt to explain this lack of agreement with regard to frequency of occurrence. However, it could be argued that nurses are able to identify the intensity of stressful situations but are unable to recall frequency.

A factor analysis was performed in order to identify the types of stress which occur most frequently. Results of this analysis identified the following categories of stress in rank order: patient-based, role-based, task ambiguity, staff movement, and physician-based. When correlations were calculated between categories it was found that these five groups were not completely independent. The highest correlation was .2 and it occurred between patient-based and role-based stress.

An analysis was performed to examine the data for differences in the stress categories for each type of speciality represented by the head nurses. Significant differences were present for the type of stress between the nine specialities represented with the exception of role-based stress. The investigators suggest that differences do not exist within the administrative role of the head nurse. The data were further examined and revealed a difference of type of stress as perceived by the individual head nurse of respective specialities.

When the data were examined in terms of perceived frequency of occurrence of types of stress for head nurses in relation to age, experience and education, it was found that there were no significant differences with respect to age and experience but that there were differences with respect to education. However, the investigators state these findings must be viewed with caution as a distorting influence may exist because of unequal numbers of nurses per educational category.

Griffith (1973) reported on a descriptive study undertaken to identify stress and coping behaviors of ICU nurses. Twenty-seven ICU

nurses were interviewed using an open ended format to elicit as wide a variety of responses as possible. Demographic data concerning age, years of nursing experience, educational preparation, types of inservice education, length of time in current ICU, as well as previous experience in an ICU, were requested. In addition to stressors, coping behaviors were identified. Griffith found that responses concerning stressors grouped easily into the following categories: direct patient care, working conditions and staff relationships, the ICU environment and intrapersonal sources. Coping behaviors were identified as: talking about it at work, support of other staff, ventilate at home, emotional reaction (other than crying), crying, do my best and not let the rest bother me, establish priorities of tasks, go home and forget it, leave unit temporarily, humor, activity during time off to dissipate stress, experience in the unit, deal openly with problems, and look up things that will help next time.

Katz and Kahn (1964) reported on research designed for the study of role conflict and ambiguity. Their study was accomplished in two parts. The purpose of the "intensive" study or first part was to produce a design which could be used to identify, for a limited number of positions, the role expectations held by all relevant role senders. The role senders were defined as that set of persons whose behavior was likely to have major influence on the focal role person. The intensive study involved interviews of personnel within the chosen organization to determine the individual's reaction to his job environment, interpersonal relations, personality predispositions and various attributes

of his job. The major variables with which this study was concerned were the individual's location in the organization, the pressures exerted upon him by his role senders and the emotional tensions he experienced in connection with his work.

In the second part of the study, a nationwide survey of role conflict and ambiguity was undertaken to complement the approach and findings of the intensive study which had selected focal persons and their role senders. The major variables in part two concerned the respondents job-related tensions in relation to various attributes of the job and the organization. This major research project produced a complete battery of tests designed to study role conflict and ambiguity. Kahn (1964) defined three major sources of stress in organizations: role-ambiguity, that is, not knowing quite what the job entailed or how to do it, role-conflict, that is, being caught between conflicting expectations by different role senders, and role-overload, that is, an excessive amount of work.

Based on the aforementioned research, a study which hypothesized that certain jobs in hospitals are considerably more stressful than others, was conducted (Bates & Moore, 1975). A slightly modified portion of Kahn's instrument was administered to 800 staff members in 20 different hospitals and to 102 public servants in 17 different departments. Items dealt with role ambiguity, role conflict and role overload. Respondents were asked to rate frequency of a certain stress according to the scale of "never", "rarely", "sometimes", "rather often", or "nearly all the time". In addition, open-ended interviews

were conducted with 200 hospital staff members and 50 public servants.

Stress scores for interns and nurses were significantly higher on the average, than the scores for nurse aides, hospital administrators, and public servants. Other differences appeared between the occupational groups. The highest score for nurses was associated with not having enough time or resources to do the job. Bates and Moore concluded that it was very evident that trained nurses and interns who deal with direct patient care have the highest stress scores of hospital personnel.

Coping

Lazarus (1971) defines coping as "those direct active tendencies aimed at eliminating or minimizing a stressful event which are task and reality oriented." He suggests two major categories: direct actions and palliative modes (Monat & Lazarus, 1977). Direct actions are behaviors, while "palliative modes refers to thoughts or actions whose goal is to relieve the emotional impact of stress."

Closely related to the definition of coping is the question of the effectiveness of the mechanisms frequently used to handle stress. Lazarus and Monat (1977) contend that "what is considered to be an optimal or beneficial response is highly dependent upon one's perspective and judgements."

In an effort to develop a reliable instrument for measuring coping behaviors, Sidle, Moos, Adams, and Cady (1969) constructed a pencil and paper tool. A group of heterogeneous college students, 20 males and 40 females, were asked to respond to three stressful

narratives using both a free-response and a closed-ended rating scale. The ten coping strategies used in the instrument were derived from the literature. The findings indicated that the ten strategies represented relatively independent ways of coping and that a pencil and paper measure is capable of eliciting information about less-socially-approved ways of coping.

Bell (1977) also utilized a modified version of the Sidle coping scale in a comparative study of stressful life events, mental illness and wellness behaviors and the coping methods used by individuals exhibiting these behaviors. She used the Holmes and Rahe Social Readjustment Rating Scale (SRRS) to determine the total life change units (LCU) score. Holmes and Rahe had pre-established through research that a low score indicated mild stress, a moderate score, moderate stress and a high score a major life crisis and high stress. The 30 mentally ill patients and their control group were then asked to respond to an 18 item coping scale. The choices were defined from "never" to "always" on a scale from one to five. The coping mechanisms could be divided into short and long term methods. The data were analyzed in order to compare the responses of mentally ill patients and well individuals. The experimental group had significantly more stressful life events within the last six months and had used significantly more short term than long term coping methods as compared to the control group. A significant association was found between high stress scores and short term coping methods for subject in both groups. These findings support the concept that inadequate coping may increase the probability of disease.

Oskins (1977) modified Sidle's coping scale by adding seven mechanisms derived from the literature. She used her tool to study situational stressors and coping mechanisms of nurses working in an intensive care unit. Based on a review of the literature and interviews with ICU nurses, Oskins established 12 narratives. Seventy-nine ICU nurses representing five different hospitals responded to the following four questions or statements: Do you perceive the situation as stressful? Do you believe that the situation could be a threat or challenge? Identify the major source or sources in this situation which could cause you the most stress or discomfort: (a) the ICU, (b) the ICU nurse, (c) the patient and his care, (d) the patient's family, (e) hospital administration, and (f) ICU personnel; and identify the coping method or coping methods from the attached list that you may use at or away from work in regard to this situation.

All narratives were identified as stressful by the nurses. Some stressors were identified as challenging, others threatening. Along with these stressors, the major source(s) of stress were identified. The nurses identified four leading coping strategies which they used more than 50% of the time. These coping strategies included talking it out with others, taking definite action on the basis of present understanding, drawing upon past experiences in similar situation and becoming anxious. Oskins stated that in reviewing the coping pattern developed by her sample population, many of the methods appeared to be of the "direct action" type.

It might be argued that the development of the 12 narratives in a study such as Oskins implies that these are universally stressful situations. Yet she asked her subjects whether they perceived the narrative as stressful or not. She also asked if the identified narratives could be considered a threat or a challenge, further implying a stressful situation. This type of fixed response negates freedom of the subject to identify the situations perceived as most stressful for each individual.

Individuals attempting to function in a fast paced society can be taught coping mechanisms. Baily and Claus as a follow-up to their study in ICU in 1980 devised 15 instructive modules designed to help nurses cope with their identified stressors. They taught concepts such as relaxation response and techniques, massage and touch, communication skills, assertiveness, group process, conflict resolution, crisis intervention, problem-solving and ethics related to death and dying (Bailey & Claus, 1980).

