EFFECTS OF A MODIFIED BICULTURAL TRAINING PROGRAM ON NEW GRADUATE NURSES

by

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CHAPTER I

INTRODUCTION

Statement of the Problem

> Training more nurses is a waste of money, believes Health Education and Welfare secretary Patricia Roberts Harris, who supports a proposed slashing of nurse training subsidies in 1981. Harris recommends a 74% cut in nursing funds next year, from $106 million to $28 million. Her reason: there are enough nurses trained and certified to meet community needs; but too many are, she says, then leaving the profession. "We shouldn't use support for nurse education to train people to be administrative assistants and secretaries in business," Harris said. (RN, 1980, p. 13)

The powers that fund monies for nursing education are noting what the profession has been documenting for years. Nurses are leaving nursing.

A number of studies provide data on nurses who are leaving nursing. In a 1972 survey of registered nurses there were 1,127,657 registered nurses in the United States (ANA, 1977, pp. 76-77). These are the most recent data collected by the American Nurses Association, and the Division of Nursing of the United States Public Health Service; the 1977-78 survey is in progress. Of the 1972 group of registered nurses, 27.67% were not employed in nursing and not actively seeking positions in nursing.

In the fall of 1980, Lindeman, Whitman, Alexander, Nelson, and Rosenfeld (1981) surveyed all of the nurses registered in Oregon to determine whether the current

nursing shortage reflected an actual shortage of numbers of nurses or a move of nurses away from nursing. From the questionnaires returned, four hundred replies of nurses currently employed in nursing were randomly selected. When asked how likely it was that they would be employed in nursing in 1983, 355 replied they expected to be employed in nursing and 45 replied they did not expect to be involved in nursing. In other words, 11.25% of these nurses thought they would leave nursing in the next three years.

Kramer and Baker (1971) studied a sample of 220 baccalaureate registered nurses who were working in hospitals in 1968. By 1970, only a little over 50% were still working in hospitals. About one-fourth of the nurses were in public health nursing jobs, were teaching, or were not working because of marriage or pregnancy. Another 29.33% had totally left nursing practice.

This exodus from nursing has potentially serious negative effects on the profession. Supervisors of nursing units that are staffed entirely with registered nurses may be forced to fill vacant positions with nurses aides. The increasing use of temporary nursing personnel workers to staff hospital units means that the hospital has lost the ability to monitor the skill levels of its staff. Furthermore morale of the regular staff is lowered because of the constant influx of new or inexperienced personnel. This creates disproportionately heavier workloads for regular

hospital staff who must assume the burden on a regular basis (Lindeman, Whitman, Alexander, Nelson, & Rosenfeld, 1981). With more temporary staff or continuous understaffing, the quality of patient care consequently suffers, and very often the nurse feels dissatisfied with the quality of nursing she is able to practice (Randolph, 1980).

It is difficult to compare the nursing dropout rate to the dropout rates of other professions. There is no other profession where jobs are numerous and the dropout rate is high. "Even the things that should send nurses out looking for work, the recession and getting kids back to school in the fall, aren't doing it" (Lindeman et al., 1981, p. 1). Other predominantly women's professions, such as teaching and social work, are difficult to compare with nursing, since in the past these job markets have been affected by factors such as a tight economy or inflation, whereas nursing has not.

Why are nurses leaving nursing? The American Nurses Association survey (ANA, 1977) does not address this question. The study by Kramer and Baker (1971) of 220 baccalaureate registered nurses suggests that these nurses left nursing because they could not make the transition from the perspective and dreams of the student nurse to the reality of the graduate nurse in the hospital setting. Marlene Kramer has labeled this painful process of transition <u>reality shock</u>. How is reality shock related to the exodus of new graduate nurses from nursing?

Review of the Literature

Nursing Role Expectations

One of the principle components of reality shock is conflict of nursing role expectations. The role of nurse is defined by four principal sets of expectations: (a) the official expectations communicated from the top of the hierarchy down through administrative channels in the institution in which the nurse works, (b) the expectations of immediate colleagues, subordinates, and peers who are associated interdependently in the treatment of patients, (c) the expectation of professional associations and schools of nursing, and (d) the nurse's own personal expectation of who a nurse is and what she does (Benne & Bennis, 1959). When these four sets of expectations are consistent and reinforce each other the role definition of nurse is stable. When the expectations are contradictory and when, in her perception, "what should be" is different from "what is," the nurse experiences role conflict. This conflict influences the motivation, job satisfaction, and productivity of the professional nurse. In a study of 90 nurses in seven outpatient departments, Benne and Bennis (1959) concluded that for these nurses, in each of the four sets of expectations there was confusion and conflict caused by the perceived discrepancy between what the nurse's role "should be" and what the nurse's role "is."

Corwin, Torres, and Haas (1961) collapsed these four sets of expectations into the categories of the professional, the bureaucratic, and the service conceptions of the nursing role. The professional role conception (PRC) reflects loyalty to the professional ideals about nursing as taught in nursing school. The bureaucratic role conception (BRC) reflects the degree of allegiance to and agreement with the organizational system found in most nurse employing organizations. The service role conception (SRC) reflects the degree of loyalty to the altruistic "Angel of Mercy" ideal of nursing. Corwin et al. (1961) describe the professional, bureaucratic, and service role conceptions of nursing as prescribing conflicting programs of behavior and as being held simultaneously and in varying degrees by nurses. In their study of 296 graduate and student nurses in seven hospitals and four schools of nursing in the Midwest, they looked at the difference between the nurse's perception of the ideal PRC, BRC, and SRC and the real PRC, BRC, and SRC. When the new graduate nurse begins her first job in an institution (usually a hospital), the cross-pressure between school (professional) and hospital (bureaucratic) "creates both conflict between alternative roles and discrepancies between ideal conceptions of the role and perception of the reality" (Corwin, 1961, p. 605). They documented the disparity between the idealized role conception and the role conception found

operable and sanctioned in the work situation. This disparity was defined as role deprivation. The difference between "what should be" and "what is at my hospital," role deprivation, combined with the pull of the three different role conceptions, is the phenomenon Marlene Kramer called reality shock (1974).

The Exodus from Nursing

Kramer and Baker (1971) studied a nationwide sample of 220 baccalaureate nurses in medical center hospitals over a two-year period from 1968 to 1970. Results of their survey revealed that by 1970 a little over 50% were still working in hospitals, and some 29.33% had dropped out of nursing. Dropout was defined as nurses who exited from nursing practice because of job dissatisfaction and/or alienation from the profession. At the beginning of the study (1968) the nurses were given the role conception scales designed by Corwin et al. (1961). These scales measure loyalty to professional values and loyalty to bureaucratic values. By 1970, Kramer and Baker demonstrated that the nurses who had remained in hospital nursing had increased their loyalty and allegiance to the hospital, as shown by high bureaucratic role scores, and had reduced their professional role scores. Nurses with simultaneous loyalty to both systems experienced considerable role discomfort. In fact, the majority of the dropouts were nurses who had had high professional role conceptions. Kramer and Baker concluded that dissatisfaction leading to

dropout of nurses was related to professional-bureaucratic conflict areas.

Reality Shock

As she begins her first job, the graduate nurse experiences unexpected, abrupt changes in values, norms, rewards, and sanctions. As a student she was rewarded for achieving explicit objectives involving individualized patient care. As a graduate, she must achieve many implicit objectives often having to do with system maintenance and the care of large groups of patients. She must move from working on a whole-task basis, i.e., primary nursing, to working on a largely part-task basis, i.e., team or task oriented nursing; she must shift from principles of care to focusing on particulars and local interpretations. These discontinuities and the resultant conflict are part of the situational adjustment process in reality shock (Schmalenberg & Kramer, 1977). The reality shock process experienced by new graduate nurses working in nurse-employing organizations generally follows a sequential path. There are four phases: (a) honeymoon, approximately four to six weeks, (b) shock, approximately from week six to twelve, (c) recovery, approximately twelve to twenty weeks, and (d) resolution, approximately sixteen to twenty weeks or longer. In the honeymoon phase nursing is perceived through "rose-colored glasses." In the shock phase this delight of the honeymoon period turns to global

dissatisfaction with nursing, and feelings of paranoia, disillusionment, bitterness, anger, rejection, and moral outrage emerge. Preoccupation with how nursing was practiced as a student, excessive fatigue, and perceptual distortion are common. In the recovery phase, a sense of balance returns; nursing is seen as both good and bad and the nurse regains her sense of humor. In resolution, there is some reduction in the tension between professional and bureaucratic roles. The reduction in tension can happen by (a) "going native," i.e., rejecting the school values and completely adopting the work values, (b) "lateral arabesque," i.e., rejecting all the work values and returning to the school environment (often as a teacher) and keeping only school values, (c) becoming a "rutter," i.e., one who has low allegiance to both sets of values, and an accompanying attitude that it is just a job, (d) being "burned out," i.e., one who turns the conflict inward and bottles it up inside, (e) "job hopping," i.e., leaving nursing altogether, or (g) "bicultural adaptation." The nurse who makes integrative compromises and comes up with creative solutions to conflicts caused by the two different value systems is a bicultural nurse (Schmalenberg & Kramer, 1976). These phases of reality shock as identified by Kramer and Schmalenberg are only roughly sequential and new graduates typically move back and forth among stages during the first six months or more of employment. Of

the possible resolutions of reality shock, it seems evident that biculturalism is the most desirable.

> The bicultural individual views conflict as healthy, creative, and potentially growth producing--as an avenue to producing change. With such a view of conflict, and constructive conflict resolution, the bases of tension and global dissatisfaction with nursing are removed. Hope is restored; there is no need for flight, suppression or withdrawal behavior with the end result that the nurse can simultaneously be the kind of person she wants to be and be more creatively and professionally productive in her job. (Kramer & Schmalenberg, 1977, p. 7)

Intervention in Reality Shock to Produce Bicultural Nurses

There have been several different interventions designed to deal with reality shock and assist the new graduate toward the "bicultural adaptation" resolution. In 1969, Marlene Kramer (1974) developed an Anticipatory Socialization Program for student nurses at University of California School of Nursing, San Francisco. Forty-five students in the class of 1968 constituted the control group. The classes of 1969 and 1970 formed the experimental groups and underwent the Anticipatory Socialization Program (ASP) during the last three years of nursing school. The classes were similar in age, experience, sex, and marital status. The ASP used ideological immunization and exposure to knowledge and behaviors of a reference group of unique, highly adaptive nurse practitioners to help the student acquire strategies and lines of action that would decrease the effects of reality shock and move the student along

the road to biculturalism. The study concluded that the ASP was effective in decreasing role deprivation upon employment, and in increasing the length of time nurses remained in their initial jobs. In their nursing practice, ASP helped the nurses to develop integrative role strategies useful in managing conflict. The experimental group had fewer days of absence from work and were perceived as being happier, more stimulated, and exerting more leadership than the nurses who did not have the program.

The ASP involved student nurses during the last three years of nursing school. When this program was completed, Kramer and Schmalenberg went on to develop a bicultural training program that was much shorter and involved not students but new graduates and their head nurses. Kramer and Schmalenberg (1977) studied 260 newly graduated registered nurses employed in eight medical centers throughout the country. Half of the new graduates had received a traditional clinically-based orientation program (CBOP) and half received the bicultural training program (BTP). Both programs were matched for time and format. Content was the variable. The CBOP content focused on a variety of topics of interest to newly employed nurses such as fluid and electrolyte balance and legal aspects of nursing. The BTP contained the content found to be impactful on reality schock. Nurses who received the bicultural training stayed on their jobs longer (90.2% in the bicultural

group compared with 60.2% in the clinically-based group); made more changes in nursing practice and procedures (95.3% in the bicultural group compared with 73.2% in the clinically-based orientation group); and they received higher ratings from their supervisors (52% "above average" in the bicultural training group as compared to 30% "above average" in the traditionally trained group) (Kramer, 1977).

The Kramer-Schmalenberg Bicultural Training Program includes an affective, a cognitive, and a behavioral component. The affective component consists of a series of six 90-minute weekly seminars for the new graduate. The purpose is to provide a safe environment for the new graduates to talk about what is happening to them in the work setting. During these seminars the co-leaders facilitate discussion, clarify issues, and strive to create a climate conducive to increasing the group members' trust and confidence in themselves and the group. The cognitive component, beginning on week 4, involves reading and completing the exercises in Path to Biculturalism, which describe the situations and value systems around which conflict between the work world and school world develops. The behavioral component consists of one 6-1/2 hour workshop for new graduates only, one 6-1/2 hour workshop for their head nurses only, followed by one joint 6-1/2 hour conflict resolution workshop for both new graduates and their head nurses.

Holloran, Miskin, and Hanson (1980) utilized the Kramer-Schmalenberg Bicultural Training model at New England Deaconess Hospital, a 500-bed hospital in metropolitan Boston. The hospital employs 50 to 60 new graduates a year and during the years prior to the implementation of the bicultural program the average length of employment of new graduate registered nurses was 4 to 8 months.

The bicultural training began on a voluntary basis. In the first 6 months only 26 out of 51 of the new graduate nurses chose to participate; after this period, the program became mandatory and all new graduate nurses employed at the hospital were involved in the program.

The baseline data were collected in the 15-month period prior to the implementation of the program. During that time 42% (N = 19) of the new graduates had resigned. At the 15-month post-employment assessment following implementation of the bicultural training program, 31% (N = 16) of the new graduates had resigned. Of that number, 81.25% (N = 13) of the resignations were from new graduates who did not participate in the bicultural training program. Of those new graduates involved after the program was mandatory, only 3% (N = 4) resigned. In addition to the increased employment retention, the attitude evaluation survey indicated an increase in job satisfaction for these new graduates who participated in the bicultural program.

As these studies show, the phenomenon of reality shock exists, and does seem to be a factor in the exodus of new graduate nurses from nursing. The Kramer-Schmalenberg Bicultural Training Program (BTP) was designed to assist new graduates in dealing with the role conflict inherent in their first job, and to assist new graduates in integrating the professional and service values learned in school with the realities of the bureaucratic work world of the hospital. New graduate nurses who participated in the BTP have been shown to have less role deprivation, increased job satisfaction, and to remain in hospital nursing longer than nurses who have not participated in the BTP.

At this time, however, BTPs are not widely used, despite these findings. The BTP as described involves a specially trained program leader, two days of head nurse's time, three days of a new graduate nurse's time, and requires the new graduates to complete a five-module workbook on their own. The full three-component program may seem formidable and too expensive to hospital administration; a modification of the BTP leading to comparable results might lead to wider utilization. This study proposes to test the effects of a modified program that may be more practical and lead to wider use.

Hypotheses

To test a Modified Bicultural Training Program the following research hypotheses are proposed.

1. After 5-1/2 to 6-1/2 months of employment, new graduate nurses in their first job who attend the Modified Bicultural Training Program will show less role deprivation than new graduates who do not attend such a program.

2. After 5-1/2 to 6-1/2 months of employment, new graduate nurses in their first job who attend the Modified Bicultural Training Program will be more satisfied with their jobs than new graduates who do not attend the program.

3. After 8 months of employment, new graduate nurses in their first job who attend the Modified Bicultural Training Program will have higher employment retention rates than those who do not attend the program.

CHAPTER II

METHOD

Design

To test the effectiveness of a Modified Bicultural Training Program, the study utilized a post test design with random assignment of subjects to an experimental or a control group. All new graduates received the standard hospital orientation program. The experimental group attended the Modified Bicultural Training Program (MBTP). The control group did not participate. Involvement in the program was strongly recommended to the experimental group but there were no negative sanctions for non-attendance.

At 5-1/2 to 6-1/2 months post employment, the Corwin Nursing Role Conception Scale was used to measure role deprivation and the Job Descriptive Index was used to measure job satisfaction. At 8 months post employment, each subject's personnel file was assessed to ascertain employment status.

Setting and Subjects

The setting was a 425-bed university medical center hospital in a city of approximately 400,000 people. Subjects were 53 new graduate nurses beginning their initial nursing jobs in May, June, or July 1980. Nurses hired only for the summer were excluded from the study. The nurses were

of varied educational preparation. In an attempt to reduce the problem of spillover of MBTP concepts from the experimental to the control group, randomization to either the experimental or control groups was accomplished by ward. New graduates assigned to each ward became part of either the experimental or control group by nature of their ward assignment. Thirty three graduates from 12 wards comprised the experimental group while the control group included 20 graduates from 6 wards.