Conceptual Framework

The supervisor fills one of the most critical roles in the administration of nursing services. She is the person through which hospital and nursing service administrators implement their decisions and goals for patient care. As a middle manager, she must interpret to her staff policies and procedures in which she had little or no opportunity to formulate. She functions as a role sender inasmuch as her behavior has a major influence upon each focal role person. Although her multifaceted role predisposes to stress no studies could be found in the literature

that sought to identify specific stressors and effective coping mechanisms for nursing supervisors. Identification of the stressors and coping mechanisms will facilitate the planning and implementation of programs in which nursing supervisors learn effective ways of handling stress. It will also provide administrators the information necessary to reduce the stressors within the environment.

Statement of the Purpose

It is the aim of this descriptive study first to identify the stressors most frequently noted by nursing supervisors in a private hospital. Secondly, the study will determine the frequency with which these nursing supervisors utilize specific behavioral responses in coping with stressful situations.

The study sought to find answers to the following research questions:

1. What are the qualifications and characteristics of the supervisors in the study?
2. What are the stressors which the nursing supervisor encounters in her practice of nursing?
3. Do the identified stressors readily group into categories?
4. What is the frequency with which supervisors use each of the coping mechanisms identified from the literature?
5. Can specific trends be identified in relation to Lazarus' "direct action" or "Palliative mode" concepts?

CHAPTER II

METHODS

Design and Purpose

The aim of this descriptive study was to identify the major stressors encountered by nursing supervisors in their practice of nursing, and the coping mechanisms used by these same individuals in stressful situations. The study also collected data to describe professional and personal characteristics which the literature had implicated as qualities that influenced perception of the responses to stress.

Subjects and Setting

The convenience sample for this study was recruited from the 24 supervisors employed by a private community hospital. These supervisors encompassed four levels of professional education, with numerous reasons for selecting the position, and a variety of family and personal responsibilities.

The hospital is staffed by private physicians and maintains a large resident house staff supplied primarily by the nearby state university medical school. Nursing students from two baccalaureate programs and students from one associate degree program receive part of their clinical experience in this institution. In addition, a community college contracts with nursing service administration to provide nurses re-entering the employment field with comprehensive clinical experience.

The hospital administrator delegates responsibility for patient coordination to two assistant administrators who are responsible for patient care activities. One assistant administrator is responsible for nursing care activities in the departments of Mental Health, Operating Room, and Outpatient nursing while the second administrator is responsible for Pharmacy-Intravenous therapy, Nursing Service and Home Health. Thus, nursing care activities are divided into six departments, each with its own director. Nursing Education reports directly to the Director of Nursing Service. One supervisor reports directly to the Mental Health Director. Two other supervisors report to the Director of the Operating Room and four are directly responsible to the Director of Pharmacy and one to the Home Health Director. This constitutes a total of 24 nursing supervisors for the institution. Figure 1 illustrates the organizational chart.

These supervisors generally are responsible for management functions related to personnel, patient care and budget planning. Managerial aspects of personnel include activities such as interviewing, hiring and terminating employees, counseling, evaluation and scheduling as well as accountability for all aspects of the daily functioning of the unit. Included in these activities are 24 hour staffing, providing continuity in a multidisciplinary team relationship, maintaining effective communications through staff meetings on all shifts and responding to unforeseen or emergency occurrences. In addition, each supervisor has individual responsibilities related to her area of special services.

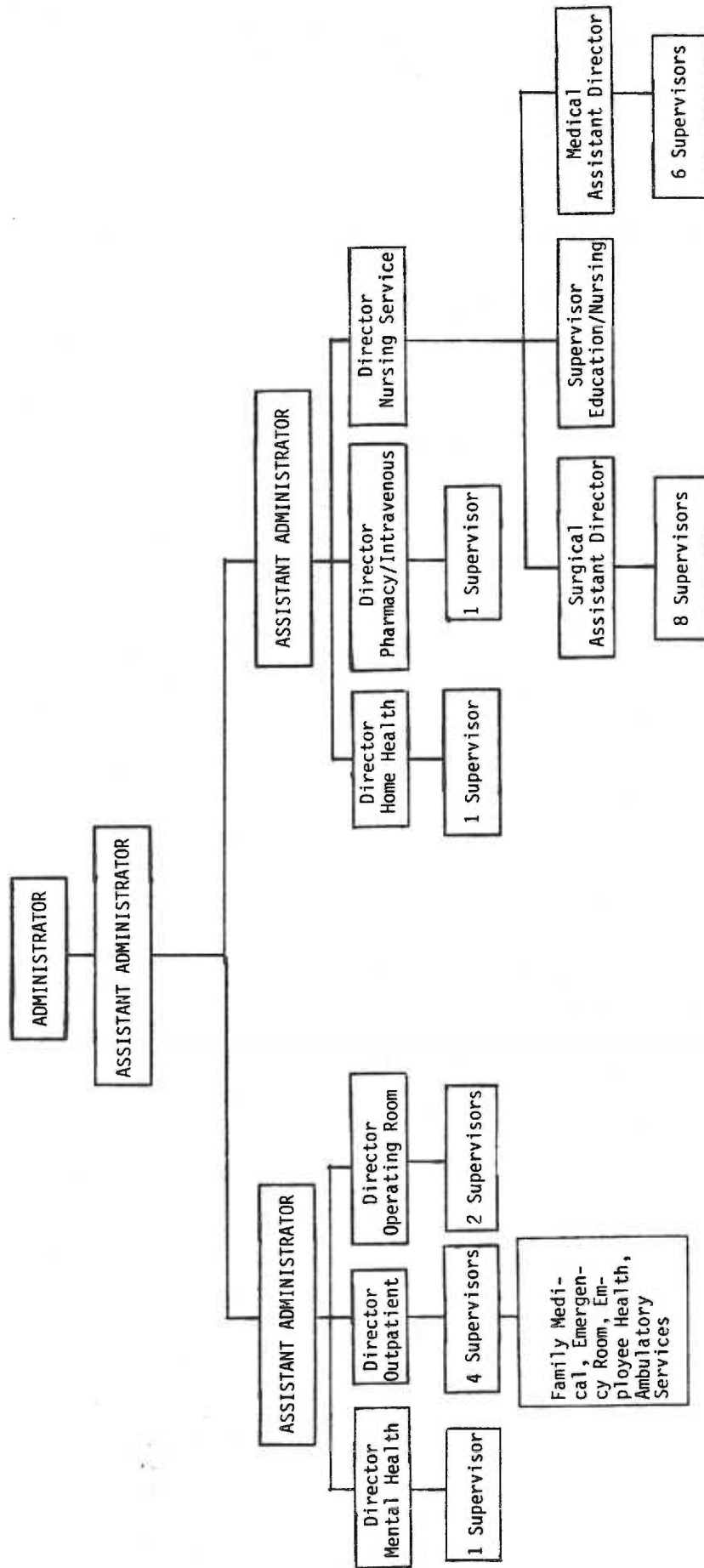


FIGURE 1. Organizational Structure of Patient Care Services

Instruments

1. Demographic data and identification of stressors.

Stressors are perceived in a different manner by each individual and may be viewed as either positive or negative (Lazarus, 1971). These individually unique perceptions are in part the result of both life and professional experiences.

The instrument for the collection of data in respect to the personal and professional backgrounds of the supervisors and for the identification of stressors was developed by the investigator, as no suitable tool could be found. Demographic data were collected in order to describe the study sample and to enable comparison of this population to future studies. See Appendix A for a copy of this tool.

a. Demographic data

The investigator collected data in respect to four categories: educational preparation, professional experience, reason(s) for selecting present position and life events.

Data were collected on the educational preparation and the evidence of motivation towards further education. Since continuing education credits may be viewed as an indicator of professional growth, data were collected on the number of credits accrued. In addition, information was gathered concerning whether the continuing education efforts were initiated by the individual or were required.