Description of the Independent Variable

Modified Bicultural Training Program. The behavioral component of BTP as described by Kramer and Schmalenberg required two days of head nurse time, two days or more of graduate nurse time, and one group leader's time. Because of the cost and the indication from the results of the Anticipatory Socialization program (Kramer, 1974) that a program without a behavioral component could be helpful, the behavioral component was omitted from the modified program.

The affective and cognitive components of the Kramer-Schmalenberg BTP were combined into a 5-week program presented over a period of 7 weeks. The Modified Bicultural Training Group met once each week for 2 weeks, engaged in independent study for 2 weeks, followed by weekly meetings for 3 consecutive weeks. Each meeting lasted

90 minutes. Meeting format included (a) the success story, (b) presentation of content and (c) sharing in small groups (see Appendix A for a description of the content of the MBTP).

The success story involved having participants interact in groups of three. Each one shared a success they had had during that week, and each received positive feedback on the personal and professional qualities that helped make that success happen. This promoted sharing and helped to prepare the nurse to take an active part in the group that day. The content was derived from the book Path to Biculturalism by Kramer. Following the success story, one of the five modules from the book was briefly presented. The remainder of the time was spent in small group discussion that was focused on how the material related to each new graduate personally.

Description of the Dependent Variables

The dependent variables were role deprivation, job satisfaction, and employment retention rate.

1. The role deprivation score was operationally defined as the difference between the "ideal" and "observed" responses on the Corwin Nursing Role Conception Scale.

Twenty-two hypothetical situations are described on the Corwin Nursing Role Conception Scale. Six items compose a bureaucratic subscale, 8 compose a professional subscale,

and 8 compose a service subscale. Each situation is followed by two 5-point rating-scale type items (strongly agree to strongly disagree). For item A the respondent indicates the extent of agreement-disagreement with the situation relative to how nursing should be. This total score is the role conception scale. On item B, the respondent indicates the extent of agreement-disagreement to which the situation has been observed in her nursing situation. The deprivation score is the total of the differences between Answer A and Answer B of each question.

Score values are assigned as follows: strongly agree = 5, strongly disagree = 1. Possible role conception scores are 5 to 30 for the bureaucratic scale and 5 to 40 for the professional and service scales.

The possible range of the deprivation scale is 0 to 24 for the bureaucratic scale and 0 to 32 for the professional and service scales.

In reliability testing done by Kramer (1974), 52 senior nursing students were given the Corwin scale before and after a 3-week Christmas break. The test-retest reliability ranged from .86 to .89.

Kramer (1966) used two approaches to validate the Corwin scale. One approach was the "known group" method. Nurses in bureaucratic roles, professional or teaching roles, and nurses with religious views showed significant differences in their scale responses in the predicted

directions. The other approach used was a study of two groups of nurses who were predicted to be at the extremes of the role deprivation continuum on the basis of behavioral criteria. These nurses scored significantly different and in the predicted direction on the role deprivation scales.

The scale is self-administered; no time for completion is indicated. However, 10 to 15 minutes is considered adequate for most respondents (see Appendix B).

2. Job satisfaction was measured by the Job Descriptive Index (JDI). This instrument consists of 72 items--18 in each of work, supervision, and people subscales and 9 each in pay and promotions (Appendix C). Each grouping consists of a list of adjectives or descriptive phrases. The respondent is asked to write "yes" next to each item which describes his pay (promotion, etc.) and "no" for each item which does not. A question ("?") response is reserved for items on which the respondent cannot decide. Some "Y" answers are scored 3, some "N" answers are scored 3, and all "?" as 1 point, according to the key. The higher the score, the greater the satisfaction. Reliability is good. Corrected split-half internal consistency coefficients are reported to exceed .80 for each of the scales. Some evidence for stability over time is reported by Hulin (Robinson, Athanasious, & Head, 1969). Hulin also reports

a correlation of -.27 between satisfaction and turnover (over a 12-month period) for the female clerical employees.

The JDI was developed in 1960 and is representative of the range of conditions found in American industry and business at that time. It approaches job satisfaction indirectly. The instrument asks the respondent to describe the job rather than feelings about the job. The JDI was chosen for this study because (a) of the lengthy, extensive, and competent research that went into its construction, and (b) it has been administered to workers at all organization levels on a nationwide basis and there is extensive normative data available for comparison (Smith, Kendall, & Hulin, 1969). No time for completion is indicated; however, 10 minutes is considered adequate for most respondents (see Appendix C).

3. Personnel records were examined to determine if a graduate nurse remained in her first job 8 months after the date she was hired.

An invitation to participate in this study was sent to 53 new graduate nurses from the randomly selected experimental wards. The invitation contained an explanation of the study, a consent form, the Corwin Role Conception Scale, the Job Descriptive Index, the demographic data sheet, and a return envelope. The Study Packets were distributed at five different times. Each nurse received the packet 5-1/2 months after she was hired and was

requested to return it within 1 month. The first two distributions were processed through the hospital mail. Only 1 out of 8 nurses responded. All other distributions were made personally to each nurse and a verbal as well as written explanation was given. For every possible subject, if the packet was not returned after 10 days, a phone call was made to ask the nurse if she was willing to complete the packet. If the nurse agreed to participate but the packet was not returned after another 10 days, a second call was made, again asking if the nurse was willing to participate in the study. If the nurse agreed but did not return the packet in the next 5 days, a final written reminder was sent. Nurses who had left employment (n = 9) were sent packets in the mail. If they did not reply they were sent three follow-up postcards. A total of 44 nurses returned the questionnaire (83% return rate).

CHAPTER III

RESULTS AND DISCUSSION

Characteristics of the Sample

The 53 new graduates were divided into Group A, the experimental group who attended the MBTP (N = 20), Group B, the experimental group who were invited but did not attend the MBTP (N = 13), and Group C, the control group who were not involved in the MBTP in any way (N = 20). Responding to the questionnaires and demographic data sheet were 19 nurses from Group A, 8 nurses from Group B, and 17 nurses from Group C (see Table 1). The only data known concerning the nurses who did not return the questionnaires and demographic data sheets is employment retention or resignation data at the study hospital.

Demographic Characteristics of Experimental and Control Groups

The experimental group (Group A who attended the MBTP and Group B who were invited but did not attend (N = 27)) was compared with the control group (Group C who were not involved with MBTP in any way (N = 17)) on the demographic variables. A chi-square statistic was computed for each variable. The groups did not differ significantly in age, sex, previous experience, assignment to the unit of their first choice, type of nursing they were practicing, and

Table 1

Description of Sample: Number of Subjects Who Returned Questionnaires and Demographic Data Sheet According To Type of Unit and MBTP Attendance

	Experimental Units		Control Units
	Group A attended MBTP	Group B did not attend MBTP	Group C did not attend MBTP
Returned Questionnaires and Demographic Data	19 (95%)	8 (61.5%)	17 (85%)
Did Not Return Questionnaires and Demographic Data	1 (5%)	5 (38.5%)	3 (15%)
Total	20 (100%)	13 (100%)	20 (100%)

their reported career plans for the next two years. They were significantly different in marital status and educational preparation: 88.9% (N = 24) of the experimental group was single compared to 52.95% (N = 9) of the control group, and 81.5% (N = 22) of the experimental group were baccalaureate prepared nurses compared to 64.7% (N = 11) of the control group (see Appendix F).

The experimental group had more single members and more members with baccalaureate preparation. This may have made them more mobile and may have made them available to consider more job options than their married counterparts. On the other hand, the larger number of married members of the control group might feel free to leave the hospital if they were unhappy because they may not have been so dependent on their own salary for support.

Baccalaureate prepared nurses have been found to have higher professional and lower bureaucratic role conception scores than either the diploma or the Associate Degree nurse, and to be more susceptible to role deprivation (Corwin, 1961; Kramer, 1974). If this holds true for the study subjects, then given the differences between the groups on the educational variable, without any intervention the experimental group should experience more severe reality shock and consequently demonstrate higher role deprivation scores and be less likely to remain employed in the study hospital than the control group. The control group with

fewer baccalaureate prepared nurses would likewise be expected to be more prepared for the work world, have an easier time adjusting, have lower role deprivation scores, and be more likely to remain employed in the study hospital than nurses in the experimental Groups A and B.

Demographic Characteristics of Experimental Groups A and B

Of the 33 possible subjects from the randomly chosen experimental units, 20 nurses attended the MBTP (Group A) and 13 nurses did not attend the MBTP (Group B). Of Group A, 19 (95%) and of Group B, 8 (61.5%) returned the questionnaires. The two groups were compared to determine the extent to which those who voluntarily attended the program differed from those who did not. A chi-square statistic was computed for each demographic variable. The two groups did not differ significantly on any of the variables, including age, sex, marital status, educational background, previous experience, assignment to the unit of their first choice, type of nursing they were practicing, or their reported career plans (see Appendix G).

Tests of Hypotheses

Hypothesis 1: After 5-1/2 to 6-1/2 months of employment, new graduate nurses in their first job who attend the MBTP will show less role deprivation than new graduates who do not attend such a program.

To test the hypothesis, the role deprivation scores of the new graduates from the experimental units who attended the program (Group A) were compared with those of new graduates from the control units who did not attend the program (Group C) (see Table 2). The mean total role deprivation score for Group C (24.7) was higher than the mean score for Group A (19.52). The difference, however, was not statistically significant ($\tau = 1.659$, $p < .10$).

On each of the subscales, Group C had higher mean scores than Group A. However, only the difference on the service role deprivation scale was statistically significant ($\tau = 1.81$, $p < .05$).

Based only on statistical significance the first hypothesis could not be accepted; however, the results obtained were in the expected direction and the analysis is based on the direction of the response, not the statistical significance.

In attempting to explore the possible meaning of the difference in the role deprivation scores between Group A and Group C, the Corwin scale can be broken down into its specific components. The Corwin Nursing role deprivation scores reflect the difference between the new graduate's ideal of how nursing "should be" and their perception of "how it is at my hospital." In other words, the role conception section of the scale gives an indication of the new graduate's values. Group A and Group C had very similar

Table 2

Mean Deprivation Scores of the Corwin Nursing Role Conception Scale for Group A and Group C

	Group A (N=19)		Group C (N=17)				
	Mean Scores	SD	Mean Scores	SD	τ* value	Df	p
Bureaucratic role deprivation scores	5.63	2.145	6.12	3.31	.610	34	NS
Professional role deprivation scores	7.98	3.03	9.76	3.94	1.39	34	NS
Service role deprivation scores	6.10	3.94	9	5.72	1.81	34	<.05
Total role deprivation scores	19.52	7.12	24.7	10	1.659	28	<.10

*one-tailed test

mean scores on the role conception scales (see Table 3). This indicates Groups A and C had similar values about the bureaucratic, professional, and service roles in nursing. Since role conception, i.e. the "should be" scores, are similar for Group A and Group C and the role deprivation scores are significantly different, it can be concluded that the new graduates in the two groups had different views of how nursing "is at my hospital." Group C sees nursing reality as more discrepant with their ideals than Group A. This suggests that the role deprivation may be reflective of an inability to translate role values into nursing actions. Problems in implementing values may result from lack of skill, constraints in the environment, or a lack of shared understanding with co-workers (Benner & Benner, 1979). The above results might mean that nurses in Group A were able to put their values into practice and this is the factor that accounts for lower role deprivation scores. If so, this would indicate that resolution for nurses in Group A would be more likely to involve their keeping and utilizing their values rather than rejecting the values in the area of role conception. This interpretation is consistent with that of Kramer and Schmalenberg (1978) who demonstrated that nurses who experience a BTP put more of their values into practice than those who do not attend a BTP.

Table 3

Mean Role Conception Scores of the Corwin Role Conception Scale for Groups A, B and C

	Group A (N = 19)	Group B (N = 8)	Group C (N = 17)
Bureaucratic Role Mean Scores	18.36	15.37	16.18
Professional Role Mean Scores	28.3	26.1	28.3
Service Role Mean Scores	30.68	26.1	30.76

It is not known if experimental groups A and B differed upon beginning employment, nor is it clear why Group A attended the MBTP and Group B did not attend the program.

Prior to conducting the MBTP there were no measures taken on any variable studied. After 5-1/2 to 6-1/2 months of employment, the major difference noted between Group A and Group B was the lower scores of Group B on the role conception scale. Group B had lower values concerning the bureaucratic, professional and service components of nursing practice than Group A (see Table 3). The lower scores of Group B could mean those graduates have less investment in nursing and so did not attend the MBTP. Another explanation of their failure to attend the MBTP is a lack of sufficient encouragement. Holleran et al. (1980) point out that it is unrealistic to expect a nurse experiencing reality shock to make a choice at that time to attend or not attend a BTP and that the encouragement to attend must come strongly from nursing administration and the head nurse.

Hypothesis II: After 5-1/2 to 6-1/2 months of employment, new graduate nurses in their first jobs who attend the MBTP will be more satisfied with their jobs than new graduates who do not attend the program.

The hypothesis was not tested because the data on job satisfaction are of questionable validity. When the JDI was administered 5-1/2 to 6-1/2 months after employment,

6 new graduates in Group C and a total of 3 new graduates in Group A and Group B had resigned. Since the JDI was administered to these subjects after they had terminated employment with the study hospital, it is likely that their responses were influenced by the fact that they were in a new job. Furthermore, the JDI was developed in business and industry settings in the 1960s. It asks subjects about work conditions and is not geared towards satisfaction with the intrinsic rewards of the job.

In retrospect, the JDI was not the best tool to measure job satisfaction in this study, because of the factors it measures, that is, environment rather than job satisfaction. In addition, the methodological problems of administering the index after former employees had begun employment in a new setting would, in any case, render the data invalid for this study's purposes.

Hypothesis III: After 8 months of employment, new graduate nurses who attend the MBTP will have higher employment retention rates than those who did not attend the program.

To test this hypothesis, the employment retention rate of new graduates for the experimental units who attended the program (Group A) was compared with the retention rate of new graduates from the control units who did not attend the program (Group C) using Fischer's exact method. As demonstrated by this statistic, $p = .002$,

Group A had significantly more nurses who stayed in their first jobs, 95% (N = 19), than Group C, 65% (N = 11) (see Table 4). Therefore Hypothesis III was not rejected.

These findings support the findings of Kramer and Schmalenberg (1978) and Holloran et al. (1980) that nurses who attended a bicultural training program remained in their first jobs longer than those who did not attend such a program. The 8-month time frame used by this study is shorter than the time frames utilized by Kramer and Schmalenberg (1978) (9 months) and Halloran et al. (1980) (15 months), and consequently it would be useful to measure retention rates of each group again one year or more after initial employment.

A total of 11 nurses resigned during the first 8 months of employment. Resignations peaked at 3 months after employment (see Table 5). According to the reality shock framework, 3 months is about the time at which the new graduate struggles to begin a recovery period to reduce the role deprivation of reality shock. For some new graduates, leaving may seem the only way to resolve the tension of role deprivation and reality shock.

In continuing to explore the employment retention rate, it is evident that there is a strong correlation between employment retention and nursing role deprivation scores. In a comparison of the mean role deprivation scores between all new graduates who resigned (N = 9)

Table 4

Employment Status of Nurses in Their Initial Employment Eight Months After They Were Hired

	Remained Employed		Resigned Employment		Total	
	N	%	N	%	N	%
Experimental Group A	19	95	1	5	20	100
Experimental Group B	10	76.9	3	23.1	13	100
Control Group	13	65	7	35	20	100

Table 5

Number of New Graduates Who Resigned by Length of Time After Employment

Number of months after employment	Number of new graduates who resigned
8	0
7	1
6	1
5	1
4	2
3	4
2	1
1	1

and all new graduates who remained employed (N = 35), new graduates who resigned had significantly higher mean role deprivation scores on the bureaucratic, professional, service, and total deprivation scales than new graduates who remained (see Table 6).