No studies were found in the literature relating professional experience to stressors or responses to stress, however, nursing leaders

state that the nurse manager must be a "clinical nursing expert" which implies experience to gain expertise (Stevens, 1974). In order to describe the sample, and to enable future comparisons to the study, information was gathered on the length of time since graduation and the number of years of active practice within various levels.

Realistic role perception is related to both job satisfaction and the ability to deal effectively with stress related to the job (Stevens, 1974; Dooley & Hauben, 1979). Thus, information concerning the initial attractors to the supervisory position was collected.

Since personal life events may influence the supervisor's ability to perform, data were collected with regard to marital status, number of grown or dependent children, economic support and hobbies and/or recreational interests.

b. Identification of stressors

An open-ended questionnaire was utilized as the instrument of choice, to elicit a free rather than forced response for the identification of stressors (Bailey & Claus, 1980; Griffith, 1973). The national study conducted by Bailey and Claus (1980) utilized an open-ended questionnaire and found that the stressors grouped into the following seven categories: interpersonal conflicts, management of the units, nature of direct patient care, inadequate knowledge and skill, physical work environment, life events, and lack of administrative rewards.

The paper and pencil tool used for data collection in this study was pilot tested on two groups of students enrolled in the graduate

program in nursing administration at the Oregon Health Sciences University. The purpose of the pilot testing was to determine whether the subjects would be able to recall stressful situations without cues. Group A responded to a number of potentially stressful areas related to the supervisors' responsibility while Group B were asked to recall stressful incidents in a free response manner. This was done to ascertain whether nurses could recall stressful incidents without being cued. Responses from Group A and B were similar in content.

2. Coping Scale

A paper and pencil tool was used to establish the frequency with which supervisors utilized specific coping mechanisms. Oskins (1979), as part of her study of stress in ICU nurses, utilized a coping scale adapted from Sidle et al. (1969) and Bell (1977) in which she identified 20 coping mechanisms readily scored by the use of a Likert-type scale. Verbal consent for the use of and a minor modification in this tool was obtained by telephone from Oskins.

Because no instruments were available to measure the specific ways in which individuals cope with a given problem, Sidle et al. (1969) developed a scale to measure behavioral mechanisms. A heterogeneous sample of 60 college students who were enrolled in a summer school psychology course, were asked to respond to three narratives dealing with transitional student-life events, i.e., college choice, early marriage, and an important examination. These situations were selected to maximize student involvement and because it was postulated that differing strategies

used in periods of gradual change where past experience plays a greater role. The students were asked to keep the following tasks in mind as they read the stories: 1) How can the distress be relieved? 2) How can a sense of personal worth be maintained? 3) How can a rewarding continuity of interpersonal relationship be maintained? and 4) How can the requirements of the stressful task be met, or the opportunities utilized?

Part I of the exercise included the narratives with a request that the students list all the possible coping strategies they could enlist to handle the situations (free responses). Part II requested them to quantify from "very likely" to "very unlikely" on a seven point scale, the possibility of utilizing each one of the ten strategies for the same situations used in Part I.

The ten coping strategies identified from the literature included were: try to find out more about the situation; seek additional information; talk with others about the problem (friend, relative, professional person); try to see the humorous aspects of the situation; don't worry about it, everything will probably work out fine; become involved in other activities in order to help keep your mind off the problem; take some positive, concerted action on the basis of your present understanding of the situation; be prepared to expect the worst; make several alternative plans for handling the situation, after all you never know which might work; draw upon your past experiences, perhaps you've been in a similar situation before; and try to reduce the tension (e.g., drink, eat, smoke more, exercise).

In order to assess the effect of social desirability on stated preferences for various coping strategies, and to estimate the relationship between coping variables such as anxiety, self-esteem and perceived locus of control, each respondent also completed six well-established instruments.

The authors state that the fact that the ten strategies represent relatively independent ways of coping, did not tend to cluster, and that "good" and "bad" coping mechanisms were not negatively correlated support the inclusion of all ten strategies in assessment of coping behavior. Secondly, the authors claim that the lack of correlation between the Marlowe-Crowe Social Desirability Scale and the closed or open-ended scores suggests a paper and pencil tool is capable of eliciting information about less approved ways of coping. Thirdly, the extent of agreement between strategies rated on the closed-ended format and the high scores on the open-ended format suggest that the two types of items represent different forms of information about coping strategies and both types should be included at this stage of research in developing tools related to coping.

Significant correlations between background data and the free responses or the ratings were limited to six differences for five of the ten strategies. This difference suggests that females tend to seek additional information, talk with others, become involved in other activities, and reduce tension more than males. Men appear more prepared to expect the worst. Years of education correlated positively to the use of humor and drawing on past experiences.

Menninger (1963) writing about stress identified common behaviors that reduce fluctuations in adaptation and adjustment. He states that the coping behavior used by the individual is dependent upon the suddenness of the stimulus, the strength of the disturbance and past experiences with the stressors. He believes that certain patterns or responses have been established and suggests that soft reassuring voice sounds and/or rhythmic movement, alcoholic beverages, laughing, crying, swearing, self-discipline, fantasizing, sleeping, thinking it through, exercise, and praying are behavioral manifestations of the coping process.

Bell (1977) drawing from Menninger's concepts related to coping behaviors, modified and expanded the Sidle et al. coping scale into an 18 item instrument. She divided the combined mechanisms into short and long term strategies in order to compare the methods used by mentally ill and healthy individuals. Using a group of 30 psychiatric patients and 30 well individuals, she collected data on the Social Readjustment Rating Scale (SRRS) and her tool. She compared the SRRS score to the mechanisms used most frequently by the experimental and control group to determine methods of coping with stress. The subjects were asked to rate themselves on a scale of one to five, "never" to "always" in regard to their likelihood of using each item when feeling stress and tension. She does not claim reliability or validity for the coping scale but found that persons with a high social readjustment score used more short term ways of dealing with stress. She stated that "there is a great need for an experimental study to develop a reliable and valid coping scale." She further stated "that such a study might

be used to determine real coping, by observing actual behavior in a stressful situation rather than obtaining theoretical information through pencil and paper methods."

Oskins (1979) modified Bell's coping scale for her identification of stressors and coping methods used by ICU nurses. She combined eight of the Sidle et al. mechanisms with four additional strategies from Bell's research, and added eight other methods extracted from the literature. In addition to the Sidle's et al. list she added the following behaviors: I become anxious, I become angry and strike out verbally at the problem, I physically avoid the problem and move away from its source, I rationalize my decisions or actions as being correct or good, I take actions that are not based on my true feelings of the situation, I become depressed or apathetic, I project my feelings on others, I think of a super-natural power who cares about me, I sleep more, I cry, I daydream, and I use medication to make me feel better. Oskins does not claim reliability for her tool, however, she makes the same claims as Sidle et al., that a pencil and paper test is a valid instrument for eliciting information regarding coping mechanisms.

Jalowiec and Powers (1981) developed a similar tool in their study of stress and coping mechanisms in hypertensive and emergency room patients. The results of their study were published following data collection for this current study. Following a review of the literature related to coping mechanisms, each strategy identified was listed on an index card. Forty coping methods emerged. A Likert-type format with a five point scale ranging from "never" to "always" was employed

so that respondents could rate each mechanism according to the degree of use. The investigators claim content validity based on the literature of authorities in the field of coping and adaptation. Reliability of the scale was determined through use of the test re-test method in a pilot study with 28 adult volunteers. The data collected indicated reliability using Spearman rank order ($r_s = .79, p < .001$).

Following the pilot study a panel of experts classified the coping strategies into problem-solving or an affective-oriented way of coping with stress. Problem-oriented mechanisms attempted to deal with the problem while affective-oriented strategies attempted to handle the emotions evoked by the situation. The 20 member panel of experts had an 85% agreement between the two groupings.