Nurses in Group A had a lower mean role deprivation score and a higher retention rate than nurses in Group C. To avoid the ecological fallacy of assuming that those nurses in Group C who had high role deprivation scores were the same nurses who resigned, nurses in Group A were compared on the variables of mean role deprivation score and retention rate with the subgroup of nurses in Group C who remained employed and then with the subgroup nurses in Group C who resigned. In addition, a comparison of these variables was made between the subgroups of Group C. In comparing nurses in Group A (N = 19) with the subgroup of nurses in Group C who continued employment (N = 11), there was no significant difference in mean role deprivation scores (see Table 7). In comparing nurses in Group A with the subgroup of nurses in Group C who had resigned (N = 6), this subgroup of nurses in Group C had significantly higher professional service, and total mean role deprivation scores than nurses in Group A (see Table 8). These mean score differences account for the mean score differences between Group A and all of Group C. In a comparison of Group C who resigned (N = 6) and Group C who remained (N = 11),

Table 6

Mean Deprivation Scores of the Corwin Nursing Role Conception Scale for All Subjects Who Remained Employed and All Subjects Who Resigned

	Remained Employed (N=35)	Resigned (N=9)	τ* value	Df	p
Bureaucratic role deprivation scores	5.4	7.5	2.14	42	<.025
Professional role deprivation scores	7.8	10.5	1.95	42	<.05
Service role deprivation scores	6.4	11.2	2.96	42	<.005
Total role deprivation scores	19.68	29.33	3.035	42	<.005

*one tailed test

Table 7

Mean Deprivation Scores of the Corwin Nursing Role Conception Scale for Group A and the Subgroup of Group C Who Remained Employed Eight Months After They Were Hired

	Group A (N=19)		Group C who remained employed (N=11)		t* value	Df	p
	Mean	SD	Mean	SD			
Bureaucratic role deprivation scores	5.63	2.45	5.3	2.11	.245	27	NS
Professional role deprivation scores	7.98	3.03	8.8	4.49	.609	27	NS
Service role deprivation scores	6.1	3.94	6.7	4.69	.392	27	NS
Total role deprivation scores	19.52	7.12	20.8	8.96	.418	27	NS

*One tailed test

Table 8

Mean Deprivation Scores of the Corwin Nursing Role Conception Scale for Group A and the Subgroup of Group C Who Resigned within Eight Months After They Were Hired

	Group A (N=19)		Group C Who Resigned (N=6)		t* value	Df	p
	Mean	SD	Mean	SD			
Bureaucratic role deprivation scores	5.63	2.45	7.28	4.46	.827	8	NS
Professional role deprivation scores	7.98	3.03	10.71	3.15	2.25	24	<.025
Service role deprivation scores	6.1	3.94	12.28	5.73	3.42	24	<.005
Total role deprivation scores	19.52	7.12	30.28	11.78	2.36	8	<.025

*one tailed test

there were statistically significant differences in the service and total role deprivation scores (see Table 9). Again, the new graduates who resigned had significantly higher role deprivation scores on the service and total scales than the new graduates who remained. These comparisons show that the nurses who left were the nurses who had significantly higher mean role deprivation scores. This finding is consistent with the reality shock framework, that is, that the new graduates who cannot resolve their role deprivation leave hospital nursing. Those who stay have some resolution of reality shock and thus lower role deprivation scores.

In a further exploration of the factors related to retention rate, a within-group comparison of demographic variables was made between new graduates who resigned and new graduates who remained employed. The comparison was possible only in Group C, since Group A had only one resignation. Group C had a 35% resignation rate. In comparing the demographic variables of those in Group C who resigned with those who remained employed, the only variable that was significantly different was educational preparation. Of the 17 nurses who responded to the questionnaires and demographic data sheet, all 6 who resigned were baccalaureate prepared; of the nurses who remained, 5 were baccalaureate prepared and 6 had an associate degree. The variables of age, sex, marital status, previous experi-

Table 9

Mean Deprivation Scores of the Corwin Nursing Role Conception Scale for the Subgroup of Group C Who Remained Employed and the Subgroup of Group C Who Resigned Eight Months After They Were Hired

	Group C who remained employed (N=11)		Group C who resigned (N=6)		τ* value	Df	p
	Mean	SD	Mean	SD			
Bureaucratic role deprivation scores	5.3	2.11	7.28	4.46	1.09	9	NS
Professional role deprivation scores	8.8	4.49	10.71	3.15	.969	15	NS
Service role deprivation scores	6.7	4.69	12.28	5.73	2.20	15	<.025
Total role deprivation scores	20.08	8.96	30.28	11.78	1.889	15	<.05

*one tailed test

ence, assignment to unit of first choice, type of nursing, and reported career plans were not significantly different in the subgroups of Group C (see Appendix H). This finding suggests that the baccalaureate prepared nurses may have been at greater risk for role deprivation and subsequent resignation without intervention to help them deal with reality shock.

Up to now the comparisons concerning the hypothesis have been between new graduates in Group A, the experimental group who attended the MBTP and new graduates in Group C, the control group who did not attend the program. The study was not directly concerned with the graduates in Group B, the experimental group who were invited but did not attend the MBTP. These nurses, their head nurses, and other personnel in the experimental wards were exposed to the publicity about the MBTP and conversations about the program. Some also worked with new graduates who did attend the MBTP and the book Path to Biculturalism was available on the ward. A comparison of retention rates among Groups A, B, and C showed that the retention rate of nurses in Group B was almost midway between the retention rates of nurses in Group A and the nurses in Group C. The more direct the participation in the program, the higher the retention rate of the Group. Group A, who participated in the MBTP, had the highest retention rate (95%); Group B, who were on the experimental wards did not participate,

but were exposed to the program, had the middle retention rate (76.9%); and Group C, the control group, had the lowest retention rate (65%) (see Table 4). This substantiates Kramer and Schmalenberg's (1978) contention that there is some spillover effect on the experimental wards even if new graduates do not attend the program.

Other Factors Influencing Outcomes

Role and Influence of Head Nurses

Although no formal survey was conducted of head nurses' attitudes toward the MBTP, there is some data which emerged about head nurse attitudes and their influence on outcomes. Two head nurses of experimental units had been involved in the Kramer and Schmalenberg (1977) study as head nurses. One felt the program was useful and one did not. Two other head nurses, also from experimental units, had been involved in the Kramer and Schmalenberg (1977) study as new graduates. One felt positive about it, but the other had not felt it was valuable. The attitudes of those with previous experience with a bicultural training program may have had some influence on their behavior in this study. Nurses from the wards managed by the two head nurses with positive attitudes were more frequent attenders at the MBTP than the nurses on the other two wards whose head nurses were not so enthusiastic. No head nurses in the control group

were involved in the Kramer and Schmalenberg (1977) study in any way.

Because the influence of the head nurse was considered to be a crucial factor in encouraging the new graduate to attend the MBTP, head nurses were included in the planning for the MBTP. A meeting was held to give the head nurses background information, including the results of the Kramer and Schmalenberg (1977) and Halloran et al. (1980) studies. Head nurses were consulted for meeting days and times that would be most convenient. Nursing administration sponsored the program, supported the concept that new graduates were expected to participate, and provided reimbursement for attendance on off-duty time. There were logistical problems in (a) scheduling the new graduates on duty at group time (group times were Wednesday, 7:15 to 9:15 AM, 1:30 to 3:00 PM, and 3:30 to 5:00 PM), (b) providing coverage so that the new graduates could attend if they were on duty, and (c) supporting and encouraging new graduates to attend. Concrete support for the head nurses and new graduates is essential and whether it is provided or not may reflect either an attitude of mentoring, nurturance, and concern toward the new professional, or a "sink or swim" approach.

Hospital and Hospital Ward Factors

The hospital or the ward could also be factors in nurse employment retention rates. Using one hospital holds constant many variables, such as pay, fringe benefits, location, and educational and advancement opportunities. However, the ward milieu, i.e., the attitudes of the head nurse and other staff, types of patient, and physical plant itself could possibly affect the employment retention rate. The 53 subjects were on 17 different wards. Group A and Group B (N = 33) were on 11 wards and Group C (N = 20) were employed on 6 wards. Because of the small number of nurses on each ward, it was impossible to ascertain if the ward and not the MBTP might account for the differences in employment retention. Since the 53 subjects were distributed over 17 wards, it seems unlikely that the ward was a significant variable.

Financial Considerations

A MBTP must be economically feasible to be utilized. Because the MBTP seems to increase new graduate nurse retention rate, the cost of the program should be compared to the cost of not having the program, that is, the present cost of recruiting and retaining nurses. In July and August, 1980, new graduates earned $7.82 an hour, therefore the cost for a nurse to attend all five MBTP sessions was $58.65. A copy of Path to Biculturalism was purchased

and placed on each of the 12 experimental wards at a cost of $167.40. The other expenses that would need to be considered in duplicating the program would be the salary of the nurse who arranged and facilitated the program. If three hours of preparation and follow-up were allowed for the facilitator per session, the cost would approximate $200 per group. Total cost for this program then is approximately $1,000 for a group of 10 nurses, or $100 per nurse, based on the rate of pay in the summer of 1980 at the study hospital. National figures for the cost of recruiting one nurse range from $150 to $4,000, averaging about $1,500 (Lublin, 1980), while the cost of orienting a new nurse at the study hospital is $7,000 per nurse. The use of the MBTP as a means of increasing retention, then, is far less expensive than the cost of recruitment and orientation of a new employee.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The profession of nursing is concerned about the number of nurses leaving nursing. Of special concern is the 29.33% of new graduate nurses who leave the profession within two years after graduation (Kramer & Baker, 1971). The present study was conducted to test a Modified Bicultural Training Program (MBTP) for new graduate nurses. The MBTP was designed to decrease role deprivation, increase job satisfaction, and increase employment retention rates of new graduate nurses.

New graduates who attended the MBTP did show less role deprivation and higher employment retention rates than new graduates who did not attend the program. Job satisfaction was not tested.

The results indicate that baccalaureate nurses are more susceptible to both role deprivation and leaving employment if they do not attend a MBTP. The results also suggest that new graduates who attended the MBTP may have resolved reality shock in a bicultural manner, realized their values in their nursing practice, and thus are more likely to remain an active member of the profession.

Conclusions

This study adds to the slowly growing body of research that attempts to do more than describe reality shock and give an anecdotal description of the phenomenon. There is evidence from the role deprivation scores and the retention rate results of this study that new graduate nurses, and most especially those who prepared for four years to become nurses, need a special kind of attention during the first months of their initial employment. This attention should be specifically aimed at acknowledging the role conflict inherent in the hospital situation and providing a MBTP or BTP to aid them in dealing with the phenomenon.

Is it not time to provide a nurturing experience for our new graduates and relinquish the sink or swim attitude that experienced nurses have traditionally felt and shown towards new graduates? The MBTP is a cost-effective method that seems to reduce role deprivation and increase retention of new graduate nurses. One can hope that the MBTP also lessens the personal pain of each new graduate as she struggles to find her place in professional nursing.

Recommendations

Implications for Practice

Evidence both from the literature and from this study is strong enough to suggest that the MBTP is both useful

and cost-effective in assisting new graduates through the transition from being students to being professional nurses. To insure success of the MBTP when it is repeated, it is recommended that

1. Nursing administrative support be given to head nurses to assist them in encouraging the new graduate nurses to attend the MBTP.

2. The MBTP be mandatory for all new graduates and that participation in the MBTP be agreed upon at the time the new graduate is employed.

3. The new graduates be encouraged to attend the MBTP by (a) nursing administrators' expectation that they attend, (b) the active encouragement of the head nurse, (c) the support of other nurses on the unit, (d) the scheduling of working hours so attendance is convenient, and (e) the provision of nursing coverage for the unit during their absence.

4. A method of evaluating the effectiveness of the MBTP be included in the program.

Implications for Further Research

If this study is repeated or if the implementation of a MBTP is evaluated, it is recommended that

1. A pretest on the dependent variable of role deprivation be done before the MBTP is offered.

2. Job satisfaction be measured in a way that reflects intrinsic satisfaction, not just work conditions.

3. The job satisfaction questionnaire be administered at the time a new graduate terminates employment.

4. The dependent variables be measured again 1 year, 18 months, and 2 years after beginning employment.

In addition, other related research areas that need further exploration are

1. The attitudes of nursing administrators, head nurses, and other staff nurses towards new graduates.

2. The role of nursing educators in the reality shock process.

3. The reasons why a MBTP or BTP is not being utilized to assist new graduate nurses in the transition from student to professional nurse.

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APPENDIX A

CONTENT OF THE MODIFIED BICULTURAL TRAINING PROGRAM

Content of the Modified Bicultural Training Program

The content of the Modified Bicultural Training Program is taken directly from Path to Biculturalism.

Week 1. Program I: Reality Shock

Week 2. Program II: A look at you

Week 3. Suggestion to read the text, no meeting

Week 4. Suggestion to read the text, no meeting

Week 5. Program III: The elusive quest

Week 6. Program IV: Walk a mile in my shoes

Week 7. Conflict resolution: The mating of dreams and reality

APPENDIX B

CORWIN NURSING ROLE CONCEPTION SCALE

CORWIN NURSING ROLE CONCEPTION SCALE

Instructions

This consists of a list of 22 hypothetical situations in which a nurse might find herself.

You are asked to indicate both:

(A) the extent to which you think the situation should be the ideal nursing;

(B) the extent to which you have observed the situation in your hospital.

Notice that two (2) questions must be answered for each situation. Consider the questions of what ought to be the case and what is really the case separately; try not to let your answer to one question influence your answer to the other question. Give your opinions; there are no "wrong" answers.

Indicate the degree to which you agree or disagree with the statement by checking one of the alternative answers, ranging from: STRONGLY AGREE, AGREE, UNDECIDED, DISAGREE, and STRONGLY DISAGREE.

STRONGLY AGREE indicates that you agree with the statement with almost no exceptions.

AGREE indicates that you agree with the statement with some exceptions.

UNDECIDED indicates that you could either "agree" or "disagree" with the statement with about an equal number of exceptions in either case.

STRONGLY DISAGREE indicates that you disagree with the statement with almost no exceptions.

CORWIN NURSING ROLE CONCEPTION SCALE-Continued

Here is an example:

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
Some graduate nurses in New York hospitals believe that doctors are more professional than nurses.					
A. On the basis of the facts graduate nurses <u>should</u> believe doctors are more professional.	✓				
B. Graduate nurses at my hospital actually <u>do</u> believe that doctors are more professional.				✓	

Suppose that, almost without exception, you agree that nurses <u>should</u> regard doctors as more professional. Then check (✓) the first column (STRONGLY AGREE) for question A.

Suppose that, with some exceptions, you disagree that nurses in your hospital <u>do</u> believe that doctors are more professional. Then check (✓) column four (DISAGREE) after question B.

Be <u>sure</u> you place a check mark (✓) after <u>both</u> questions A and B.

CORWIN NURSING ROLE CONCEPTION SCALE-Continued

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
Bureaucratic Items					
1. One graduate nurse, who is an otherwise excellent nurse except that she is frequently late for work, is not being considered for promotion, even though she seems to get the important work done.					
A. Do you think this is the way it <u>should</u> be in nursing?					
B. <u>Is</u> this the way things are at your hospital?					
2. A head nurse at one hospital insists that the rules be followed in detail at all times, even if some of them do seem impractical.					
A. Do you think this is the way head nurses and supervisors <u>should</u> act?					
B. <u>Is</u> this the way head nurses and supervisors at your hospital actually <u>do</u> act when the occasion arises?					
3. A graduate staff nurse observes another graduate staff nurse, licensed practical nurse, or aide who has worked in the hospital for months violating a very important hospital rule or policy and mentions it to the head nurse or supervisor.					
A. Do you think that this is what graduate nurses <u>should</u> do?					
B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					
4. When a supervisor at one hospital considers a graduate for promotion, one of the most important factors is the length of experience on the job.					
A. Do you think this is what supervisors <u>should</u> regard as important?					
B. <u>Is</u> this what supervisors at your hospital actually <u>do</u> regard as important?					