Fifty patients ranging in age from 20-60 years of age volunteered for the study in which stress and the coping scale were tested. Stress was measured by the use of the stressful life event scale developed by Holmes and Rahe (1967) and coping was measured by the aforementioned tool. Jalowiec and Powers found that emergency room patients reported significantly more stressful life events for the one year period preceding illness than did hypertensive patients. They also found that hypertensive subjects used more coping methods in handling stress in their lives than emergency room subjects. Four of the five most frequently used mechanisms were the same for both groups: hope, control, objectivity, and abstract problem solving. Three of the five least frequently used methods were the same for both groups with drug use rated lowest.

The researchers found no significant difference between the hypertensive and emergency room subjects with regard to type of strategy used. However, when problem and affective scores were compared separately for each group, problem oriented coping methods were used by both groups significantly more than affective methods.

Neither Bell (1977) nor Oskins (1979) make any claims for reliability or validity of their tool. They both repeat the claim made by Sidle et al. (1969) that a paper and pencil tool is capable of "eliciting information about less-socially approved ways of coping" (Sidle et al., 1969). Through validity and reliability cannot be claimed for the tool credibility is claimed because of the fact that several other researchers have approached the problem in the same manner using healthy as well as ill subjects. Validity is implied. The pencil and paper tool used by this researcher is identified to that utilized by Oskins with the exception that one coping mechanism, namely that of the use of alcohol was added. Since Sidle et al., Menniger, Bell and Jalowiec and Powers have all identified this as a coping mechanism. Verbal permission for use of the Oskins' tool and this modification was granted by the author.

Data Collection

The research proposal was reviewed by the Committee on Human Research at the Oregon Health Sciences University and determined to all under the category of exempted review. Institutional approval was sought and granted by the Director of Nursing Services. The letter of consent appears in Appendix B. Data were collected within a two

week period in March 1982. This was a period of relative stability within the institution, that is, there were no administrative changes and nursing contracts were not being negotiated.

The data collection instrument was distributed at the beginning of a regularly scheduled meeting of the nursing service supervisors. An explanation concerning the purpose of the research was given by the principal investigator and an opportunity to examine the questionnaire was afforded each supervisor. This was done in an attempt to elicit any questions concerning the document. All questions were answered fully by the investigator. Assurance of anonymity was given as indicated by an identification number on each document.

Individual demographic data and the completed coping scale were available to the principle investigator. The situations of stress provided by the subjects were not submitted to the investigator. They were reviewed for content by an impartial research assistant chosen for her expertise in the field. This assistant categorized the situations in respect to domains without the demographic information. Therefore, no correlation between stressful events and the individual supervisor was possible. The responses to the stressful events were mailed in a pre-addressed stamped envelope to the research assistant while the demographic information was mailed to the principle investigator. Demographic data and the open-ended questionnaire received corresponding numbers to allow for data analysis; however, no correlations were drawn between demographic data and stressful incidents. Anonymity of the respondents was preserved and no administrative pressure was brought to bear upon the respondent. It was entirely within the respondent's

right not to participate in the study. Consent to participate was implicit in the return of the questionnaire. A two-week deadline for return of the questionnaire was established. The explanation of the documents to the supervisors required approximately 30 minutes while completion of the questionnaire required approximately 60 minutes. The supervisors were asked to complete the questionnaire on their personal time.

CHAPTER III

RESULTS AND DISCUSSION

Introduction

Review of the literature revealed studies of the concept of stress related to almost all areas of life and groups of people. In contrast, in nursing there are few stress related studies and these have generally focused upon intensive care nurses. Only one study was found which focused upon the stress of head nurses, however, it could not be compared directly to the present study as it examined the stressors of these nurses between their sub-specialities such as pediatrics and medical-surgical and the scope of the responsibilities were not identified. No studies were found that identified stressors within the scope of practice for nurse supervisors.

The aim of the present study was to identify the situational stressors noted by nurse supervisors within the scope of their practice and to examine the frequency with which these supervisors used coping strategies which had been documented in the literature.

The supervisors were requested to complete a questionnaire of demographic information and use a Likert-like scale to select the frequency with which they utilized the coping mechanisms. They were also asked to describe briefly or identify five to ten of their most stressed situations. In order to safeguard anonymity, the stressors were not correlated to the coping mechanisms.

The results of the study are presented in the following order: description of the sample and the response rate; the qualifications and characteristics of the supervisors are described; the grouping of situational stressors are discussed; comparisons are drawn between the coping strategies used by nursing supervisors and those reported for college students. The frequency with which the supervisors used each coping mechanism is presented and the strategies used most frequently by the supervisors are categorized.

Description of the Sample and Response Rate

Twenty-three nurse supervisors from a large Pacific Northwest metropolitan private general hospital were recruited to participate in the descriptive study. Twenty-one of these supervisors returned their demographic questionnaire and coping scale to the principal investigator while 19 completed and mailed their situational stressors to an independent researcher. This dual mailing system was established to protect the anonymity of the respondents as the principal investigator is a supervisor in the same institution and therefore known to all who participated in the study.

The 21 responded containing the demographic data and the coping scale were tabulated for a response rate of 91%. It may be inferred that the high return rate is indicative of the interest and concern that nurse supervisors feel in respect to the factors of stress connected to their positions. It must be acknowledged that the principal investigator was known to the entire group and was completing the requirements for her

Masters in Nursing with this study. The degree to which this factor influenced the response rate is not known. Nineteen responses of situational stressors were mailed to the nurse researcher for a response rate of 83%. Reasons for the differences in return probably relate to the amount of time necessary to complete each of the tasks. The demographic information and coping mechanisms could be completed in 10-15 minutes whereas the description of stressors took considerably longer and may have evoked unpleasant and/or uncomfortable feelings.

Qualifications and Characteristics of the Supervisors

In order to describe the sample and make future comparisons possible, data were collected on the educational preparation of the nurse supervisors. These data are displayed in Table 1.

TABLE 1
Educational Preparation of the Supervisors

Education	Number	Percent
Associate Degree	4	19.0
Diploma	8	38.1
Baccalaureate Degree	6	28.6
Masters Degree	3	14.3
Total	21	100.0

In an attempt to ascertain the importance placed on educational pursuits, the supervisors were requested to specify the number of academic and continuing education credits acquired beyond their basic preparation. The responses showed a wide range in number of both academic and continuing education credits. It was evident from the data that the baccalaureate program emphasizes academic credit whereas the diploma program is more closely related to blocks of experience which are not readily converted to academic credits. It was also apparent from the data regarding educational background that the questionnaire was not constructed in a manner which elicited the information necessary to evaluate educational preparation and pursuits.

Since no studies have been published in respect to the stressors of nursing supervisors, comparison of this study sample could only be made to the two major studies of stress among ICU nurses when this study sample is compared to that of Oskins (1979), it is noted that her sample contained a greater number of nurses with diploma preparation (60%). However, this difference in education is to be expected since her sample consisted of both staff nurses and supervisors, and only 24% of these individuals were employed as supervisory personnel. The samples are similar with respect to baccalaureate preparation. Oskins reported 27% while in the present sample 29% of the supervisors had earned a baccalaureate degree. The typical ICU nurse in the study reported by Bailey and Claus (1980) was a diploma graduate who was not presently enrolled in additional education.

The supervisors were requested to identify the number of years of experience in nursing and the types of positions held. The range was from eight to 30 years of active practice of nursing with a mean of 18.6 years. All but one supervisor had been employed as a staff nurse. The length of time as a staff nurse ranged from one to 19 years, with a mean of eight years.

Of the present sample, 85.7% had been employed as head nurses. Only five of the supervisors (less than 25%) had practiced as clinical specialists and the length of time in this position ranged from three to 11 years. It may be speculated that the low number of participants who had been employed as clinical specialists may be attributed to the relative newness of this position within the scope of nursing practice. Further, it is possible that the educational demands which the certified clinical specialist role requires may have influenced the number who had practiced in this area.

The number of years of experience in nursing reported in the two studies of ICU nurses varied considerably from the present sample. Oskins did not report an upper range limit or mean, therefore comparisons are not possible. Bailey and Claus stated that the typical ICU nurse had three to five years of experience. Since the role of the supervisor carries additional responsibilities it is to be anticipated that nurses who have had experience in a variety of positions and have been employed for more years would be recruited for these positions.

The supervisors were asked to select from a list of possible options,

The reason(s) for accepting their present position. Ten of the respondents indicated that they viewed their position as a promotion; 15 viewed it as professional growth; eight cited an increase in salary as a reason for accepting the position. Seven supervisors perceived the position as having a more flexible schedule; six indicated that they needed a change; 13 selected the option of needing a challenge; one person who had been a supervisor for many years when she applied for the present position did not see it as a change in status. Generally most of the supervisors viewed their present positions as a positive step within their practice. Comparisons to the other nursing studies could not be made as neither study collected data on similar factors.

In respect to personal data the following characteristics emerged. Thirteen (62%) of the supervisors were married while eight were single, divorced or widowed. They had a total of 48 children, 24 of whom are still dependent. These data are shown in Table 2. Five supervisors were the sole support of their children.

TABLE 2
Children of Supervisors

A. Numbers of children per supervisor		
Supervisors	Children	Total
4	0	0
2	1	2
8	2	16
4	3	12
3	6	18
<u>21</u>		<u>48</u>
Total	21	48

B. Numbers of dependent children per supervisor		
Supervisors	Children	Total
8	0	0
4	1	4
7	2	14
2	3	6
<u>21</u>		<u>24</u>
Total	21	24

The supervisors were asked to indicate their leisure time activities. This information was requested in an effort to ascertain if a pattern of sedentary versus active lifestyle emerged. All respondents listed several hobbies and/or recreational activities in which they participated. All but three supervisors participated in physical activities. These activities included a wide variety of outdoor recreation such as beachcombing, mountain climbing, canoeing, fishing, camping, swimming, running, and jogging. The only indoor sports activity listed was racquetball.

Hobbies included reading, bridge, stamp collecting, sewing, music, arts and crafts, homemaking, professional activities, church activities, trap shooting and collecting Japanese art. The two hobbies cited most frequently were cooking and gardening.

Situational Stressors Identified by Supervisors

In an effort to elicit from the supervisors the widest range of stressors, an open-ended or free response questionnaire was utilized. These anecdotes or reports were reviewed, evaluated, and placed in related categories by an independent nurse researcher. Generally, the anecdotes described only one stressor and were categorized into groups. In some instances it was not possible to identify a primary stressor, rather dual stressors were described. For instance, an anecdote may have indicated stress arising because of responsibility without authority coupled with unclear directives. In such instances items were grouped to reflect dual stressors. The researcher found that

the narratives grouped readily into eight categories and sub-categories. These categories are displayed in Table 3.

TABLE 3
Frequency of Situational Stressors Within Categories

Situational Stressor	Frequency	Percent
Interpersonal relationships between administration and supervisors	14	25.0
Interpersonal relationships between supervisor and staff	6	11.0
Interpersonal relationships between supervisors and physicians	7	12.0
Physical environment	6	11.0
Performance of non-nursing duties	1	2.0
Lack of time	9	16.0
Staffing issues	6	11.0
Personal life events	7	12.0
Total	56	100.0

The instructions to the supervisors gave them the option of naming specific areas of stress and/or describing specific situations which proved stress producing. The responses revealed a combination of both named stressors and descriptions of stressful situations. For example,

"staffing", was more frequently named as a stressor than was a situation which described staffing as a "stressful situation." Thus it appears that certain stressors are specific and can be named with a term that is universally understood by nurses. Other stressors are broader in nature and require a description or narrative. However, the independent nurse researcher did not have difficulty in identifying the stressor(s) whether named or described. Bailey and Claus (1980) had also been able to identify categories of stress in ICU nurses: interpersonal conflicts, management of the unit, nature of direct patient care, inadequate knowledge of skill, physical work environment, life events and lack of administrative rewards.

It should be noted that the independent nurse researcher did not attempt to force the anecdotal data into predetermined categories, however, there are similarities between the categories identified by Bailey and Claus and the present study. The differences in the categories of stressors between the nurse supervisor and ICU nurse may be accounted for by both the increased number of the more complex responsibilities carried by the supervisors. For instance, the three categories of interpersonal relationship stressors which emerged in this study no doubt reflect the variety of groups of professional and non-professional individuals with whom the supervisor must interact in her practice of nursing. The greatest number of sub-categories emerged within the category interpersonal relationships between administration and supervisors. The higher number of dual stressors within this sub-category may be indicative of situations representing greater complexities. Also within

This sub-category it should be noted that only five supervisors did not cite either a single or dual stressor. Lack of rewards or reinforcements, either as a single stressor or in combination as a dual stressor, emerged as the most frequently cited situational stressor within the entire study. These findings are represented in Table 4.

TABLE 4

Sub-categories of Interpersonal Relationships Between Administration and Supervisors

Sub-Categories	Number of super- visors identifying stressors	Percent
1. Responsibility without authority	0	0.0
2. Unclear directives	2	10.5
3. Lack of rewards or reinforcements	4	21.1
4. Management non-supportive of goals	1	5.3
5. Responsibility without authority and unclear directives*	3	15.8
6. Lack of rewards or reinforcement and management non-supportive of goals*	1	5.3
7. Unclear directives and lack of rewards or reinforcements*	2	10.5
8. Responsibility without authority and lack of rewards or reinforcements*	1	5.3
9. Not cited	5	26.3
Total	19	100.0

*Dual Stressors

Within the category interpersonal relationship between supervisors and staff there were no dual stressors identified. These stressors are shown in Table 5.

TABLE 5

Sub-categories of Interpersonal Relationships Between Supervisor and Staff

Sub-Categories	Number of super- visors identifying stressors	Percent
1. No understanding of supervisor's role	1	5.3
2. Unreasonable requests made by staff	1	5.3
3. Inadequate management experience or skills	4	21.1
4. Not cited	13	68.4
Total	19	100.0

Thirteen or 68.4% of the supervisors did not perceive this category as being stressful which would indicate a good working relationship within the unit. In contrast to the majority of supervisors who did not perceive stress in this area, there was a smaller group who identified inadequate management experience or skills as a sub-category stressor. Whether these few supervisors accurately perceived their situational stress or not, this stressor may be related to the

observation of Stevens (1974) that often the "best nurse" is selected for a management position irrespective of educational preparation.

Within the organizational framework of the institution within which the study was conducted, it needs to be pointed out that the numbers of staff with whom the supervisor must relate varies from department to department. For instance, the supervisor who carries responsibility for nursing education as well as the employee health supervisor have a significantly smaller staff and are not directly responsible for patient care services. Undoubtedly, these differences in numbers of staff and responsibilities are reflected in the stressors perceived by the supervisors.

The third category of interpersonal relationships related to the interactions between supervisors and physicians. These findings appear in Table 6.

Twelve (63.2%) indicated that this category was not an area of concern for them. The largest percent of conflict within this area occurred not between the supervisor and physician, but between the staff and physician and suggests the importance of the counseling, intermediary, and advocacy role of the supervisor. The fact that 36.8% of the supervisors identified stressors within this category suggests the potential for problems between these two professional groups. However, it should be noted that a large majority appear to be handling these interpersonal relationships satisfactorily.

TABLE 6
Sub-Categories of Interpersonal Relationships Between Supervisors and
Physicians

	Number of super- visors identifying stressors	Percent
1. Physician-supervisor conflict	2	10.5
2. Interpersonal conflicts of staff with physicians	5	26.3
3. Not cited	12	63.2
Total	19	100.0

While the physical environment emerged as a category of situational stress the largest majority (68.4%) of the supervisors (13) did not perceive this as a factor. This information is summarized in Table 7.