CORWIN NURSING ROLE CONCEPTION SCALE-Continued

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
5. In talking to acquaintances who aren't in nursing, a graduate nurse gives her opinions about things she disagrees with in the hospital.					
A. Do you think this is what graduate nurses <u>should</u> do?					
B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					
6. A graduate nurse is influenced mainly by the opinions of hospital authorities and doctors when she considers what truly "good" nursing is.					
A. Do you think this is what graduate nurses <u>should</u> consider in forming their opinions?					
B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> consider in forming their opinions?					
<u>Professional Items</u>					
7. One graduate nurse tries to put her standards and ideals about good nursing into practice even if hospital rules and procedures prohibit it.					
A. Do you think that this is what graduate nurses <u>should</u> do?					
B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					
8. One graduate nurse does not do anything which she is told to do unless she is satisfied that it is best for the welfare of the patient.					
A. Do you think that this is what graduate nurses <u>should</u> do?					
B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					

CORWIN NURSING ROLE CONCEPTION SCALE-Continued

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
9. All graduate nurses in a hospital are active members in professional nursing associations, attending most conferences and meetings of the association.					
A. Do you think this <u>should</u> be true of all nurses?					
B. <u>Is</u> this true of nurses at your hospital?					
10. All graduate nurses in a hospital spend, on the average, at least six hours a week reading professional journals and taking refresher courses.					
A. Do you think this <u>should</u> be true of all nurses?					
B. <u>Is</u> this true of nurses at your hospital?					
11. Some nurses try to live up to what they think are the standards of their profession, even if other nurses on the ward or supervisors don't seem to like it.					
A. Do you think that this is what graduate nurses <u>should</u> do?					
B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					
12. Some graduate nureses believe that they can get along very well without a lot of formal education, such as required for a B.S., M.S., or M.A. college degree.					
A. Do you think that this is what graduate nurses <u>should</u> believe?					
B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> believe?					

CORWIN NURSING ROLE CONCEPTION SCALE-Continued

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
13. At some hospitals when a graduate nurse is considered for promotion, one of the most important factors considered by the supervisor is her knowledge of, and ability to use, judgment about nursing care procedures.					
A. Do you think this is what supervisors <u>should</u> regard as important?					
B. <u>Is</u> this what supervisors at your hospital actually <u>do</u> regard as important?					
14. Some hospitals try to hire only graduate nurses who took their training in colleges and universities which are equipped to teach the basic theoretical knowledge of nursing science.					
A. Do you think this is the way it <u>should</u> be in nursing?					
B. <u>Is</u> this the way things are at your hospital?					
<u>Service Items</u>					
15. At one hospital graduate nurses spend more time at bedside nursing than any other nursing task.					
A. Do you think this is the way it <u>should</u> be in nursing?					
B. <u>Is</u> this the way things are at your hospital?					
16. Head nurses and doctors at one hospital allow the graduate nurse to tell patients as much about their physical and emotional condition as the nurse thinks is best for the patient.					
A. Do you think this is the way it <u>should</u> be in nursing?					
B. <u>Is</u> this the way things are at your hospital?					

CORWIN NURSING ROLE CONCEPTION SCALE-Continued

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
17. A doctor orders a patient to sit up in a wheel chair twice a day, but a graduate nurse believes that he is not emotionally ready to sit up; the doctor respects her opinion and changes the treatment. A. Do you think this is the way it <u>should</u> be in nursing? B. <u>Is</u> this the way things are at your hospital?					
18. Doctors and head nurses at the hospital respect and reward nurses who spend time talking with patients in an attempt to understand the hostilities, fear, and doubts which may affect the patient's recovery. A. Do you think this is what doctors and head nurses <u>should</u> regard as important? B. <u>Is</u> this what doctors and head nurses at your hospital actually <u>do</u> regard as important?					
19. A graduate nurse believes that a patient ought to be referred to a psychologist or a public health nurse and tries to convince the doctor of this, even though he is doubtful. A. Do you think this is what graduate nurses <u>should</u> do? B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> when the occasion arises?					
20. At one hospital the nurse's ability to understand the psychological and social factors in the patient's background is regarded as more important than her knowledge of such other nursing skills as how to give enemas, IVs, or how to chart accurately. A. Do you think this is the way it <u>should</u> be in nursing? B. <u>Is</u> this the way things are at your hospital?					

CORWIN NURSING ROLE CONCEPTION SCALE-Continued

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	
21. Some graduate nurses believe that the professional nurses who should be rewarded most highly are the ones who regard nursing as a calling in which one's religious beliefs can be put into practice. A. Do you think that this is what graduate nurses <u>should</u> believe? B. <u>Is</u> this what graduate nurses at your hospital actually <u>do</u> believe?					
22. At some hospitals the graduate nurses who are most successful are the ones who are realistic and practical about their jobs, rather than the ones who attempt to live according to idealistic principles about serving humanity. A. Do you think this is the way it <u>should</u> be in nursing? B. <u>Is</u> this the way things are at your hospital?					

APPENDIX C

JOB DESCRIPTIVE INDEX

JOB DESCRIPTIVE INDEX

Items in Final Version of JDI

Each of the five scales was presented on a separate page.

The instructions for each scale asked the subject to put "Y" beside an item if the item described the particular aspect of his job (e.g., work, pay, etc.), "N" if the item did not describe that aspect, or "?" if he could not decide.

The response shown beside each item is the one scored in the "satisfied" direction for each scale.

	Work
Y	Fascinating
N	Routine
Y	Satisfying
N	Boring
Y	Good
Y	Creative
Y	Respected
N	Hot
Y	Pleasant
Y	Useful
N	Tiresome
Y	Healthful
Y	Challenging
N	On your feet
N	Frustrating
N	Simple
N	Endless
N	Gives sense of accomplishment

	Supervision
Y	Asks my advice
N	Hard to please
N	Impolite
Y	Praises good work
Y	Tactful
Y	Influential
Y	Up-to-date
N	Doesn't supervise enough
N	Quick-tempered
Y	Tells me where I stand
N	Annoying
N	Stubborn
Y	Knows job well
N	Bad
Y	Intelligent
Y	Leaves me on my own
Y	Around when needed
N	Lazy

	People
Y	Stimulating
N	Boring
N	Slow
Y	Ambitious
N	Stupid
Y	Responsible
Y	Fast
Y	Intelligent
N	Easy to make enemies
N	Talk too much
Y	Smart
N	Lazy
N	Unpleasant
N	No privacy
Y	Active
N	Narrow interests
Y	Loyal
N	Hard to meet

	Pay
Y	Income adequate for normal expenses
Y	Satisfactory profit sharing
N	Barely live on income
N	Bad
Y	Income provides luxuries
N	Insecure
N	Less than I deserve
Y	Highly paid
N	Underpaid

	Promotions
Y	Good opportunity for advancement
N	Opportunity somewhat limited
Y	Promotion on ability
N	Dead-end job
Y	Good chance for promotion
N	Unfair promotion policy
N	Infrequent promotions
Y	Regular promotions
Y	Fairly good chance for promotion

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APPENDIX D

CONSENT FORM AND INVITATION TO PARTICIPATE IN THE STUDY

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER
SCHOOL OF NURSING
CONSENT FORM

The Modified Bicultural Training Program is being evaluated by Anne Rossi, a nursing graduate student, under the supervision of Susan Will, RN, MSN. You are requested to participate in this evaluation effort by completing the enclosed questionnaires. These questionnaires will take about 20 minutes total time. All nurses who graduated in 1980 and were employed by this institution in their first job are being asked to participate in the study, whether you were part of the Training Program or not.

Participation in this study is voluntary, and will not jeopardize your employment status in any way. You as an individual will not be identified in any way. All information will be kept confidential and only group scores will be used. Your length of employment will be verified through personnel records but only group data will be used.

I _____, have read the above explanation of the study of the Modified Bicultural Training Program and agree to participate. I have directed my questions to Anne Rossi.

I would like a copy of the study results Y___ N___

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER

SCHOOL OF NURSING

November 1980

Dear

From July to September 1980, new graduate nurses on randomly selected wards at UOHSC Hospital were offered a Modified Bicultural Training Program. The program was designed to decrease the reality shock that most new graduate nurses feel during the transition from the school world to the work world, and to increase the nurse's job satisfaction. Similar programs have been helpful to new graduates and have facilitated their adjustment to their first job and helped increase their job satisfaction.