TABLE 7

Sub-categories of Stressor Related to Physical Environment

	Number of super- visors identifying stressors	Percent
1. Lack of Space	1	5.3
2. Stressful physical work environment	4	21.1
3. Lack of space and stressful work environment	1	5.3
4. Not cited	13	68.4
Total	19	100.0

The marked discrepancy in respect to the perception of the physical environment as conducive to stress is undoubtedly influenced by the disproportionate amount of space allocated to the individual supervisor within the various departments. The effect of the environment upon work productivity and the need for personal space are well recognized. In light of the responsibilities carried by the nurse supervisor for staff development alone, it is necessary that adequate, functional office space be provided.

Lack of time was cited as a stressful situation by nearly 50% of the respondents. The breakdown of sub-categories are shown in Table 8.

TABLE 8

Sub-categories in Respect to Lack of Time as a Stressor

Sub-Categories	Number of super- visors identifying stressors	Percent
1. Lack of time to give proper nursing care	1	5.3
2. Lack of time to learn advances in nursing	1	5.3
3. Lack of time to accomplish responsibilities	7	36.8
4. Not cited	10	52.6
Total	19	100.0

Ten supervisors did not perceive lack of time as a sufficiently significant stressor to identify it within their listing. Of the supervisors who indicated lack of time as a stressor, the largest majority (36.8%) indicated inadequate time to accomplish the responsibilities of the position. It might be expected that since the supervisors are salaried and have 24 hour responsibility for their unit, that working in excess of the 40 hour work week is not perceived as lack of time.

One category revolving around staffing issues emerged. These data are displayed in Table 9.

TABLE 9
Sub-categories in Respect to Staffing Issues

Sub-Categories	Number of super- visors identifying stressors	Percent
1. Unequal nursing time allotted to various departments	1	5.3
2. Staffing problems: too little or too much	3	15.8
3. Staff resentment to extra days off and job insecurity	1	5.3
4. Staffing problems: too little or too much, staff resentment to extra days off and job insecurity*	1	5.3
5. Not cited	13	68.4
	Total	19
		100.0

*Dual Stressor

Staffing issues appeared to be explicit with only one dual stressor. However, the sub-categories also appear to reflect a greater degree of subjective evaluation. They also suggest the dilemma of the supervisor in trying to provide adequate staffing while practicing responsible fiscal management with an ever fluctuating patient census. An additional problem arises because of the current economy. Staff nurses may feel

threatened and interpret extra days without pay as lack of job security and loss of income. This enforced time away from work without salary is particularly problematic to single income families.

Two categories emerged which were identified as stressors by a small number of supervisors. The first of these categories related to the performance of non-nursing tasks and was identified by only one supervisor (5.3%). The other category related to personal life events and was listed as a stressor by seven (36.8%) supervisors. The study had been designed to protect the anonymity of the subjects; therefore no correlations were drawn between demographic data, stressors, or coping mechanisms. However, the fact that more than one-third of the sample perceived stress in their personal life events, appears to indicate that family and/or home responsibilities are additional stressors to the nursing supervisor.

Since similar studies were not found in the literature, no comparisons can be made of the descriptive data found in this study. Analysis of the data shows what stressors are encountered by the nursing supervisors in the practice of nursing at the particular institution in which the study was conducted. Furthermore, these identified stressors were readily grouped into categories and appropriate sub-categories.

Coping Mechanisms Utilized by Nursing Supervisors

A review of the literature revealed a variety of professional persons investigating coping mechanisms used by groups of both healthy and ill individuals as a part of their interaction with life events.

One of the purposes of the present study was to determine the frequency with which supervisors utilized selected behavioral mechanisms identified in the nursing literature. Table 10 displays the findings in terms of the frequency with which the specified coping mechanisms were utilized by the supervisors.

In order to examine the data more closely, coping mechanisms utilized by seven or more supervisors were compared by frequency category and in terms of the two concepts of Lazarus, that is, "direct action" and "palliative mode." Lazarus defines "direct action" as any method which attempts to respond in a direct manner to that stressor and "palliative mode" as a response which ignores the stressor and tends to make the individual feel better. Table 11 represents the four mechanisms used "frequently."

TABLE 11
Coping Mechanisms Used Frequently

Mechanism	Number of super- visors identifying coping behavior	Percent
I take some definite action on the basis of present understanding	11	52.4
I talk it out with others	13	61.9
I try to see the humor of the situation	10	47.6
I think of a supernatural power who cares about me	9	42.9

TABLE 10

Frequency With Which Coping Mechanisms Were Used

	NEVER	RARELY	OCCASIONALLY	FREQUENTLY	VERY FREQUENTLY
1. I talk it out with others			2 (9.5%)	13(61.9%)	6 (28.6%)
2. I take some definite action on the basis of present understanding			5(23.8%)	11(52.4%)	5(23.8%)
3. I become anxious		5(23.8%)	14(66.7%)	2(9.5%)	
4. I become angry and strike out verbally at the problem	1(4.8%)	14(66.7%)	6(28.6%)		
5. I get prepared to meet the worst		8(38.1%)	8(38.1%)	5(23.8%)	
6. I physically avoid the problem and move away from its source	4(19.0%)	11(52.4%)	6(28.6%)		
7. I become involved in other activities to keep my mind off the problem	1(4.8%)	3(14.3%)	13(61.9%)	4(19.0%)	
8. I rationalize my decisions or actions as being correct or good		2(9.5%)	13(61.9%)	5(23.8%)	1(4.8%)
9. I try to see the humor of the situation		2(9.5%)	7(33.3%)	10(47.6%)	2(9.5%)
10. I take actions that are not based on my true feelings of the situation	1(4.8%)	9(42.9%)	11(52.4%)		
11. I become depressed or apathetic	2(9.5%)	17(81.0%)	1(4.8%)		
12. I project my feelings on others		16(76.2%)	4(19.0%)		
13. I use food and food substitutes	2(9.5%)	7(33.3%)	7(33.3%)	4(19.0%)	1(4.8%)
14. I try to forget the problem	2(10.0%)	8(40.0%)	8(40.0%)	2(10.0%)	
15. I think of a supernatural power who cares about me*	3(15.0%)	5(25.0%)	3(15.0%)	9(45.0%)	
16. I sleep more	4(19.0%)	12(57.1%)	4(19.0%)		
17. I cry	6(28.6%)	12(57.1%)		3(14.3%)	
18. I daydream	7(33.3%)	8(38.1%)	5(28.6%)		
19. I use medication to make me feel better	19(90.5%)	1(4.8%)			1(4.8%)
20. I use a glass of wine or cocktail to make me feel better	9(42.9%)	8(38.1%)	4(19.0%)		

* N = 20

Two of the mechanisms clearly fall in the category of "direct action" while the remaining two may be considered as "direction action" or "palliative mode" depending on the individual perception of belief system.

The mechanisms identified by the supervisors as used "occasionally" are shown in Table 12.

TABLE 12
Coping Mechanisms Used Occasionally

Mechanism	Number of super- visors identifying coping behavior	Percent
I become anxious	14	66.7
I get prepared to meet the worst	8	38.1
I become involved in other activities to keep my mind off the problem	13	61.9
I rationalize my decisions or actions as being correct or good	13	61.9
I try to see the humor of the situa- tion	7	33.3
I take actions that are not based on my true feelings of the situation	11	52.4
I use food and food substitutes	7	33.3
I try to forget the problem	8	38.1

It can be noted from these data that the items are distributed equally between "direct action" and "palliative mode."

Of the behavioral mechanisms categorized as used "rarely", four coping behaviors were "direct action" while seven can best be described as "palliative mode." These findings are shown in Table 13.

TABLE 13
Coping Mechanisms Used Rarely

Mechanism	Number of super- visors identifying coping behavior	Percent
I become angry and strike out verbally at the problem	14	66.7
I get prepared to meet the worst	8	38.1
I physically avoid the problem and move away from its source	11	52.4
I take actions that are not based on my true feelings of the situation	9	42.9
I become depressed or apathetic	17	81.0
I project my feelings on others	16	76.2
I use food and food substitutes	7	33.3
I try to forget the problem	8	38.1
I sleep more	12	57.1
I cry	12	57.1
I daydream	8	38.1
I use a glass of wine or cocktail to make me feel better	8	38.1

Three behavioral mechanisms were categorized as never by at least seven supervisors. They include: I daydream; I use medication to make me feel better; and I use a glass of wine or cocktail to make me feel better.

The supervisors used a variety of behavioral mechanisms with varying degrees of frequency. Approximately half of the mechanisms were of "direct action" and the remainder of "palliative mode." Both direct action and palliative mode responses may be regarded as positive. There are situations wherein a "palliative mode" response is not only an appropriate response, but one of choice. For instance, the coping mechanism of sleep may lead to a clear rational decision that could not have been made at a time of fatigue and stress.

Summary of Findings

This descriptive study contains demographic findings related to the supervisors who participated in the study. This information will permit future researchers to compare their findings to this study. Situational stressors were readily identified and categorized by an independent researcher from anecdotal notes. These situational stressors were generated by the use of an open-ended, or free response tool. These categories were similar, but not identical to the seven groups identified by Bailey and Claus (1980) using a large sample of ICU nurses.

Comparison of the findings in respect to coping behaviors could not be made to the studies of Bell and Oskins because of the manner in which their data were reported. Generally the supervisors used equally

as many of Lazarus' "direct action" behaviors as those classified as "palliative mode."

CHAPTER IV

SUMMARY, LIMITATION, AND RECOMMENDATION

Summary

This descriptive study sought to identify the perceived situational stressors of nursing supervisors and the frequency with which they used 20 behavioral mechanisms for coping. Review of the literature showed no studies identifying situational stressors or coping mechanisms of nurse supervisors. An open-ended questionnaire was used to enable the subjects to identify readily named stressors and/or to describe stressful situations. The coping scale which was used to establish the frequency with which the respondents utilized the behavioral mechanisms was constructed by Bell (1977) and Oskins (1979), by adaptation of the Sidle et al. (1969) scale.

Demographic data were gathered in respect to educational preparation and experience, additional education and continuing education, reasons for accepting the supervisory position, marital status, and family responsibilities, as well as hobbies and/or interests, in order to enable future investigators to compare their sample to that of the present study.

Because one of the goals of the study was to protect the anonymity of the supervisors, while at the same time creating an environment that would foster forthright anecdotal records, it was not possible to make correlations between demographic data, situational stressors or the frequency of the coping mechanisms used.

The convenience sample was drawn from the 24 nursing supervisors who are employed in a large private suburban hospital in the Pacific Northwest. Of the 23 individuals who were invited to participate in the study, 21 completed the demographic data sheet and the coping scale while 19 returned the situational stressors questionnaire yielding a response rate of 91% and 83%, respectively. Data collection was completed within a two week period of time.

Four levels of nursing education were represented in the sample with a wide range in the number of academic and CE credits earned beyond the basic program. There was a wide range in the numbers of years of nursing practice: eight to 30 years. All but one supervisor had been employed as staff nurses and the range of time within this level was also wide - one to 18.6 years. Eighty-six percent of the sample had held head nurse positions while only 25% had practiced as clinical specialists.

In general, the respondents viewed their position as a promotion and as professional growth. Several cited increase in salary as an incentive for accepting the position and a smaller number perceived the more flexible schedule as a positive factor. A small number felt they needed a change while the majority regarded the position as a challenge. Sixty-two percent of the respondents were married and 38% were either single, divorced or widowed. They had a total of 48 children, 24 of whom were dependent. Five of the supervisors were the sole support of their children.

All but three of the supervisors participated in outdoor physical activities during their leisure time. The two hobbies cited most frequently were cooking and gardening.

The independent nurse researcher who reviewed the anecdotal notes found that the stressors grouped readily into eight primary categories. Three of the primary categories concerned interpersonal relationships, while the remaining five related to physical environment, performance of non-nursing duties, lack of time, staffing issues and personal life events. In every instance there were supervisors who did not perceive stress in that particular area, while in other areas the number of supervisors identifying that stressor was small.

Certain sub-categories emerged as stressful to a larger number of supervisors. For example, lack of rewards or reinforcements, inadequate management experience or skills, interpersonal conflicts of staff with physicians, stressful physical work environment, lack of time to accomplish responsibilities and personal life events.

A likert scale was used to identify the frequency with which nurse supervisors utilized 20 coping mechanisms. These behavioral responses were abstracted from the literature and the coping scale of Sidle et al. Four behaviors were rated as being used frequently; eight were classified as used occasionally; 12 were ranked as used rarely; while three behavior mechanisms were categorized as never. Approximately half of the coping mechanisms used were of "direct action" while the remainder were "palliative mode."

Limitation and Recommendations for Further Study

There are certain limitations of the study that need to be recognized along with recommendations for future studies. The first of these limitations relate to the sample. In order to control for extraneous variables, the investigator should recruit the sample from a single institution. Though private institutions may be similar in many respects, subtle differences in the administrative organization may result in marked differences in supervisory roles. Comparisons between supervisory roles in private and public institutions are even more difficult. Thus the findings from this descriptive study are not generalizable to other nursing service administrations. Even within the institution sampled, there were variations in job descriptions which may have influenced the kinds of stressors experienced by the supervisors.

Not only was the sample recruited from one institution, but the sample size was small. Furthermore, it must be recognized that within this small sample there are individual differences between supervisors that influence their perception of situational stressors and coping behaviors. Both Lazarus and Menninger point out that individuals react in terms of past experiences and tend to use those mechanisms which have proved successful. In order to overcome these sampling problems, a large heterogeneous, randomly selected sample, drawn from a variety of hospitals nationally, would be required.

The conduct of a research study related to supervisory stress within an institution in which the principal investigator also is employed as a supervisor may have positive and negative effects. The high response

rate in this study may have been influenced by the fact that the investigator was known to the subjects. Equally as valid is the contention that the subjects may have been reticent to discuss their stressors or stressful situations despite the fact that assurances of anonymity were included in the design. The nursing supervisors may have felt freer to disclose the frequency with which they used selected coping mechanisms had the researcher been unknown to them.

Generally the design of the study proved to be effective. Demographic data collected were relevant to describing the sample. The questionnaire was readily understood with the exception of the questions relating to academic and continuing education credits. There appeared to be some difference in interpretations of "basic preparation." The investigator had anticipated using the data relative to nursing preparation in comparing her finding to those of Sidle et al. (1969) who found that educational preparation significantly influenced coping mechanisms. However, modifications in the tool negated comparisons between the two studies.

Bell (1977), based on findings in the literature, had increased the number of behavioral responses from ten to 20. Oskins (1979) further modified the tool deleting certain mechanisms while adding others. Neither Bell nor Oskins claim reliability or validity for their tools. Certain of the behavioral mechanisms included in the Oskins tool have been questioned by other nurse researchers. For instance, "I take actions that are not based on my true feelings of the situation", may

require more personal insight than the nurse experiencing a situational stressor is capable of applying. This critique is supported by Sidle et al. (1969) who found the lowest agreement in those statements which have a negative connotation. He suggested that negative statements may create ambivalence in the subjects since they may feel uncomfortable in admitting to the use of these strategies.

Because of the significant implications which coping strategies have in nursing practice and intervention, it is imperative that a reliable tool be created. Such a task is difficult since the concept of coping implies a holistic approach, that is, a total unique individual interacting with a changing environment.

This study confirms the findings of Bailey and Claus (1980) and Griffith (1973) that an open-ended questionnaire can be used to identify situational stressors in nursing supervisors. It also supports Bailey and Claus' finding that stressors can be readily grouped into appropriate categories.