The Program used at this hospital is somewhat different from other programs. A study is being undertaken to evaluate the effectiveness of this particular program. It is very important that both nurses who were not involved in the program and nurses who were involved in the program fill out the questionnaires for the study to adequately evaluate the program. By participating in the study, you will help to increase our knowledge of the experience of new graduate nurses and help in the decision to repeat the Program or not.

If you have any questions about the study, please give me a call at 246-9647.

Thank you,

Anne Rossi, RN

APPENDIX E

DEMOGRAPHIC DATA SHEET

Demographic Data Sheet

Below each heading please circle the appropriate description:

Age	Sex	Marital Status	Number of Children
20-25	Female	Married	None
25-30	Male	Single	1
30-35		Other	2 or 3
over 35			4 or more

Educational Program	Previous Nursing Experience
B.S. in Nursing	Nurses Aide
Diploma then B.S.N.	Health Related
A.D. then B.S.N.	None
Diploma	
A.D.	

Type of Nursing Care	Are you working on unit of first choice?
Primary Nursing	Yes
Team Nursing	No
Other _____	

Please fill in the appropriate information for each item:

Date hired to work _____

Did you attend the Modified Bicultural Training Program? ____

If yes, how many sessions did you attend? _____

Comments: _____

How long do you now plan to stay at your job? _____

How long did you plan to work in your first job when you started? _____

What do you plan to be doing professionally in two years?

_____

APPENDIX F

DEMOGRAPHIC CHARACTERISTICS OF THE EXPERIMENTAL AND CONTROL GROUPS

Demographic Characteristics of the Experimental and Control Groups

Characteristic		Experimental N = 27		Control N = 17		χ^2
		N	%	N	%	
Age	20-24	16	59.3	7	41.2	$\chi^2 = 5.8$
	25-30	10	37	5	29.4	df = 2
	over 30	1	3.7	5	29.4	NS
Sex	Female	26	96.3	14	82.4	$\chi^2 = 2.45$
	Male	1	3.7	3	17.6	df = 1
						NS
Marital Status	Single	24	88.9	9	52.95	$\chi^2 = 7.14$
	Married	3	11.1	8	47.05	df = 1
						Sig at .01
Educ. Program	BSN	22	81.5	11	64.7	$\chi^2 = 11.7$
	RN or AD	5	18.5	6	35.3	df = 1
						Sig at .01
Prev. Exper.	Aide	16	59.3	9	52.9	$\chi^2 = .285$
	Health Related	2	7.4	1	5.9	df = 2
						NS
	Other	9	33.3	7	41.2	
Unit of 1st Choice	Yes	22	81.5	13	76.5	$\chi^2 = 1.86$
	No	5	18.5	2*	11.8	df = 1
						NS
Type of Nursing	Primary	23	85.2	8	47	$\chi^2 = 2.537$
	Not Prim.	3	11.1*	7*	41.1	df = 1
						NS
Plans in 2 Years	Hosp.	3	11.1	1	5.9	$\chi^2 = 6.4$
	School	17	63	8	47.05	df = 4
	Other Nsg.	1	3.7	5	29.4	NS
	Non Nsg.	1	3.7	0	0	
	Und.	5	18.5	3	17.65	

*Not all subjects answered this question.

APPENDIX G

DEMOGRAPHIC CHARACTERISTICS OF EXPERIMENTAL GROUP A AND EXPERIMENTAL GROUP B

Demographic Characteristics of Experimental Group A and Experimental Group B

Characteristic		Group A (N = 17)		Group B (N = 8)		χ^2
		N	%	N	%	
Age	20-24	13	68.42	5	62.5	$\chi^2 = 8.88$
	25-35	6	31.57	3	37.5	df = 1
						NS
Sex	Female	18	94.7	7	87.5	$\chi^2 = .429$
	Male	1	5.3	1	12.5	df = 1
						NS
Marital Status	Single	14	73.68	7	87.5	$\chi^2 = .621$
	Married	5	26.31	1	12.5	df = 1
						NS
Education	BSN	15	78.94	7	87.5	$\chi^2 = .272$
	AD + Diploma	4	21.05	1	12.5	df = 1
						NS
Previous Experience	Yes	13	68.42	6	75	$\chi^2 = .116$
	No	6	31.57	2	25	df = 1
						NS
Unit of first choice	Yes	17	89.47	6	75	$\chi^2 = .093$
	No	2	10.52	2	25	df = 1
						NS
Type of Nursing	Primary	16	84.42	7	87.5	$\chi^2 = 4.82$
	Nonprimary	3	15.78	1	12.5	df = 1
						NS
Plans in 2 years	Hospital	2	10.52	1	12.5	$\chi^2 = 8.0979$
	School	12	63.15	5	62.5	df = 3
	Other Nsg	2	10.52	0	0	NS
	Non nursing or undecided	3	15.78	2	25	

APPENDIX H

DEMOGRAPHIC CHARACTERISTICS OF GROUP C SUBGROUPS

Demographic Characteristics of Group C Subgroups

Characteristic		Group C Who Remained Employed (N = 11)	Group C Who Resigned Employment (N = 6)	χ^2
Age	20-24	6	2	$\chi^2 = 2.039$
	25-30	3	1	df = 3
	30-35	1	2	p = .5681
	35+	1	1	
Sex	Female	9	5	$\chi^2 = .006$
	Male	2	1	df = 1
				p = .93551
Marital Status	Married	7	2	$\chi^2 = 2.682$
	Single	3	4	df = 2
	Unknown	1	0	p = .26091
Education	BSN	5	6	$\chi^2 = 5.057$
	AD	6	0	df = 1
				p = .02323
Previous Experience	Yes	7	3	$\chi^2 = .019$
	No	4	2	df = 1
				p = .88428
Unit of first preference	Yes	9	4	$\chi^2 = .007$
	No	2	1	df = 1
				p = .92869
Type of Nursing	P	4	4	$\chi^2 = 2.967$
	T	3	0	df = 2
	O	4	1	p = .22
Plans in 2 years	Hospital	5	4	$\chi^2 = 2.0148$
	School	3	2	df = 3
	Non nursing	1	0	p = .5732
	Undecided	2	0	

AN ABSTRACT OF THE THESIS OF

ANNE ROSSI

For the MASTER OF NURSING

Date of Receiving this Degree: June 12, 1981

Title: EFFECTS OF A MODIFIED BICULTURAL TRAINING PROGRAM ON NEW GRADUATE NURSES

Approved: [redacted]

Susan Will, R.N., M.S.N., Thesis Advisor

The exodus of nurses from nursing has become a matter of concern to the nursing profession. The new graduate nurse in her initial employment is at risk to drop out of nursing. A Modified Bicultural Training Program (MBTP) to assist new graduate nurses in the transition from the school world to the work world was developed from the Kramer-Schmalenberg Bicultural Training Program.

The subjects were 53 new graduate nurses who began employment in May, June, and July 1980. Hospital units on which these new graduates worked were randomly assigned to either the experimental or control groups. The experimental group was 33 new graduates from twelve wards while the control group was 20 graduates from six wards.

It was hypothesized that the experimental group would experience less role deprivation, greater job satisfaction, and higher employment retention rates than the control group.

Data were collected 5-1/2 and 6-1/2 months after employment with two interview instruments, the Corwin Nursing Role Conception Scale and the Job Descriptive Index, and a demographic data sheet. Personnel records were examined 8 months after employment for employment retention data. The questionnaires and demographic data sheets were returned by 83% of the subjects.

Major findings of the study were:

1. New graduate nurses who attended a MBTP showed less role deprivation than graduates who did not attend the program.

2. The job satisfaction was not tested.

3. New graduate nurses who attended a MBTP had a higher employment retention rate (95%) than new graduates who did not attend the program (65%).

4. New graduates who attend a MBTP may be more able to practice according to their professional and service values.

5. Job satisfaction data were inadequate for the required comparison. Baccalaureate nurses may be more likely to suffer role deprivation and therefore be more in need of a MBTP than associate degree nurses.