Conclusions

The nursing supervisor practices nursing within a complex organizational milieu. She is responsible for the nursing care of acutely ill individuals assigned to her unit. She is held responsible for the fiscal management of the unit that offers a service and must attempt to predict the staffing needs of an ever fluctuating daily census and patient acuity. Further, she is responsible to implement administrative decisions over which she has little or no control and into which she had no

input. Her role is that of a middle manager, yet no studies have been reported that address the problems of this level of worker within the institution providing acute health care.

This descriptive study of a small sample of nursing supervisors showed that they frequently carry heavy responsibilities in their personal lives in addition to the responsibilities of their positions. They use equally as many "direct actions" as "palliative mode" behaviors as they cope with their situational stressors. There is no evidence to suggest that present hospital administration will be reorganized. Thus, as long as nursing service administration is responsible to hospital administrators, the role of the nursing supervisor as a middle manager will continue. It is hoped that when situational stressors have been identified and behavioral responses correlated to these stressors that suitable programs of intervention can be established. Such programs will assist the supervisor in developing and utilizing behavioral mechanisms which are effective in coping with the stressors. Research conducted by and for nurses in respect to the concept of coping is a new and important frontier for nursing.

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APPENDIX A
Institutional Release

ST. VINCENT HOSPITAL
AND MEDICAL CENTER

9205 SOUTHWEST BARNES ROAD
PORTLAND, OREGON 97225
PHONE: (503) 297-4411



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March 10, 1982

Dr. Robert Brummett, Ph.D.
Chairperson, Committee on Human Research
Oregon Health Sciences University
3181 S. W. Sam Jackson Park Road
Portland, OR 97201

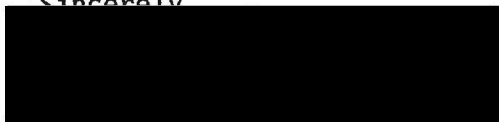
Dear Dr. Brummett:

Margaret Daniel, R.N., has asked permission to conduct a study under the supervision of Wilma E. Peterson, Ph.D. concerning "Identification of Stressors and Coping Mechanisms in Nurse Supervisors" in St. Vincent Hospital and Medical Center. I understand that this study has been approved by the Committee on Human Research at the Oregon Health Sciences University.

This letter is to inform you that this institution agrees to give Margaret Daniel access to the facilities of this institution for the purpose of collecting the data for this study.

Margaret Daniel has provided a copy of her approved proposal for the institution file.

Sincerely,


Jane A. Smith, R.N.
Director of Nursing Services

JAS:kkv

APPENDIX B

Demographic Data and Situational Stressors

DEMOGRAPHIC DATA

Identification Number _____

I. Educational Background

1. ADN _____ Diploma _____ BSN _____ MN _____
2. Number of academic credits above basic preparation _____
3. Approximate number of CE credits
 - A. Initiated by self _____
 - B. Required or suggested by institution _____

II. Professional Experience

1. Year of graduation _____
2. Number of years actively practicing nursing _____
 - A. As staff _____
 - B. As head nurse _____
 - C. As clinical specialist or teacher _____
 - D. Other and please specify _____

III. Reason(s) for selecting present position (you may select more than one)

1. Viewed as promotion _____
2. Professional growth _____
3. Increased salary _____
4. More flexible schedule _____
5. Needed a change _____
6. Needed a challenge _____
7. Other - please specify _____

IV. Life Events

1. M () S () D () Sep. () W ()
2. Number of children _____
3. Number of dependent children _____
4. Sole support of family _____
5. Hobbies and recreation (cooking, crafts, camping, arts, exercise program, etc.). Please specify _____

SITUATIONAL STRESSORS

In your position as supervisor, you daily encounter situations that may produce stress. Stress may be either positive or negative depending on the perception of the individual. Positive stress energized and results in increased performance. Negative stress depletes energy reserves and can be identified as distress.

Using the above definition of stress, please identify 5 - 10 situations which have produced stress/distress related to your job.

In recent study the following categories were identified as the major stressful areas:

- interpersonal conflicts
- management of your units
- nature of direct patient care
- inadequate knowledge and skill
- physical work environment
- personal life events
- lack of administrative rewards

Please do not feel limited to the above categories as you briefly describe 5 - 10 stressful situations.

APPENDIX C
Coping Mechanisms

COPING MECHANISMS

The following are a list of behaviors that have been identified as ways that nurses handle stressful situations. Keeping in mind what you already identified as stressful, please check those coping mechanisms you have utilized in dealing with stress.

	Never	Rarely	Occasion- ally	Frequently	Very Frequently
I talk it out with others.	_____	_____	_____	_____	_____
I take some definite action on the basis of present understanding.	_____	_____	_____	_____	_____
I become anxious.	_____	_____	_____	_____	_____
I become angry and strike out verbally at the problem.	_____	_____	_____	_____	_____
I get prepared to meet the worst.	_____	_____	_____	_____	_____
I physically avoid the problem and move away from its source.	_____	_____	_____	_____	_____
I become involved in other activities to keep my mind off the problem.	_____	_____	_____	_____	_____
I rationalize my decisions or actions as being correct or good.	_____	_____	_____	_____	_____
I try to see the humor of the situaion.	_____	_____	_____	_____	_____

	Never	Rarely	Occasion-ally	Frequently	Very Frequently
I take actions that are not based on my true feelings of the situation.	_____	_____	_____	_____	_____
I become depressed or apethetic.	_____	_____	_____	_____	_____
I project my feelings on others.	_____	_____	_____	_____	_____
I use food and food substitutes.	_____	_____	_____	_____	_____
I try to forget the problem.	_____	_____	_____	_____	_____
I think of a supernatural power who cares about me.	_____	_____	_____	_____	_____
I sleep more.	_____	_____	_____	_____	_____
I cry.	_____	_____	_____	_____	_____
I daydream.	_____	_____	_____	_____	_____
I use medication to make me feel better.	_____	_____	_____	_____	_____
I use a glass of wine or cocktail to make me feel better.	_____	_____	_____	_____	_____

ABSTRACT

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

Margaret F. Daniel

For the MASTER OF NURSING

Date of Receiving this Degree: June 12, 1983

Title: THE IDENTIFICATION OF STRESSORS AND COPING MECHANISMS
IN NURSE SUPERVISORS

Approved:


Wilma E. Peterson, Ph.D., Clinical Investigation Advisor

This descriptive study sought to identify the situational stressors of nurse supervisors and the frequency with which they used coping mechanisms. A free response questionnaire developed by the investigator was used to aid supervisors in recalling stressors or stressful situations. A coping scale developed by two nurse researchers and based on Sidle's et al. (1969) tool was used to gather information related to coping mechanisms. Selected demographic data were collected to enable comparison of the sample to future studies.

The sample consisted of 21 supervisors employed in a private suburban hospital in the Pacific Northwest. In order to protect the anonymity of the supervisors, content analysis of the anecdotal records was performed by an independent nurse researcher. Correlations were not made between demographic data, situational stressors or the coping mechanisms used.

The stressors grouped readily into eight primary categories and a number of sub-categories. Three of the primary categories related to interpersonal relationships while the remaining five included physical environment, performance of non-nursing duties, lack of time, staffing issues, and personal life events. For each primary category there were supervisors who did not perceive stress in that area while in other categories the number of supervisors identifying stressors was small. Certain sub-categories were stressful to a large number of supervisors.

These sub-categories included lack of rewards or reinforcement, inadequate management experience or skills, interpersonal conflicts of staff with physicians, stressful physical work environment, lack of time to accomplish responsibilities and personal life events. The study

sample used all 20 coping mechanisms in varying degrees from never to very frequently, depending on the mechanism. Approximately half of the coping mechanisms could be classified as "direct action" and the remainder in "palliative mode."

Limitations of the study are addressed, recommendations for further study suggested, and implications for nursing practice cited.